Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa, and related eating disorders

NICE guideline

Second draft for consultation, September, 2003

If you wish to comment on the recommendations, please make your comments on the full version of the draft guideline.
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Key recommendations

Anorexia nervosa

- Most adults with anorexia nervosa should be managed on an outpatient basis with psychological treatment provided by a healthcare professional competent in the psychological treatment and assessment of physical risk of people with eating disorders.

- Patients with anorexia nervosa requiring inpatient treatment should normally be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring, in combination with psychosocial interventions.

- Family interventions focused explicitly on eating disorders should be offered to children and adolescents with anorexia nervosa.

Bulimia nervosa

- Cognitive behaviour therapy for bulimia nervosa (CBT-BN), a specifically adapted form of CBT, should be offered to most adults with bulimia nervosa.

- As an alternative or additional first step to using an evidence-based self-help programme, adults with bulimia nervosa may be offered a trial of an antidepressant drug.

- Older adolescents with bulimia nervosa may be treated with CBT-BN adapted as needed to suit their age, circumstances and level of development.

Atypical eating disorders

- In the absence of evidence to guide the management of atypical eating disorders (eating disorders not otherwise specified) other than binge eating disorder, it is recommended that the clinician considers following
the guidance on the treatment of the eating problem that most closely resembles the individual patient’s eating disorder.

- Cognitive behaviour therapy for binge eating disorder (CBT-BED), a specifically adapted form of CBT, should be offered to adults with binge eating disorder.
The following guidance is evidence based. The grading scheme used for the recommendations (A, B, C) is described in Appendix A; a summary of the evidence on which the guidance is based is provided in the full guideline (see Section 5).

1 Guidance

This guideline makes recommendations for the identification, treatment and management of anorexia nervosa, bulimia nervosa, and atypical eating disorders (including binge eating disorder) in primary, secondary and tertiary care.

Section 1.1 contains the recommendations that apply across all three conditions.

1.1 Care across all conditions

Certain elements of care are common to all the eating disorders covered in this guideline. They include effective assessment, the coordination of care, the involvement of patients and carers, and the provision of good and appropriate information to patients and carers.

1.1.1 Assessment and coordination of care

1.1.1.1 Assessment of people with eating disorders should be comprehensive and include medical, psychological and social needs, and a comprehensive assessment of risk to self. [C]

1.1.1.2 The level of risk to the patient’s mental and physical health should be monitored as treatment progresses as it may increase – for example, following weight gain or at times of transition in cases of anorexia nervosa. [C]

1.1.1.3 For people with eating disorders presenting in primary care, GPs should take responsibility for the initial assessment and the initial coordination of care. This includes the determination of the need for emergency medical or psychiatric assessment. [C]
1.1.4 Where management is shared between primary and secondary care, there should be clear agreement between individual healthcare professionals on the responsibility for monitoring of patients with eating disorders. This agreement should be in writing and should be shared with the patient and, where appropriate, families and carers. [C]

1.1.2 Providing good information and mutual support

The provision of information and support is important in promoting understanding and collaboration between patients, their families and carers and healthcare professionals.

1.1.2.1 Patients and carers should be provided with appropriate education and information on the nature, course and treatment of eating disorders. [C]

1.1.2.2 In addition to the provision of high quality information, family and carers may be informed of self-help groups and support groups, and offered the opportunity to participate in such programmes where they exist. [C]

1.1.2.3 Healthcare professionals should acknowledge the ambivalence about treatment of many people with eating disorders and the consequent demands and challenges this presents for helping them. [C]

1.1.3 Getting help early

In anorexia nervosa and bulimia nervosa, there can be serious long-term consequences to a delay in obtaining treatment.

1.1.3.1 People with eating disorders seeking help should be assessed and receive treatment at the earliest opportunity. [C]

1.1.3.2 Whenever possible patients should be engaged and treated before reaching severe emaciation. This requires both early identification
and intervention. Effective monitoring and engagement of patients at severely low weight or with falling weight should be a priority. (C)

1.1.4 Special considerations for children and adolescents

1.1.4.1 Healthcare professionals assessing children and adolescents with eating disorders should be alert to indicators of abuse (emotional, physical and sexual) and should remain so throughout treatment. [C]

1.1.4.2 The right to confidentiality of children and adolescents with eating disorders should be respected. [C]

1.1.4.3 Healthcare professionals working with children and adolescents with eating disorders should familiarise themselves with national guidelines and their employers’ policies in the area of confidentiality. [C]

1.1.5 Identification and management of eating disorders in primary care and non-mental health settings

Primary care and non-specialist mental health settings are commonly where people with eating disorders first present. Healthcare professionals, in particular GPs, working in these areas need to be alert to the presence of eating disorders and take appropriate steps to screen and identify individuals with eating disorders.

1.1.5.1 Target groups for screening questions should include young women with low body mass index (BMI) compared with age norms, patients consulting with weight concerns who are not overweight, menstrual disturbances or amenorrhoea, gastrointestinal symptoms, patients with physical signs of starvation or repeated vomiting and children with poor growth. [C]

1.1.5.2 When screening for eating disorders one or two simple questions should be considered for use with specific target groups (for
example, “Do you think you have an eating problem?” and “Do you worry excessively about your weight?”). [C]

1.1.5.3 Young women with type 1 diabetes and poor treatment adherence should be screened and assessed for the presence of an eating disorder. [C]

1.1.5.4 In anorexia nervosa, although weight and BMI are important indicators they should not be considered the sole indicators of physical risk (as they are unreliable in adults and especially in children). [C]

1.1.5.5 In assessing whether a person has anorexia nervosa, attention should be paid to the overall clinical assessment (repeated over time), including rate of weight loss, growth rates in children, objective physical signs and appropriate laboratory tests. [C]

1.1.6 Management of eating disorders in primary care

Primary care has a particularly important role in the management of those with enduring eating disorders who are not in contact with specialist services.

1.1.6.1 Patients with enduring anorexia nervosa not under the care of a specialist service should be offered an annual physical and mental health review by their GP. [C]

1.2 Anorexia nervosa

1.2.1 Psychological interventions for anorexia nervosa

Psychological interventions are a key element in the management of anorexia. There is evidence for the effectiveness of a number of interventions and patient preference will be a key factor in choosing the most appropriate one. For children and adolescents the involvement of family and carers will be important whatever the nature of the intervention. The delivery of psychological interventions should be accompanied by regular monitoring of a patient’s physical state including weight and specific indicators of increased physical risk.

Eating disorders: NICE guideline (September, 2003)
Common elements of the psychological treatment of anorexia nervosa

1.2.1.1 Therapies to be considered for the psychological treatment of anorexia nervosa include cognitive analytical therapy (CAT), cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT), focal psychodynamic therapy and family interventions focused explicitly on eating disorders. [C]

1.2.1.2 Patient and, where appropriate, carer preference should be taken into account in deciding which psychological treatment is to be offered. [C]

1.2.1.3 The aims of psychological treatment should be to encourage weight gain and healthy eating, reduce other eating-disorder-related symptoms, and to facilitate psychological and physical recovery. [C]

Outpatient psychological treatments for adults in first episode and later episodes

1.2.1.4 Most adults with anorexia nervosa should be managed on an outpatient basis, with psychological treatment provided by a healthcare professional competent in the psychological treatment and assessment of physical risk of people with eating disorders. [C]

1.2.1.5 Outpatient psychological treatment for anorexia nervosa should normally be of at least 6 months’ duration. [C]

1.2.1.6 For adults with anorexia nervosa, if during outpatient psychological treatment there is significant deterioration, or the completion of an adequate course of outpatient psychological treatment does not lead to any significant improvement, more intensive forms of treatment (for example, a move from individual therapy to combined individual and family work; or day-care or inpatient care) should be considered. [C]
1.2.1.7 Dietary counselling should not be provided as the sole treatment for anorexia nervosa. [C]

Psychological aspects of inpatient care

Psychological treatment is often a key element of an inpatient stay but evidence for what kinds of treatment or approaches to treatment are effective is limited.

1.2.1.8 For inpatients with anorexia nervosa, a structured symptom-focused treatment regimen with the expectation of weight gain should be provided in order to achieve weight restoration. It is important to carefully monitor the patient’s physical status during refeeding. [C]

1.2.1.9 Psychological treatment should be provided which has a focus both on eating behaviour and attitudes to weight and shape, and on wider psychosocial issues with the expectation of weight gain. [C]

1.2.1.10 Rigid inpatient behaviour modification programmes should not be used in the management of anorexia nervosa. [C]

Post-hospitalisation treatment in adults with anorexia nervosa

For patients with anorexia nervosa following discharge from hospital it is usually necessary to extend the duration of psychological treatment over that normally provided to those who have not been hospitalised.

1.2.1.11 Following inpatient weight restoration, people with anorexia nervosa should be offered outpatient psychological treatment that focuses both on eating behaviour and attitudes to weight and shape, and on wider psychosocial issues, with regular monitoring of both physical and psychological risk. [C]

1.2.1.12 The length of outpatient psychological treatment following inpatient weight restoration should typically be of at least 12 months’ duration. [C]
Children and adolescents with anorexia nervosa

Special considerations are needed in the treatment of children and adolescents. The involvement of families and other carers is particularly important here.

1.2.1.13 Family interventions focused explicitly on eating disorders should be offered to children and adolescents with anorexia nervosa. [B]

1.2.1.14 Children and adolescents with anorexia nervosa should be offered individual appointments with a healthcare professional separate from those with their family members or carers. [C]

1.2.1.15 The therapeutic involvement of siblings and other family members should be considered in all cases because of the effects of anorexia nervosa on other family members. [C]

1.2.1.16 In children and adolescents with anorexia nervosa the need for inpatient treatment and the need for urgent weight restoration should be balanced alongside the educational and social needs of the young person. [C]

1.2.2 Pharmacological interventions for anorexia nervosa

There is a very limited evidence base for the pharmacological treatment of anorexia nervosa. A range of drugs may be used in the treatment of comorbid conditions but caution should be exercised in their use given the physical vulnerability of many people with anorexia nervosa.

1.2.2.1 Medication should not be used as the sole or primary treatment for anorexia nervosa. [C]

1.2.2.2 Caution should be exercised in the use of medication for comorbid conditions such as depression or obsessive–compulsive disorder, as many of these features may resolve with weight gain alone. [C]

1.2.2.3 When medication is used to treat people with anorexia nervosa, the side effects of drug treatment (in particular, cardiac side effects),
should be carefully considered and discussed with the patient because of the compromised cardiovascular function of many people with anorexia nervosa. [C]

1.2.2.4 Healthcare professionals should be aware of the risk of drugs that prolong the QTc interval; for example, antipsychotics, tricyclic antidepressants, macrolide antibiotics, and some antihistamines. [C]

1.2.2.5 In patients with anorexia nervosa with borderline/prolonged QTc interval the prescription of drugs with side effects that may compromise cardiac functioning should be avoided. [C]

1.2.2.6 If the prescription of medication that may compromise cardiac functioning is essential, ECG monitoring should be undertaken. [C]

1.2.2.7 All patients with a diagnosis of anorexia nervosa should have an alert placed in their prescribing record concerning the risk of side effects. [C]

1.2.3 Physical management of anorexia nervosa

Anorexia nervosa carries considerable risk of serious physical morbidity. Awareness of the risk, careful monitoring and, where appropriate, close liaison with an experienced physician are important in the management of the physical complications of anorexia nervosa.

Managing weight gain

1.2.3.1 In most patients with anorexia nervosa an average weekly weight gain of 0.5–1 kg in inpatient settings and 0.5 kg in outpatient settings should be an aim of treatment. This requires about 3500 to 7000 extra calories a week. [C]

1.2.3.2 Healthcare professionals should ensure for children and adolescents with anorexia nervosa that once a healthy weight is reached the increased energy and necessary nutrients are available in the diet to support growth and development. [C]
1.2.3.3 Regular physical monitoring, and in some cases treatment with multivitamin/multimineral supplement in oral form, is recommended for people with anorexia nervosa during both inpatient and outpatient weight restoration. [C]

1.2.3.4 In the nutritional management of children and adolescents with anorexia nervosa, carers should be included in any dietary education or meal planning. [C]

1.2.3.5 Total parenteral nutrition should not be used for people with anorexia nervosa, unless there is gastrointestinal dysfunction. [C]

**Managing risk**

1.2.3.6 Healthcare professionals should monitor physical risk in patients with anorexia nervosa and, where this leads to the identification of increased physical risk, the frequency of the monitoring and nature of the investigations should be adjusted accordingly. [C]

1.2.3.7 People with anorexia nervosa and their carers should be informed if the risk to their physical health is high. [C]

1.2.3.8 The involvement of a physician or paediatrician with expertise in the treatment of medically at-risk patients with anorexia nervosa should be considered for all individuals who are medically at-risk. [C]

1.2.3.9 Pregnant women with either current or remitted anorexia nervosa should be considered for more intensive prenatal care to ensure adequate prenatal nutrition and fetal development. [C]

1.2.3.10 Oestrogen administration should not be used to treat bone density problems in children and adolescents as this may lead to premature fusion of the epiphyses. [C]
Feeding against the will of the patient

1.2.3.11 Feeding against the will of the patient should be an intervention of last resort in the care and management of anorexia nervosa. [C]

1.2.3.12 Feeding against the will of the patient is a highly specialised procedure requiring expertise in the care and management of those with severe eating disorders and the physical complications associated with it. This should only be done in the context of the Mental Health Act 1983 or Children Act 1989. [C]

1.2.3.13 When making the decision to feed against the will of the patient the legal basis for any such action must be clear. [C]

1.2.4 Service interventions

This section considers those aspects of the service system relevant to the treatment and management of anorexia nervosa. It pays particular attention to the use of inpatient services and the particular challenges in the inpatient management of children and adolescents with anorexia nervosa.

1.2.4.1 Inpatient treatment should be considered for people with anorexia nervosa whose disorder is associated with high or moderate physical risk. [C]

1.2.4.2 Patients with anorexia nervosa requiring inpatient treatment should normally be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring, in combination with psychosocial interventions. [C]

1.2.4.3 Inpatient treatment or day patient treatment should be considered for people with anorexia nervosa whose disorder has not improved with appropriate outpatient treatment, or for whom there is a significant risk of suicide or severe self-harm. [C]

1.2.4.4 Healthcare professionals without specialist experience, or in situations of uncertainty, should consider seeking advice from an appropriate specialist when considering a formal admission for a...
patient with anorexia nervosa, regardless of the age of the patient. [C]

1.2.4.5 Healthcare professionals managing patients with anorexia nervosa, especially that of the binge–purging sub-type, should be aware of the increased risk of self-harm and suicide, particularly at times of transition between services or service settings. [C]

1.2.5 Special considerations for children and adolescents

1.2.5.1 Admission of children and adolescents with anorexia nervosa should be to age-appropriate facilities (with the potential for separate children and adolescent services), which have the capacity to provide appropriate educational and related activities. [C]

1.2.5.2 When a young person with anorexia nervosa refuses treatment which is deemed essential, consideration should be given to the use of the Mental Health Act 1983 or the right of those with parental responsibility to override the young person’s refusal. [C]

1.2.5.3 Continuing treatment relying indefinitely on parental consent should be avoided. It is recommended that the legal basis under which treatment is being carried out should be recorded in the patient’s case notes in all cases but particularly in the case of children and adolescents. [C]

1.2.5.4 For children and adolescents with anorexia nervosa, where issues of consent to treatment are highlighted, healthcare professionals should consider seeking a second opinion. [C]

1.2.5.5 If the patient with anorexia nervosa and those with parental responsibility refuse treatment, and treatment is deemed to be essential, legal advice should be sought in order to consider proceedings under the Children Act 1989. [C]
1.3 Bulimia nervosa

1.3.1 Psychological interventions

Psychological interventions are the key element in the treatment and management of bulimia nervosa. There is evidence for the effectiveness of specific psychological interventions and some evidence for the use of self-help as part of a stepped-care approach.

1.3.1.1 As a possible first step, patients with bulimia nervosa should be encouraged to follow an evidence-based self-help programme. [B]

1.3.1.2 Healthcare professionals should consider providing direct encouragement and support to patients undertaking an evidence-based self-help programme as this may improve outcomes. This may be sufficient treatment for a limited subset of patients. [B]

1.3.1.3 Cognitive behaviour therapy for bulimia nervosa (CBT-BN), a specifically adapted form of CBT, should be offered to most adults with bulimia nervosa. [A]

1.3.1.4 An adequate course of CBT-BN should normally be of 16 to 20 sessions over 4 to 5 months. [A]

1.3.1.5 Older adolescents with bulimia nervosa may be treated with CBT-BN adapted as needed to suit their age, circumstances and level of development. [C]

1.3.1.6 When people with bulimia nervosa have not responded to or do not want CBT, other psychological treatments should be considered. [B]

1.3.1.7 Interpersonal psychotherapy should be considered as an alternative to CBT, but patients should be informed it takes 8–12 months to achieve results comparable to CBT. [B]
1.3.2 Pharmacological interventions

There is good evidence that pharmacological treatment can benefit patients with bulimia nervosa in the short term but very little is known about the maintenance of these beneficial effects. Antidepressants may be used alone or in combination with psychological treatment to increase the likelihood of a response to treatment.

1.3.2.1 As an alternative or additional first step to using an evidence-based self-help programme, adults with bulimia nervosa may be offered a trial of an antidepressant drug. [B]

1.3.2.2 Patients should be informed that antidepressant drugs can reduce the frequency of binge eating and purging, but the long-term effects are unknown. Any beneficial effects will be rapidly apparent. [B]

1.3.2.3 Selective serotonin reuptake inhibitors (SSRIs) (specifically fluoxetine) are the drugs of first choice for the treatment of bulimia nervosa in terms acceptability, tolerability and reduction of symptoms. [C]

1.3.2.4 For people with bulimia nervosa, the effective dose of fluoxetine is higher than for depression (60 mg daily). [C]

1.3.2.5 For people with bulimia nervosa who are not responding to CBT-BN, the addition of an antidepressant drug should be considered as this may improve outcome. [B]

1.3.2.6 No drugs, other than antidepressants, are recommended for the treatment of bulimia nervosa. [B]

1.3.3 Management of physical aspects of bulimia nervosa

Patients with bulimia nervosa can experience physical problems as a result of a range of behaviours associated with bulimia nervosa. Awareness of the risks and careful monitoring should be a concern of all healthcare professionals working with people with this disorder.
1.3.3.1 Patients with bulimia nervosa who are vomiting frequently or taking large quantities of laxatives (especially if they are also underweight) should have their fluid and electrolyte balance assessed. [C]

1.3.3.2 When electrolyte disturbance is detected, it is usually sufficient to focus on eliminating the behaviour responsible. In the small proportion of cases where supplementation is required to restore electrolyte balance, oral rather than intravenous administration is recommended, unless there are problems with gastrointestinal absorption. [C]

1.3.3.3 Where laxative abuse is present, patients should be advised to gradually reduce laxative use and informed that laxative use does not significantly reduce calorie absorption. [C]

1.3.3.4 Treatment of both subthreshold and clinical cases of bulimia nervosa in people with diabetes is essential because of the greatly increased physical risk in this group. [C]

1.3.3.5 Patients with type 1 diabetes and bulimia nervosa should have intensive regular physical monitoring as they are at high risk of retinopathy and other complications. [C]

1.3.3.6 Pregnant women with bulimia nervosa require careful monitoring throughout the pregnancy and in the post-partum period. [C]

1.3.4 Dental care

It should be noted that patients with an eating disorder other than bulimia nervosa are also at risk of poor dental health if vomiting is a symptom of the disorder.

1.3.4.1 Patients with bulimia nervosa should have regular dental reviews. [C]

1.3.4.2 Patients who are vomiting should be given appropriate advice on dental hygiene including avoiding brushing after vomiting, rinsing
with a non-acid mouth wash after vomiting, and measures to reduce an acid oral environment (for example, limiting acidic foods). [C]

1.3.5 Service interventions

The great majority of patients with bulimia nervosa can be treated as outpatients. There is a very limited role for the inpatient treatment of bulimia nervosa. This is primarily concerned with the management of suicide risk or severe self-harm.

1.3.5.1 The great majority of patients with bulimia nervosa should be treated in an outpatient setting. [C]

1.3.5.2 For patients with bulimia nervosa who are at risk of suicide or severe self-harm, admission as an inpatient or day patient, or the provision of more intensive outpatient care, should be considered. [C]

1.3.5.3 Psychiatric admission for people with bulimia nervosa should normally be undertaken in a setting with experience of managing this disorder. [C]

1.3.5.4 Healthcare professionals should be aware that patients with bulimia nervosa who have poor impulse control, notably substance misuse, may be less likely to respond to a standard programme of treatment. As a consequence treatment should be adapted to the problems presented. [C]

1.4 Treatment and management of atypical eating disorders including binge eating disorder

Binge eating disorder (BED), has a growing evidence base relating to psychological treatment and self-help approaches. Little is known about the effective treatment of the comorbid obesity that often accompanies binge eating disorder.
1.4.1 Psychological treatments for binge eating disorder

1.4.1.1 As a possible first step, patients with binge eating disorder should be encouraged to follow an evidence-based self-help programme. [B]

1.4.1.2 Healthcare professionals should consider providing direct encouragement and support to patients undertaking an evidence-based self-help programme as this may improve outcomes. This may be sufficient treatment for a limited subset of patients. [B]

1.4.1.3 Cognitive behaviour therapy for binge eating disorder (CBT-BED), a specifically adapted form of CBT, should be offered to adults with binge eating disorder. [A]

1.4.1.4 Other psychological treatments (interpersonal psychotherapy for binge eating disorder and modified dialectical behaviour therapy) may be offered to adults with persistent binge eating disorder. [B]

1.4.1.5 Patients should be informed that all psychological treatments for binge eating disorder have a limited effect on body weight. [A]

1.4.1.6 When providing psychological treatments for patients with binge eating disorder consideration should be given to the provision of concurrent or consecutive interventions focusing on the management of any comorbid obesity. [C]

1.4.1.7 Suitably adapted psychological treatments should be offered to adolescents with persistent binge eating disorder. [C]

1.4.2 Pharmacological interventions for binge eating disorder

1.4.2.1 As an alternative or additional first step to using an evidence-based self-help programme or a behavioural weight control programme, consideration should be given to offering a trial of a SSRI antidepressant drug to patients with binge eating disorder. [B]
1.4.2.2 Patients with binge eating disorders should be informed that SSRIs can reduce binge eating, but the long-term effects are unknown. Antidepressant drug treatment may be sufficient treatment for a limited subset of patients. [B]

1.4.3 General treatment of atypical eating disorders

1.4.3.1 In the absence of evidence to guide the management of atypical eating disorders (eating disorders not otherwise specified) other than binge eating disorder, it is recommended that the clinician considers following the guidance on the treatment of the eating problem that most closely resembles the individual patient’s eating disorder. [C]

2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, following a period of consultation; it is available from www.nice.org.uk/Docref.asp?d=22703

This guideline is relevant to people aged 8 years and over with anorexia nervosa, bulimia nervosa or related conditions and to all healthcare professionals involved in the help, treatment and care of people with eating disorders and their carers. These include:

- Professional groups who share in the treatment and care for people with a diagnosis of an eating disorder, including psychiatrists, clinical psychologists, mental health nurses, community psychiatric nurses, social workers, practice nurses, secondary care medical staff, dietitians, dental, nursing and paramedical staff, occupational therapists, pharmacists, paediatricians, other physicians, general medical and dental practitioners, physiotherapists and family/other therapists
- Professionals in other health and non-health sectors who may have direct contact with or are involved in the provision of health and other public
services for those diagnosed with eating disorders. These may include
prison doctors, the police, and professionals who work in the criminal
justice and education sectors
• Those with responsibility for planning services for people with a diagnosis
of an eating disorder and their carers, including directors of public health,
NHS trust managers and managers in primary care trusts.

The guidance does not specifically address:

• The diagnosis or treatment of people with eating disorders in the context of
a separate physical or other primary mental disorder of which a disorder of
eating is a symptom.
• The practice of other professionals such as A&E staff and those who work
in education sectors.

Although this guideline addresses the issue of identifying eating disorders, it
has not made evidence-based recommendations in this regard nor has it
referred to evidence regarding primary prevention or assessment.

3 Implementation in the NHS

3.1 In general

Local health communities should review their existing practice in the treatment
and management of anorexia nervosa, bulimia nervosa, and related eating
disorders (core interventions) against this guideline as they develop their
Local Delivery Plans. The review should consider the resources required to
implement the recommendations set out in Section 1, the people and
processes involved and the timeline over which full implementation is
envisaged. It is in the interests of patients that the implementation timeline is
as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be
reviewed in the light of this guidance and revised accordingly.
This guideline should be used in conjunction with the National Service Framework for Mental Health, which is available from www.doh.gov.uk/nsf/mentalhealth.htm.

3.2 Audit

Suggested audit criteria are listed in Appendix D. These can be used as the basis for local clinical audit, at the discretion of those in practice.

4 Research recommendations

The GDG identified the following research recommendations specifically to address gaps in the evidence base:

4.1 Adequately powered efficacy studies of specific treatments and services for people with anorexia nervosa are needed.

4.2 Adequately powered efficacy studies of the treatment of atypical eating disorders (eating disorders not otherwise specified) are needed.

4.3 Adequately powered efficacy studies of the treatment of adolescents with bulimia nervosa, and non-responders to cognitive behaviour therapy are needed.

4.4 Effectiveness studies of the treatment of bulimia nervosa in adults are needed.

4.5 Patient and carer satisfaction is an important outcome and may influence treatment approaches. It should be considered a routine outcome in research.

4.6 Further research is needed to assess the validity of screening instruments in primary care.

5 Full guideline

The National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Mental Health. The Centre established a Guideline Development Group, which reviewed the
evidence and developed the recommendations. The full guideline *Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa, and related eating disorders* will be published by the National Collaborating Centre for Mental Health; it will be available from its website (www.rcpsych.ac.uk/cru/nccmh.htm), the NICE website (www.nice.org.uk) and on the website of the National Electronic Library for Health (www.nelh.nhs.uk). [This will be the case once the guideline has been published]

The members of the Guideline Development Group are listed in Appendix B. Information about the independent Guideline Review Panel is given in Appendix C.

The booklet *The Guideline Development Process – Information for the Public and the NHS* has more information about the Institute’s guideline development process. It is available from the Institute’s website and copies can also be ordered by telephoning 0870 1555 455 (quote reference N0038).

### 6 Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

A version of this guideline for people with eating disorders, their advocates, carers and the public is available from the NICE website (www.nice.org.uk) or from NHS Response Line (0870 1555 455; quote reference number N0xxx for an English version and N0xxx for an English and Welsh version)
Appendix A: Grading scheme

All evidence was classified according to an accepted hierarchy of evidence that was originally adapted from the US Agency for Healthcare Policy and Research Classification (see Box 1). Recommendations were then graded A to C based on the level of associated evidence or noted as a NICE recommendation (see Box 1) – this grading scheme is based on a scheme formulated by the Clinical Outcomes Group of the NHS Executive (1996).

Box 1: Hierarchy of evidence

<table>
<thead>
<tr>
<th>Level</th>
<th>Type of evidence</th>
<th>Grade</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials</td>
<td>A</td>
<td>At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation</td>
</tr>
<tr>
<td>IIa</td>
<td>Evidence obtained from at least one well-designed controlled study without randomisation</td>
<td>B</td>
<td>Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level I evidence</td>
</tr>
<tr>
<td>IIb</td>
<td>Evidence obtained from at least one other well-designed quasi-experimental study</td>
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</tr>
<tr>
<td>III</td>
<td>Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities</td>
<td>C</td>
<td>Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV). This grading indicates that directly applicable clinical studies of good quality are absent or not readily available</td>
</tr>
<tr>
<td>NICE</td>
<td>Evidence from NICE guideline or health technology appraisal</td>
<td>NICE</td>
<td>Evidence from NICE guideline or health technology appraisal</td>
</tr>
</tbody>
</table>

Appendix B: The Guideline Development Group

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University of Liverpool

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Kings College London
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Lead, Topic Group on Physical Management

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Lead, Topic Group on Psychological Interventions

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Chief Executive
Eating Disorders Association (March 2002–03)
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Honorary Senior Lecturer, University of Southampton

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Phoenix Centre Eating Disorder Service
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Child and Adolescent Psychiatrist
St George's Eating Disorder Service
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Patient Representative, London

Dr Deborah Waller
GP, Oxford

Ms Susan Ringwood
Chief Executive, Eating Disorders Association (December 2002 – January 2004)

Dr Ulrike Schmidt
Senior Lecturer in Eating Disorders
Eating Disorders Unit, Institute of Psychiatry
Appendix C: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The Panel includes experts on guideline methodology, healthcare professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel were as follows.

<table>
<thead>
<tr>
<th>Member</th>
<th>Area of expertise/experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Chaand Nagpaul</td>
<td>Clinical practice</td>
</tr>
<tr>
<td>GP, Stanmore</td>
<td></td>
</tr>
<tr>
<td>Dr Marcia Kelson</td>
<td>Patient and carer issues</td>
</tr>
<tr>
<td>Director, Patient Involvement</td>
<td></td>
</tr>
<tr>
<td>Unit for NICE, College of Health, London</td>
<td></td>
</tr>
<tr>
<td>Mr John Seddon</td>
<td>Patient and carer issues</td>
</tr>
<tr>
<td>Patient Representative</td>
<td></td>
</tr>
<tr>
<td>Professor Kenneth Wilson</td>
<td>Methodology</td>
</tr>
<tr>
<td>Professor of Psychiatry of Old Age and Honorary Consultant Psychiatrist, Cheshire and Wirral Partnership NHS Trust</td>
<td></td>
</tr>
<tr>
<td>Professor Shirley Reynolds</td>
<td>Clinical practice</td>
</tr>
<tr>
<td>Professor of Clinical Psychology, School of Medicine, Health Policy and Practice, University of East Anglia, Norwich</td>
<td></td>
</tr>
<tr>
<td>Dr Roger Paxton</td>
<td>Implementation</td>
</tr>
<tr>
<td>R&amp;D Director, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust</td>
<td></td>
</tr>
</tbody>
</table>
Appendix D: Technical detail on the criteria for audit

Possible objectives for an audit

One or more audits could be carried out in different care settings to ensure that:

- individuals with an eating disorder are involved in their care
- treatment options, including psychological interventions, are appropriately offered and provided for individuals with an eating disorder.

People that could be included in an audit

A single audit could include all individuals with an eating disorder. Alternatively, individual audits could be undertaken on specific groups of individuals such as:

- people with a specific eating disorder, for example, bulimia nervosa
- a sample of patients from particular populations in primary care.

Measures that could be used as a basis for an audit

Please see tables overleaf.
<table>
<thead>
<tr>
<th>Criterion</th>
<th>Standard</th>
<th>Exception</th>
<th>Definition of terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cognitive behaviour therapy (CBT) in bulimia nervosa in adults</td>
<td>In patients with bulimia nervosa, CBT specially adapted for the disorder should be offered to adult patients assessed as needing treatment in secondary care services. The course of treatment should normally be 16 to 20 individual sessions provided by a trained healthcare professional over 4 to 5 months.</td>
<td>Individuals who decline such an offer of treatment, who choose an alternative psychological intervention (such as interpersonal psychotherapy) and those with severe comorbidity of a type that will interfere with the patient benefiting from CBT (for example, severe depression, marked substance abuse).</td>
<td>The notes should indicate that the healthcare professional responsible has discussed the process and potential benefits of the intervention. The notes should record if the patient completes a full course of treatment. The course of the treatment should also be described in the notes and it should have followed the specific strategies and procedures employed in</td>
</tr>
</tbody>
</table>
## 2. Cognitive behaviour therapy (CBT) in bulimia nervosa in adolescents

Older adolescents with bulimia nervosa may be treated with CBT-BN adapted as needed to suit their age, circumstances and level of development.

The course of treatment should normally be 16 to 20 individual sessions over 4 to 5 months.

<table>
<thead>
<tr>
<th>CBT should be offered to the majority of older adolescents with bulimia nervosa assessed as needing treatment in secondary care services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals who decline such an offer of treatment and those with severe comorbidity or developmental problems of a type that will interfere with the patient benefiting from CBT.</td>
</tr>
</tbody>
</table>

The notes should indicate that the healthcare professional responsible has discussed the process and potential benefits of the intervention.

The notes should record if the patient completes a full course of treatment.

The course of the treatment should also be described in the notes and it should have followed the specific strategies.
### 3. Psychological treatment in anorexia nervosa

Most adults with anorexia nervosa should be managed on an outpatient basis with psychological treatment provided by a health professional competent in the psychological treatment of eating disorders.

The course of treatment should normally last for at least 6 months.

<p>| Psychological treatment should be offered to the great majority of individuals with anorexia nervosa assessed as needing outpatient treatment in secondary care services. The course of treatment should normally be for at least 6 months. | Individuals who decline such an offer of treatment and those with severe comorbidity of a type that will interfere with the patient benefiting from psychological treatment (for example, severe depression, marked substance abuse). | The notes should indicate that the healthcare professional responsible has discussed the process and potential benefits of the intervention. The notes should record if the patient completes a full course of treatment. The course of the treatment should also be described in the notes and it should have followed the specific strategies set out for the chosen |</p>
<table>
<thead>
<tr>
<th>4. Family interventions in anorexia nervosa</th>
<th>Family interventions focused explicitly on eating disorders should be offered to the great majority of families with a child or adolescent with anorexia nervosa who is not engaged in individual psychological treatment.</th>
<th>Families who decline such an offer of treatment, and possibly where the child or adolescent is engaged in individual psychological treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For children and adolescents with anorexia nervosa, family interventions that have an explicit focus on the eating disorder and family relationships should be offered to the families of all patients in secondary care services. Both separate (parents and patient meet separately with the therapist) and conjoint (parents and patient together with therapist) forms of family intervention may be beneficial.</td>
<td>The course of treatment should normally last between 6 and 12 months.</td>
<td>The notes should indicate that the healthcare professional responsible has discussed the process and potential benefits of the intervention. If the offer of intervention was not taken up, the notes should record whether the parent, child or both declined the offer and the number already in individual psychological treatment. The notes should record the form of family intervention (separate or conjoint) and if the family completed a full course of treatment.</td>
</tr>
</tbody>
</table>
The course of treatment should normally last between 6 and 12 months.

The course of the treatment should also be described in the notes and it should have followed the specific strategies and procedures employed in family interventions for anorexia nervosa.

<table>
<thead>
<tr>
<th>5. Physical health review in anorexia nervosa</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients with enduring anorexia nervosa not under the care of secondary care services should be offered an annual health review by their GP.</td>
</tr>
<tr>
<td>Physical and mental health review offered by GP to 100% of patients with enduring anorexia nervosa who are not in contact with secondary care services.</td>
</tr>
<tr>
<td>None.</td>
</tr>
</tbody>
</table>

The notes should indicate that the offer of a review was made to the patient and whether or not the patient attended for review.
### 6. Inpatient care of anorexia nervosa

Patients with anorexia nervosa who require admission to a psychiatric unit should be admitted to a unit experienced in the treatment of eating disorders.

| All patients requiring inpatient care should be admitted to a psychiatric unit experienced in the treatment of eating disorders. | Individuals who are admitted as psychiatric emergencies to general psychiatric wards. | An annual review of all admissions for anorexia in each PCT should be conducted for all services that have provided inpatient services for anorexia nervosa. |

### 7. Patient satisfaction

All patients treated in secondary care for an eating disorder should be asked to complete a satisfaction questionnaire at the end of treatment.

| All patients should be asked to complete a satisfaction questionnaire at the end of treatment. The expected completion rate for the questionnaire is 50%. | Individuals who decline to complete the questionnaire. | The report should specify the percentage of questionnaires returned and the characteristics of those who did and did not complete the questionnaire. |
8. Atypical eating disorders

In the absence of evidence to guide the management of atypical eating disorders (eating disorders not otherwise specified) other than as binge eating disorder, it is recommended that the clinician considers following the guidance on treatment of the eating problem that most closely resembles the individual's eating disorder.

<table>
<thead>
<tr>
<th>Section</th>
<th>Statement</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with atypical eating disorders are expected to comprise at least 40% of patients assessed and taken on for treatment for eating disorders.</td>
<td>None.</td>
<td>The record system should record the diagnosis of all patients assessed and taken on for treatment in a service.</td>
</tr>
</tbody>
</table>
Appendix E: The algorithms

[Presented as a separate file for consultation]