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Eating disorders: recognition and treatment

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NICE guideline: short version

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Draft for consultation, December 2016

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This guideline covers assessment, treatment, monitoring and inpatient care for people with eating disorders. In addition to general recommendations for all eating disorders, specific recommendations are made on the treatment of anorexia nervosa, bulimia nervosa, binge eating disorder and other specified feeding and eating disorders (OSFED).

Who is it for?

- Healthcare professionals responsible for assessing and treating eating disorders.
- Commissioners of eating disorder services.
- Other professionals who may provide public services to people with eating disorders (including in criminal justice and education settings).
- People with suspected or diagnosed eating disorders and their families and carers.

This guideline will update and replace NICE guideline CG9 (published January 2004).

New recommendations have been made on assessment, treatment, monitoring and inpatient care for people with eating disorders.

This version of the guideline contains the draft recommendations, context and recommendations for research. Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the guideline committee's discussion and the evidence reviews (in

the full guideline), the scope, and details of the committee and any declarations of interest.

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Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity) and safeguarding.

1.1 General principles of care

Improving access to services

1.1.1 Be aware that people with an eating disorder may:

- avoid contact with and find it difficult or distressing to interact with healthcare professionals, staff and other service users
- be vulnerable to stigma and shame.

1.1.2 Ensure that people with an eating disorder and their parents or carers (as appropriate) get equal access to treatments for eating disorders, regardless of:

- gender or gender identity (including people who are transgender)
- sexual orientation
- religion, belief, culture or family origin
- where they live and who they live with
- any mental or physical health problems or disabilities.

Communication and information

1.1.3 When assessing a person with a suspected eating disorder, find out what they and their family members or carers (as appropriate) know about eating disorders and address any misconceptions.

1.1.4 Offer people with eating disorders and their family members or carers (as appropriate) education and information on:

- the nature and risks of their eating disorder and how it is likely to affect them
- the treatments available and their likely benefits and limitations.

1.1.5 When communicating with people with an eating disorder and their family members or carers (as appropriate):

- check that they understand what is being said
- be sensitive when discussing a person's weight and appearance
- be aware that family members or carers may feel guilty and responsible for the eating disorder
- show empathy, compassion and respect.

1.1.6 Ensure that people with an eating disorder and their parents or carers (as appropriate) understand the purpose of any meetings and the reasons for sharing information about their care with others.

Support for children and young people with an eating disorder

1.1.7 For children and young people, assess the impact of their home, education, work and wider social environment on their eating disorder. Ensure that their emotional, education and social needs are met throughout treatment.

1.1.8 If appropriate, encourage family members, carers, teachers, and peers of children and young people to support them during their treatment.

Working with family members and carers

1.1.9 Be aware that the family members or carers of a person with an eating disorder may experience severe distress. Offer them an assessment of their own needs, including:

- what impact the eating disorder has on them
- what support they need, including practical support and emergency plans for increasing medical or psychiatric risk.

1.1.10 If appropriate, provide written information for family members or carers who cannot attend meetings with their child for assessment or treatment of an eating disorder.

Consent and confidentiality

1.1.11 When working with people with an eating disorder and their family members or carers (as appropriate):

- hold discussions in places where confidentiality, privacy and dignity can be respected
- explain the limits of confidentiality (that is, which health and social care professionals have access to information about their care and when this may be shared with others).

1.1.12 When seeking consent for assessments or treatments for children or young people under 16, respect Gillick competence if they do not want their family members or carers involved.

Training and competencies

1.1.13 Health, social care and education professionals working with children and young people with an eating disorder should be trained and skilled in:

- negotiating and working with parents and carers
- managing issues around information sharing and confidentiality
- safeguarding
- working with multidisciplinary teams.

1.1.14 Professionals who assess and treat eating disorders should be competent to do this for the age groups they care for.

1.1.15 Base the content, structure and duration of psychological treatments on relevant manuals that focus on eating disorders.

1.1.16 Professionals who provide treatments for eating disorders should:

- receive appropriate supervision
- use standardised outcome measures, for example the Eating Disorder Examination Questionnaire (EDE-Q), bulimic behaviours or weight
- monitor their competence (for example, by using recordings and external audit and scrutiny)
- monitor treatment adherence in people who use their service.

1.2 Identification and assessment

Initial assessments in primary and secondary mental health care

1.2.1 Be aware that eating disorders present in a range of settings, including:

- primary and secondary health care
- social care
- education.

1.2.2 Think about the possibility of an eating disorder in people with one or more of the following:

- an unusually low or high BMI or body weight for their age
- dieting or restrictive eating practices (such as dieting when they are underweight) that are worrying them, their family members or carers, or professionals
- family members or carers report a change in eating behaviour
- other mental health problems
- a disproportionate concern about their weight (for example, concerns about weight gain as a side effect of contraceptive medication)

- problems managing a chronic illness that affects diet, such as diabetes
- menstrual or other endocrine disturbances, or unexplained gastrointestinal symptoms
- physical signs of:
  - starvation, such as poor circulation, dizziness, palpitations, fainting or pallor
  - compensatory behaviours, such as laxative misuse, vomiting or excessive exercise
- dental erosion
- taking part in activities associated with a high risk of eating disorders (for example, professional sport, fashion, dance, or modelling).

1.2.3 When assessing for an eating disorder, think about all of the points in recommendation 1.2.2 regardless of the person's gender, ethnicity or socio-economic background.

1.2.4 Think about the possibility of an eating disorder in children and young people with poor growth (for example a low weight or height for their age).

1.2.5 Be aware that the risk of eating disorders is highest in young women (13–17 years), and that young men are also at greater risk between 13 and 17 years than at other ages.

1.2.6 Do not use screening tools (for example SCOFF) as the sole method to determine whether or not people have an eating disorder.

1.2.7 Do not use single measures such as BMI or duration of illness to determine whether to offer treatment for an eating disorder.

1.2.8 Professionals in primary and secondary mental health settings should assess the following in people with a suspected eating disorder:

- their physical health, including checking for any physical effects of starvation or of compensatory behaviours such as vomiting
- the presence of mental health problems commonly associated with eating disorders, including depression, anxiety, self-harm and obsessive compulsive disorder
- the possibility of alcohol or substance misuse
- the need for emergency care in people whose physical health is compromised or who have a suicide risk.

Referral

1.2.9 If an eating disorder is still suspected after the initial assessment, refer without delay to:

- a community based, age-appropriate eating disorders service for an assessment and treatment (if possible) **or**
- day patient or inpatient services for people with clinical signs in the concern or alert ranges (see recommendations 1.10.2 and 1.11.4).

Coordination of care for people with an eating disorder

1.2.10 Take particular care to ensure services are well coordinated when:

- a young person moves from children's to adult services (see the NICE guideline on transition from children's to adults' services)
- more than one service is involved (such as inpatient and outpatient services, or when a comorbidity is being treated by a separate service)
- people need care in different places at different times of the year (for example, university students).

Safeguarding

1.2.11 Healthcare professionals assessing children and young people with eating disorders should be alert throughout assessment and treatment to signs of bullying, teasing, abuse (emotional, physical

and sexual) and neglect. For guidance on when to suspect child maltreatment, see the NICE guideline on child maltreatment.

Treating anorexia nervosa

1.2.12 Be aware that a key goal of treatment for anorexia nervosa is to help people reach a healthy body weight or BMI for their age.

1.2.13 When weighing people with anorexia, consider sharing the results with them and (if appropriate) their family members or carers.

Psychological treatment for adults with anorexia nervosa

1.2.14 Consider either individual eating-disorder-focused cognitive behavioural therapy (CBT-ED) or eating-disorder-focused focal psychodynamic therapy for adults with anorexia nervosa.

1.2.15 Individual CBT-ED programmes for adults with anorexia nervosa should:

- use a CBT-ED manual
- consist of up to 40 sessions over 40 weeks
- aim to reduce the risk to physical health and any other symptoms of the eating disorder
- encourage reaching a healthy body weight and healthy eating
- cover nutrition, relapse prevention, cognitive restructuring, mood regulation, social skills, body image concern and self-esteem
- create a personalised treatment plan based on the processes that appear to be maintaining the eating problem
- explain the risks of starvation and being underweight
- enhance self-efficacy
- include self-monitoring
- include homework, to help the person practice what they have learned in their daily life.

1.2.16 Eating-disorder-focused focal psychodynamic therapy programmes for adults with anorexia nervosa should:

- use a focal psychodynamic manual specific to eating disorders
- consist of up to 40 sessions over 40 weeks
- include psychoeducation about nutrition and the effects of starvation
- make a patient-centred focal hypothesis that is specific to the individual and addresses:
  - what the symptoms mean to the person
  - how the symptoms affect the person
  - how the symptoms influence the person's relationships with others and with the therapist
- in the first phase, focus on developing the therapeutic alliance between the therapist and person with anorexia nervosa, addressing pro-anorexic behaviour and ego-syntonic beliefs (beliefs, values and feelings consistent with the person's sense of self) and building self-esteem
- in the second phase, focus on relevant relationships with other people and how these affect eating behaviour
- in the final phase, focus on transferring the therapy experience to situations in everyday life and address any concern the person has about what will happen when treatment ends.

1.2.17 If individual CBT-ED or focal psychodynamic-ED is ineffective, not available or not acceptable for adults with anorexia nervosa, consider specialist supportive clinical management (SSCM) or the Maudsley Anorexia Treatment for Adults (MANTRA).

Psychological treatment for young people with anorexia nervosa

1.2.18 Consider anorexia-nervosa-focused family therapy for young people with anorexia nervosa, delivered as single- or multi-family therapy and with sessions provided either:

- separately for the young person and for their family members and carers or
- for the young person and their family together.

1.2.19 Anorexia-nervosa-focused family therapy for young people with anorexia nervosa should:

- use a family-based treatment for eating disorders manual
- consist of 18–20 sessions over at most one year
- review the needs of the young person 4 weeks after treatment begins and then every 3 months, to establish how regular sessions should be and how long treatment should last
- emphasise the role of the family in helping the young person to recover
- not blame the young person or their family members or carers
- include psychoeducation about nutrition and the effects of starvation
- in the first phase, aim to establish a good therapeutic alliance with the young person, their parents or carers and other family members
- help the parents or carers take charge of the young person's eating and return control to the young person when they are ready
- in the final phase:
  - support the young person (with help from their parents or carers) to establish a level of independence appropriate for their level of development
  - focus on plans for when treatment ends (including any concerns the young person and their family have) and on relapse prevention.

1.2.20 Consider support for family members who are not involved in the family therapy, to help them to cope with distress caused by the condition.

1.2.21 Consider giving young people with anorexia nervosa additional appointments separate from their family members or carers.

1.2.22 If family therapy is unacceptable, contraindicated or ineffective for young people with anorexia nervosa, consider individual CBT-ED or adolescent focused eating disorder therapy.

1.2.23 Assess whether family members or carers (as appropriate) need support if the young person with anorexia nervosa is having therapy on their own.

Dietary advice for those with anorexia nervosa

1.2.24 Only offer dietary counselling as part of a multidisciplinary approach.

1.2.25 Encourage people with anorexia nervosa to take an age-appropriate oral multi-vitamin and multi-mineral supplement until their diet includes enough to meet their dietary reference values.

1.2.26 Include family members or carers (as appropriate) in any dietary education or meal planning for children and young people with anorexia nervosa who are having therapy on their own.

1.2.27 Offer individualised supplementary dietary advice to children and young people with anorexia nervosa and their parents or carers (as appropriate) to help them meet their nutritional needs for growth and development (particularly during puberty).

Medication

1.2.28 Do not offer medication as the sole treatment for anorexia nervosa.

Low bone mineral density in women with anorexia nervosa

1.2.29 Explain to women with anorexia nervosa that the primary aim of prevention and treatment of a low bone mineral density is to achieve and maintain a healthy body weight or BMI for their age.

1.2.30 Do not routinely offer oral or transdermal oestrogen therapy to treat low bone mineral density in children or young people with anorexia nervosa.

1.2.31 Seek specialist paediatric or endocrinological advice before starting any hormonal treatment for a low bone mineral density. Coordinate any treatment with the eating disorders team.

1.2.32 Consider transdermal 17-β-estradiol (with cyclic progesterone) for young women (aged 13–17 years) with anorexia nervosa who have long-term low body weight and low bone mineral density with a bone age over 15.

1.2.33 Consider incremental physiological doses of oestrogen in young women (aged 13–17 years) with anorexia nervosa who have delayed puberty, long-term low body weight and low bone mineral density with a bone age under 15.

1.2.34 Consider bisphosphonates for women (18 years and over) with anorexia nervosa who have long-term low body weight and low bone mineral density. Discuss the benefits and risks (including risk of teratogenic effects) with women before starting treatment.

1.2.35 Advise people with anorexia nervosa and osteoporosis or related bone disorders to avoid high-impact physical activities and activities that significantly increase the chance of falls or fractures.

1.3 Treatment of bulimia nervosa

Psychological treatment for adults

1.3.1 Consider bulimia-nervosa-focused guided self-help for adults with bulimia nervosa.

1.3.2 Bulimia-nervosa-focused guided self-help programmes for adults with bulimia nervosa should:

- use a cognitive behavioural self-help book for eating disorders
- supplement the self-help programme with brief supportive sessions (for example four to nine sessions lasting 20 minutes each over 16 weeks running weekly at first)

- be delivered by a practitioner who is competent in delivering the treatment.

1.3.3 If bulimia-nervosa-focused guided self-help is ineffective after 4 weeks or is not acceptable, consider individual eating-disorder-focused cognitive behavioural therapy (CBT-ED).

1.3.4 Individual CBT-ED for adults with bulimia nervosa should:

- follow a CBT-ED manual
- consist of up to 20 sessions over 20 weeks, with sessions held twice-weekly in the first phase
- in the first phase focus on:
  - engagement and education
  - establishing a pattern of regular eating, and providing encouragement, advice and support while people do this
- follow by addressing the eating disorder psychopathology (that is, the extreme dietary restraint, the concerns about body shape and weight, and the tendency to binge in response to difficult thoughts and feelings)
- towards the end of treatment, spread appointments further apart and focus on maintaining positive changes and minimising the risk of relapse
- if appropriate, involve significant others to help with one-to-one treatment.

1.3.5 Explain to people with bulimia nervosa that psychological treatments have a limited effect on body weight.

Psychological treatment for young people

1.3.6 Offer bulimia-nervosa-focused family therapy to young people with bulimia nervosa.

1.3.7 Bulimia-nervosa-focused family therapy for young people with bulimia nervosa should:

- use a bulimia-nervosa-focused family therapy manual
- consist of 18–20 sessions over 6 months
- support and encourage the family to help the young person recover
- not blame the young person or their family members or carers
- include information about regulating body weight, dieting and the adverse effects of controlling weight with self-induced vomiting or laxatives
- establish a good therapeutic relationship with the young person and their family members or carers
- use a collaborative approach between the parents and the young person to establish regular eating patterns and minimise compensatory behaviours
- include regular meetings with the young person on their own throughout the treatment
- include self-monitoring of bulimic behaviours and discussions with family members or carers
- in later phases of treatment, support the young person and their family members or carers to establish a level of independence appropriate for their level of development
- in the final phase of treatment, focus on plans for when treatment ends (including any concerns the young person and their family have) and on relapse prevention.

1.3.8 If family therapy is ineffective, or is not acceptable, consider bulimia-nervosa-focused guided self-help for young people with bulimia nervosa.

Medication

1.3.9 Do not offer medication as the sole treatment for bulimia nervosa.

1.4 Treating binge eating disorder

Psychological treatment for adults

1.4.1 Offer a binge-eating-focused guided self-help programme to adults with binge eating disorder.

1.4.2 Binge-eating-focused guided self-help programmes for adults should:

- use a cognitive behavioural self-help book
- focus on adherence to the self-help programme
- supplement the self-help programme with brief supportive sessions (for example four to nine sessions lasting 20 minutes each over 16 weeks that are first run weekly):
  - delivered by a practitioner who is competent in delivering the treatment
  - that focus exclusively on helping the person follow the programme.

1.4.3 If guided self-help is ineffective after 4 weeks or is not acceptable, offer group eating-disorder-focused cognitive behavioural therapy (CBT-ED).

1.4.4 Group CBT-ED programmes for adults with binge eating disorder should:

- use a CBT-ED manual
- consist of 16 weekly 90-minute group sessions over four months
- focus on psychoeducation, self-monitoring of the eating behaviour and helping the person analyse their problems and goals
- include making a daily food intake plan and identifying binge eating cues
- include body exposure training and helping the person to identify and change negative beliefs about their body

- help with avoiding relapses and coping with current and future risks and triggers.

1.4.5 Explain to people with binge eating disorder that psychological treatments aimed at treating binge eating have a limited effect on body weight and that weight loss is a post-therapy target. Refer to the NICE guideline on obesity identification, assessment and management for guidance on weight loss and bariatric surgery.

Psychological treatment for young people

1.4.6 For young people with binge eating disorder, offer the same treatments recommended for adults with binge eating disorder.

Medication

1.4.7 Do not offer medication as the sole treatment for binge eating disorder.

1.5 Treating other specified feeding and eating disorders (OSFED)

Psychological treatment

1.5.1 For people with OSFED, consider using the treatments for the eating disorder it most closely resembles.

1.6 Treating eating disorders in children

Psychological treatment

1.6.1 For children with an eating disorder, consider using the treatments recommended for young people with the same eating disorder.

1.7 Physical therapy for any eating disorder

1.7.1 Do not offer a physical therapy (such as transcranial magnetic stimulation, acupuncture, eye movement desensitisation, weight training, yoga or warming therapy) as part of the treatment for eating disorders.

1.8 Physical and mental health comorbidities

1.8.1 Eating disorder specialists and other care teams should collaborate when caring for people with physical or mental health comorbidities that may be affected by their eating disorder.

1.8.2 When collaborating, teams should use outcome measures for both the eating disorder and the physical and mental health comorbidities, to monitor the effectiveness of treatments for each condition and the potential impact they have on each other.

Diabetes

1.8.3 Eating disorder teams and diabetes teams should collaborate to explain the importance of physical health monitoring to people with an eating disorder and diabetes.

1.8.4 Consider involving family members and carers (as appropriate) in the treatment programme to help the person with blood glucose control.

1.8.5 Agree between the eating disorder and diabetes teams who has responsibility for monitoring the physical health of people with an eating disorder and diabetes.

1.8.6 Explain to the person and their diabetes team that they may need to monitor their blood glucose control more closely during the treatment for the eating disorder.

1.8.7 Address insulin misuse as part of any psychological treatments for eating disorders in people with diabetes.

1.8.8 Offer people with an eating disorder who are misusing insulin the following treatment plan:

- a low carbohydrate diet, so that insulin can be started at a low level
- gradually increasing insulin doses to reduce blood glucose levels

- adjusted total glycaemic load and carbohydrate distribution to meet their individual needs and prevent rapid weight gain
- carbohydrate counting when adjusting their insulin dose (including via pumps)
- a diabetic educational intervention such as DAFNE
- education about the problems caused by misuse of diabetes medication.

1.8.9 For more guidance on managing diabetes, refer to the NICE guidelines on type 1 and type 2 diabetes in children and young people, type 1 diabetes in adults, and type 2 diabetes in adults.

Comorbid mental health problems

1.8.10 When deciding which order to treat an eating disorder and a comorbid mental health condition (in parallel, as part of the treatment or one after the other), take the following into account:

- the severity and complexity of the eating disorder and comorbidity
- the person's level of functioning
- the patient's preference.

1.8.11 Refer to the NICE guidelines on specific mental health problems for further guidance on treatment.

Medication risk management

1.8.12 When prescribing medication for people with an eating disorder and comorbid mental or physical health conditions, take into account the impact malnutrition and compensatory behaviours can have on the effectiveness and the risk of side effects.

1.8.13 When prescribing for people with an eating disorder and a comorbidity, assess how the eating disorder will affect medication adherence (for example, for medication that can affect body weight).

1.8.14 When prescribing for people with an eating disorder, take account of the risks of medication that can compromise physical health because of pre-existing medical complications.

1.8.15 Offer ECG monitoring for people with an eating disorder who are taking medication that can compromise cardiac functioning (for example, bradycardia below 50 beats per minute or a prolonged QT interval).

Substance or medication misuse

1.8.16 For people with an eating disorder who are misusing substances, or over the counter or prescribed medication, provide treatment for the eating disorder unless the substance misuse is interfering with this treatment.

1.8.17 If substance misuse or medication is interfering with treatment, consider a multidisciplinary approach with substance misuse services.

Growth and development

1.8.18 Seek specialist paediatric or endocrinology advice for delayed physical development or stunted growth in children and young people with an eating disorder.

1.9 Pregnancy

1.9.1 Provide advice and education to women with an eating disorder who plan to conceive, to increase the likelihood of conception and to reduce the risk of miscarriage. This may include information on the importance of:

- maintaining good mental health and wellbeing
- ensuring adequate nutrient intake and a healthy body weight
- stopping behaviours such as bingeing, vomiting, laxatives and excessive exercise.

1.9.2 Nominate a dedicated professional (such as a GP or midwife) to monitor and support pregnant women with an eating disorder during pregnancy and in the post-natal period, because of:

- concerns they may have specifically about gaining weight
- possible health risks to the mother and child
- the high risk of mental health problems in the perinatal period.

1.9.3 For guidance on providing advice to pregnant women about healthy eating and feeding their baby, see the NICE guideline on maternal and child nutrition.

1.9.4 Consider more intensive prenatal care for pregnant women with current or remitted anorexia nervosa, to ensure adequate prenatal nutrition and foetal development.

1.10 Health monitoring

All eating disorders

1.10.1 GPs should assess fluid and electrolyte balance in people with an eating disorder who are using compensatory behaviours, such as vomiting, taking laxatives or diuretics, or water or salt loading.

1.10.2 GPs, paediatricians or psychiatrists should think about the need for acute medical care (including emergency admission) for people with severe electrolyte imbalance, dehydration or signs of incipient organ failure.

1.10.3 For people with continued unexplained electrolyte imbalance, GPs, eating disorder specialists, paediatricians or dieticians should assess whether it could be caused by another condition.

1.10.4 For people who need supplements to restore electrolyte balance, GPs, eating disorder specialists or dieticians should offer these orally unless the person has problems with gastrointestinal absorption.

1.10.5 GPs, eating disorder specialist, paediatricians, psychiatrists or cardiologists should assess whether ECG monitoring is needed, based on the following risk factors:

- rapid weight loss
- excessive exercise
- severe purging behaviours, such as laxative or diuretic use or vomiting
- bradycardia
- hypotension
- excessive caffeine (including from energy drinks)
- prescribed or non-prescribed medications
- muscular weakening
- electrolyte imbalance
- previous abnormal heart rhythm.

1.10.6 GPs, eating disorder specialists or dieticians should encourage people who are vomiting to:

- have regular dental and medical reviews
- avoid brushing teeth immediately after vomiting
- rinse with non-acid mouthwash after vomiting
- avoid highly acidic foods and drinks.

1.10.7 GPs, eating disorder specialists or dieticians should advise people who are misusing laxatives:

- that laxatives do not reduce calorie absorption and so do not help with weight loss.
- to gradually reduce and stop laxative use.

1.10.8 For guidance on identifying, assessing and managing overweight and obesity, see the NICE guideline on obesity.

Anorexia nervosa

1.10.9 GPs should offer a physical and mental health review at least annually to people with anorexia nervosa who are not receiving ongoing treatment for their eating disorder. The review should include:

- weight or BMI
- blood pressure
- relevant blood tests
- mood
- any problems with daily functioning
- assessment of risk (related to both physical and mental health)
- an ECG, for people with purging behaviours and/or significant weight changes
- discussion of treatment options.

1.10.10 Monitor physical and mental health (including weight and indicators of increased risk) in people who are having psychological interventions for anorexia nervosa.

1.10.11 Offer a bone mineral density scan:

- after six months of amenorrhea in young women (aged 13 to 17) and yearly after this even if the person gains weight
- after 12 months of amenorrhea in adult women (18 and above) and every 2 years after this even if the person gains weight.

Continue to offer scans until either menses has resumed or bone mineral density is within healthy limits.

1.10.12 Monitor growth and development in children and young people with anorexia nervosa who have not completed puberty (for example, not reached menarche or final height).

1.10.13 For guidance on osteoporosis risk assessment, see the NICE guideline on assessing the risk of fragility fractures in osteoporosis.

1.11 Inpatient and day patient treatment

1.11.1 For people with an eating disorder and compromised physical health, consider inpatient treatment or appropriate day patient care for medical stabilisation and to initiate refeeding if these cannot be done in an outpatient setting.

1.11.2 Children and young people with an eating disorder who need inpatient treatment or day patient care should be admitted to age-appropriate facilities that are as near to their home as possible and that have the capacity to provide appropriate educational activities.

1.11.3 For people with acute mental health risk (such as suicide risk), consider psychiatric crisis care or inpatient treatment.

1.11.4 When deciding whether to use day patient or inpatient care, take the following into account:

- the person's BMI or weight, and whether either of these are below the safe range and rapidly dropping (for example more than 1 kg per week; be aware that there is no absolute weight or BMI threshold for admission)
- whether several medical risk parameters (such as blood tests, physical observations and ECG [for example bradycardia below 50 beats per minute or a prolonged QT interval]) have values and/or rates of change in the concern or alert ranges (refer to Box 1 in MARSIPAN or Guidance 1 and 2 in junior MARSIPAN)
- the person's current physical health and whether this is declining
- whether the parents or carers of children and young people can support them and keep them from significant harm.

1.11.5 If a person is admitted for physical health problems caused by an eating disorder, start or continue psychological treatments for the eating disorder if appropriate.

1.11.6 Do not use inpatient care solely to provide psychological treatment for eating disorders.

1.11.7 Inpatient services should collaborate with other teams (including the community team) and the person's family members or carers (as appropriate), to help with treatment and transition.

Refeeding

1.11.8 Ensure that staff of inpatient services for people with eating disorders are trained to recognise the symptoms of refeeding syndrome and how to manage it.

1.11.9 Use a standard operating procedure for refeeding that emphasises the need to avoid under-nutrition and refeeding syndrome. Refer to existing national guidance, for example Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) and junior MARSIPAN.

Discharge with an appropriate care plan

1.11.10 Make a care plan for each person with an eating disorder, to cover the care they need after discharge.

1.11.11 Within one month of admission, review with the referring team, the person with an eating disorder and their parents or carers (as appropriate) whether inpatient care should be continued, stepped down to a less intensive setting, or stopped.

1.11.12 As part of the review:

- assess whether enough progress has been made towards the goals agreed at admission (such as medical progress)
- take into account the risk that people with an eating disorder can become institutionalised, and that a lack of change in their condition could indicate that inpatient treatment is harmful
- consider seeking an independent second opinion.

1.11.13 Reaching a healthy weight should not be used as the only reason for discharging people with an eating disorder.

1.12 Using the Mental Health Act and compulsory treatment

1.12.1 If a person's physical health is at serious risk due to their eating disorder, they do not consent to treatment, and they can only be treated safely in an inpatient setting, use an appropriate legal framework for compulsory treatment (for example the Mental Health Act 1983).

1.12.2 If a child or young person lacks capacity, their physical health is at serious risk and they do not consent to treatment, ask their parents or carers to consent on their behalf and if necessary, use an appropriate legal framework for compulsory treatment (such as the Mental Health Act 1983 or the Children Act 1989).

1.12.3 Feeding people without their consent should only be done by multidisciplinary teams who are competent in doing so.

Terms used in this guideline

Children

Aged 0–12 years.

Young people

Aged 13-17 years

Context

Eating disorders are defined by negative beliefs and behaviours about eating, body shape and weight. People with an eating disorder believe it is important to have a particular body type (for people with anorexia nervosa it is often very thin, but sometimes very muscular) and because of this they may adopt restricted eating, binge eating and compensatory behaviours (such as vomiting and excessive exercise). The emotional and physical consequences of these beliefs and behaviours maintain the disorder and result in a high mortality rate from starvation, suicide and physical issues (such as electrolyte imbalances). There are also other physical complications (such as

osteoporosis) and psychiatric comorbidities (such as anxiety disorders) that raise the cost of treatment.

In 2015, the eating disorders charity Beat reported that there were approximately 725,000 people with eating disorders in the UK, approximately 90% of whom were female. Eating disorders most commonly start in adolescence, but can also start during childhood or adulthood. About 15% of people with an eating disorder have anorexia nervosa, which is more common in younger people. Most people with an eating disorder meet diagnostic criteria for bulimia nervosa, binge eating disorder, or other specified feeding and eating disorder (OSFED). Each disorder is associated with poor quality of life, social isolation, and a substantial burden for family members and carers. Eating disorders are long-lasting conditions if they are not treated.

This guideline covers identifying, assessing, diagnosing, treating and managing eating disorders in people of all ages. It does not cover avoidant/restrictive food intake disorder (ARFID), or obesity in people who do not have an eating disorder. The guideline makes recommendations for different stages of the care process on identifying eating disorders, ensuring patient safety, supporting people with eating disorders and their family members and carers, and ensuring people have access to evidence-based care. Given the high level of physical complications and psychological comorbidities, recommendations on care cover both physical care and psychological interventions. The guideline applies to all settings in which NHS care is provided, and to settings in which eating disorders might be identified.

Recommendations for research

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

1 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, including complex 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 one 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 no evidence on treatments for children and very little for young people. One study was found on individual CBT-ED for young people, 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.

For both trials, there should be at least a six month to one 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.

2 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 is 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.

3 Stepped care for psychological treatment

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

Why this is important

There is little evidence to show that people with an eating disorder who have found a first-line psychological treatment ineffective would benefit from a stepped care approach (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 pre-determined 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.

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?

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 (such as type 1 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.

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?

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 Beat estimates that around 10% of these people 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

1 - weight or BMI.

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

5 Update information

6 **November 2016**

7 This guideline is a full update of NICE guideline CG9 (published January
8 2004) and will replace it.

9 NICE proposes to delete all of the recommendations from the 2004 guideline,
10 because the evidence has been reviewed and the recommendations have
11 been updated.