Eating disorders: recognition and management

Appendices A - G

NICE Guideline

Methods, evidence and recommendations

December 2016

Draft for Consultation
Commissioned by the National Institute for Health and Care Excellence
Disclaimer
Healthcare professionals are expected to take NICE clinical guidelines fully into account when exercising their clinical judgement. However, the guidance does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of each patient, in consultation with the patient and/or their guardian or carer.

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Appendices

Appendix A: Scope

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline scope

Eating disorders: recognition and treatment

Topic

This guideline will replace the NICE guideline on eating disorders (CG9) and will be used to develop the NICE quality standard on eating disorders.

Who the guideline is for

This guideline is intended for use by:

- People with a diagnosis of an eating disorder (including anorexia nervosa, bulimia nervosa, binge eating disorder, and eating disorders generally called 'atypical eating disorders') and their families and carers.
- Professional groups involved in the recognition and treatment of eating disorders and in care for people with a diagnosis of an eating disorder. These include the following professionals from primary and secondary care: psychiatrists, clinical psychologists, mental health nurses, community psychiatric nurses, social workers, practice nurses, dieticians, secondary care medical, dental, nursing and paramedical staff, occupational therapists, pharmacists, paediatricians, other physicians, general medical and dental practitioners, psychotherapists and family/other therapists.
- Professionals in other health and non-health sectors who may have direct contact with or be involved in providing health or other public services for people with a diagnosis of an eating disorder. These may include professionals who work in the criminal justice and education sectors.
- People with responsibility for planning services for people with a diagnosis of an eating disorder and their families and carers, including directors of public health, NHS trust managers and managers in clinical commissioning groups.

NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the Welsh Government, Scottish Government, and Northern Ireland Executive.

Equality considerations

NICE has carried out an equality impact assessment during scoping. The assessment:

- lists equality issues identified, and how they have been addressed
- explains why any groups are excluded from the scope, if this was done.

The guideline will look at inequalities relating to gender, age, ethnicity and geographical location.
1 What the guideline is about

1.1 Who is the focus?

Groups that will be covered

- Children, young people and adults with an eating disorder (anorexia nervosa, bulimia nervosa, binge eating disorder or atypical eating disorder), or a suspected eating disorder.

Groups that will not be covered

- People with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression).
- People with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating).
- People with obesity without an eating disorder.

1.2 Settings

Settings that will be covered

The guideline will cover all settings in which care commissioned by health and social care is provided, including health, social care and educational settings.

1.3 Activities, services or aspects of care

Key areas that will be covered

Identification, assessment and monitoring:

- recognition and early identification of eating disorders (including formal recognition tools)
- assessment in people with an eating disorder (including formal assessment tools)
- monitoring in people with an eating disorder.

Interventions to treat eating disorders through all phases of the disorder including:

- psychological interventions, including low-intensity interventions such as self-help and Internet-based therapies, high-intensity interventions such as family therapy and family-based treatments, and individual therapies such as psychodynamically informed therapies, cognitive behavioural therapy (CBT), interpersonal psychotherapy and behavioural interventions
- pharmacological interventions (note that guideline recommendations will normally fall within licensed indications; exceptionally, and only if clearly supported by evidence, use outside a licensed indication may be recommended. The guideline will assume that prescribers will use a drug’s summary of product characteristics to inform decisions made with individual patients)
- nutritional interventions, including tube feeding
- physical interventions, such as transcranial magnetic stimulation and physiotherapy.

The management of physical health problems caused by an eating disorder.

Interventions for eating disorders in the context of common physical and psychological comorbidities.

Interventions to support families and carers.
1.4 Economic aspects

We will take economic aspects into account when making recommendations. We will develop an economic plan that states for each review question (or key area in the scope) whether economic considerations are relevant, and if so whether this is an area that should be prioritised for economic modelling and analysis. We will review the economic evidence and carry out economic analyses, using an NHS and personal social services (PSS) perspective, as appropriate.

1.5 Key issues and questions

While writing this scope, we have identified the following key issues, and key questions related to them:

1. Identification, assessment and monitoring:
   - What is the validity and reliability of the instruments, tools and methods used to identify the early onset of eating disorders in populations and in clinical samples?
   - What is the validity and reliability of the instruments, tools and methods used to assess and monitor eating disorders?

2. Interventions to treat eating disorders in children, young people and adults:
   - Does any group or individual psychological intervention produce benefits/harms on the specified outcomes in people with eating disorders compared with treatment as usual, wait-list controls or another psychological intervention?
   - Does any psychological intervention involving families and carers produce benefits/harms on specified outcomes in people with eating disorders?
   - Does any pharmacological intervention produce benefits/harms on specified outcomes in people with eating disorders?
   - Does any nutritional intervention produce benefits/harms on specified outcomes in people with eating disorders?
   - Do physical interventions, such as transcranial magnetic stimulation or physiotherapy, produce benefits/harm on specified outcomes in people with eating disorders?

3. The management of the physical symptoms and negative after effects of eating disorders, including weight management:
   - Does any method of managing the physical symptoms and negative after effects of eating disorders, such as low bone mineral density, produce benefits/harms on specified outcomes in people with eating disorders?
Eating disorders: recognition and management

Scope

1. Interventions for eating disorders where there is comorbidity with other mental health or physical health problems:
2. Does any intervention for other mental and physical health problems in people with eating disorders (for example, interventions for diabetes) affect the presentation or management of specified outcomes in people with eating disorders?

3. Interventions to support families and carers:
4. Does any intervention aimed at supporting families and carers produce benefits/harms on specified outcomes in families and carers of people with eating disorders?

5. Interventions to support families and carers:
6. Does any intervention aimed at supporting families and carers produce benefits/harms on specified outcomes in families and carers of people with eating disorders?

6. Organisation and delivery of services:
7. Does the setting (inpatient, outpatient or other specific setting) for treating eating disorders produce benefits/harms in people with eating disorders?
8. Do different ways of coordinating care produce benefits/harms for people with eating disorders?

7. Consent and compulsory treatment:
8. What factors/indicators should be considered when assessing whether a person with an eating disorder should be admitted for compulsory treatment (including any form of restrictive interventions usually implemented in refeeding)?

1.6 Main outcomes

9. The main outcomes that will be considered when searching for and assessing the evidence are:
10. All-cause mortality.
11. Remission and long-term recovery.
12. Relapse.
13. General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF).
15. Weight and body mass index.
16. Family functioning.
17. Quality of life.
20. Growth/bone density.
21. Service user experience.
2.1 Links with other NICE guidance and NICE pathways

2.1.3 NICE guidance

4 NICE guidance that will be updated by this guideline

5 This guideline will replace the existing NICE guideline on eating disorders (CG9).

6 NICE guidance about the experience of people using NHS services

7 NICE has produced the following guidance on the experience of people using the NHS. This guideline will not include additional recommendations on these topics unless there are specific issues related to eating disorders.

8 • Patient experience in adult NHS services (2012) NICE guideline CG138

9 • Service user experience in adult mental health (2011) NICE guideline CG136

10 • Medicines adherence (2009) NICE guideline CG76

2.2 NICE Pathways

14 When this guideline is published, the recommendations will be added to NICE Pathways.

15 NICE Pathways bring together all related NICE guidance and associated products on a topic in an interactive topic-based flow chart.

17 A draft pathway outline on eating disorders, based on this scope, is included below. It will be adapted and more detail added as the recommendations are written during guideline development.

Eating disorders overview

20 The pathway will link to the NICE pathways on nutrition support in adults and behaviour change.
3.1 Context

3.1.2 Key facts and figures

- Estimates of the incidence and prevalence of eating disorders vary, depending on the population studied and the methodology. The prevalence of anorexia nervosa is estimated to be about 0.3% across all age groups and up to 1.7% in adolescence; 90% of people diagnosed with anorexia nervosa are women. The annual incidence in primary care for anorexia nervosa is 14 per 100,000 per year in women. The prevalence of bulimia nervosa is estimated to be about 0.8%. Again, 90% of people diagnosed with bulimia nervosa are women. Binge eating disorder has a prevalence of 2.2% and a female to male ratio of around 3:1.

- Other eating disorders include 'atypical eating disorders' (also known as eating disorders not otherwise specified [EDNOS] and other specified feeding and eating disorders [OSFED]). These include subthreshold cases of anorexia nervosa, bulimia nervosa and binge eating disorder, and other specified disorders (for example, night eating syndrome and purging disorder). Although they are less well researched, such atypical cases are estimated to make up approximately 50% of all cases of eating disorder.

- Because eating disorders are less common in men, and are more likely to be 'atypical', they can go undetected. Eating disorders are also underdiagnosed in people of normal weight, people who are overweight and in black, Asian and minority ethnic group populations, despite similar prevalence rates.

- Severe eating disorders can result in long-term ill health or death

The existing NICE guideline on eating disorders (CG9) was 11 years old in January 2015 and was developed before the publication of the 2004 guidelines manual. Consequently it contains no review protocols, no clear methodology of how evidence synthesis was achieved, no evidence tables, and no statement linking the evidence to the recommendations or documentation of decision-making. In addition, an arbitrary lower age limit of 8 years was used for the guideline population.

We are updating CG9 using the methods and processes set out in 2014 in Developing NICE guidelines: the manual. The updated guideline will cover the identification, treatment and management of eating disorders as defined in the World Health Organization's International Classification of Diseases (ICD) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM–5). These include anorexia nervosa, bulimia nervosa, binge eating disorder and eating disorders generally called 'atypical eating disorders'.

The updated guideline will be used to develop a NICE quality standard.

3.2 Current practice

Current practice is for healthcare professionals and service users with eating disorders to refer to the existing NICE guideline on eating disorders (CG9). However, there is new evidence that may change current recommendations on psychotherapy.

3.3 Policy, legislation, regulation and commissioning

- Legislation, regulation and guidance

- The Children Act 1989

- The Mental Health Act 1983

- The Mental Capacity Act 2005

**Commissioning**


**Further information**

This is the final scope, incorporating comments from registered stakeholders during consultation.

The guideline is expected to be published in April 2017.

You can follow progress of the [guideline](#).

Our website has information about how [NICE guidelines](#) are developed.
## Appendix B: Declarations of Interest

### Guideline Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Job title and organisation</th>
<th>Declaration of interest</th>
<th>Type of interest</th>
<th>Action taken</th>
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</thead>
<tbody>
<tr>
<td>Anthony Bateman</td>
<td>Consultant Psychiatrist and Psychotherapist and Honorary Senior Lecturer. Visiting Professor in the Psychoanalysis Unit at University College London.</td>
<td>None</td>
<td>n/a</td>
<td>None</td>
</tr>
<tr>
<td>Jane Dalgliesh</td>
<td>Nurse Practitioner/Team Manager/Head of Service Eating Disorders Service, South Essex University Foundation Trust</td>
<td>None</td>
<td>n/a</td>
<td>None</td>
</tr>
<tr>
<td>Ivan Eisler</td>
<td>Emeritus Professor of Family Psychology and Family Therapy, Kings College Institute of Psychiatry, Psychology and Neuroscience. Consultant Clinical Psychologist and Joint Head of Child and Adolescent Eating Disorders Service, South London and Maudsley NHS Foundation Trust. Lead for Psychological Treatments, CAMHS, South London and Maudsley NHS Foundation Trust.</td>
<td>Published a significant number of academic papers/chapters on psychological treatments for eating disorders. This includes papers on the use of family interventions and published studies on psychodynamic psychotherapy, CBT and cognitive analytic therapy. Also published researched and expressed opinions on specialist and non-specialist services for child and adolescent eating disorders.</td>
<td>Personal, non-financial, specific</td>
<td>None</td>
</tr>
<tr>
<td>Ivan Eisler</td>
<td>Emeritus Professor of Family Psychology and Family Therapy, Kings College Institute of Psychiatry, Psychology and Neuroscience. Consultant Clinical Psychologist and Joint Head of Child and Adolescent Eating Disorders Service, South London and Maudsley NHS Foundation Trust.</td>
<td>Member of the curriculum group for Systemic Family Practice for the Children’s and Young People’s Increasing Access to Psychological Treatments (CYP IAPT) and co-writer of the CYP IAPT specialist ED training module. Evidence has been submitted to the</td>
<td>Personal, non-financial, specific</td>
<td>None</td>
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### Declarations of Interest

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</thead>
<tbody>
<tr>
<td>Christopher Fairburn</td>
<td>Lead for Psychological Treatments, CAMHS, South London and Maudsley NHS Foundation Trust.</td>
<td>House of Commons Health Select Committee CAMHS Inquiry as well as to the NHS England London Region Group on the organisation of Child and Adolescent Eating Disorders Services.</td>
<td>Personal, financial, specific</td>
<td>None</td>
</tr>
<tr>
<td>Christopher Fairburn</td>
<td>Welcome Principal Research Fellow, University of Oxford. Professor of Psychiatry, University of Oxford. Honorary Consultant Psychiatrist, Oxford Health NHS Foundation Trust. Governor, MQ – Research for Mental Health. Governor, Oxford Mindfulness Foundation</td>
<td>Author of research papers, review articles and books that have commented on the effectiveness of various treatments for eating disorders. Royalties received from publishers of the books concerned.</td>
<td>Personal, financial, specific</td>
<td>None</td>
</tr>
<tr>
<td>Christopher Fairburn</td>
<td>Welcome Principal Research Fellow, University of Oxford. Professor of Psychiatry, University of Oxford. Honorary Consultant Psychiatrist, Oxford Health NHS Foundation Trust. Governor, MQ – Research for Mental Health. Governor, Oxford Mindfulness Foundation</td>
<td>Held (paid and unpaid) training workshops for clinicians on eating disorders; on eating disorder treatment in general; and on specific treatments for eating disorders (CBT; IPT; guided self-help).</td>
<td>Personal, financial, specific</td>
<td>None</td>
</tr>
<tr>
<td>Christopher Fairburn</td>
<td>Welcome Principal Research Fellow, University of Oxford. Professor of Psychiatry, University of Oxford. Honorary Consultant Psychiatrist, Oxford Health NHS Foundation Trust. Governor, MQ – Research for Mental Health. Governor, Oxford Mindfulness Foundation</td>
<td>Funding from Wellcome Trust to develop an online means of training therapists in a specific treatment for eating disorders, CBT-E, and in a treatment for depressions (behavioural activation). The training is cost-free</td>
<td>Non-personal, financial, specific</td>
<td>None</td>
</tr>
<tr>
<td>Christopher Fairburn</td>
<td>Welcome Principal Research Fellow, University of Oxford.</td>
<td>Author of a book for sufferers from eating disorders (Overcoming</td>
<td>Personal, financial, specific</td>
<td>None</td>
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<tr>
<td>Jessica Parker</td>
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<td>Mandy Scott</td>
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<td>Clinical Director Dentistry and Oral and Maxillo-Facial Surgery (OMFS). Clinical Lead Restorative Dentistry, Barts Health NHS Trust, The Dental Hospital, London.</td>
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</tr>
<tr>
<td>Dominique Thompson</td>
<td>GP and Director of the University of Bristol Student Health Service. Lead GP Bristol For Eating Disorders.</td>
<td>Member of GPCare, a local GP federation in Bristol.</td>
<td>Non-personal, non-financial, non-specific</td>
<td>None</td>
</tr>
<tr>
<td>Janet Treasure</td>
<td>Director of Eating Disorders Unit and Professor of Psychiatry, Kings College, London.</td>
<td>Edited professional texts, and written several self-help books for people with eating disorders (Schmidt &amp; Treasure, 1993; Treasure, 1997) and a book for carers to share expertise and understanding (Treasure J et al., 2007).</td>
<td>Personal, financial, specific</td>
<td>None</td>
</tr>
<tr>
<td>Janet Treasure</td>
<td>Director of Eating Disorders Unit and Professor of Psychiatry, Kings College, London.</td>
<td>Charity work: Trustee or other various roles on several eating disorders charities: BEAT, SUCCEED, Student Minds, FEAST, Diabetics with Eating Disorders DWED, Psychiatry Research Trust, Charlottes Helix.</td>
<td>Personal, non-financial, specific</td>
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<tbody>
<tr>
<td>Janet Treasure</td>
<td>Director of Eating Disorders Unit and Professor of Psychiatry, Kings College, London.</td>
<td>Funding from BRC Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King's College London, National Institute for Health Research (NIHR), Swiss Anorexia Foundation, Psychiatric Research Trust, Guys and St Thomas Research Trust</td>
<td>Non-personal, financial, specific</td>
<td>None</td>
</tr>
<tr>
<td>Janet Treasure</td>
<td>Director of Eating Disorders Unit and Professor of Psychiatry, Kings College, London.</td>
<td>Honorarium for participation in: AACAP meeting, Lilly diabetic meeting, ECNP, Hilda Bruch lecture</td>
<td>Personal, non-financial, specific</td>
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<tr>
<td>Janet Treasure</td>
<td>Title: Anorexia Nervosa – a survival guide for families, friends and sufferers. Publisher: Routledge ISBN: 0-86377-760-0</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Janet Treasure, Pam MacDonald, Ulrike Schmidt</td>
<td>Title: A Clinicians Guide to Collaborative Care Publisher: Routledge ISBN: 978-0-415</td>
<td></td>
<td></td>
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<tr>
<td>Janet Treasure, Pam MacDonald, Ulrike Schmidt</td>
<td>Title: A Clinicians Guide to Collaborative Care Publisher: Routledge ISBN: 978-0-415-48424-4 hbk 978-0-415-48425-1 pbk Date: 2009</td>
<td></td>
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<tr>
<td>Laird Birmingham, Janet Treasure.</td>
<td>Title: Medical Management of Eating Disorders Publisher: Oxford University Press ISBN: 978-0-521-72710-5 Date: 2010</td>
<td></td>
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<tr>
<td>Hannah Turner</td>
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<td>None</td>
<td>n/a</td>
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<tr>
<td>Christine Vize</td>
<td>Consultant Psychiatrist in Eating Disorders and Medical Lead for Eating Disorders, Oxford Health NHS Foundation Trust,</td>
<td>Fellow of the Royal College of Psychiatrists and an Executive Member of the College Eating Disorders Section (now the Faculty of Eating Disorders) since July 2011. Re-elected once but not eligible for further re-election, will step down in June 2015. Held the position of Policy Lead for the Faculty.</td>
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<tr>
<td>Christine Vize</td>
<td>Consultant Psychiatrist in Eating Disorders and Medical Lead for Eating Disorders,</td>
<td>Vice-Chair of the Clinical Reference Group for Specialist Eating Disorders for NHS England.</td>
<td>Personal, non-financial, specific</td>
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1 Developer staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Job title and organisation</th>
<th>Declaration of interest</th>
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<th>Decision taken</th>
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<tbody>
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<td>Annabel Flint</td>
<td>Senior Project Manager, NGA</td>
<td>None</td>
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<td>Project Manager, NGA</td>
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<td>Professor Tim Kendall</td>
<td>National Clinical Director for Mental Health. Consultant Psychiatrist for the homeless, Sheffield Health and Social Care NHS Foundation Trust.</td>
<td>Director and Chief Executive Officer of a healthcare organisation which provides clinical care.</td>
<td>Personal, financial, specific</td>
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<td>Professor Steve Pilling</td>
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<td>Professor Steve Pilling</td>
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<td>9.6.2015 Grant from National Alliance for Research on Schizophrenia and Depression to look at transcranial direct-</td>
<td>Non-personal financial non-specific</td>
<td>None</td>
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<td>Name</td>
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<tr>
<td>Professor Steve Pilling</td>
<td>Clinical Advisor, NGA Director, Centre for Outcomes Research and Effectiveness, University College London</td>
<td>current stimulation in treatment of depression.</td>
<td>Non-personal financial non-specific</td>
<td>None</td>
</tr>
<tr>
<td>Professor Steve Pilling</td>
<td>Clinical Advisor, NGA Director, Centre for Outcomes Research and Effectiveness, University College London</td>
<td>9.6.2015 Involved in CADET, IAPT and PRMOS study programmes</td>
<td>Non-personal financial non-specific</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25.5.2016 Funding from DHSE on the development of Evidence-Based Treatment Pathways and Safer Staffing Mental Health</td>
<td>Non-personal financial non-specific</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.9.2016 Chief Investigator, Programme Grant of £2.3M from NIHR (2017-2022), Open Dialogue: Evaluating Service System for Severe Mental Illness (ODESSI)</td>
<td>Non-personal financial non-specific</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9.6.2015 Medical Research Council funding looking at psilocybin</td>
<td>Non-personal financial non-specific</td>
<td>None</td>
</tr>
<tr>
<td>Ifigeneia Mavranezouli</td>
<td>Senior Health Economist, UCL</td>
<td>None</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Leanne Saxon</td>
<td>Senior Systematic Reviewer, University College London</td>
<td>None</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Eric Slade</td>
<td>Senior Health Economist, NGA</td>
<td>None</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Sarah Stockton</td>
<td>Senior Information Scientist, NGA</td>
<td>None</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Jo Wolfreys</td>
<td>Project Manager, UCL</td>
<td>None</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>
Appendix C: Special advisors to the committee

No special advisors on specialist topics contributed to the process by meeting the Guideline Committee:
1 Appendix D: Stakeholders for the Guideline

2 2gether NHS Foundation Trust
3 2gether NHS Foundation Trust
4 5 Boroughs Partnership NHS Foundation Trust
5 5 Boroughs Partnership NHS Foundation Trust
6 AbbVie
7 AbbVie
8 Adoption UK
9 Alder Hey Children’s NHS Foundation Trust
10 Alder Hey Children’s NHS Foundation Trust
11 Alliance Pharmaceuticals
12 Allocate Software PLC
13 Anorexia and Bulimia Care
14 Association of NHS Occupational Physicians
15 Association for Cognitive Analytic Therapy
16 Association for Dance Movement Psychotherapy UK
17 Association for Family Therapy and Systemic Practice in the UK
18 Association for Improvements in the Maternity Services
19 Association for Improvements in the Maternity Services
20 Association for the advancement of meridian energy techniques
21 Association of Anaesthetists of Great Britain and Ireland
22 Association of Anaesthetists of Great Britain and Ireland
23 Association of Child Psychotherapists, the
24 Association of Clinical Pathologists
25 Association of Professional Music Therapists
26 Association of Psychoanalytic Psychotherapy in the NHS
27 Association of School and College Leaders
28 Association of School and College Leaders
29 Association of Teachers and Lecturers
30 Barnsley Youth Offending Team
1 Behind The Mask Foundation
2 Belfast Health and Social Care Trust
3 Betsi Cadwaladr University Health Board
4 Big White Wall
5 Birmingham and Solihull Mental Health NHS Foundation Trust
6 Birmingham Women’s NHS Foundation Trust
7 Black Country Partnership Foundation Trust
8 Bradford District Care Trust
9 British Acupuncture Council
10 British Association for Counselling and Psychotherapy
11 British Association for Counselling and Psychotherapy
12 British Association for Music Therapy
13 British Association for Music Therapy
14 British Association for Parenteral & Enteral Nutrition
15 British Association for Parenteral & Enteral Nutrition
16 British Association of Art Therapists
17 British Association of Dramatherapists
18 British Association of Music Therapy
19 British Association of Psychodrama and Sociodrama
20 British Association of Social Workers
21 British Dental Association
22 British Dietetic Association
23 British Dietetic Association
24 British Medical Association
25 British Medical Journal
26 British National Formulary
27 British Nuclear Cardiology Society
28 British Nuclear Cardiology Society
29 British Paediatric Mental Health Group
30 British Paediatric Respiratory Society
31 British Psychodrama Association
32 British Psychological Society
33 British Red Cross
1 British Society for Disability and Oral Health
2 British Society of Gastroenterology
3 British Society of Gastroenterology
4 British Society of Paediatric Gastroenterology Hepatology and Nutrition
5 British Society of Paediatric Gastroenterology Hepatology and Nutrition
6 Buckinghamshire County Council
7 Calderdale and Huddersfield NHS Trust
8 Cambridgeshire & Peterborough NHS Foundation Trust
9 Camden Link
10 Caplond Services
11 Capsulation PPS
12 Capsulation PPS
13 Care Council for Wales
14 Care Quality Commission
15 Care Quality Commission
16 CCBT Ltd
17 Central & North West London NHS Foundation Trust
18 British Paediatric Mental Health Group
19 Chartered Physiotherapists in Mental Health
20 Chartered Society of Physiotherapy
21 Cheshire & Wirral Partnership NHS Trust
22 Cheswold Park Hospital
23 Childhood First
24 Childhood First
25 Child Psychology London
26 CIS’ ters
27 Citizens Commission on Human Rights
28 Clarity Informatics Ltd
29 Cochrane Depression Anxiety and Neurosis Group
30 Cochrane UK
31 College of Mental Health Pharmacy
32 College of Occupational Therapists
33 College of Occupational Therapists
1 College of Paramedics
2 Complementary Health Professionals
3 Connect Therapeutic Community
4 Counselling for prisoners network
5 Covidien Ltd.
6 Creating Change Arts Therapy
7 Cregagh Nursing Home
8 Critical Psychiatry Network
9 Croydon Clinical Commissioning Group
10 Croydon Health Services NHS Trust
11 Croydon University Hospital
12 Cumbria Partnership NHS Foundation Trust
13 Cumbria Partnership NHS Foundation Trust
14 Cygnet Health Care
15 Department for Education
16 Department of Academic Psychiatry - Guy's
17 Department of Health
18 Department of Health
19 Department of Health
20 Department of Health, Social Services and Public Safety - Northern Ireland
21 Derbyshire County Council
22 Diabetes UK
23 Diabetics with Eating Disorders
24 Dorset Action on Abuse
25 East and North Hertfordshire NHS Trust
26 East Kent Hospitals University NHS Foundation Trust
27 East Riding of Yorkshire Council
28 East Sussex County Council
29 Eating Disorder Association (NI)
30 Eating Disorders Service
31 Eli Lilly and Company
32 Eli Lilly and Company
33 Elm Healthcare
1 Equalities National Council  
2 Esoteric Practitioners Association UK/EU  
3 Ethical Medicines Industry Group  
4 Ethical Medicines Industry Group  
5 Europa Healthcare Solutions  
6 Experts by experience  
7 Faculty of Dental Surgery  
8 Faculty of Dental Surgery  
9 Faculty of Public Health  
10 Faculty of Sport and Exercise Medicine  
11 Faculty of Sport and Exercise Medicine  
12 Fetal Anti Convulsant Syndrome Association  
13 First Person Plural  
14 Five Boroughs Partnership NHS Trust  
15 Five Boroughs Partnership NHS Trust  
16 Food and Drink Federation  
17 Freshwinds  
18 General Hypnotherapy Register  
19 General Hypnotherapy Register  
20 Gloucestershire County Council  
21 Gloucestershire LINk  
22 Great Ormond Street Hospital  
23 Great Western Hospitals NHS Foundation Trust  
24 Greater London Prevention Center  
25 Greater Manchester & Beyond Coalition of PLW & HIV  
26 Greater Manchester West Mental Health NHS Foundation Trust  
27 Greater Manchester West Mental Health NHS Foundation Trust  
28 Hafan Cymru  
29 Hampshire Partnership NHS Trust  
30 Health and Care Professions Council  
31 Health and Care Professions Council  
32 Healthcare Improvement Scotland  
33 Healthcare Quality Improvement Partnership
1 Healthwatch Bristol
2 Healthwatch Darlington
3 Healthwatch East Sussex
4 Hertfordshire Partnership NHS Trust
5 Hertfordshire Partnership University NHS Foundation Trust
6 Hindu Council UK
7 Hiraeth Services Ltd
8 HM Treasury
9 Hockley Medical Practice
10 Huntercombe Group
11 Hywel Dda University Health Board
12 Independent Children's Homes Association
13 Islington Youth Health Forum
14 James Paget Hospital
15 Journey Method Therapy
16 JT Healing
17 Kent and Medway NHS and Social Care Partnership Trust
18 King's College London
19 Lancashire Care NHS Foundation Trust
20 Lancashire Care NHS Foundation Trust
21 Lanes Health
22 laughter ball yoga
23 Leeds and York Partnership Foundation Trust
24 Leeds and York Partnership Foundation Trust
25 LGBT Foundation
26 Liverpool John Moores University
27 Local-Medic.co.uk Limited
28 London and South Perinatal Consultant Psychiatrists Association
29 Luton and Dunstable Hospital NHS Trust
30 Making Waves
31 Mascot Child & Family Services Ltd
32 Mastercall Healthcare
33 Maternal Mental Health Alliance
1 Maternal Mental Health Alliance
2 Medical Directorate Services
3 Men Get Eating Disorders Too
4 Mental Health Group - British Dietetic Association
5 Mersey Care NHS Trust
6 METRO Charity
7 Middlesex University
8 Mind
9 Ministry of Defence
10 Ministry of Defence
11 Monash Health
12 Msb consultancy
13 Muslim Doctors and Dentists Association
14 National Association of Primary Care
15 National Association of Psychiatric Intensive Care and Low Secure Units
16 National Centre for Eating Disorders
17 National Collaborating Centre for Cancer
18 National Collaborating Centre for Cancer
19 National Collaborating Centre for Cancer
20 National Collaborating Centre for Cancer
21 National Collaborating Centre for Mental Health
22 National Collaborating Centre for Women's and Children's Health
23 National Deaf CAMHS
24 National Deaf Children's Society
25 National Guideline Centre
26 National Institute for Health Research
27 National Nurse Consultants in CAMHS forum
28 National Nurse Consultants in CAMHS forum
29 National Obesity Forum
30 National Osteoporosis Society
31 National Osteoporosis Society
32 National Patient Safety Agency
33 National Patient Safety Agency
1 National Public Health Service for Wales
2 National Public Health Service for Wales
3 Neonatal & Paediatric Pharmacists Group
4 NEt
5 NHS Barnsley Clinical Commissioning Group
6 NHS Birmingham South and Central CCG
7 NHS Choices
8 NHS Chorley and South Ribble CCG
9 NHS Digital
10 NHS Digital
11 NHS England
12 NHS Haringey CCG
13 NHS Health at Work
14 NHS Lothian
15 NHS Nene CCG
16 NHS NEW Devon CCG
17 NHS North East Lincolnshire CCG
18 NHS Oxfordshire CCG
19 NHS Plus
20 NHS Sheffield CCG
21 NHS Somerset CCG
22 NHS South Cheshire CCG
23 NHS Wakefield CCG
24 NHS Warwickshire North CCG
25 NHS West Cheshire CCG
26 NICE - Clinical Guideline Updates team
27 NICE - Clinical Guidelines Surveillance
28 NICE - CPHE
29 NICE - CPHE
30 NICE - DAP
31 NICE - DAP
32 NICE - Implementation
33 NICE - Implementation
1 NICE - Internal Clinical Guidelines Programme
2 NICE - Interventional Procedures
3 NICE - Medicines and Prescribing Centre
4 NICE - Medicines and Prescribing Centre
5 NICE - MTEP
6 NICE - PIP
7 NICE - PIP
8 NICE - Quality Programme
9 NICE - Scientific Advice
10 NICE - Scientific Advice
11 NICE - Social Care
12 NICE - Technology Appraisals & HST
13 NICE - Topic selection
14 NICE - Topic selection
15 Norfolk and Suffolk NHS Foundation Trust
16 North Essex Mental Health Partnership Trust
17 North Essex Partnership Foundation Trust
18 North of England Commissioning Support
19 Northamptonshire county council
20 Northern Health and Social Care Trust
21 Northern School of Child and Adolescent Psychotherapy
22 Northumberland, Tyne & Wear NHS Trust
23 Northumberland, Tyne & Wear NHS Trust
24 Northumbria Healthcare NHS Foundation Trust
25 Nottingham City Hospital
26 Nottinghamshire Healthcare NHS Foundation Trust
27 Nursing and Midwifery Council
28 Nurtured Journey
29 Nutricia Advanced Medical Nutrition
30 Nutrition and Diet Resources UK
31 Obesity Action Campaign
32 Oxford Health NHS Foundation Trust
33 Panacea Healthcare
Eating disorders: recognition and management
Stakeholders for the Guideline

1 PERIGON Healthcare Ltd
2 PINNT
3 Plymouth Community Healthcare CIC
4 Pontefract Family Centre
5 PrescQIPP NHS Programme
6 Primary Care Pharmacists Association
7 Primary Care Pharmacists Association
8 Primrose Bank Medical Centre
9 Priory Group
10 Psychology Associates
11 Public Health Agency
12 Public Health England
13 Public Health England
14 QNHS
15 Research Autism
16 Residential Community Care Services
17 Restorative Dentistry UK
18 Rethink Mental Illness
19 Retreat, The
20 Roche Products
21 Roundhouse Care Ltd
22 Royal Berkshire NHS Foundation Trust
23 Royal College of Anaesthetists
24 Royal College of General Practitioners
25 Royal College of General Practitioners in Wales
26 Royal College of Midwives
27 Royal College of Midwives
28 Royal College of Nursing
29 Royal College of Obstetricians and Gynaecologists
30 Royal College of Obstetricians and Gynaecologists
31 Royal College of Paediatrics and Child Health
32 Royal College of Paediatrics and Child Health
33 Royal College of Paediatrics and Child Health
Eating disorders: recognition and management
Stakeholders for the Guideline

1 Royal College of Paediatrics and Child Health
2 Royal College of Pathologists
3 Royal College of Pathologists
4 Royal College of Pathologists
5 Royal College of Physicians
6 Royal College of Physicians
7 Royal College of Psychiatrists
8 Royal College of Psychiatrists
9 Royal College of Psychiatrists
10 Royal College of Psychiatrists in Scotland
11 Royal College of Radiologists
12 Royal College of Speech and Language Therapists
13 Royal College of Speech and Language Therapists
14 Royal College of Surgeons of Edinburgh
15 Royal Pharmaceutical Society
16 Royal Pharmaceutical Society
17 Royal Society of Medicine
18 Royal Society of Medicine
19 Sandoz Ltd
20 Sandoz Ltd
21 Scottish CAMHS Eating Disorders Steering Group
22 Scottish Intercollegiate Guidelines Network
23 Self Help Services
24 Sensory Integration Network
25 Shared Lives Plus
26 Sheffield Children’s NHS Trust
27 Sheffield Eating Disorders Service, Sheffield Health and Social Care Trust
28 Sheffield Health and Social Care NHS Foundation Trust
29 Sheffield Teaching Hospitals NHS Foundation Trust
30 SIARI
31 SJ Helpline Services CIC
32 SNDRi
33 Social Care Institute for Excellence
1 Social Care Institute for Excellence
2 Society for Endocrinology
3 Society for Existential Analysis
4 Solent NHS Trust
5 Somerset Partnership NHS Foundation Trust
6 South Belfast Partnership Board
7 South Eastern Health and Social Care Trust
8 South London & Maudsley NHSFT
9 South Staffordshire and Shropshire NHS trust
10 South West London and St George’s Mental Health NHS Trust
11 South West Yorkshire Partnership NHS Foundation Trust
12 Southern Health & Social Care Trust
13 Southport and Ormskirk Hospital NHS Trust
14 St Andrews Healthcare
15 St Mary’s Hospital
16 Staffordshire and Stoke on Trent Partnership NHS Trust
17 Staffordshire and Stoke on Trent Partnership NHS Trust
18 States of Jersey
19 Stockport Clinical Commissioning Group
20 Surrey and Borders Partnership NHS Foundation Trust
21 Surrey and Borders Partnership NHS Foundation Trust
22 Sussex Partnership NHS Foundation Trust
23 TACT
24 Talking Couch
25 Tavistock & Portman NHS Foundation Trust
26 Tavistock & Portman NHS Foundation Trust
27 Tees, Esk and Wear Valleys NHS Trust
28 The Autistic Women’s Empowerment Project
29 The British False Memory Society
30 The Children’s Family Trust
31 The Reiki Guild
32 The Retreat York
33 The Survivors Trust
1 Theale Medical Centre
2 Together for Mental Wellbeing
3 Torbay & Southern Devon Health & Care Trust
4 Tracscare
5 Trafford Healthcare NHS Trust
6 Tuke Centre, The
7 UK Pain Society
8 uMotif Digital Health
9 Unite - the Union
10 United Kingdom Council for Psychotherapy
11 United Lincolnshire Hospitals NHS
12 University College Dublin
13 University Hospitals Birmingham
14 University Mental Health Advisors Network
15 University of Bristol Students Health Service
16 University of Chester
17 University of Edinburgh
18 University of Essex
19 University of Portsmouth
20 University of Wolverhampton
21 Voyage Care
22 WellBeing of Women
23 Welsh Government
24 Welsh Government
25 Welsh Government
26 Welsh Health Specialised Services Committee
27 Welsh Scientific Advisory Committee
28 Welsh Scientific Advisory Committee
29 Wembley Centre for health and care, Community Dental Department
30 West London Mental Health Trust
31 Western Health and Social Care Trust
32 White Ribbon Association
33 Wiltshire Council
1 WISH - A voice for women's mental health
2 Women’s Support Network
3 Women's Health Alliance
4 Worcestershire Acute Hospitals Trust
5 Worcestershire Health and Care NHS Trust
6 Wrightington, Wigan and Leigh NHS Foundation Trust
7 Young Person's Advisory Service
8
9
## Appendix E: Researchers contacted to request information about unpublished or soon to be published studies

<table>
<thead>
<tr>
<th>Researcher contacted</th>
<th>Reason</th>
<th>Outcome</th>
<th>Date contacted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chris Fairburn</td>
<td>Clarification on remission numbers in Fairburn 1991 and Fairburn 1993</td>
<td>Author responded with clarification</td>
<td>2/12/2015</td>
</tr>
<tr>
<td>Ivan Eisler</td>
<td>Remission data in terms of Morgan-Russell outcomes for Robin 1999 and Lock 2010</td>
<td>Provided with data from previously published paper</td>
<td>05/10/2015</td>
</tr>
<tr>
<td>Daniel le Grange</td>
<td>Remission data in terms of Morgan-Russell outcomes for Le Grange 2016</td>
<td>Author not responded</td>
<td>28/07/2016</td>
</tr>
<tr>
<td>Simone Munsch</td>
<td>Clarification regarding inconsistent published remission data in Munsch 2007</td>
<td>Researcher provided clarification and correct data by email</td>
<td>30/03/2016</td>
</tr>
<tr>
<td>Glenn Waller</td>
<td>Request for clarification regarding diagnostic accuracy data in Waller 1992</td>
<td>Researcher not able to provide details as was over 20 years ago</td>
<td>09/06/2016</td>
</tr>
<tr>
<td>Christine Vize</td>
<td>Request for data to supplement description of trial in Schmidt 2004</td>
<td>Researcher not able to provide details as trial was conducted in 1980s</td>
<td>17/05/2016</td>
</tr>
</tbody>
</table>
## Appendix F: Review questions and protocols

### Case identification

<table>
<thead>
<tr>
<th>Topic</th>
<th>Identification, assessment and monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review question</td>
<td>What are the utility, validity and reliability of the instruments, tools and methods used for case identification in eating disorders?</td>
</tr>
<tr>
<td>Objectives</td>
<td>To identify valid and reliable tools that can detect eating disorders in clinical samples.</td>
</tr>
<tr>
<td>Population</td>
<td>Children, young people and adults with: early onset of eating disorders, e.g. people with body shape dissatisfaction clinical samples (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). <strong>Strata:</strong> children (≤12), adolescents (13–≤17 years), adults ≥18 years</td>
</tr>
<tr>
<td>Exclude</td>
<td>People with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression). People with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating). People with obesity without an eating disorder. People from the general population where the tool would be used for screening.</td>
</tr>
<tr>
<td>Instruments, tools and methods</td>
<td>The following will be investigated: SCOFF questionnaire DAWBA (self-assessment and parent/clinician component diagnostic and comorbidities) ESP (compared with SCOFF)</td>
</tr>
<tr>
<td>Reference tool</td>
<td>Reference tool (full diagnostic test for both clinical samples and population) DSM ICD-10</td>
</tr>
<tr>
<td>Critical outcomes</td>
<td>Sensitivity (Se): the proportion of true positives of all cases diagnosed in the population Specificity (Sp): the proportion of true negatives of all cases not-diagnosed in the population Positive predictive value Negative predictive value Likelihood values</td>
</tr>
<tr>
<td>Important, but not critical outcomes</td>
<td>VALIDITY Concurrent validity, convergent validity, construct validity, content validity, predictive and discriminant validity RELIABILITY Inter-rater reliability. Intra-rater reliability, test re-test reliability, internal consistency</td>
</tr>
<tr>
<td>Topic</td>
<td>Identification, assessment and monitoring</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Study design</td>
<td>RCT&lt;br&gt;Cohort&lt;br&gt;Cross-sectional</td>
</tr>
<tr>
<td>Include unpublished data?</td>
<td>Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study’s characteristics will be published in the full guideline.</td>
</tr>
<tr>
<td>Restriction by date?</td>
<td>No</td>
</tr>
<tr>
<td>Minimum sample size</td>
<td>N=10 per arm</td>
</tr>
<tr>
<td>Study setting</td>
<td>Primary and secondary</td>
</tr>
<tr>
<td>Search strategy</td>
<td>Databases: Central, Embase, HMIC, Medline, PreMedline, PsycINFO&lt;br&gt;Years searched: inception to current day</td>
</tr>
<tr>
<td>The review strategy</td>
<td>Forest plots of sensitivity and specificity with their 95% confidence intervals will be presented side-by-side for individual studies using RevMan5 software.&lt;br&gt;To show visually any heterogeneity in study results, sensitivity and specificity will be plotted for each study in receiver operating characteristics (ROC) space in RevMan5. A ROC plot shows true positive rate (i.e. sensitivity) as a function of false positive rate (i.e. 1 – specificity).&lt;br&gt;When data from 5 or more studies are available, a diagnostic meta-analysis will be carried out. To show the differences between study results, pairs of sensitivity and specificity will be plotted for each study on one receiver operating characteristics (ROC) curve. Study results will be pooled using the bivariate method for the direct estimation of summary sensitivity and specificity using a random effects approach.&lt;br&gt;This model also assesses the variability by incorporating the precision by which sensitivity and specificity have been measured in each study. A confidence ellipse is shown in the graph that indicates the confidence region around the summary sensitivity / specificity point. A summary ROC curve is also presented.&lt;br&gt;Note: If there is a variation in thresholds across studies, a summary ROC curve is appropriate to summarise the data. If there is a common threshold across studies, a summary estimate point is best used. We report the summary estimate of sensitivity and specificity (plus their 95% confidence intervals) as well as between study variation measured as logit sensitivity and specificity as well as correlations between the two measures of variation. The summary diagnostic odds ratio with its 95% confidence interval is also reported.&lt;br&gt;If data cannot be meta-analysed a narrative of results will be included.</td>
</tr>
<tr>
<td>Heterogeneity (sensitivity analysis and subgroups)</td>
<td>If heterogeneity is found it will first be explored by performing a sensitivity analysis removing papers that carry a high risk of bias. If heterogeneity is still present, the influence of the following subgroups will be considered:&lt;br&gt;Stage of illness/duration (&lt;5 years versus &gt;5 years)&lt;br&gt;Severity (For AN: BMI &lt;16 versus &gt;16. For BED, BN, EDNOS: number of binges per month &lt;18 versus &gt;18)</td>
</tr>
<tr>
<td>Topic</td>
<td>Identification, assessment and monitoring</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>Co-morbidity (presence of comorbidities versus not; e.g. depression/personality disorder/OCD)</td>
<td></td>
</tr>
</tbody>
</table>

### 1 Assessment and monitoring

<table>
<thead>
<tr>
<th>Topic</th>
<th>Identification, assessment and monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review question</td>
<td>What is the validity and reliability of the instruments, tools and methods used to assess and monitor eating disorders?</td>
</tr>
<tr>
<td>Objectives</td>
<td>To identify tools that can reliably monitor the symptoms of eating disorders over time.</td>
</tr>
<tr>
<td>Population</td>
<td>Children, young people and adults with a suspected eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). Strata: children (≤12), adolescents (13≤17 years), adults ≥18 years.</td>
</tr>
<tr>
<td>Exclude</td>
<td>People with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression). People with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating). People with obesity without an eating disorder. People from the general population where the tool would be used for screening.</td>
</tr>
<tr>
<td>Instruments, tools and methods</td>
<td>The following will be investigated as a tool to use after a suspected index case has been raised: EAT, Eating Attitudes test (including different versions: EAT-40, EAT-26, ChEAT etc). EDI Eating Disorder Inventory (distinguish between different versions) BITE Bulimic Investigatory Test, Edinburgh EDE-Q Eating Disorder Examination Questionnaire (distinguish between different versions) SEED ED-15 The Structured Inventory for Anorexic and Bulimic Eating Disorders: available as a structured clinical interview for experts (SIAB-EX) and as a self rating questionnaire(SIAB-S) Munich Eating Disorder Questionnaire and the Anorexia Nervosa Inventory for self-rating (Munich ED-Quest) The Eating Disorder Assessment for DSM-5 (EDA-5): for feeding or eating disorders or related conditions according to the DSM-5 criteria Anorexia Nervosa Inventory for Self-rating (ANIS)</td>
</tr>
<tr>
<td>Reference</td>
<td>Gold standard, relevant ED definition as reported in: DSM ICD-10 EDE –Interview SCID (1)</td>
</tr>
<tr>
<td>Critical outcomes</td>
<td>Sensitivity (Se): the proportion of true positives of all cases diagnosed in the population</td>
</tr>
</tbody>
</table>
### Review questions and protocols

**Eating disorders: recognition and management**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Identification, assessment and monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specificity (Sp):</td>
<td>the proportion of true negatives of all cases not-diagnosed in the population</td>
</tr>
<tr>
<td>Positive predictive value</td>
<td></td>
</tr>
<tr>
<td>Negative predictive value</td>
<td></td>
</tr>
<tr>
<td>Likelihood values</td>
<td></td>
</tr>
</tbody>
</table>

**Important, but not critical outcomes**

| VALIDITY | Concurrent validity, convergent validity, construct validity, content validity, predictive and discriminant validity |
| RELIABILITY | Inter-rater reliability. Intra-rater reliability, test re-test reliability, internal consistency |

**Study design**

| RCT | Cohort | Cross-sectional |

**Include unpublished data?**

| Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline |

**Restriction by date?**

| No |

**Minimum sample size**

| N=10 per arm |

**Study setting**

| Primary and secondary |

**Search strategy**

| Databases: Central, Embase, HMIC, Medline, PreMedline, PsycINFO | Years searched: inception to current day |

**The review strategy**

Forest plots of sensitivity and specificity with their 95% confidence intervals will be presented side-by-side for individual studies using RevMan5 software.

To show visually any heterogeneity in study results, sensitivity and specificity will be plotted for each study in receiver operating characteristics (ROC) space in RevMan5. A ROC plot shows true positive rate (i.e. sensitivity) as a function of false positive rate (i.e. 1 – specificity).

When data from 5 or more studies are available, a diagnostic meta-analysis will be carried out. To show the differences between study results, pairs of sensitivity and specificity will be plotted for each study on one receiver operating characteristics (ROC) curve.

Study results will be pooled using the bivariate method for the direct estimation of summary sensitivity and specificity using a random effects approach.

This model also assesses the variability by incorporating the precision by which sensitivity and specificity have been measured in each study. A confidence ellipse is shown in the graph that indicates the confidence region around the summary sensitivity / specificity point. A summary ROC curve is also presented.

Note: If there is a variation in thresholds across studies, a summary ROC curve is appropriate to summarise the data. If there is a common threshold across studies, a summary estimate point is best used.

We report the summary estimate of sensitivity and specificity (plus their 95% confidence intervals) as well as between study variation measured as logit sensitivity and specificity as well as correlations between the two measures of variation. The summary diagnostic odds ratio with its 95% confidence interval is also reported.
If data cannot be meta-analysed a narrative of results will be included. For systematic reviews the quality will be assessed using the following criteria:

- how relevant the data was for the review
- studies are relevant to the guideline
- literature search is rigorous
- study quality is assessed
- adequate description of the methods.

If heterogeneity is found it will first be explored by performing a sensitivity analysis removing papers that carry a high risk of bias. If heterogeneity is still present, the influence of the following subgroups will be considered:

- Stage of illness/duration (<5 years versus >5 years)
- Severity (For AN: BMI <16 versus >16. For BED, BN, EDNOS: number of binges per month <18 versus >18)
- Co-morbidity (presence of comorbidities versus not; e.g. depression/personality disorder/OCD)

1 Psychological interventions to help parents or carers of children or young people with eating disorders

<table>
<thead>
<tr>
<th>Topic</th>
<th>Interventions to help parents or carers of children or young people with eating disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review question</td>
<td>Does any psychological intervention produce benefits/harms in the parents or carers of children or young people with an eating disorder compared with any other intervention or controls?</td>
</tr>
<tr>
<td>Objectives</td>
<td>To identify psychological interventions that will benefit family or carers with eating disorders</td>
</tr>
<tr>
<td>Population</td>
<td>Family or carers of people with eating disorders</td>
</tr>
<tr>
<td>Exclude</td>
<td>Parents or carers of people with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression). Parents or carers of people with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating). Parents or carers of people with obesity without an eating disorder.</td>
</tr>
<tr>
<td>Intervention</td>
<td>Psychological interventions may include:</td>
</tr>
<tr>
<td></td>
<td>Family based:</td>
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<tr>
<td></td>
<td>Parent only (not necessarily focused on ED)</td>
</tr>
<tr>
<td></td>
<td>Parent focused therapy (PFT)</td>
</tr>
<tr>
<td></td>
<td>Group Parent-Training (GPT)</td>
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<tr>
<td></td>
<td>Separated family therapy</td>
</tr>
<tr>
<td></td>
<td>Parents with child with ED (greater focus on ED)</td>
</tr>
<tr>
<td></td>
<td>Behavioural Family Therapy (BFT)</td>
</tr>
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<td></td>
<td>Behavioural family systems therapy (BFST).</td>
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<td></td>
<td>Family Based Treatment (FBT)</td>
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<tr>
<td></td>
<td>Family Day Workshops (FDW)</td>
</tr>
<tr>
<td></td>
<td>Family Therapy (FT)</td>
</tr>
</tbody>
</table>
## Interventions to help parents or carers of children or young people with eating disorders

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<tbody>
<tr>
<td></td>
<td>Family therapy for anorexia nervosa (FT-AN)</td>
</tr>
<tr>
<td></td>
<td>Multi-Family Group Day Treatment (MFGDT)</td>
</tr>
<tr>
<td></td>
<td>Multi-Family Group Therapy (MFGT)</td>
</tr>
<tr>
<td></td>
<td>Systemic Family Therapy (SFT)</td>
</tr>
<tr>
<td></td>
<td>Systemic Family Therapy for AN (SFT-AN)</td>
</tr>
<tr>
<td></td>
<td>Multifamily therapy (MFT) is synonymous with (MFGT; MFGDT).</td>
</tr>
<tr>
<td></td>
<td>Uniting couples in the treatment of AN (UCAN)</td>
</tr>
<tr>
<td></td>
<td>Conjoint family therapy</td>
</tr>
<tr>
<td>Control</td>
<td>Waiting list</td>
</tr>
<tr>
<td></td>
<td>Treatment as usual</td>
</tr>
<tr>
<td></td>
<td>Another intervention</td>
</tr>
</tbody>
</table>

### Critical outcomes
- Parent’s or carer’s general psychopathology (including mood/depression/anxiety)
- Family functioning.
- Quality of life.
- Other primary outcomes commonly reported in studies that just target the family/carer
  - The following outcomes will be included if the family or carer intervention includes the child or young person with an eating disorder: Remission and long-term recovery (GC decided to include if symptoms were measured over a minimum 2 week period)
  - Binge eating for BN and BED.
  - Body weight / BMI for AN.

### Important, but not critical outcomes
- General functioning
- Resource use.
- Service user experience
- All-cause mortality.
- Adverse events
- Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion)

### Study design
- Systematic reviews
- RCTs

### Include unpublished data?
Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study’s characteristics will be published in the full guideline.

### Restriction by date?
No

### Minimum sample size
N=10 per arm

### Study setting
Primary and secondary

### Search strategy
Databases searched: ASSIA, CDSR, CENTRAL, CINAHL, DARE, Embase, ERIC, HMIC, HTA database, IBSS, Medline, PreMedline, PsycINFO, Social Services Abstracts, Sociological Abstracts

Years searched: inception to current day

### The review strategy
- Reviews
  - Cochrane reviews will be quality assessed and presented if deemed relevant and important.
  - If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since...
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<tr>
<th>Topic</th>
<th>Interventions to help parents or carers of children or young people with eating disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>the review was conducted. If new studies could change the conclusions, we will update the review and conduct a new analysis. If new studies could not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.</td>
</tr>
<tr>
<td>Data analysis</td>
<td>Where appropriate, a meta-analysis will be used to combine results from similar studies. Alternatively, a narrative synthesis will be used. Therapeutic approaches based on similar theories will be grouped together where possible.</td>
</tr>
<tr>
<td>For randomised controlled trials</td>
<td>Outcomes will be downgraded for risk of bias if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the investigators, assessors or participants in some way, i.e. by either not knowing the aim of the study. Outcomes will also downgraded if there is considerable missing data (see below).</td>
</tr>
<tr>
<td>Handling missing data</td>
<td>For remission, the committee agreed to assume that any missing persons from the analysis had not recovered. Thus, intention to treat analysis will be used. Outcomes were downgraded if there was a dropout of more than 20%, or if there was a difference of &gt;20% between the groups.</td>
</tr>
<tr>
<td>For heterogeneity: outcomes will be downgraded once if $I^2$&gt;50%, twice if $I^2$ &gt;80%</td>
<td></td>
</tr>
<tr>
<td>For imprecision: outcomes will be downgraded if: Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes were downgrade one or two levels depending on how many minimal important differences it crosses. Step 2: If a minimal important difference is not crossed, the outcome will be downgraded one level if it does not meet the following criterion for Optimal Information Size: for dichotomous outcomes: &lt;300 events for continuous outcomes: &lt;400 participants</td>
<td></td>
</tr>
<tr>
<td>For clinical effectiveness (favourable or less effective) the following criteria will be used: SMD &lt;0.2 too small to likely show an effect SMD 0.2 small effect SMD 0.5 moderate effect SMD 0.8 large effect RR &lt;0.90 or &gt;1.10 benefit</td>
<td></td>
</tr>
<tr>
<td>Heterogeneity (sensitivity analysis and subgroups)</td>
<td>If heterogeneity is found it will first be explored by performing a sensitivity analysis removing papers that carry a high risk of bias. If heterogeneity is still present, the influence of the following subgroups will be considered: Stage of illness/duration (&lt;5 years versus &gt;5 years) Severity (For AN: BMI &lt;16 versus &gt;16. For BED, BN, EDNOS: number of binges per month &lt;18 versus &gt;18) Co-morbidity (presence of comorbidities versus not; e.g. depression/personality disorder/OCD)</td>
</tr>
</tbody>
</table>
### Interventions to help parents or carers of children or young people with eating disorders

**Notes**

The difference between family/carer psychotherapies with or without the child with an eating disorder is that therapy for the family/carer alone will address any personal problems they have (i.e. marital discord or depression) that may be impacting upon the child’s eating disorder. Whilst therapy with the child will be more practical and address how the home environment is influencing the child’s eating disorder.

The GC agreed not to include observational studies if no RCTs were found because it is a question that RCT evidence would provide the best answers and if none were found, they preferred to make a consensus recommendation or a research recommendation.

## Pharmacological interventions to treat eating disorders in children, young people and adults

<table>
<thead>
<tr>
<th>Topic</th>
<th>Interventions to treat eating disorders in children, young people and adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review question</strong></td>
<td>Does any pharmacological intervention produce benefits/harms on specified outcomes in people with eating disorders?</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>To identify pharmacological interventions that benefit people with eating disorders.</td>
</tr>
</tbody>
</table>
| **Population** | Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder)
Strata:
- children (≤12), adolescents (13–≤17 years), adults ≥18 years
- Eating disorder (Anorexia nervosa, Bulimia nervosa, Binge eating, Atypical eating disorder) |
| **Exclude** | People with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression).
People with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating).
People with obesity without an eating disorder. |
| **Intervention** | Pharmacological intervention
Pharmacological + psychological:
Pharmacological interventions may include:
- Anti-depressants i.e. SSRIs, Fluoxetine – Prozac
- Anxiolytic (antianxiety)
- Antipsychotic
- Anti-emetic medication, i.e. Ondansetron
- Anticonvulsant topiramate/antiepileptic (Topomax)
- Appetite suppressant (i.e. lisdexamfetamine dimesylate) |
| **Control** | Placebo
Waiting list
Treatment as usual
Another intervention (psychological, pharmacological, nutritional, physical) |
| **Critical outcomes for decision making** | Remission and long-term recovery (GC decided to include if symptoms were measured over a minimum 2 week period) |
### Topic

#### Interventions to treat eating disorders in children, young people and adults

- Binge eating for BN and BED.
- Body weight / BMI for AN.
- Adverse events

#### Important, but not critical outcomes

- Quality of life.
- All-cause mortality.
- Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion)
- General psychopathology (including mood/depression/anxiety)
- Relapse.
- General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF).
- Family functioning.
- Adverse events
- Cost effectiveness.
- Resource use.
- Service user experience (in patient vs. community).

#### Study design

- Systematic Reviews
- RCTs

#### Include unpublished data?

- Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study’s characteristics will be published in the full guideline.

#### Restriction by date?

- No

#### Minimum sample size

- N=10 per arm

#### Study setting

- Primary and secondary

#### Search strategy

- Databases searched: ASSIA, CDSR, CENTRAL, CINAHL, DARE, Embase,ERIC, HMIC, HTA database, IBSS, Medline, PreMedline, PsycINFO, Social Services Abstracts, Sociological Abstracts
- Years searched: inception to current day

#### The review strategy

- **Reviews**
  - Cochrane reviews will be quality assessed and presented if deemed relevant and important.
  - If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies could change the conclusions, we will update the review and conduct a new analysis. If new studies could not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.

- **Data analysis**
  - Where appropriate, a meta-analysis will be used to combine results from similar studies. Alternatively, a narrative synthesis will be used. Therapeutic approaches based on similar theories will be grouped together where possible.

- **For randomised controlled trials**
  - Outcomes will be downgraded for risk of bias if the randomisation and/or allocation concealment methods are unclear or inadequate.
  - Outcomes will also be downgraded if no attempts are made to blind the investigators, assessors or participants in some way, i.e. by either not...
<table>
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<tr>
<th>Topic</th>
<th>Interventions to treat eating disorders in children, young people and adults</th>
</tr>
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<tbody>
<tr>
<td>knowing the aim of the study. Outcomes will also downgraded if there is considerable missing data (see below).</td>
<td>Handling missing data</td>
</tr>
<tr>
<td>For remission, the committee agreed to assume that any missing persons from the analysis had not recovered. Thus, intention to treat analysis will be used.</td>
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<td>Outcomes were downgraded if there was a dropout of more than 20%, or if there was a difference of &gt;20% between the groups.</td>
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</tr>
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<td>For heterogeneity: outcomes will be downgraded once if $I^2 &gt; 50%$, twice if $I^2 &gt; 80%$</td>
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</tr>
<tr>
<td>For imprecision: outcomes will be downgraded if:</td>
<td></td>
</tr>
<tr>
<td>Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes were downgraded one or two levels depending on how many minimal important differences it crosses.</td>
<td></td>
</tr>
<tr>
<td>Step 2: If a minimal important difference is not crossed, the outcome will be downgraded one level if it does not meet the following criterion for Optimal Information Size:</td>
<td></td>
</tr>
<tr>
<td>for dichotomous outcomes: &lt;300 events</td>
<td></td>
</tr>
<tr>
<td>for continuous outcomes: &lt;400 participants</td>
<td></td>
</tr>
<tr>
<td>For clinical effectiveness (favourable or less effective) the following criteria will be used:</td>
<td></td>
</tr>
<tr>
<td>SMD &lt;0.2 too small to likely show an effect</td>
<td></td>
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<tr>
<td>SMD 0.2 small effect</td>
<td></td>
</tr>
<tr>
<td>SMD 0.5 moderate effect</td>
<td></td>
</tr>
<tr>
<td>SMD 0.8 large effect</td>
<td></td>
</tr>
<tr>
<td>RR &lt;0.90 or &gt;1.10 benefit</td>
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<tr>
<td>Heterogeneity (sensitivity analysis and subgroups)</td>
<td>If heterogeneity is found it will first be explored by performing a sensitivity analysis removing papers that carry a high risk of bias. If heterogeneity is still present, the influence of the following subgroups will be considered:</td>
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<td>Stage of illness/duration (&lt;5 years versus &gt;5 years)</td>
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<tr>
<td>Severity (For AN: BMI &lt;16 versus &gt;16. For BED, BN, EDNOS: number of binges per month &lt;18 versus &gt;18)</td>
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<tr>
<td>Co-morbidity (presence of comorbidities versus not; e.g. depression/personality disorder/OCD)</td>
<td></td>
</tr>
<tr>
<td>Note</td>
<td>Note: consider the prescription of medications that may be misused or inappropriately prescribed by those with ED.</td>
</tr>
<tr>
<td>The GC agreed not to include observational studies if no RCTs were found because it is a question that RCT evidence would provide the best answers and if none were found, they preferred to make a consensus recommendation or a research recommendation.</td>
<td></td>
</tr>
</tbody>
</table>
**Nutritional interventions to treat eating disorders in children, young people and adults**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Interventions to treat eating disorders in children, young people and adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review question</td>
<td>Does any nutritional intervention produce benefits/harms on specified outcomes in people with eating disorders?</td>
</tr>
<tr>
<td>Objectives</td>
<td>To identify nutritional interventions that benefit people with eating disorders.</td>
</tr>
</tbody>
</table>
| Population | Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder)  
Strata: children (≤12), adolescents (13–≤17 years), adults ≥18 years  
Eating disorder (Anorexia nervosa, Bulimia nervosa, Binge eating, iv. Atypical eating disorder) |
| Exclude | People with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression).  
People with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating).  
People with obesity without an eating disorder. |
| Intervention | Nutritional intervention  
Nutritional intervention in combination with a pharmacological intervention  
Method of feeding  
Example of nutritional interventions  
Nutrition counselling (with or without educational and supportive groups)  
Supplements (e.g. zinc) |
| Control | Waiting list  
Placebo  
Treatment as usual  
Another intervention |
| Critical outcomes for decision making | Remission and long-term recovery (GC decided to include if symptoms were measured over a minimum 2 week period)  
Binge eating for BN and BED.  
Body weight / BMI for AN. |
| Important, but not critical outcomes | Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion)  
General psychopathology (including mood/depression/anxiety)  
General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF).  
Family functioning.  
Adverse events  
Resource use.  
All-cause mortality.  
Quality of life.  
Relapse.  
Service user experience (in patient vs. community). |
<p>| Study design | Systematic Reviews |</p>
<table>
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<tr>
<th>Topic</th>
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<tbody>
<tr>
<td>Include unpublished data?</td>
<td>Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study’s characteristics will be published in the full guideline.</td>
</tr>
<tr>
<td>Restriction by date?</td>
<td>No</td>
</tr>
<tr>
<td>Minimum sample size</td>
<td>N=10 per arm</td>
</tr>
<tr>
<td>Study setting</td>
<td>Primary and secondary</td>
</tr>
<tr>
<td>Search strategy</td>
<td>Databases searched: ASSIA, CDSR, CENTRAL, CINAHL, DARE, Embase, ERIC, HMIC, HTA database, IBSS, Medline, PreMedline, PsycINFO, Social Services Abstracts, Sociological Abstracts. Years searched: inception to current day</td>
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<tr>
<td>The review strategy</td>
<td>Reviews</td>
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<td>Cochrane reviews will be quality assessed and presented if deemed relevant and important.</td>
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<td>If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies could change the conclusions, we will update the review and conduct a new analysis. If new studies could not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.</td>
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<td>For randomised controlled trials</td>
<td>Outcomes will be downgraded for risk of bias if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the investigators, assessors or participants in some way, i.e. by either not knowing the aim of the study. Outcomes will also downgraded if there is considerable missing data (see below).</td>
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<td>For remission, the committee agreed to assume that any missing persons from the analysis had not recovered. Thus, intention to treat analysis will be used. Outcomes were downgraded if there was a dropout of more than 20%, or if there was a difference of &gt;20% between the groups. For heterogeneity: outcomes will be downgraded once if ( I^2 &gt; 50% ), twice if ( I^2 &gt; 80% ). For imprecision: outcomes will be downgraded if: Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes were downgrade one or two levels depending on how many minimal important differences it crosses. Step 2: If a minimal important difference is not crossed, the outcome will be downgraded one level if it does not meet the following criterion for Optimal Information Size:</td>
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<tbody>
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<td>for dichotomous outcomes: &lt;300 events</td>
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<td></td>
<td>for continuous outcomes: &lt;400 participants</td>
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For clinical effectiveness (favourable or less effective) the following criteria will be used:
- SMD <0.2 too small to likely show an effect
- SMD 0.2 small effect
- SMD 0.5 moderate effect
- SMD 0.8 large effect
- RR <0.90 or >1.10 benefit

**Heterogeneity (sensitivity analysis and subgroups)**

If heterogeneity is found it will first be explored by performing a sensitivity analysis removing papers that carry a high risk of bias.

If heterogeneity is still present, the influence of the following subgroups will be considered:

- Stage of illness/duration (<5 years versus >5 years)
- Severity (For AN: BMI <16 versus >16. For BED, BN, EDNOS: number of binges per month <18 versus >18)
- Co-morbidity (presence of comorbidities versus not; e.g. depression/personality disorder/OCD)

**Notes**
The GC agreed not to include observational studies if no RCTs were found because it is a question that RCT evidence would provide the best answers and if none were found, they preferred to make a consensus recommendation or a research recommendation.

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1. **Psychological interventions to treat eating disorders in children, young people and adults**

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<tr>
<th>Topic</th>
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<tbody>
<tr>
<td>Review question</td>
<td>Does any group or individual psychological intervention with or without a pharmacological intervention produce benefits/harms in people with eating disorders compared with any other intervention or controls?</td>
</tr>
<tr>
<td>Objectives</td>
<td>To identify psychological interventions that will benefit people with eating disorders</td>
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<tr>
<td>Population</td>
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<tr>
<td>Exclude</td>
<td>People with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression). People with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating). People with obesity without an eating disorder.</td>
</tr>
</tbody>
</table>
### Interventions to treat eating disorders in children, young people and adults

<table>
<thead>
<tr>
<th>Topic</th>
<th>Interventions that address the symptoms not the eating disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
<td>Psychological intervention including:</td>
</tr>
<tr>
<td></td>
<td>Dialectical behaviour therapy (DBT)</td>
</tr>
<tr>
<td></td>
<td>Counselling (Nutritional/Other)</td>
</tr>
<tr>
<td></td>
<td>Integrative Cognitive-Affective Therapy for Binge Eating (ICAT)</td>
</tr>
<tr>
<td></td>
<td>Maudsley model for treatment of adults with anorexia nervosa (MANTRA)</td>
</tr>
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<td></td>
<td>Cognitive remediation therapy (CRT)</td>
</tr>
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<td>Specialist supportive clinical management for anorexia nervosa (SSCM)</td>
</tr>
<tr>
<td></td>
<td>Behavioural therapy (BT)</td>
</tr>
<tr>
<td></td>
<td>CBT (General or ED specific)</td>
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<tr>
<td></td>
<td>Dynamic (IPT, Psychodynamic General or ED specific)</td>
</tr>
<tr>
<td></td>
<td>Guided Self Help with therapist guidance</td>
</tr>
<tr>
<td></td>
<td>Pure self help</td>
</tr>
<tr>
<td></td>
<td>E-therapies</td>
</tr>
<tr>
<td></td>
<td>Psychological in combination with any pharmacological intervention.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Control</th>
<th>Waiting list</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Treatment as usual</td>
</tr>
<tr>
<td></td>
<td>Another other intervention (psychological, pharmacological, nutritional, physical)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Critical outcomes</th>
<th>Remission and long-term recovery (GC decided to include if symptoms were measured over a minimum 2 week period)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Binge eating for BN and BED.</td>
</tr>
<tr>
<td></td>
<td>Body weight / BMI for AN.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Important, but not critical outcomes</th>
<th>Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General psychopathology (including mood/depression/anxiety)</td>
</tr>
<tr>
<td></td>
<td>Discontinuation (due to any reason or adverse events)</td>
</tr>
<tr>
<td></td>
<td>General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF).</td>
</tr>
<tr>
<td></td>
<td>Family functioning.</td>
</tr>
<tr>
<td></td>
<td>Service user experience</td>
</tr>
<tr>
<td></td>
<td>Resource use.</td>
</tr>
<tr>
<td></td>
<td>Adverse events</td>
</tr>
<tr>
<td></td>
<td>Quality of life.</td>
</tr>
<tr>
<td></td>
<td>All-cause mortality.</td>
</tr>
<tr>
<td></td>
<td>Relapse.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study design</th>
<th>Systematic reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RCTs</td>
</tr>
</tbody>
</table>

| Include unpublished data? | Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study’s characteristics will be published in the full guideline |

<table>
<thead>
<tr>
<th>Restriction by date?</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum sample size</td>
<td>N=10 per arm</td>
</tr>
<tr>
<td>Study setting</td>
<td>Primary and secondary</td>
</tr>
</tbody>
</table>
### Topic

#### Interventions to treat eating disorders in children, young people and adults

**Search strategy**  
Databases searched: ASSIA, CDSR, CENTRAL, CINAHL, DARE, Embase, ERIC, HMIC, HTA database, IBSS, Medline, PreMedline, PsycINFO, Social Services Abstracts, Sociological Abstracts  
Years searched: inception to current day

**The review strategy**  
**Reviews**  
Cochrane reviews will be quality assessed and presented if deemed relevant and important.  
If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies could change the conclusions, we will update the review and conduct a new analysis. If new studies could not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.  

**Data analysis**  
Where appropriate, a meta-analysis will be used to combine results from similar studies. Alternatively, a narrative synthesis will be used. Therapeutic approaches based on similar theories will be grouped together where possible.  

**For randomised controlled trials**  
Outcomes will be downgraded for risk of bias if the randomisation and/or allocation concealment methods are unclear or inadequate.  
Outcomes will also be downgraded if no attempts are made to blind the investigators, assessors or participants in some way, i.e. by either not knowing the aim of the study. Outcomes will also downgraded if there is considerable missing data (see below).  

**Handling missing data**  
For remission, the committee agreed to assume that any missing persons from the analysis had not recovered. Thus, intention to treat analysis will be used.  
Outcomes were downgraded if there was a dropout of more than 20%, or if there was a difference of >20% between the groups.  

For heterogeneity: outcomes will be downgraded once if $I^2 > 50\%$, twice if $I^2 > 80\%$  

For imprecision: outcomes will be downgraded if:  
Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes were downgrade one or two levels depending on how many minimal important differences it crosses.  
Step 2: If a minimal important difference is not crossed, the outcome will be downgraded one level if it does not meet the following criterion for Optimal Information Size:  
for dichotomous outcomes: <300 events  
for continuous outcomes: <400 participants  

For clinical effectiveness (favourable or less effective) the following criteria will be used:  
SMD <0.2 too small to likely show an effect  
SMD 0.2 small effect  
SMD 0.5 moderate effect  
SMD 0.8 large effect
### Topic: Interventions to treat eating disorders in children, young people and adults

<table>
<thead>
<tr>
<th><strong>Review question</strong></th>
<th>Do physical interventions, such as transcranial magnetic stimulation or physiotherapy, produce benefits/harms in people with eating disorders?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>To identify physical interventions, such as TMS or physiotherapy, that benefit people with eating disorders.</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) Strata: children (≤12), adolescents (13–≤17 years), adults ≥18 years</td>
</tr>
<tr>
<td></td>
<td>eating disorder (Anorexia nervosa, Bulimia nervosa, Binge eating, Atypical eating disorder)</td>
</tr>
<tr>
<td><strong>Exclude</strong></td>
<td>People with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression). People with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating). People with obesity without an eating disorder.</td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td>Physical interventions may include:</td>
</tr>
<tr>
<td></td>
<td>transcranial magnetic stimulation</td>
</tr>
<tr>
<td></td>
<td>deep brain stimulation</td>
</tr>
<tr>
<td></td>
<td>physiotherapy</td>
</tr>
<tr>
<td></td>
<td>yoga</td>
</tr>
<tr>
<td></td>
<td>physical exercise</td>
</tr>
<tr>
<td></td>
<td>acupuncture</td>
</tr>
<tr>
<td></td>
<td>mandometer</td>
</tr>
<tr>
<td></td>
<td>massage</td>
</tr>
</tbody>
</table>

1. **Physical interventions to treat eating disorders in children, young people and adults**

2. **Notes**

   The GC agreed not to include observational studies if no RCTs were found because it is a question that RCT evidence would provide the best answers and if none were found, they preferred to make a consensus recommendation or a research recommendation.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Interventions to treat eating disorders in children, young people and adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>Placebo&lt;br&gt;Waiting list&lt;br&gt;Treatment as usual&lt;br&gt;Another intervention</td>
</tr>
<tr>
<td>Critical outcomes for decision making</td>
<td>Remission and long-term recovery (GC decided to include if symptoms were measured over a minimum 2 week period)&lt;br&gt;Binge eating for BN and BED.&lt;br&gt;Body weight / BMI for AN.</td>
</tr>
<tr>
<td>Important, but not critical outcomes</td>
<td>General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF).&lt;br&gt;Quality of life.&lt;br&gt;All-cause mortality.&lt;br&gt;Family functioning.&lt;br&gt;Resource use.&lt;br&gt;Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion)&lt;br&gt;General psychopathology (including mood/depression/anxiety)&lt;br&gt;Relapse.&lt;br&gt;Service user experience.</td>
</tr>
<tr>
<td>Study design</td>
<td>Systematic Reviews&lt;br&gt;RCTs</td>
</tr>
<tr>
<td>Include unpublished data?</td>
<td>Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study’s characteristics will be published in the full guideline</td>
</tr>
<tr>
<td>Restriction by date?</td>
<td>None</td>
</tr>
<tr>
<td>Minimum sample size</td>
<td>N=10 per arm</td>
</tr>
<tr>
<td>Study setting</td>
<td>Primary and secondary</td>
</tr>
<tr>
<td>Search strategy</td>
<td>Databases searched: ASSIA, CDSR, CENTRAL, CINAHL, DARE, Embase, ERIC, HMIC, HTA database, IBSS, Medline, PreMedline, PsycINFO, Social Services Abstracts, Sociological Abstracts&lt;br&gt;Years searched: inception to current day</td>
</tr>
<tr>
<td>The review strategy</td>
<td><strong>Reviews</strong>&lt;br&gt;Cochrane reviews will be quality assessed and presented if deemed relevant and important.&lt;br&gt;If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies could change the conclusions, we will update the review and conduct a new analysis. If new studies could not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.&lt;br&gt;<strong>Data analysis</strong>&lt;br&gt;Where appropriate, a meta-analysis will be used to combine results from similar studies. Alternatively, a narrative synthesis will be used. Therapeutic approaches based on similar theories will be grouped together where possible.&lt;br&gt;<strong>For randomised controlled trials</strong></td>
</tr>
<tr>
<td>Topic</td>
<td>Interventions to treat eating disorders in children, young people and adults</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
|       | Outcomes will be downgraded for risk of bias if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the investigators, assessors or participants in some way, i.e. by either not knowing the aim of the study. Outcomes will also be downgraded if there is considerable missing data (see below). **Handling missing data**<br>For remission, the committee agreed to assume that any missing persons from the analysis had not recovered. Thus, intention to treat analysis will be used. Outcomes were downgraded if there was a dropout of more than 20%, or if there was a difference of >20% between the groups. For heterogeneity: outcomes will be downgraded once if \( I^2 \geq 50\% \), twice if \( I^2 > 80\% \) For imprecision: outcomes will be downgraded if:<br>Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes were downgraded one or two levels depending on how many minimal important differences it crosses.<br>Step 2: If a minimal important difference is not crossed, the outcome will be downgraded one level if it does not meet the following criterion for Optimal Information Size:<br>for dichotomous outcomes: <300 events<br>for continuous outcomes: <400 participants<br>For clinical effectiveness (favourable or less effective) the following criteria will be used:<br>SMD <0.2 too small to likely show an effect<br>SMD 0.2 small effect<br>SMD 0.5 moderate effect<br>SMD 0.8 large effect<br>RR <0.90 or >1.10 benefit |}

Heterogeneity (sensitivity analysis and subgroups) If heterogeneity is found it will first be explored by performing a sensitivity analysis removing papers that carry a high risk of bias. If heterogeneity is still present, the influence of the following subgroups will be considered:<br>- Stage of illness/duration (<5 years versus >5 years)<br>- Severity (For AN: BMI <16 versus >16. For BED, BN, EDNOS: number of binges per month <18 versus >18)<br>- Co-morbidity (presence of comorbidities versus not; e.g. depression/personality disorder/OCD)<br

Notes The GC agreed not to include observational studies if no RCTs were found because it is a question that RCT evidence would provide the best answers and if none were found, they preferred to make a consensus recommendation or a research recommendation.
1 **The management of the physical symptoms and negative after effects of eating disorders, including weight management**

<table>
<thead>
<tr>
<th>Topic</th>
<th>The management of the physical symptoms and negative after effects of eating disorders, including weight management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review question</td>
<td>What interventions are effective at managing or reducing short and long-term physical complications of eating disorders?</td>
</tr>
<tr>
<td>Objectives</td>
<td>To manage potential physical complications of eating disorders.</td>
</tr>
<tr>
<td>Population</td>
<td>Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) Include Recovered service users Current service users Strata: children (≤12), adolescents (13-≤17 years), adults ≥18 years eating disorder (Anorexia nervosa, Bulimia nervosa, Binge eating, Atypical eating disorder)</td>
</tr>
<tr>
<td>Exclude</td>
<td>People with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression). People with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating). People with obesity without an eating disorder.</td>
</tr>
<tr>
<td>Intervention</td>
<td>Interventions to address the following: Low bone mineral density (risk of fracture) Growth (physical development) Pubertal development Tooth wear Low body weight Interventions to address the long-term physical complications may include: GH/IGF-I Calcium with and without Vitamin D Bisphosphonates (age dependent and exclude pregnancy) Exercise (low impact)/Physiotherapy Oestrogen (patches/exogenous/pills other) Testosterone (males/females) Weight gain vs. Weight restoration (brain size) Interventions to address the short-term physical complications may include Phosphates supplementation (refeeding) Potassium Thiamine (refeeding) Laxatives (for when underweight patients are constipated) Salbutamol (reduce food intake)</td>
</tr>
<tr>
<td>Control</td>
<td>Control arm as defined by the study.</td>
</tr>
<tr>
<td>Critical outcomes</td>
<td>Primary outcomes as reported by the study.</td>
</tr>
<tr>
<td>Topic</td>
<td>The management of the physical symptoms and negative after effects of eating disorders, including weight management</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Important, but not critical outcomes</td>
<td>Secondary outcomes as reported by the study.</td>
</tr>
</tbody>
</table>
| Study design | Systematic Reviews  
  RCTS  
  Observational studies: prospective or retrospective cohort (if no RCTs) |
| Include unpublished data? | Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study’s characteristics will be published in the full guideline. |
| Restriction by date? | No |
| Minimum sample size | N=10 per arm |
| Study setting | Primary and secondary |
| Search strategy | Databases searched: ASSIA, CDSR, CENTRAL, CINAHL, DARE, Embase, ERIC, HMIC, HTA database, IBSS, Medline, PreMedline, PsycINFO, Social Services Abstracts, Sociological Abstracts  
  Years searched: inception to current day |
| The review strategy | Reviews  
  Cochrane reviews will be quality assessed and presented if deemed relevant and important.  
  If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies could change the conclusions, we will update the review and conduct a new analysis. If new studies could not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.  
  Data analysis  
  Where appropriate, a meta-analysis will be used to combine results from similar studies. Alternatively, a narrative synthesis will be used. Therapeutic approaches based on similar theories will be grouped together where possible.  
  For randomised controlled trials  
  Outcomes will be downgraded for risk of bias if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the investigators, assessors or participants in some way, i.e. by either not knowing the aim of the study. Outcomes will also downgraded if there is considerable missing data (see below).  
  Handling missing data  
  For remission, the committee agreed to assume that any missing persons from the analysis had not recovered. Thus, intention to treat analysis will be used. Outcomes were downgraded if there was a dropout of more than 20%, or if there was a difference of >20% between the groups.  
  For heterogeneity: outcomes will be downgraded once if $I^2 > 50\%$, twice if $I^2 > 80\%$.  
  For imprecision: outcomes will be downgraded if:  
  Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes were
### Topic

The management of the physical symptoms and negative after effects of eating disorders, including weight management

- Downgrade one or two levels depending on how many minimal important differences it crosses.
- Step 2: If a minimal important difference is not crossed, the outcome will be downgraded one level if it does not meet the following criterion for Optimal Information Size:
  - For dichotomous outcomes: <300 events
  - For continuous outcomes: <400 participants

- For clinical effectiveness (favourable or less effective) the following criteria will be used:
  - SMD <0.2 too small to likely show an effect
  - SMD 0.2 small effect
  - SMD 0.5 moderate effect
  - SMD 0.8 large effect
  - RR <0.90 or >1.10 benefit

#### Heterogeneity (sensitivity analysis and subgroups)

If heterogeneity is found it will first be explored by performing a sensitivity analysis removing papers that carry a high risk of bias. If heterogeneity is still present, the influence of the following subgroups will be considered:

- Stage of illness/duration (<5 years versus >5 years)
- Severity (For AN: BMI <16 versus >16. For BED, BN, EDNOS: number of binges per month <18 versus >18)
- Co-morbidity (presence of comorbidities versus not; e.g. depression/personality disorder/OCD)

#### Notes

The GC agreed not to include observational studies if no RCTs were found because it is a question that RCT evidence would provide the best answers and if none were found, they preferred to make a consensus recommendation or a research recommendation.

### Interventions for eating disorders where there is comorbidity with other mental health or physical health problems

#### 1 Interventions for eating disorders where there is comorbidity with other mental health or physical health problems

<table>
<thead>
<tr>
<th>Topic</th>
<th>Interventions for eating disorders where there is comorbidity with other mental health or physical health problems:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review question</td>
<td>Does any intervention for an eating disorder need to be modified in the presence of common long-term health conditions?</td>
</tr>
<tr>
<td>Objectives</td>
<td>To understand how to manage the behaviour of those with eating disorders and common comorbidities, such as diabetes.</td>
</tr>
<tr>
<td>Population</td>
<td>Children, young people and adults with eating disorders and a common comorbidity such as diabetes and hypothyroidism. Mental comorbidities may include: Depression Anxiety Social anxiety Autism Obsessive Compulsive Disorder Personality Disorder Learning disability</td>
</tr>
</tbody>
</table>
**Topic**

**Interventions for eating disorders where there is comorbidity with other mental health or physical health problems:**

<table>
<thead>
<tr>
<th>Topic</th>
<th>ADHD (Bulimia)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self-harm</td>
</tr>
<tr>
<td></td>
<td>Substance misuse</td>
</tr>
<tr>
<td></td>
<td>Physical comorbidities (highly prevalent) may include:</td>
</tr>
<tr>
<td></td>
<td>Celiac disease</td>
</tr>
<tr>
<td></td>
<td>Diabetes (type II – relevant to obesity)</td>
</tr>
<tr>
<td></td>
<td>Irritable Bowel Disease</td>
</tr>
<tr>
<td></td>
<td>Cystic Fibrosis</td>
</tr>
<tr>
<td></td>
<td>Strata:</td>
</tr>
<tr>
<td></td>
<td>children (≤12), adolescents (13-≤17 years), adults ≥18 years</td>
</tr>
<tr>
<td></td>
<td>eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)</td>
</tr>
</tbody>
</table>

**Exclude**

- People with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression).
- People with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating).
- People with obesity without an eating disorder.

**Intervention**

- Trials will be included that address the ED as primary or secondary aim to treating the comorbidity.
- Interventions may include:
  - Psychotherapy (including psychoeducation)
  - Pharmacological
  - Nutritional
  - Physical
  - Combination of any listed above

**Control**

- The same intervention but delivered to people with an eating disorder without a comorbidity.

**Critical outcomes for decision making**

- Primary outcomes as reported by the studies (will vary depending on the comorbidity)
- Remission and long-term recovery (GC decided to include if symptoms were measured over a minimum 2 week period)
- Binge eating for BN and BED.
- Body weight / BMI for AN.

**Important, but not critical outcomes**

- General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF).
- Quality of life.
- Family functioning.
- Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion)
- General psychopathology (including mood/depression/anxiety)
- Relapse.
- All-cause mortality.
- Resource use.
- Service user experience.

**Study design**

- Systematic Reviews
- RCTs
### Interventions for eating disorders where there is comorbidity with other mental health or physical health problems:

- Observational studies: prospective or retrospective cohort (if no RCTs)

#### Include unpublished data?

Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study’s characteristics will be published in the full guideline.

#### Restriction by date?

No

#### Minimum sample size

10 per arm

#### Study setting

Primary and secondary

#### Search strategy

Databases searched: ASSIA, CDSR, CENTRAL, CINAHL, DARE, Embase, ERIC, HMIC, HTA database, IBSS, Medline, PreMedline, PsycINFO, Social Services Abstracts, Sociological Abstracts

Years searched: inception to current day

#### The review strategy

**Reviews**

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If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies could change the conclusions, we will update the review and conduct a new analysis. If new studies could not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.

**Data analysis**

Where appropriate, a meta-analysis will be used to combine results from similar studies. Alternatively, a narrative synthesis will be used. Therapeutic approaches based on similar theories will be grouped together where possible.

**For randomised controlled trials**

Outcomes will be downgraded for risk of bias if the randomisation and/or allocation concealment methods are unclear or inadequate.

Outcomes will also be downgraded if no attempts are made to blind the investigators, assessors or participants in some way, i.e. by either not knowing the aim of the study. Outcomes will also downgraded if there is considerable missing data (see below).

**Handling missing data**

For remission, the committee agreed to assume that any missing persons from the analysis had not recovered. Thus, intention to treat analysis will be used.

Outcomes were downgraded if there was a dropout of more than 20%, or if there was a difference of >20% between the groups.

For heterogeneity: outcomes will be downgraded once if $I^2 > 50\%$, twice if $I^2 > 80\%$

For imprecision: outcomes will be downgraded if:

- Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes were downgraded one or two levels depending on how many minimal important differences it crosses.
- Step 2: If a minimal important difference is not crossed, the outcome will be downgraded one level if it does not meet the following criterion for Optimal Information Size:
### Interventions for eating disorders where there is comorbidity with other mental health or physical health problems:

- For dichotomous outcomes: <300 events
- For continuous outcomes: <400 participants

For clinical effectiveness (favourable or less effective) the following criteria will be used:
- SMD <0.2 too small to likely show an effect
- SMD 0.2 small effect
- SMD 0.5 moderate effect
- SMD 0.8 large effect
- RR <0.90 or >1.10 benefit

### Heterogeneity (sensitivity analysis and subgroups)

If heterogeneity is found it will first be explored by performing a sensitivity analysis removing papers that carry a high risk of bias. If heterogeneity is still present, the influence of the following subgroups will be considered:

- Stage of illness/duration (<5 years versus >5 years)
- Severity (For AN: BMI <16 versus >16. For BED, BN, EDNOS: number of binges per month <18 versus >18)
- Co-morbidity (presence of comorbidities versus not; e.g. depression/personality disorder/OCD)

### Notes

GC highlighted the transgender community needs special consideration when treating an eating disorder because they are often on hormone replacement therapy.

### Setting, coordinating, transitioning and integrating care

<table>
<thead>
<tr>
<th>Topic</th>
<th>Organisation and delivery of services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review question</strong></td>
<td>Does the setting (inpatient, outpatient or other specific setting) and different ways of coordinating, transitioning and integrating care for treating eating disorders produce benefits/harms in people with eating disorders?</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>To identify the optimal setting for treating people with eating disorders.</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) Strata: children (≤12), adolescents (13–≤17 years), adults ≥18 years eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)</td>
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<tr>
<td><strong>Exclude</strong></td>
<td>People with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression). People with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating). People with obesity without an eating disorder.</td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td>Inpatient care (medical stabilisation, psychological interventions or weight restoration, symptom interruption) provided by a specialist or non-specialist eating disorder service and health professionals; Stepped care Primary care</td>
</tr>
<tr>
<td>Topic</td>
<td>Organisation and delivery of services</td>
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</tr>
<tr>
<td>Control</td>
<td>Outpatient care provided by specialist and non-specialist eating disorder health professionals; Inpatient care from a specialist eating disorder service or a non-specialist service for medical stabilisation that is time limited (maximum three weeks) and discharge before full weight restoration with planned outpatient follow-up; Waiting-list (no active treatment for the eating disorder); Partial hospital or day patient care (more than two contacts per week and more than three hours per day and includes clinician supervised meals).</td>
</tr>
<tr>
<td>Critical outcomes</td>
<td>Remission and long-term recovery (GC decided to include if symptoms were measured over a minimum 2 week period) Binge eating for BN and BED. Body weight / BMI for AN.</td>
</tr>
<tr>
<td>Important, but not critical outcomes</td>
<td>General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF). Family functioning. Resource use. Service user experience. All-cause mortality. Quality of life. Relapse. Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) General psychopathology (including mood/depression/anxiety)</td>
</tr>
<tr>
<td>Study design</td>
<td>Systematic Reviews RCTs Observational studies: prospective or retrospective cohort studies (if no RCTs)</td>
</tr>
<tr>
<td>Include unpublished data?</td>
<td>Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study’s characteristics will be published in the full guideline</td>
</tr>
<tr>
<td>Restriction by date?</td>
<td>No</td>
</tr>
<tr>
<td>Minimum sample size</td>
<td>N=10 per arm</td>
</tr>
<tr>
<td>Study setting</td>
<td>In-patient (UK inpatient is equivalent to residential setting in US) /psychiatric clinic/ other acute paediatric Outpatient care</td>
</tr>
<tr>
<td>Search strategy</td>
<td>Databases searched: ASSIA, CDSR, CENTRAL, CINAHL, DARE, Embase, ERIC, HMIC, HTA database, IBSS, Medline, PreMedline, PsycINFO, Social Services Abstracts, Sociological Abstracts Years searched: inception to current day</td>
</tr>
<tr>
<td>The review strategy</td>
<td>Reviews Cochrane reviews will be quality assessed and presented if deemed relevant and important. If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since</td>
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<td>---------------------------------------</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Data analysis**

Where appropriate, a meta-analysis will be used to combine results from similar studies. Alternatively, a narrative synthesis will be used. Therapeutic approaches based on similar theories will be grouped together where possible.

**For randomised controlled trials**

Outcomes will be downgraded for risk of bias if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the investigators, assessors or participants in some way, i.e. by either not knowing the aim of the study. Outcomes will also downgraded if there is considerable missing data (see below).

**Handling missing data**

For remission, the committee agreed to assume that any missing persons from the analysis had not recovered. Thus, intention to treat analysis will be used.

Outcomes were downgraded if there was a dropout of more than 20%, or if there was a difference of >20% between the groups.

For heterogeneity: outcomes will be downgraded once if $I^2>50\%$, twice if $I^2>80\%$.

For imprecision: outcomes will be downgraded if:

1. If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes were downgraded one or two levels depending on how many minimal important differences it crosses.
2. If a minimal important difference is not crossed, the outcome will be downgraded one level if it does not meet the following criterion for Optimal Information Size:
   - for dichotomous outcomes: <300 events
   - for continuous outcomes: <400 participants

For clinical effectiveness (favourable or less effective) the following criteria will be used:

- SMD <0.2 too small to likely show an effect
- SMD 0.2 small effect
- SMD 0.5 moderate effect
- SMD 0.8 large effect
- RR <0.90 or >1.10 benefit

**Heterogeneity (sensitivity analysis and subgroups)**

If heterogeneity is found it will first be explored by performing a sensitivity analysis removing papers that carry a high risk of bias. If heterogeneity is still present, the influence of the following subgroups will be considered:

- Stage of illness/duration (<5 years versus >5 years)
- Severity (For AN: BMI <16 versus >16. For BED, BN, EDNOS: number of binges per month <18 versus >18)
- Co-morbidity (presence of comorbidities versus not; e.g. depression/personality disorder/OCD)

**Notes**

Key papers to refer to:
### Coordination of care

<table>
<thead>
<tr>
<th>Topic</th>
<th>Organisation and delivery of services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review question</td>
<td>Do different ways of coordinating care produce benefits/harms for people with eating disorders?</td>
</tr>
<tr>
<td>Objectives</td>
<td>To identify hazards associated with various ways of coordinating care for people with eating disorders</td>
</tr>
<tr>
<td>Population</td>
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</tr>
<tr>
<td>Intervention</td>
<td>Case management (named person coordinates patient) vs. none Specialist vs. non-specialist (RCTs) Mental health vs. paediatric (physical health) practitioner Teams vs. individual practitioners Stepped care Compulsory vs. voluntary treatment</td>
</tr>
<tr>
<td>Control</td>
<td>Note the comparison listed against the intervention.</td>
</tr>
<tr>
<td>Critical outcomes</td>
<td>Remission and long-term recovery (GC decided to include if symptoms were measured over a minimum 2 week period) Binge eating for BN and BED. Body weight / BMI for AN.</td>
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</tr>
<tr>
<td>Study design</td>
<td>Systematic Reviews</td>
</tr>
</tbody>
</table>
### Organisation and delivery of services

**Topic**

- RCTs
- Observational studies: prospective or retrospective cohort (if no RCTs)

**Include unpublished data?**

Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline.

**Restriction by date?**

No

**Minimum sample size**

10 per arm

**Study setting**

- Inpatient and outpatient
- Primary and secondary care

**Search strategy**

Databases searched: ASSIA, CDSR, CENTRAL, CINAHL, DARE, Embase, ERIC, HMIC, HTA database, IBSS, Medline, PreMedline, PsycINFO, Social Services Abstracts, Sociological Abstracts

Years searched: inception to current day

**The review strategy**

**Reviews**

Cochrane reviews will be quality assessed and presented if deemed relevant and important.

If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies could change the conclusions, we will update the review and conduct a new analysis. If new studies could not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.

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For remission, the committee agreed to assume that any missing persons from the analysis had not recovered. Thus, intention to treat analysis will be used.

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Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes were downgrade one or two levels depending on how many minimal important differences it crosses.
Eating disorders: recognition and management
Review questions and protocols

### Topic: Organisation and delivery of services

**Step 2:** If a minimal important difference is not crossed, the outcome will be downgraded one level if it does not meet the following criterion for Optimal Information Size:
- for dichotomous outcomes: <300 events
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For clinical effectiveness (favourable or less effective) the following criteria will be used:
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- Co-morbidity (presence of comorbidities versus not; e.g. depression/personality disorder/OCD)

---

### Consent and compulsory treatment

#### Review question

What factors/indicators should be considered when assessing whether a person with an eating disorder should be admitted for compulsory treatment (including any form of restrictive interventions usually implemented in refeeding).

#### Objectives

To identify factors that need to be considered when admitting a person with an eating disorder for compulsory treatment.

#### Population

Children, young people and adults with eating disorders who need to be admitted for compulsory treatment.

**Strata:**
- children (≤12), adolescents (13≤17 years), adults ≥18 years
- Eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)

#### Exclude

People with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression).

People with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating).

People with obesity without an eating disorder.

#### Factors

The following factors may be considered when admitting for compulsory treatment:
- body weight
- consent
- family functioning
<table>
<thead>
<tr>
<th>Topic</th>
<th>Consent and compulsory treatment:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>general functioning or general mental health functioning measures such as Global Assessment of Functioning (GAF).</td>
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<td></td>
<td>other medical indicators (i.e. low potassium)</td>
</tr>
<tr>
<td></td>
<td>MARSIPAN check list</td>
</tr>
<tr>
<td>Critical outcomes</td>
<td>Primary outcomes as reported by the authors (may include ANOVA, or multiple regression analysis showing what factors are associated with a higher likelihood of compulsory treatment)</td>
</tr>
<tr>
<td>Important, but not critical outcomes</td>
<td>Secondary outcomes as reported by the papers</td>
</tr>
<tr>
<td>Study design</td>
<td>Individual patient data meta-analysis</td>
</tr>
<tr>
<td></td>
<td>Systematic reviews</td>
</tr>
<tr>
<td></td>
<td>Observational non-RCT studies (prospective, retrospective or cross-sectional studies)</td>
</tr>
<tr>
<td></td>
<td>RCTs will be included if they provided a multiple regression analysis looking at predictors of any relevant outcomes</td>
</tr>
<tr>
<td></td>
<td>It is important to note that a regression analysis only shows a link between a factor and an outcome, it cannot establish whether the factor plays any causal role in the onset of the disorder.</td>
</tr>
<tr>
<td>Include unpublished data?</td>
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<td>No.</td>
</tr>
<tr>
<td>Minimum sample size</td>
<td>10 per arm</td>
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<tr>
<td>Study setting</td>
<td>Primary and secondary</td>
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<td>In-patient and outpatient</td>
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<td></td>
<td>Data analysis</td>
</tr>
<tr>
<td></td>
<td>A narrative may be presented showing the results from a multiple logistic regression analysis or ANOVA. The studies should report which factors are strongly associated with:</td>
</tr>
<tr>
<td></td>
<td>the likelihood of compulsory treatment or</td>
</tr>
<tr>
<td></td>
<td>a better/worse outcome from compulsory treatment</td>
</tr>
<tr>
<td>Notes</td>
<td>Possible questions or aims asked by the authors in the studies found:</td>
</tr>
<tr>
<td></td>
<td>What is the outcome of mandatory admission/compulsory treatment in patients with an ED?</td>
</tr>
<tr>
<td>Topic</td>
<td>Consent and compulsory treatment:</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>What are the risk factors for the use of compulsory treatment in</td>
<td>What are the risk factors for the use of compulsory treatment in patients with an ED?</td>
</tr>
<tr>
<td>patients with an ED?</td>
<td>How to decide when to stop treating eating disorders? (may include managed death/ethical issue)</td>
</tr>
<tr>
<td>How to decide when to stop treating eating disorders? (may include</td>
<td>When to begin compulsory treatment at the assessment stage (including the MH act/at the courts)?</td>
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<td>Guidance on how to maintain management (i.e. advice for those who experience repeated admissions)</td>
</tr>
<tr>
<td>When to begin compulsory treatment at the assessment stage</td>
<td>Key papers:</td>
</tr>
<tr>
<td>(including the MH act/at the courts)?</td>
<td>Control and compulsory treatment in anorexia nervosa: the views of patients and parents. Tan JO,</td>
</tr>
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<td>Guidence on how to maintain management (i.e. advice for those who</td>
<td>Hope T, Stewart A, Fitzpatrick R. Int J Law Psychiatry. 2003 Nov-Dec;26(6):627-45</td>
</tr>
<tr>
<td>experience repeated admissions)</td>
<td>Attitudes of patients with anorexia nervosa to compulsory treatment and coercion. Tan JO,</td>
</tr>
<tr>
<td>Control and compulsory treatment in anorexia nervosa: the views of</td>
<td>Compulsory treatment in anorexia nervosa: a review. Elzakkers IF1, Danner UN, Hoek HW, Schmidt</td>
</tr>
</tbody>
</table>
Appendix G: Research recommendations

The Guideline Committee has made the following recommendations for research. The Committee’s full set of research recommendations is detailed in the full guideline.

Psychological treatments for binge eating disorder

- Compare the clinical and cost-effectiveness of individual eating-disorder focused cognitive behavioural therapy (CBT-ED) with guided self-help and group CBT-ED for adults with binge eating disorder.
- Investigate the clinical and cost effectiveness of psychological treatments for children and young people with binge eating disorder.

Why this is important

- There is little evidence on psychological treatments for people with binge eating disorder. The studies that have been published have not always provided remission outcomes or adequate definitions of remission. While there is some evidence for guided self-help and individual CBT-ED, only 1 study was identified for individual CBT-ED and no remission data were available. It is also unclear if individual CBT-ED is more effective than guided self-help or group CBT-ED (especially for people that find these treatments ineffective).
- There is also very little evidence for treatments for young people. One study was found on individual CBT-ED, but only 26 participants were included in the data for remission. The evidence on family therapy and internet-based self-help is scarce and shows no real benefit.
- Randomised controlled trials should be carried out to compare the clinical and cost effectiveness of psychological treatments for adults, children and young people with binge eating disorder. In adults, the treatment should focus on the effectiveness of individual CBT-ED compared with guided self-help and group CBT-ED. For children and young people, family-based therapy should be included and compared with individual CBT-ED and different kinds of self-help (such as internet self-help, guided self-help). Primary outcome measures could include:
  - remission
  - bingeing and other compensatory behaviours
  - weight or BMI.
- For both trials, there should be at least a 6-month to 1-year follow-up. Qualitative data could also be collected on the service user’s and (if appropriate) their parents’ or carers’ experience of the treatment. Other factors that have an effect on treatment effectiveness should also be measured, so that treatment barriers can be addressed and positive factors can be promoted.

Duration of psychological treatment

- Are shorter psychological treatment lengths equally effective compared with the treatment lengths recommended in this guideline for children, young people and adults with an eating disorder?

Why this important

- The psychological treatments currently recommended consist of a high number of sessions (typically between 20 and 40) delivered over a long period of time. Attending a high number
of sessions is a major commitment for a person with an eating disorder and a large cost for services, but people may be able to achieve remission with a smaller number of sessions.

Randomised controlled trials of the psychological treatments recommended in this guideline should be carried out to compare whether a reduced number of sessions is as effective as the recommended number. Primary outcome measures could include:

- remission
- bingeing and other compensatory behaviours
- weight or BMI.

Factors that have an effect on treatment effectiveness should also be measured, so that treatment barriers can be addressed and positive factors can be promoted.

G.3 Stepped care for psychological treatment

Evaluate the effectiveness of stepped care for psychological treatment of eating disorders for people of all ages.

G.3.1 Why this is important.

There is little evidence to show whether people with an eating disorder benefit from a stepped care approach for those who do not respond to treatment (for example, more sessions of the same treatment or an alternative treatment).

Clinicians may be unsure about what to do if first-line treatment is ineffective, so more studies are needed to investigate the effectiveness of stepped care. Randomised controlled trials should be carried out for people who have found a first-line psychological treatment ineffective after a predetermined number of sessions. They should be randomised to either a more intensive treatment, to continued treatment or to an alternative treatment. Primary outcome measures may include:

- remission
- bingeing and other compensatory behaviours
- weight or BMI.

Factors that have an effect on treatment effectiveness should also be measured, so that treatment barriers can be addressed and positive factors can be promoted.

G.4 Treating an eating disorder in people with a comorbidity

Do treatments need to be modified for people of all ages with an eating disorder and a comorbidity?

G.4.1 Why this is important

People with an eating disorder often have physical or mental health comorbidities (such as substance abuse or diabetes). However, there is little evidence on which treatments work best for people with an eating disorder and a comorbidity. A modified eating disorder therapy that addresses both conditions may avoid the need for different types of therapy (either in parallel or one after the other). Alternatively, a comorbidity may be severe enough that it needs addressing before treating the eating disorder, or treatment solely for the eating disorder may help with the comorbidity.

This is a complex area and likely to depend on the severity of the comorbidity and the eating disorder. There is limited evidence and randomised controlled trials are needed. For example, a trial could randomise people with an eating disorder and the same comorbidity
Eating disorders: recognition and management
Research recommendations

1 (such as type I diabetes) to either a modified eating disorder therapy or a non-modified eating disorder therapy. Primary outcome measures may include:

- remission
- bingeing and other compensatory behaviours
- weight or BMI
- critical outcomes relating to the specific comorbidity.

Other factors that have an effect on treatment effectiveness should also be measured, so that treatment barriers can be addressed and positive factors can be promoted.

G.5 Treating eating disorders in men

How effective are the current guideline recommendations in improving symptoms and remission rates for men (aged over 18 years) with an eating disorder?

G.5.1 Why this is important.

While eating disorders have a higher incidence in females, males are also at risk. Research from the eating disorders charity Beat suggests more than 725,000 people in the UK are affected by an eating disorder and the National Institute of Health and Care Excellence estimates around 11% of those affected by an eating disorder are male. However, there is very little evidence on eating disorders in men.

Psychological treatments recommended in the guideline should be investigated using randomised controlled trials in men with eating disorders, to assess whether they are effective or if alternatives should be recommended. Primary outcome measures could include:

- remission
- bingeing and other compensatory behaviours
- weight or BMI.

Factors that have an effect on treatment effectiveness should also be measured, so that treatment barriers can be addressed and positive factors can be promoted.