to avoid a youngster's possible death, not to divert them from a pathway into chronicity. The COSI-CAPS multicentre study of adolescent psychiatric hospitalisation is particularly instructive in throwing light on how risk in these patients is constructed.[5] Anorexia nervosa was the single most frequent diagnosis at admission (108/403 patients); only a sixth of those patients were detained but two-thirds nevertheless were considered at risk to themselves. The cohort was disproportionally White, female, aged 15–17, living at home, and with an over-representation of single parents. The body mass index (BMI) of all patients with anorexia on admission was within the ICD-10 diagnostic threshold (of 16, for adults), but most were not far below it (14.8; s.d. = 1.8, $n = 108$, 95% CI 14.3–15.4). Since the normal range of BMI for adolescents aged 15–17 is also less than for adults, it seemed that a relatively low threshold for admission was occurring.

This study had usefully included a number of independently provided units (private hospitals), accounting for a third of their non-eating disorder cases. Such youngsters were significantly less likely to have been receiving any psychiatric treatment before admission ($P < 0.001$), emphasising the part community concerns play in hastening hospitalisation. In short, the second lesson taught me that risk often seems to have been 'socially constructed' rather than medically evidenced, a concept developed by Mary Douglas, the distinguished anthropologist who died last year. This concept has also been important for the support I provide to clinical practice in remote and rural communities.

Robinson posed questions for further research, for example: (1) how to manage severely physically ill patients who resist nutritional treatment; and (2) what is the best model of cooperative care between medical and specialist psychiatric services. In my experience, any request for medical care of these patients must be very carefully defined, usually circumscribed to stabilising metabolic problems. Nasogastric refeeding is not required for that, however self-evident the case might seem for rapidly improving poor nutritional state (it does not directly stabilise a patient's illness and might instead produce other medical problems, as I have observed and Robinson has indicated, as well as to adversely affect the therapeutic alliance).

Addressing his question on 'how to manage severely physically ill patients who resist nutritional treatment', my experience suggests that it is important to distinguish between what is being 'resisted': normalising metabolism, restoration of metabolic rate in particular (since this directly affects cognition, mood and exercise intolerance), or the additional caloric requirement to improve absolute weight gain or BMI, which frighten these patients. Teenagers often develop anorexia nervosa in response to otherwise unaddressed, perhaps previously unrecognised, psychological distress (problems that might have first resulted in compensatory overeating and excessive weight gain). So nutritional treatment addressing metabolic rate, and thus general well-being, is a far more readily agreed first treatment goal between the patient and their professional carer. Securing collaborative care is an unarguable vital step towards eventual recovery.

1 Robinson P. Avoiding deaths in hospital from anorexia nervosa: the MARSIPAN project. *Psychiatrist* 2012; **36**: 109–13.

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3 Rothery DJ, Wrate RM, McCabe R, Aspin J, Bryce G. Treatment goal-planning: outcome findings of a British prospective multi-centre study of adolescent inpatient units. *Eur Child Adolesc Psychiatry* 1995: **4**: 209–21.

4 Reas DL, Kjelsås E, Heggestad T, Eriksen L, Nielsen S, Gjertsen F, et al. Characteristics of anorexia nervosa-related deaths in Norway (1992–2000): data from the National Patient Register and Causes of Death Register. *Int J Eat Disord* 2005; **37**: 181–7.

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Author's response: I am grateful to Dr Wrate for raising the issues he has. I would point out, first, that the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) report[1] was intended for clinicians caring for adult patients over 18 with severe anorexia nervosa. It was clear during the preparation of MARSIPAN that a further document for children and adolescents was required. The work was done and the junior MARSIPAN report[2] is the result. I think that the main issue raised by Dr Wrate, namely the appropriateness or otherwise of specialist hospital care for children and adolescents with anorexia nervosa, needs to be addressed by a child and adolescent psychiatrist such as those involved in the junior MARSIPAN report. However, I should be grateful if I could comment on some of the other issues discussed in the letter.

Assessing whether a person is at a risk high enough to warrant hospital treatment is one such problem. In adults, current opinion suggests that a body mass index (BMI) of < 13 kg/m^2, electrocardiographic abnormalities, low potassium (especially < 3.0 mmol) and severe anorexic myopathy constitute a serious threat to life. In one study, the patients who died from malnutrition had BMI between 9.1 and 12.9.[3] In adolescents, junior MARSIPAN recommends that a BMI < 0.4th percentile indicates high ('red') risk. This turns out to be more conservative, as a BMI at the 0.4th percentile in a 15-year-old is 15. I hope that my child and adolescent psychiatrist or physician colleagues will take the opportunity to give a view on this. From my practice, the most reliable sign that a patient requires admission is when I feel my own heart sinking. This usually accords with the high-risk parameters in the patient, quoted in the MARSIPAN report.

Dr Wrate correctly notes that the past two decades saw a decline in death rates for anorexia nervosa, but argues that this is due to the fact that treatment is now more effective and introduced earlier, not necessarily because it is hospital based. It is uncertain whether patients presenting with very high risk would have similar survival rates outside hospital with community care. The Scottish Anorexia Nervosa Intensive Treatment Team (ANITT; www.anitt.org.uk) provides community care for adults of very low weight, but no evaluation of that or any other similar service has been published, nor are there randomised trials of care in this very high-risk group of (adult) patients.

On the question of chronicity, Dr Wrate identifies progressive loss of bone mineralisation as the only significant

medical complication of adolescent anorexia nervosa. However, I am aware of many reports of serious complications such as irreversible failure of linear growth, irreversible failure of breast development, and cardiac abnormalities in this patient group.[4] Again, the views of my colleagues treating younger patients would be appreciated.

Another interesting point raised by Dr Wrate is that with regard to young people with anorexia nervosa, risk may be 'socially constructed'. The implication is that if a risk is socially constructed rather than medically evidenced, it is related to the needs of individuals and systems such as the family and hospitals rather than a real risk of death. This may be true in many cases, especially if the usual risk factors are not too seriously impaired. However, I think it would be dangerous to apply it to the most seriously ill, for example a patient with a BMI of 10.

Finally, there is the issue of patients resisting nasogastric feeding as opposed to treatment as such. This is a complicated matter. The act of admitting a patient to a specialist eating disorders unit may well engender fury in the patient and a determination not to gain weight. On the other hand, the admission may have been appropriate because of their dire physical state. In adult eating disorder services there is varying opinion about whether a seriously ill patient ever requires nasogastric feeding. If a patient resists eating, as may be the case, the option is to provide nutrition against their wishes, often under the Mental Health Act 1983. This might involve forcing the patient to eat by restraining them and pushing food into their mouth. This may be ineffective, or so aversive to staff that nasogastric feeding may be preferred. Some have said that skilled nursing can always result in a patient accepting food, thereby avoiding nasogastric feeding. I suspect that the situation in which a patient's life would be lost if forced feeding were not done is more commonly encountered in adults, as suggested by Dr Wrate. However, when it does occur, clinicians may be forced into more and more coercive treatment. Occasionally, such treatment may not be short lived and there are, at present, several adult patients in units around the UK receiving forced nutrition, under the Mental Health Act, by nasogastric or percutaneous endoscopic gastrostomy (PEG) feeds for periods which can run to several years. This may be very aversive to patients, staff and relatives, not to mention the enormous cost to the National Health Service (£1000 per day is not unusual in this situation), and merits audit and research.

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2 Royal College of Psychiatrists. *Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa: Report from the Junior MARSIPAN Group* (College Report CR168). Royal College of Psychiatrists, 2012.

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4 Katzman DK. Medical complications in adolescents with anorexia nervosa: a review of the literature. *Int J Eat Disord* 2005; **37** (suppl): S52–9; S87–9.

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From Rabone to reality

Large *et al*[1] draw valuable attention to the flawed information on which the Supreme Court based its decision to uphold the appeal of Rabone against the Pennine Care NHS Foundation Trust,[2] identifying a number of well-recognised biases that prompted the judges to overvalue the risk of suicide by a factor of 40.

Another significant bias that is often overlooked in *post-hoc* analyses of serious untoward events concerns the value framework of the assessor, described with precision by Kahneman & Tversky.[3] Expert witnesses, although owing a primary duty to provide valid information to the court, are nevertheless instructed by legal professionals who are obliged to adopt either a defensive or offensive stance given the inherently adversarial nature of the legal system. The differing value frameworks that this provides are evident in the discrepancy in the evaluations of the 'immediate risk' posed by Ms Rabone of between 70% (as estimated by the claimants) and 20% (as estimated by the defendants). That such a spectacular discrepancy might point to the meaninglessness of a numerical approach seems to have escaped consideration.

Instead, deferring to the expert status of the witnesses, the Court appears to have dealt with this variance by taking the most conservative figure as the valid baseline for their consideration.

The judgments derived from such flawed considerations do little to help those who daily face the difficult task of attempting to 'second guess' (i.e. to anticipate) the intentions and behaviours of a mind disturbed by what the Court termed 'a recurrent depressive disorder'.

Most mental health professionals appear to agree that a sincere wish to die is one of the less common reasons for the issue of a suicidal threat.[4] Unless such considerations are taken into account by those who define the laws by which our best practices are shaped and defined, misinformed legalism will continue to exert an increasingly demoralising effect on those who do their best in a very difficult situation.

The present judgment will, in all likelihood, lead to an increase in the detention of individuals with depression against their wishes in services that, especially in the current social and economic climate, may not be as well equipped to reduce risk (in either the short or long term) as either judges or the general public may like to think. Practical measures derived from ethics and common sense may be of more help here than actuarial procedures.

Ms Rabone appeared to had given a clear commitment not to self-harm at the time of her departure. It is unclear how much weight was given to this fact by the Court, but it presumably carried considerable weight in the mind of the unfortunate psychiatrist who granted her informal leave. A useful standard by which to judge the wisdom of such a decision might involve contemporary recording of unequivocal evidence of future orientation. At its simplest, this could comprise clear recording of the patient's agreement not to act on impulses of self-harm, accepted as valid regardless of the private discomfort of those involved, alongside an equally clear recording of the patient's agreement to return to care at a clearly agreed place and point in time. All individuals failing these tests should be subject to consideration for legal detention.