National Institute for Health and Care Excellence

Version 2.0

Eating disorders: recognition and treatment

Appendices A - G

Clinical Guideline

Methods, evidence and recommendations

May 2017

Final

Developed by the National Guideline Alliance, hosted by the Royal College of Obstetricians and Gynaecologists

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

1 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.
- 2 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.
- 3 The management of physical health problems caused by an eating disorder.
- 4 Interventions for eating disorders in the context of common physical and psychological comorbidities.
- 5 Interventions to support families and carers.

- 6 Organisation and delivery of services to support practitioners in the effective and competent delivery of interventions.
- 7 Consent and compulsory treatment.

Areas that will not be covered

- 1 The diagnosis or treatment of people with disordered eating in the context of a separate physical or other primary mental disorder of which a disorder of eating is a symptom (such as loss of appetite in depression)
- 2 The management of loss of appetite, psychogenic disturbance of appetite or other conditions that involve significant weight loss but which are due to known physical illness.
- 3 The management of the wider range of eating disorders typically but not exclusively occurring in children (for example, Pica or avoidant restrictive food intake disorders such as food avoidance emotional disorder or picky/selective eating).
- 4 Obesity in the absence of an eating disorder.

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?

- 4 Interventions for eating disorders where there is comorbidity with other mental health or physical health problems:
- 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?
- 5 Interventions to support families and carers:
- 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:
- Does the setting (inpatient, outpatient or other specific setting) for treating eating disorders produce benefits/harms in people with eating disorders?
- Do different ways of coordinating care produce benefits/harms for people with eating disorders?
- 7 Consent and compulsory treatment:
- 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

The main outcomes that will be considered when searching for and assessing the evidence are:

- All-cause mortality.
- Remission and long-term recovery.
- Relapse.
- General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF).
- Cognitive distortion (evidence of ongoing preoccupation with weight/shape/food/eating).
- Weight and body mass index.
- Family functioning.
- Quality of life.
- Cost effectiveness.
- Resource use.
- Growth/bone density.
- Service user experience.

2 Links with other NICE guidance and NICE pathways

2.1 NICE guidance

NICE guidance that will be updated by this guideline

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

NICE guidance about the experience of people using NHS services

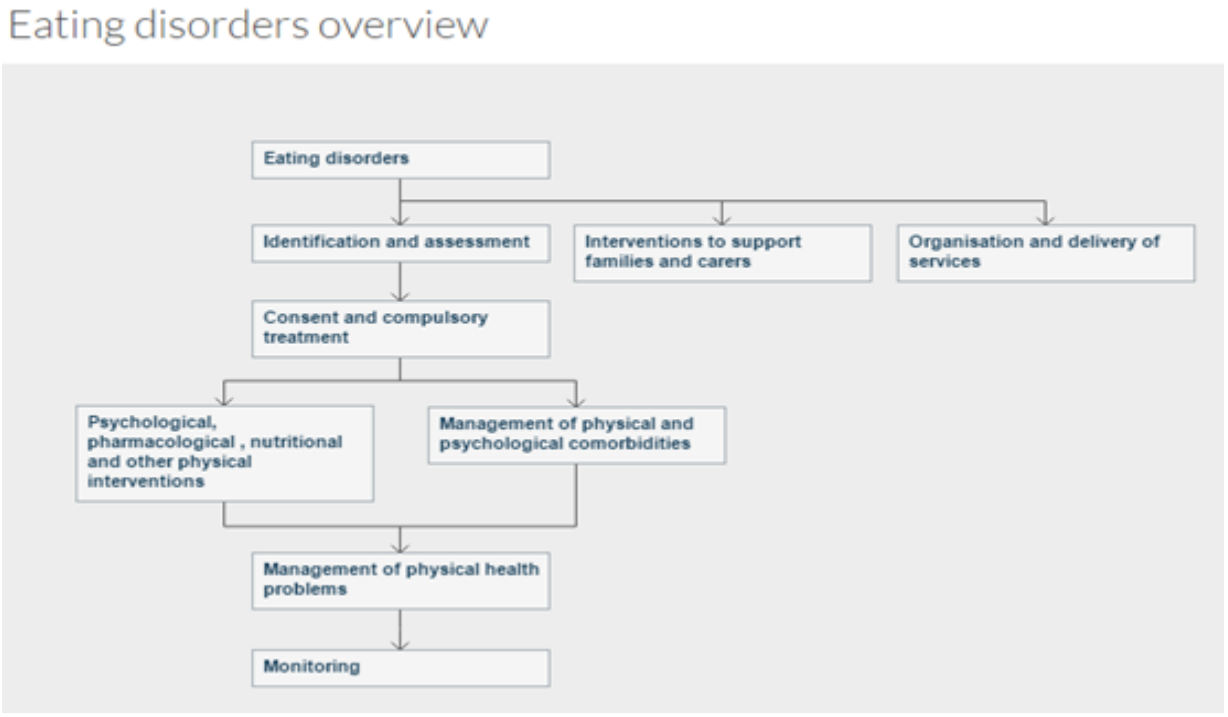
NICE has produced the following guidance on the experience of people using the NHS. This guideline will not include additional recommendations on these topics unless there are specific issues related to eating disorders.

- Patient experience in adult NHS services (2012) NICE guideline CG138
- Service user experience in adult mental health (2011) NICE guideline CG136
- Medicines adherence (2009) NICE guideline CG76

2.2 NICE Pathways

When this guideline is published, the recommendations will be added to NICE Pathways. NICE Pathways bring together all related NICE guidance and associated products on a topic in an interactive topic-based flow chart.

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.



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

3 Context

3.1 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

- The Human Rights Act 1998.

Commissioning

- Guidance for commissioners of eating disorder services. Joint Commissioning Panel for Mental Health, 2013.

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.

1 Appendix B: Declarations of Interest

2 Guideline Committee

Name	Job title and organisation	Declaration of interest	Type of interest	Action taken
Anthony Bateman	Consultant Psychiatrist and Psychotherapist and Honorary Senior Lecturer. Visiting Professor in the Psychoanalysis Unit at University College London.	None	n/a	None
Jane Dalgliesh	Nurse Practitioner/Team Manager/Head of Service Eating Disorders Service, South Essex University Foundation Trust	None	n/a	None
Ivan Eisler	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.	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.	Personal, non-financial, specific	None
Ivan Eisler	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.	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	Personal, non-financial, specific	None

Name	Job title and organisation	Declaration of interest	Type of interest	Action taken
	Lead for Psychological Treatments, CAMHS, South London and Maudsley NHS Foundation Trust.	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.		
Christopher Fairburn	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	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.	Personal, financial, specific	None
Christopher Fairburn	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	Co-author of one of the studies included in the evidence review on comorbidities of eating disorders and another study included in the assessment and monitoring review.	Personal, non-financial, specific	Withdrew from discussion of evidence and only answered questions in relation to the study for clarity
Christopher Fairburn	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	Co-author of a study included in the evidence review on bulimia nervosa.	Personal, non-financial, specific	Withdrew from discussion of evidence and only answered questions in relation to the study for clarity
Christopher Fairburn	Welcome Principal Research Fellow, University of Oxford.	Author of CBT-ED manuals related to the	Personal, non-financial, specific	Withdrew from discussion of

Name	Job title and organisation	Declaration of interest	Type of interest	Action taken
	Professor of Psychiatry, University of Oxford. Honorary Consultant Psychiatrist, Oxford Health NHS Foundation Trust. Governor, MQ – Research for Mental Health. Governor, Oxford Mindfulness Foundation	psychological interventions reviews.		evidence and only answered questions in relation to the study for clarity
Christopher Fairburn	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	Invited to be part of a group looking at completing an NMA for anorexia nervosa.	Personal, non-financial, specific	None
Christopher Fairburn	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	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).	Personal, financial, specific	None
Christopher Fairburn	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	Funding from Welcome 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	Non-personal, financial, specific	None

Name	Job title and organisation	Declaration of interest	Type of interest	Action taken
Christopher Fairburn	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	Author of a book for sufferers from eating disorders (Overcoming Binge Eating). Receive royalties from the publisher.	Personal, financial, specific	None
Lee Hudson	Consultant Paediatrician Great Ormond St Hospital, London. Consultant Paediatrician, Ellen Mead Eating Disorders Unit, Holcombe Hill, London. Honorary Senior Lecturer, University College London Institute of Child Health.	Co-author of one of the studies included in the physical complications review.	Personal, non-financial, specific	Withdrew from discussion of evidence and only answered questions in relation to the study for clarity
Lee Hudson	Consultant Paediatrician Great Ormond St Hospital, London. Consultant Paediatrician, Ellen Mead Eating Disorders Unit, Holcombe Hill, London. Honorary Senior Lecturer, University College London Institute of Child Health.	Co-lead of the MARSIPAN group	Personal, non-financial, specific	Withdrew from discussion of evidence and only answered questions in relation to the study for clarity
Lee Hudson	Consultant Paediatrician Great Ormond St Hospital, London. Consultant Paediatrician, Ellen Mead Eating Disorders Unit, Holcombe Hill, London. Honorary Senior Lecturer, University College London Institute of Child Health.	Work privately as a paediatrician in eating disorders in a private eating disorders clinic	Personal, financial, specific	None
Mike Hunter	Consultant Psychiatrist Clinical Director (Inpatient Services) and Associate Medical Director (Research and Strategy) Sheffield Health and Social	None	n/a	None

Name	Job title and organisation	Declaration of interest	Type of interest	Action taken
	Care NHS Foundation Trust.			
Dasha Nicholls	Consultant Child and Adolescent Psychiatrist, Great Ormond Street Hospital, London. Honorary Senior Lecturer, University College London Institute of Child Health.	Co-author of one of the studies included in the physical complications review	Personal, non-financial, specific	Withdrew from discussion of evidence and only answered questions in relation to the study for clarity
Jessica Parker	Service User	None	n/a	None
Daniel Perry	Service User	In discussions with BEAT regarding establishing a Manchester based support group	Personal, non-financial, non-specific	None
Daniel Perry	Service User	Ongoing work with BEAT speaking at national media outlets	Personal, non-financial, non-specific	None
Daniel Perry	Service User	New role as community leader for eating disorders and body image for LGBT Foundation (Greater Manchester)	Personal, financial, non-specific	None
Ursula Philpot	Senior Lecturer in Nutrition and Dietetics, Leeds Beckett University. Director and Advanced Practice Dietitian, Insight Eating, The Orchard, Leeds.	None	n/a	None
Susan Ringwood	Carer Representative	None	n/a	None
Mandy Scott	Mental Health Nurse and Co-Founder of PEDS (Personalised Eating Disorder Support) Charity (previously CAMHS Case Management NHS England)	None	n/a	None
Lucy Serpell	Senior Lecturer, Research Department of Clinical, Educational and Health Psychology, University College London. Clinical Lead for Eating Disorders, North East London Foundation NHS.	None	n/a	None

Name	Job title and organisation	Declaration of interest	Type of interest	Action taken
Philip Taylor	Clinical Director Dentistry and Oral and Maxillo-Facial Surgery (OMFS). Clinical Lead Restorative Dentistry, Barts Health NHS Trust, The Dental Hospital, London.	None	n/a	None
Dominique Thompson	GP and Director of the University of Bristol Student Health Service. Lead GP Bristol For Eating Disorders.	Member of GPCare, a local GP federation in Bristol.	Non-personal, non-financial, non-specific	None
Dominique Thompson	GP and Director of the University of Bristol Student Health Service. Lead GP Bristol For Eating Disorders.	Member of OneCare (BNSSG) Ltd, a local GP Federation in Bristol	Non-personal, non-financial, non-specific	None
Dominique Thompson	GP and Director of the University of Bristol Student Health Service. Lead GP Bristol For Eating Disorders.	Set up a new network for Primary Care Professionals	Personal, non-financial, non-specific	None
Janet Treasure	Director of Eating Disorders Unit and Professor of Psychiatry, Kings College, London.	Edited professional texts, and written several self-help books for people with eating disorders (AN and BN) (Schmidt & Treasure, 1993; Treasure, 1997) and a book for carers to share expertise and understanding (Treasure J et al., 2007).	Personal, financial, specific	None
Janet Treasure	Director of Eating Disorders Unit and Professor of Psychiatry, Kings College, London.	Author of papers looking at carer training and talks delivered on same topic.	Personal, non-financial, non-specific	None
Janet Treasure	Director of Eating Disorders Unit and Professor of Psychiatry, Kings College, London.	Meeting at RCP (Eli Lilly) 25 September 2015 (fee paid)	Personal, financial, non-specific	None
Janet Treasure	Director of Eating Disorders Unit and Professor of Psychiatry, Kings College, London.	Charity work: Trustee or other various roles on several eating disorders charities: BEAT, SUCCEED, Student Minds, FEAST, Diabetics with Eating Disorders DWED, Psychiatry	Personal, non-financial, specific	None

Name	Job title and organisation	Declaration of interest	Type of interest	Action taken
		Research Trust, Charlottes Helix.		
Janet Treasure	Director of Eating Disorders Unit and Professor of Psychiatry, Kings College, London.	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	Non-personal, financial, specific	None
Janet Treasure	Director of Eating Disorders Unit and Professor of Psychiatry, Kings College, London.	Invited to be part of a group looking at completing an NMA on anorexia nervosa.	Personal, non-financial, specific	None
Janet Treasure	Director of Eating Disorders Unit and Professor of Psychiatry, Kings College, London.	Honorarium for participation in: AACAP meeting, Lilly diabetic meeting, ECNP, Hilda Bruch lecture	Personal, non-financial, specific	None
Janet Treasure	Director of Eating Disorders Unit and Professor of Psychiatry, Kings College, London.	Royalties from the following books from Routledge, Wiley, Oxford University press: Szmukler, Dare Treasure, The Essential Handbook of Eating Disorders Date 1995 Publisher: Wiley ISBN: 0-47194327-4 Ulrike Schmidt & Janet Treasure Title: Getting Better Bit(e) by Bit(e) Publisher: Routledge ISBN: 0-86377-322-2 Hoek HW, Treasure, JL, Katzman MA Title: Neurobiology in the treatment of Eating DisordersPublisher: Wiley ISBN: 0-471-98102-8	Personal, financial, non-specific	None

Name	Job title and organisation	Declaration of interest	Type of interest	Action taken
		J Treasure, U Schmidt & Evan Furth Title: The Essential Handbook of Eating Disorders Publisher: Wiley ISBN: 0-470-01463-6 M Nasser, K Baistow, J Treasure Title: The Female Body in Mind Publisher: Routledge ISBN:978-0-415-38514-5 (pbk), 978-0-415-38515-2 (pbk) Date 2007 Janet Treasure Title: Anorexia Nervosa – a survival guide for families, friends and sufferers. Publisher: Routledge ISBN: 0-86377-760-0 Janet Treasure, Grainne Smith and Anna Crane S. Title: Skills-based Learning for Caring for a Loved One with an Eating Disorder. Publisher: Routledge ISBN:978-0-415-43158-3 Date: 2007 Janet Treasure, Pam MacDonald, Ulrike Schmidt Title: A Clinicians Guide to Collaborative Care Publisher: Routledge ISBN: 978-0-415 Janet Treasure, Pam MacDonald, Ulrike Schmidt Title: A Clinicians Guide to Collaborative Care Publisher: Routledge ISBN: 978-0-415-48424-4 hbk 978-0-415-48425-1 pbk Date: 2009 Laird Birmingham, Janet Treasure. Title:		

Name	Job title and organisation	Declaration of interest	Type of interest	Action taken
		Medical Management of Eating Disorders Publisher: Oxford University Press ISBN: 978-0-521-72710-5 Date: 2010 June Alexander Janet Treasure, Title: A Collaborative Approach to Eating Disorders Publisher: Routledge ISBN: 978-0-415-58146-2 Date: 2012 Janet Treasure, June Alexander.Title: Anorexia Nervosa: A Recovery Guide for Sufferers, Families and Friends 2nd Edition. Publisher: Routledge ISBN:978-0-415-63366-6 (hard), 978-0-415-63367-3 (pbk), 978-0-203-64019-7Date: 2013 Schmidt, U., J. Treasure, and J. Alexander, Getting Better Bite by Bite: A Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorders. 2015: Routledge.		
Hannah Turner	Consultant Lead Clinical Psychologist, Southern Health NHS Foundation Trust Eating Disorders Service.	Teaching and research/publications in CBT	Personal, non-financial, specific	None
Hannah Turner	Consultant Lead Clinical Psychologist, Southern Health NHS Foundation Trust Eating Disorders Service.	Involved in the development and evaluation of brief CBT interventions for eating disorders and in an effectiveness study of CBT when delivered in routine clinical settings.	Personal non-financial, specific	None
Hannah Turner	Consultant Lead Clinical Psychologist, Southern Health NHS Foundation Trust	Research interest in medical aspects of eating disorders.	Personal, non-financial, specific	None

Name	Job title and organisation	Declaration of interest	Type of interest	Action taken
	Eating Disorders Service.			
Christine Vize	Retired Consultant Psychiatrist, Cotswald House Eating Disorders Unit, and Wiltshire Community Eating Disorder Service, and Medical Lead, Oxford Health NHS Foundation Trust.	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.	Personal, non-financial, specific	None
Christine Vize	Retired Consultant Psychiatrist, Cotswald House Eating Disorders Unit, and Wiltshire Community Eating Disorder Service, and Medical Lead, Oxford Health NHS Foundation Trust.	Vice-Chair of the Clinical Reference Group for Specialist Eating Disorders for NHS England.	Personal, non-financial, specific	None
Christine Vize	Retired Consultant Psychiatrist, Cotswald House Eating Disorders Unit, and Wiltshire Community Eating Disorder Service, and Medical Lead, Oxford Health NHS Foundation Trust.	Developing an App with a company called The App Garden in collaboration with NHS Trust IT Department. The app is a food and eating diary for patients with eating disorders.	Personal, non-financial, specific	None
Glen Waller	Professor of Psychology, Department of Psychology, University of Sheffield.	Published two books and a range of papers and book chapters on CBT for eating disorders; regularly gives workshops on evidence-based CBT for eating disorders; membership of NICE GDG likely to be related to an Impact Case Study under the 2021 Research Excellence Framework	Personal, financial, specific	None
Glen Waller	Professor of Psychology, Department of Psychology, University of Sheffield.	Involved in studies that have been included in the assessment and monitoring review.	Personal, non-financial, specific	Withdrew from discussion of evidence and only answered questions in relation to

Name	Job title and organisation	Declaration of interest	Type of interest	Action taken
				the study for clarity

1 Developer staff

Name	Job title and organisation	Declaration of interest	Type of interest	Decision taken
Annabel Flint	Senior Project Manager, NGA	None	n/a	n/a
Katrina Blears	Project Manager, NGA	None	n/a	n/a
Linyun Fou	Systematic Reviewer, NGA	None	n/a	n/a
Professor Tim Kendall	National Clinical Director for Mental Health. Consultant Psychiatrist for the homeless, Sheffield Health and Social Care NHS Foundation Trust.	Director and Chief Executive Officer of a healthcare organisation which provides clinical care.	Personal, financial, specific	None
Professor Tim Kendall	National Clinical Director for Mental Health. Consultant Psychiatrist for the homeless, Sheffield Health and Social Care NHS Foundation Trust.	Appointed as National Clinical Director of Mental Health.	Personal, financial, non-specific	None
Professor Steve Pilling	Clinical Advisor, NGA Director, Centre for Outcomes Research and Effectiveness, University College London	14.7.2015 Study investigating a new model of acute services in A&E	Non-personal financial non-specific	None
Professor Steve Pilling	Clinical Advisor, NGA Director, Centre for Outcomes Research and Effectiveness, University College London	9.6.2015 Grant from National Alliance for Research on Schizophrenia and Depression to look at transcranial direct-current stimulation in treatment of depression.	Non-personal financial non-specific	None
Professor Steve Pilling	Clinical Advisor, NGA Director, Centre for Outcomes Research and Effectiveness, University College London	9.6.2015 Involved in CADET, IAPT and PRMOS study programmes	Non-personal financial non-specific	None
Professor Steve Pilling	Clinical Advisor, NGA Director, Centre for Outcomes Research and Effectiveness,	25.5.2016 Funding from DHSE on the development of Evidence-Based Treatment Pathways	Non-personal financial non-specific	None

Name	Job title and organisation	Declaration of interest	Type of interest	Decision taken
	University College London	and Safer Staffing Mental Health		
Professor Steve Pilling	Clinical Advisor, NGA Director, Centre for Outcomes Research and Effectiveness, University College London	1.9.2016 Chief Investigator, Programme Grant of £2.3M from NIHR (2017-2022), Open Dialogue: Evaluating Service System for Severe Mental Illness (ODESSI)	Non-personal financial non-specific	None
Professor Steve Pilling	Clinical Advisor, NGA Director, Centre for Outcomes Research and Effectiveness, University College London	9.6.2015 Medical Research Council funding looking at psilocybin	Non-personal financial non-specific	None
Ifigeneia Mavranezouli	Senior Health Economist, UCL	None	n/a	n/a
Leanne Saxon	Senior Systematic Reviewer, University College London	None	n/a	n/a
Eric Slade	Senior Health Economist, NGA	None	n/a	n/a
Sarah Stockton	Senior Information Scientist, NGA	None	n/a	n/a
Jo Wolfreys	Project Manager, UCL	None	n/a	n/a

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Appendix C: Special advisors to the committee

No special advisors on specialist topics contributed to the process by meeting the Guideline Committee:

Appendix D: Stakeholders for the Guideline

2gether NHS Foundation Trust

2gether NHS Foundation Trust

5 Boroughs Partnership NHS Foundation Trust

5 Boroughs Partnership NHS Foundation Trust

AbbVie

AbbVie

Adoption UK

Alder Hey Children's NHS Foundation Trust

Alder Hey Children's NHS Foundation Trust

Alliance Pharmaceuticals

Allocate Software PLC

Anorexia and Bulimia Care

Association of NHS Occupational Physicians

Association for Cognitive Analytic Therapy

Association for Dance Movement Psychotherapy UK

Association for Family Therapy and Systemic Practice in the UK

Association for Improvements in the Maternity Services

Association for Improvements in the Maternity Services

Association for the advancement of meridian energy techniques

Association of Anaesthetists of Great Britain and Ireland

Association of Anaesthetists of Great Britain and Ireland

Association of Child Psychotherapists, the

Association of Clinical Pathologists

Association of Professional Music Therapists

Association of Psychoanalytic Psychotherapy in the NHS

Association of School and College Leaders

Association of School and College Leaders

Association of Teachers and Lecturers

Barnsley Youth Offending Team

1 Beat
2 Behind The Mask Foundation
3 Belfast Health and Social Care Trust
4 Betsi Cadwaladr University Health Board
5 Big White Wall
6 Birmingham and Solihull Mental Health NHS Foundation Trust
7 Birmingham Women's NHS Foundation Trust
8 Black Country Partnership Foundation Trust
9 Bradford District Care Trust
10 British Acupuncture Council
11 British Association for Counselling and Psychotherapy
12 British Association for Counselling and Psychotherapy
13 British Association for Music Therapy
14 British Association for Music Therapy
15 British Association for Parenteral & Enteral Nutrition
16 British Association for Parenteral & Enteral Nutrition
17 British Association of Art Therapists
18 British Association of Dramatherapists
19 British Association of Music Therapy
20 British Association of Psychodrama and Sociodrama
21 British Association of Social Workers
22 British Dental Association
23 British Dietetic Association
24 British Dietetic Association
25 British Medical Association
26 British Medical Journal
27 British National Formulary
28 British Nuclear Cardiology Society
29 British Nuclear Cardiology Society
30 British Paediatric Mental Health Group
31 British Paediatric Respiratory Society
32 British Psychodrama Association
33 British Psychological Society

1 British Red Cross
2 British Society for Disability and Oral Health
3 British Society of Gastroenterology
4 British Society of Gastroenterology
5 British Society of Paediatric Gastroenterology Hepatology and Nutrition
6 British Society of Paediatric Gastroenterology Hepatology and Nutrition
7 Buckinghamshire County Council
8 Calderdale and Huddersfield NHS Trust
9 Cambridgeshire & Peterborough NHS Foundation Trust
10 Camden Link
11 Caplond Services
12 Capsulation PPS
13 Capsulation PPS
14 Care Council for Wales
15 Care Quality Commission
16 Care Quality Commission
17 CCBT Ltd
18 Central & North West London NHS Foundation Trust
19 British Paediatric Mental Health Group
20 Chartered Physiotherapists in Mental Health
21 Chartered Society of Physiotherapy
22 Cheshire & Wirral Partnership NHS Trust
23 Cheswold Park Hospital
24 Childhood First
25 Childhood First
26 Child Psychology London
27 CIS' ters
28 Citizens Commission on Human Rights
29 Clarity Informatics Ltd
30 Cochrane Depression Anxiety and Neurosis Group
31 Cochrane UK
32 College of Mental Health Pharmacy
33 College of Occupational Therapists

1 College of Occupational Therapists
2 College of Paramedics
3 Complementary Health Professionals
4 Connect Therapeutic Community
5 Counselling for prisoners network
6 Covidien Ltd.
7 Creating Change Arts Therapy
8 Cregagh Nursing Home
9 Critical Psychiatry Network
10 Croydon Clinical Commissioning Group
11 Croydon Health Services NHS Trust
12 Croydon University Hospital
13 Cumbria Partnership NHS Foundation Trust
14 Cumbria Partnership NHS Foundation Trust
15 Cygnet Health Care
16 Department for Education
17 Department of Academic Psychiatry - Guy's
18 Department of Health
19 Department of Health
20 Department of Health
21 Department of Health, Social Services and Public Safety - Northern Ireland
22 Derbyshire County Council
23 Diabetes UK
24 Diabetics with Eating Disorders
25 Dorset Action on Abuse
26 East and North Hertfordshire NHS Trust
27 East Kent Hospitals University NHS Foundation Trust
28 East Riding of Yorkshire Council
29 East Sussex County Council
30 Eating Disorder Association (NI)
31 Eating Disorders Service
32 Eli Lilly and Company
33 Eli Lilly and Company

1 Elm Healthcare
2 Equalities National Council
3 Esoteric Practitioners Association UK/EU
4 Ethical Medicines Industry Group
5 Ethical Medicines Industry Group
6 Europa Healthcare Solutions
7 Experts by experience
8 Faculty of Dental Surgery
9 Faculty of Dental Surgery
10 Faculty of Public Health
11 Faculty of Sport and Exercise Medicine
12 Faculty of Sport and Exercise Medicine
13 Fetal Anti Convulsant Syndrome Association
14 First Person Plural
15 Five Boroughs Partnership NHS Trust
16 Five Boroughs Partnership NHS Trust
17 Food and Drink Federation
18 Freshwinds
19 General Hypnotherapy Register
20 General Hypnotherapy Register
21 Gloucestershire County Council
22 Gloucestershire LINk
23 Great Ormond Street Hospital
24 Great Western Hospitals NHS Foundation Trust
25 Greater London Prevention Center
26 Greater Manchester & Beyond Coalition of PLW & HIV
27 Greater Manchester West Mental Health NHS Foundation Trust
28 Greater Manchester West Mental Health NHS Foundation Trust
29 Hafan Cymru
30 Hampshire Partnership NHS Trust
31 Health and Care Professions Council
32 Health and Care Professions Council
33 Healthcare Improvement Scotland

1 Healthcare Quality Improvement Partnership
2 Healthwatch Bristol
3 Healthwatch Darlington
4 Healthwatch East Sussex
5 Hertfordshire Partnership NHS Trust
6 Hertfordshire Partnership University NHS Foundation Trust
7 Hindu Council UK
8 Hiraeth Services Ltd
9 HM Treasury
10 Hockley Medical Practice
11 Huntercombe Group
12 Hywel Dda University Health Board
13 Independent Children's Homes Association
14 Islington Youth Health Forum
15 James Paget Hospital
16 Journey Method Therapy
17 JT Healing
18 Kent and Medway NHS and Social Care Partnership Trust
19 King's College London
20 Lancashire Care NHS Foundation Trust
21 Lancashire Care NHS Foundation Trust
22 Lanes Health
23 laughter ball yoga
24 Leeds and York Partnership Foundation Trust
25 Leeds and York Partnership Foundation Trust
26 LGBT Foundation
27 Liverpool John Moores University
28 Local-Medic.co.uk Limited
29 London and South Perinatal Consultant Psychiatrists Association
30 Luton and Dunstable Hospital NHS Trust
31 Making Waves
32 Mascot Child & Family Services Ltd
33 Mastercall Healthcare

1 Maternal Mental Health Alliance
2 Maternal Mental Health Alliance
3 Medical Directorate Services
4 Men Get Eating Disorders Too
5 Mental Health Group - British Dietetic Association
6 Mersey Care NHS Trust
7 METRO Charity
8 Middlesex University
9 Mind
10 Ministry of Defence
11 Ministry of Defence
12 Monash Health
13 Msb consultancy
14 Muslim Doctors and Dentists Association
15 National Association of Primary Care
16 National Association of Psychiatric Intensive Care and Low Secure Units
17 National Centre for Eating Disorders
18 National Collaborating Centre for Cancer
19 National Collaborating Centre for Cancer
20 National Collaborating Centre for Cancer
21 National Collaborating Centre for Cancer
22 National Collaborating Centre for Mental Health
23 National Collaborating Centre for Women's and Children's Health
24 National Deaf CAMHS
25 National Deaf Children's Society
26 National Guideline Centre
27 National Institute for Health Research
28 National Nurse Consultants in CAMHS forum
29 National Nurse Consultants in CAMHS forum
30 National Obesity Forum
31 National Osteoporosis Society
32 National Osteoporosis Society
33 National Patient Safety Agency

1 National Patient Safety Agency
2 National Public Health Service for Wales
3 National Public Health Service for Wales
4 Neonatal & Paediatric Pharmacists Group
5 NEt
6 NHS Barnsley Clinical Commissioning Group
7 NHS Birmingham South and Central CCG
8 NHS Choices
9 NHS Chorley and South Ribble CCG
10 NHS Digital
11 NHS Digital
12 NHS England
13 NHS Haringey CCG
14 NHS Health at Work
15 NHS Lothian
16 NHS Nene CCG
17 NHS NEW Devon CCG
18 NHS North East Lincolnshire CCG
19 NHS Oxfordshire CCG
20 NHS Plus
21 NHS Sheffield CCG
22 NHS Somerset CCG
23 NHS South Cheshire CCG
24 NHS Wakefield CCG
25 NHS Warwickshire North CCG
26 NHS West Cheshire CCG
27 NICE - Clinical Guideline Updates team
28 NICE - Clinical Guidelines Surveillance
29 NICE - CPHE
30 NICE - CPHE
31 NICE - DAP
32 NICE - DAP
33 NICE - Implementation

1 NICE - Implementation
2 NICE - Internal Clinical Guidelines Programme
3 NICE - Interventional Procedures
4 NICE - Medicines and Prescribing Centre
5 NICE - Medicines and Prescribing Centre
6 NICE - MTEP
7 NICE - PIP
8 NICE - PIP
9 NICE - Quality Programme
10 NICE - Scientific Advice
11 NICE - Scientific Advice
12 NICE - Social Care
13 NICE - Technology Appraisals & HST
14 NICE - Topic selection
15 NICE - Topic selection
16 Norfolk and Suffolk NHS Foundation Trust
17 North Essex Mental Health Partnership Trust
18 North Essex Partnership Foundation Trust
19 North of England Commissioning Support
20 Northamptonshire county council
21 Northern Health and Social Care Trust
22 Northern School of Child and Adolescent Psychotherapy
23 Northumberland, Tyne & Wear NHS Trust
24 Northumberland, Tyne & Wear NHS Trust
25 Northumbria Healthcare NHS Foundation Trust
26 Nottingham City Hospital
27 Nottinghamshire Healthcare NHS Foundation Trust
28 Nursing and Midwifery Council
29 Nurtured Journey
30 Nutricia Advanced Medical Nutrition
31 Nutrition and Diet Resources UK
32 Obesity Action Campaign
33 Oxford Health NHS Foundation Trust

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

1 Royal College of Paediatrics and Child Health
2 Royal College of Paediatrics and Child Health
3 Royal College of Pathologists
4 Royal College of Pathologists
5 Royal College of Pathologists
6 Royal College of Physicians
7 Royal College of Physicians
8 Royal College of Psychiatrists
9 Royal College of Psychiatrists
10 Royal College of Psychiatrists
11 Royal College of Psychiatrists in Scotland
12 Royal College of Radiologists
13 Royal College of Speech and Language Therapists
14 Royal College of Speech and Language Therapists
15 Royal College of Surgeons of Edinburgh
16 Royal Pharmaceutical Society
17 Royal Pharmaceutical Society
18 Royal Society of Medicine
19 Royal Society of Medicine
20 Sandoz Ltd
21 Sandoz Ltd
22 Scottish CAMHS Eating Disorders Steering Group
23 Scottish Intercollegiate Guidelines Network
24 Self Help Services
25 Sensory Integration Network
26 Shared Lives Plus
27 Sheffield Children's NHS Trust
28 Sheffield Eating Disorders Service, Sheffield Health and Social Care Trust
29 Sheffield Health and Social Care NHS Foundation Trust
30 Sheffield Teaching Hospitals NHS Foundation Trust
31 SIARI
32 SJ Helpline Services CIC
33 SNDRi

1 Social Care Institute for Excellence
2 Social Care Institute for Excellence
3 Society for Endocrinology
4 Society for Existential Analysis
5 Solent NHS Trust
6 Somerset Partnership NHS Foundation Trust
7 South Belfast Partnership Board
8 South Eastern Health and Social Care Trust
9 South London & Maudsley NHSFT
10 South Staffordshire and Shropshire NHS trust
11 South West London and St George's Mental Health NHS Trust
12 South West Yorkshire Partnership NHS Foundation Trust
13 Southern Health & Social Care Trust
14 Southport and Ormskirk Hospital NHS Trust
15 St Andrews Healthcare
16 St Mary's Hospital
17 Staffordshire and Stoke on Trent Partnership NHS Trust
18 Staffordshire and Stoke on Trent Partnership NHS Trust
19 States of Jersey
20 Stockport Clinical Commissioning Group
21 Surrey and Borders Partnership NHS Foundation Trust
22 Surrey and Borders Partnership NHS Foundation Trust
23 Sussex Partnership NHS Foundation Trust
24 TACT
25 Talking Couch
26 Tavistock & Portman NHS Foundation Trust
27 Tavistock & Portman NHS Foundation Trust
28 Tees, Esk and Wear Valleys NHS Trust
29 The Autistic Womens Empowerment Project
30 The British False Memory Society
31 The Children's Family Trust
32 The Reiki Guild
33 The Retreat York

1 The Survivors Trust
2 Theale Medical Centre
3 Together for Mental Wellbeing
4 Torbay & Southern Devon Health & Care Trust
5 Tracscare
6 Trafford Healthcare NHS Trust
7 Tuke Centre, The
8 UK Pain Society
9 uMotif Digital Health
10 Unite - the Union
11 United Kingdom Council for Psychotherapy
12 United Lincolnshire Hospitals NHS
13 University College Dublin
14 University Hospitals Birmingham
15 University Mental Health Advisors Network
16 University of Bristol Students Health Service
17 University of Chester
18 University of Edinburgh
19 University of Essex
20 University of Portsmouth
21 University of Wolverhampton
22 Voyage Care
23 WellBeing of Women
24 Welsh Government
25 Welsh Government
26 Welsh Government
27 Welsh Health Specialised Services Committee
28 Welsh Scientific Advisory Committee
29 Welsh Scientific Advisory Committee
30 Wembley Centre for health and care, Community Dental Department
31 West London Mental Health Trust
32 Western Health and Social Care Trust
33 White Ribbon Association

Wiltshire Council

WISH - A voice for women's mental health

Women’s Support Network

Women's Health Alliance

Worcestershire Acute Hospitals Trust

Worcestershire Health and Care NHS Trust

Wrightington, Wigan and Leigh NHS Foundation Trust

Young Person's Advisory Service

Appendix E: Researchers contacted to request information about unpublished or soon to be published studies

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

Appendix F:Review questions and protocols

Case identification

Topic	Identification, assessment and monitoring
Review question	What are the utility, validity and reliability of the instruments, tools and methods used for case identification in eating disorders?
Objectives	To identify valid and reliable tools that can detect eating disorders in clinical samples.
Population	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). **Strata:** children (≤12), adolescents (13-≤17 years), adults ≥18 years
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. People from the general population where the tool would be used for screening.
Instruments, tools and methods	The following will be investigated: SCOFF questionnaire DAWBA (self-assessment and parent/clinician component diagnostic and comorbidities) ESP (compared with SCOFF)
Reference tool	Reference tool (full diagnostic test for both clinical samples and population) DSM ICD-10
Critical outcomes	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
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

Topic	Identification, assessment and monitoring
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.
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)

Topic	Identification, assessment and monitoring
	Co-morbidity (presence of comorbidities versus not; e.g. depression/personality disorder/OCD)

1 Assessment and monitoring

Topic	Identification, assessment and monitoring
Review question	What is the validity and reliability of the instruments, tools and methods used to assess and monitor eating disorders?
Objectives	To identify tools that can reliably monitor the symptoms of eating disorders over time.
Population	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
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. People from the general population where the tool would be used for screening.
Instruments, tools and methods	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)
Reference	Gold standard, relevant ED definition as reported in: DSM ICD-10 EDE –Interview SCID (1)
Critical outcomes	Sensitivity (Se): the proportion of true positives of all cases diagnosed in the population

Topic	Identification, assessment and monitoring
	Specificity (Sp): the proportion of true negatives of all cases not-diagnosed in the population Positive predictive value Negative predictive value Likelihood values
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.

Topic	Identification, assessment and monitoring
	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.
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)

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

Topic	Interventions to help parents or carers of children or young people with eating disorders
Review question	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?
Objectives	To identify psychological interventions that will benefit family or cares with eating disorders
Population	Family or carers of people with eating disorders
Exclude	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.
Intervention	Psychological interventions may include: Family based: Parent only (not necessarily focused on ED) Parent focused therapy (PFT). Group Parent-Training (GPT) Separated family therapy Parents with child with ED (greater focus on ED) Behavioural Family Therapy (BFT) Behavioural family systems therapy (BFST). Family Based Treatment (FBT) Family Day Workshops (FDW) Family Therapy (FT)

Topic	Interventions to help parents or carers of children or young people with eating disorders
	Family therapy for anorexia nervosa (FT-AN) Multi-Family Group Day Treatment (MFGDT) Multi-Family Group Therapy (MFGT) Systemic Family Therapy (SFT) Systemic Family Therapy for AN (SFT-AN) Multifamily therapy (MFT) is synonymous with (MFGT; MFGDT). Uniting couples in the treatment of AN (UCAN Conjoint family therapy
Control	Waiting list Treatment as usual Another intervention
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

Topic	Interventions to help parents or carers of children or young people with eating disorders
	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 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)

Topic	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

Topic	Interventions to treat eating disorders in children, young people and adults
Review question	Does any pharmacological intervention produce benefits/harms on specified outcomes in people with eating disorders?
Objectives	To identify pharmacological interventions that benefit people with eating disorders.
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. lisdexamf(ph)etamine 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

Topic	Interventions to treat eating disorders in children, young people and adults
	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 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)
Note	Note: consider the prescription of medications that may be misused or inappropriately prescribed by those with ED. 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.

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

Topic	Interventions to treat eating disorders in children, young people and adults
Review question	Does any nutritional intervention produce benefits/harms on specified outcomes in people with eating disorders?
Objectives	To identify nutritional interventions that benefit people with eating disorders.
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).
Study design	Systematic Reviews

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

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

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2 Psychological interventions to treat eating disorders in 3 children, young people and adults

Topic	Interventions to treat eating disorders in children, young people and adults
Review question	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?
Objectives	To identify psychological interventions that will benefit people with eating disorders
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 (i. Anorexia nervosa, ii. Bulimia nervosa, iii. Binge eating, iv. Atypical eating disorder) mode of delivery (i. Individual ii. Family iii. Group iv. Self-help)
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.

Topic	Interventions to treat eating disorders in children, young people and adults
	Interventions that address the symptoms not the eating disorder
Intervention	Psychological intervention including: Dialectical behaviour therapy (DBT) Counselling (Nutritional/Other) Integrative Cognitive-Affective Therapy for Binge Eating (ICAT) Maudsley model for treatment of adults with anorexia nervosa (MANTRA) Cognitive remediation therapy (CRT) Specialist supportive clinical management for anorexia nervosa (SSCM) Behavioural therapy (BT) CBT (General or ED specific) Dynamic (IPT, Psychodyamic General or ED specific) Guided Self Help w therapist guidance Pure self help E-therapies Psychological in combination with any pharmacological intervention.
Control	Waiting list Treatment as usual Another other intervention (psychological, pharmacological, nutritional, physical)
Critical outcomes	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) Discontinuation (due to any reason or adverse events) General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF). Family functioning. Service user experience Resource use. Adverse events Quality of life. All-cause mortality. Relapse.
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

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
	RR <0.90 or >1.10 benefit
Heterogeneity	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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2 Physical interventions to treat eating disorders in children, 3 young people and adults

4

Topic	Interventions to treat eating disorders in children, young people and adults
Review question	Do physical interventions, such as transcranial magnetic stimulation or physiotherapy, produce benefits/harms in people with eating disorders?
Objectives	To identify physical interventions, such as TMS or physiotherapy, that benefit people with eating disorders.
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	Physical interventions may include: transcranial magnetic stimulation deep brain stimulation physiotherapy yoga physical exercise acupuncture mandometer massage

Topic	Interventions to treat eating disorders in children, young people and adults
Control	Placebo Waiting list 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	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. All-cause mortality. Family functioning. Resource use. Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) General psychopathology (including mood/depression/anxiety) Relapse. Service user experience.
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?	None
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**

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

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

Topic	The management of the physical symptoms and negative after effects of eating disorders, including weight management
Review question	What interventions are effective at managing or reducing short and long-term physical complications of eating disorders?
Objectives	To manage potential physical complications of eating disorders.
Population	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)
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	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)
Control	Control arm as defined by the study.
Critical outcomes	Primary outcomes as reported by the study.

Topic	The management of the physical symptoms and negative after effects of eating disorders, including weight management
Important, but not critical outcomes	Secondary outcomes as reported by the study.
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

Topic	Interventions for eating disorders where there is comorbidity with other mental health or physical health problems:
Review question	Does any intervention for an eating disorder need to be modified in the presence of common long-term health conditions?
Objectives	To understand how to manage the behaviour of those with eating disorders and common comorbidities, such as diabetes.
Population	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

Topic	Interventions for eating disorders where there is comorbidity with other mental health or physical health problems:
	ADHD (Bulimia) Self-harm Substance misuse Physical comorbidities (highly prevalent) may include: Celiac disease Diabetes (type II – relevant to obesity) Irritable Bowel Disease Cystic Fibrosis 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.
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

Topic	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** 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:

Topic	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.

1 Setting, coordinating, transitioning and integrating care

Topic	Organisation and delivery of services
Review question	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?
Objectives	To identify the optimal setting for treating people with eating disorders.
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 (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.
Intervention	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

Topic	Organisation and delivery of services
	Secondary care
Control	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).
Critical outcomes	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). 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)
Study design	Systematic Reviews RCTs Observational studies: prospective or retrospective cohort studies (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	In-patient (UK inpatient is equivalent to residential setting in US) /psychiatric clinic/ other acute paediatric Outpatient 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

Topic	Organisation and delivery of services
	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 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:

Topic	Organisation and delivery of services
	Cochrane review on inpatients vs. outpatient care Madden et al. Lancet paper (German authors)

1 Coordination of care

Topic	Organisation and delivery of services
Review question	Do different ways of coordinating care produce benefits/harms for people with eating disorders?
Objectives	To identify hazards associated with various ways of coordinate care for people with eating disorders
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 (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.
Intervention	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
Control	Note the comparison listed against the intervention.
Critical outcomes	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). 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)
Study design	Systematic Reviews

Topic	Organisation and delivery of services
	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. **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.

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 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)

1 Consent and compulsory treatment

Topic	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

Topic	Consent and compulsory treatment:
	general functioning or general mental health functioning measures such as Global Assessment of Functioning (GAF). other medical indicators (i.e. low potassium) MARSIPAN check list
Critical outcomes	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)
Important, but not critical outcomes	Secondary outcomes as reported by the papers
Study design	Individual patient data meta-analysis Systematic reviews Observational non-RCT studies (prospective, retrospective or cross-sectional studies) RCTs will be included if they provided a multiple regression analysis looking at predictors of any relevant outcomes 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.
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 In-patient and outpatient
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** 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: the likelihood of compulsory treatment or a better/worse outcome from compulsory treatment
Notes	Possible questions or aims asked by the authors in the studies found: What is the outcome of mandatory admission/compulsory treatment in patients with an ED?

Topic	Consent and compulsory treatment:
	What are the risk factors for the use of compulsory treatment in patients with an ED? How to decide when to stop treating eating disorders? (may include managed death/ethical issue) When to begin compulsory treatment at the assessment stage (including the MH act/at the courts)? Guidance on how to maintain management (i.e. advice for those who experience repeated admissions) Key papers: Control and compulsory treatment in anorexia nervosa: the views of patients and parents. Tan JO, Hope T, Stewart A, Fitzpatrick R. Int J Law Psychiatry. 2003 Nov-Dec;26(6):627-45 Attitudes of patients with anorexia nervosa to compulsory treatment and coercion. Tan JO, Stewart A, Fitzpatrick R, Hope T. Int J Law Psychiatry. 2010 Jan-Feb;33(1):13-9 Compulsory treatment in anorexia nervosa: a review. Elzakkers IF1, Danner UN, Hoek HW, Schmidt U, van Elburg AA. Int J Eat Disord. 2014 Dec;47(8):845-52

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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.

G.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.

Investigate the clinical and cost effectiveness of psychological treatments for children and young people with binge eating disorder.

G.1.1 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
- binge eating frequency
- compensatory behaviours
- weight or BMI (for studies of anorexia nervosa).

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.

G.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?

G.2.11 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
- binge eating frequency
- compensatory behaviours
- weight or BMI (for studies of anorexia nervosa).

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 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
- binge eating frequency
- compensatory behaviours
- weight or BMI (for studies of anorexia nervosa).

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 (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
- binge eating frequency
- compensatory behaviours
- weight or BMI (for studies of anorexia nervosa)
- 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
- binge eating frequency
- compensatory behaviours
- weight or BMI (for studies of anorexia nervosa).

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.