Eating Disorders

Stakeholder Workshop, 10am-1pm 14 February 2015

Group 1

Scope

Population

- Look at specialised groups – e.g. personality disorder, physical illness comorbid with eating disorder
- Pregnant women – not a comorbidity but can be a factor, management is important (can lead to post-natal depression)
- People with a learning disability and Autism
- People with obesity with eating disorder

Key Issues

Assessment

- Non-adherence behaviours
- Screening with professional
- Currently lots of individual practice
- Suggest competencies for clinician
- Info/screening shared between service, e.g. schools, GPs
- GP not necessarily done a physical assessment, need some level of measure of osteopathy, gastroenterology
- Use of social media (person and family) assessment
- Physical medical monitoring
- BMI not as access indicator – should be based on need

Interventions

- Consider age – developmentally appropriate, risk, shared decision making
- Additional psychological interventions to be considered: family based interventions (family therapy, skills to the family, multi family therapy); peer support; DBT; Online help – virtual wards etc; CBT; creative therapy; CFT; psychoeducation groups; hypnotherapy
- Prescriptive interventions very restrictive – find out what works best for patient instead
- Support for living well and recovery

Medications

- Use of antipsychotics – to be debated
- Data on binge eating medication
- Oxytocin
- Need to ensure treating comorbidities – medication often more for comorbidity than eating disorder

Other treatments

- Nutrition including educating and relearning eating behaviours
- Role of specialist dietician
- General case management – training, competence levels, protocols
- Consider monitoring and supportive interventions
- Neurological and neuroscience driven interventions, cognitive remediation therapies, deep brain stimulation

Outcomes

- Appropriate weight gain
- Quality of Life – no standardised measures currently

Inequalities

- Students (including transition)
- Boys and men

Additional considerations

- How to use and sequence treatments
- Bespoke care

- Longer term care (chronic) – social not mental health care
  - No definitive definition of long-term
  - stages – treatments differ at each stage
- Age and transition -important for commissioners (implementation, interpretation of guidance, potential expert)
- Boys and men – service delivery implication, LGBT, ethnic minorities
- Judgement of capacity – understanding cognitive capacity, clinical not legal setting is better
- Question of weight – look at how best this is managed, barrier to treatment, not necessarily an outcome (depends on illness), assessment of risk is more important, physical illness to determine the approach (QoL)

GDG constituency

The group suggested GDG members in addition to those suggested by NICE:

- commissioners
- gastroenterologist (as specialism)
- endocrinologist (as specialism)
- A+E
- GP
- Tier 4 (CYP inpatients)

Group 2

Scope

Population

No changes to the population were suggested.

Key Issues

Assessment

- Who conducts the assessment?
  - Identification often before clinician
  - Primary care
  - Educational setting
- Improved recommendation for early identification
  - Severe case to get entry
  - Limited resources and skill of professionals to detect
  - Inappropriate referrals
  - Distinct from early intervention
- Creating flexible systems of referrals (including self-referral)
  - Methods of improving identification, particularly for adolescents
- Evidence for benefits of early identification and early intervention
- Link between NICE guidance for perinatal and eating disorders
- Evidence for method of assessment and engagement
  - Evidence for improving methods
  - Debate in literature
- Medical assessment for treatment and medical risk
  - Two strands of assessment
  - (1) Physical risk and (2) Psychological risk
- Early Engagement
  - Maximising methods
  - Monitoring
- Methods to improve motivation for treatment
  - Link between behaviour change evidence
- Assessment in Primary Care (GPs)
- Recovery models
  - Engagement to change vs engagement to support/services
  - Impact on outcomes

- Access
    - Evidence in monitoring for specialist vs non specialist

Interventions

- Additional psychological interventions: CFT (compassion focused therapy); CRT; Supportive psychotherapy; EMDR; Motivational enhancement therapy; Dance and movement; Creative arts; Complementary therapy (massage, reflexology); Self help; Self-management; Life skills.
- Pharmacological interventions should include: SSRIs (Management of anxiety - Not for weight gain); Lansoprazol; Re-feeding = vitamin B; Omeprazol (physical symptoms); Proton pump inhibitors; Anti-ametics; Anti-psychotics; Mood stabilizers/anti convulsants; Treatment of comorbidities
- Nutritional - physical symptoms need assessment and monitoring:
    - Measurement of weight
    - Regular bloods
    - Magnesium, phosphate, zinc, ECG
    - Arm circumference
    - Bone density/Bone scans (every 2 years?)
    - Low blood sugar

- Management of refusal to be weighed - Learn from measurement of malnourished individuals
- Management of hypokalmia (Vitamins/Contraceptive pill)
- Site of physical assessment - GP vs specialist
    - Dietetics intervention (not dietician) i.e. self-catering
- Safe methods for re-feeding
    - Nasal gastric vs oral
    - Rates of re-feeding
    - NICE nutritional support overlap
- CBT delivered by dietician
- Diabetes consideration as special group?
    - Insulin purging
    - Physical and mental health comorbidities egg Type 1 diabetes

Services

- Treatment in different settings
- CAMHs
- Primary Care
- Transition from day patient status to community care
- Inpatients/outpatients
- Tertiary specialist ED units
- Medical wards
- Length of stay
- Staff dynamics in treatment settings
- Harms of units – bullying
- Impact of setting on recovery

Outcomes

No other outcomes were suggested.

Inequalities

- Diabetes
- Asian young women – accessibility of services, later presentation
- Binge eating disorder with high BMI
- Comorbid Borderline Personality Disorder and ED (especially anorexia nervosa)
- Men
- Professions – models, ballerinas

Additional considerations

- Case management
    - Definition
    - Different methods
    - Where located? Tertiary instead of secondary?

- Managing transitions
    - Organisation of services
    - Supervision for therapists
    - CAMHS to Adult services
    - Primary care to secondary care, secondary care to tertiary care
    - Ageless services vs age-bounded

- Comorbidity of Anorexia and Borderline Personality Disorder
    - Best setting for intervention
    - Special consideration

- Support for families/carers
    - Psychological support for context of patient
    - Evidence for need
    - Impact on trajectory of patient

- Compulsory treatment
    - Use of CTOs

- Management of very low weight
    - Distinct from severe and enduring ED
    - Acute vs chronic
    - Location of treatment
    - Mental Capacity Act

- Management of end of life

GDG constituency

The group suggested GDG members in addition to those suggested by NICE:

- OTs
- Family therapist
- Gastroenterologists
- Endocrinologists
- Bariatric surgeons
- Physiotherapists
- Midwives (?)
- Fertility clinic specialists

<u>Group 3</u>

Scope

Population

No changes to the population were suggested.

Key Issues

<u>Assessment</u>

- Prevention – the group felt the issue of primary and secondary prevention and the identification of high risks groups should be included, although they recognised this would greatly increase the scope. It was suggested that a separate guideline should be developed to cover prevention.
- Recognition needs to be better to ensure the cause of weight loss is not a physical illness rather than an eating disorder.
- Need clear guidance for primary care on when to refer.

Interventions
- Physiotherapy/daily living skills to be added.
- Need to clarify what is meant by nutritional interventions
- Need to clarify if comorbidities are physical or psychological.

Other
- Transitions between services, particularly for students should be considered.
- The guideline should look at different levels of severity and how each level responds to different treatments.
- Potential harms of treatments should be considered.
- Pregnancy and antenatal care needs to be included.

Outcomes
- Growth
- Bone density

Inequalities
- Older adults
- Boys and men
- People whose first language isn't English
- Different presentations in different cultural groups
- Socioeconomic
- Geographical
- Those with an eating disorder but who are a normal weight
- Those with a binge eating disorder
- Students

Additional considerations
- It is important that the guideline is 'primary care focused'.
- The guideline needs to take into consideration the difficult interaction with anti-obesity measures.
- The presentation of a-typical eating disorders needs to be included, for example in people who have had bariatric surgery.
- The management of acute eating disorders in inpatient and outpatient settings must be covered.
- The group suggested that the guideline needed to interact with the *MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa* guidance issued by the Royal College of Physicians.
- The NICE guideline on refeeding should be added to the 'related guidance' section.
- Classification of types of eating disorder is an issue – if 'boxes aren't ticked' people are not accepted into services.
- It is important to consider the delivery of psychological interventions and how interventions delivered by IAPT services compare in efficacy against those delivered in specialist services – and what is the service user experience of each.
- Therapists that have an eating disorder.

GDG constituency

The group suggested GDG members in addition to those suggested by NICE:

- Physiotherapist
- Occupational therapist
- Adult physician

Group 4

Scope

Population

- Include avoidant restrictive food disorders, chronic and non-responsive populations
- Special groups to include: diabetics, athletes, dancers
- Include siblings/family carers

Key Issues

Assessment

- Early recognition of cases and training in assessment
- Physical risk assessment

Interventions

- Include other physical interventions, e.g. TMS
- Self-help interventions, e.g. Groups
- Nutritional interventions – include technical interventions
- Psychological therapies: child and adolescent psychotherapy, MBT, CRT, DBT
- Prevention interventions, early interventions, e.g. in schools

Services

- Elaborate on what service structures are: community teams, home settings, (student) transitions, university settings, management in primary care, general psychiatric and general medical, specialist and non-specialist services, inpatient treatment (cost-effectiveness), best practice in different intensity settings

Outcomes

- No additional outcomes were suggested by the group

Inequalities

- Gender (male vs female)
- Ethnicity
- Age – older adults, care across lifespan
- Sexuality
- Diagnosis, e.g. normal weight bulimia
- Employment and study opportunities
- Socio economic status
- Distance from a local service
- Services excluding comorbidities, e.g. alcohol disorders, autism, learning difficulties/disabilities (MHLD guideline)

Additional considerations

- Level of compulsion in patient, capacity, control and restraint
- Indications for admission
- Worth highlighting diabetes as a comorbidity

GDG constituency

The group suggested GDG members in addition to those suggested by NICE:

- Family therapists
- Occupational therapist
- Professionals from community and inpatient settings (include professionals from a variety of setting)

- Clinical service managers
- Gastroenterologists
- Psychotherapist