

Eating disorders: recognition and treatment

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The application of the recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline replaces CG9.

Overview

This guideline covers assessment, treatment, monitoring and inpatient care for children, young people and adults with eating disorders. It aims to improve the care people receive by detailing the most effective treatments for anorexia nervosa, binge eating disorder and bulimia nervosa.

Who is it for?

- Healthcare professionals
- Commissioners and providers
- Other professionals who provide public services to people with eating disorders (including in education and criminal justice settings)
- People with suspected or diagnosed eating disorders and their families and carers

Recommendations

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

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

In this guideline, 'family members' includes the siblings, children and partners of people with an eating disorder.

1.1 *General principles of care*

Improving access to services

1.1.1 Be aware that people with an eating disorder may:

- find it difficult or distressing to discuss it with healthcare professionals, staff and other service users
- be vulnerable to stigma and shame
- need information and interventions tailored to their age and level of development.

1.1.2 Ensure that all people with an eating disorder and their parents or carers (as appropriate) have equal access to treatments (including through self-referral) for eating disorders, regardless of:

- age
- gender or gender identity (including people who are transgender)
- sexual orientation
- socioeconomic status
- religion, belief, culture, family origin or ethnicity
- where they live and who they live with

- any physical or other mental health problems or disabilities.

1.1.3 Healthcare professionals assessing people with an eating disorder (especially children and young people) should be alert throughout assessment and treatment to signs of bullying, teasing, abuse (emotional, physical and sexual) and neglect. For guidance on when to suspect child maltreatment, see the NICE guideline on [child maltreatment](#).

Communication and information

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

1.1.5 Offer people with an eating disorder and their family members or carers (as appropriate) education and information on:

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

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

- be sensitive when discussing a person's weight and appearance
- be aware that family members or carers may feel guilty and responsible for the eating disorder
- show empathy, compassion and respect
- provide information in a format suitable for them, and check they understand it.

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

Support for people with an eating disorder

1.1.8 Assess the impact of the home, education, work and wider social environment (including the internet and social media) on each person's eating disorder.

Address their emotional, education, employment and social needs throughout treatment.

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

Working with family members and carers

- 1.1.10 Be aware that the family members or carers of a person with an eating disorder may experience severe distress. Offer family members or carers assessments of their own needs as treatment progresses, including:

- what impact the eating disorder has on them and their mental health
- what support they need, including practical support and emergency plans if the person with the eating disorder is at high medical or psychiatric risk.

- 1.1.11 If appropriate, provide written information for family members or carers who do not attend assessment or treatment meetings with the person with an eating disorder.

Consent and confidentiality

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

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

- 1.1.13 When seeking consent for assessments or treatments for children or young people under 16, respect [Gillick competence](#) if they consent and do not want their family members or carers involved.

Training and competencies

- 1.1.14 Professionals who assess and treat people with an eating disorder should be competent to do this for the age groups they care for.

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

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

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

1.1.17 Professionals who provide treatments for eating disorders should:

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

Coordination of care for people with an eating disorder

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

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

1.2 *Identification and assessment*

- 1.2.1 People with eating disorders should be assessed and receive treatment at the earliest opportunity.
- 1.2.2 Early treatment is particularly important for those with or at risk of severe emaciation and such patients should be prioritised for treatment.

Initial assessments in primary and secondary mental health care

- 1.2.3 Be aware that eating disorders present in a range of settings, including:
- primary and secondary health care (including acute hospitals)
 - social care
 - education
 - work.
- 1.2.4 Although eating disorders can develop at any age, be aware that the risk is highest for young men and women between 13 and 17 years of age.
- 1.2.5 Do not use screening tools (for example, SCOFF) as the sole method to determine whether or not people have an eating disorder.
- 1.2.6 When assessing for an eating disorder or deciding whether to refer people for assessment, take into account any of the following that apply:
- an unusually low or high BMI or body weight for their age
 - rapid weight loss
 - dieting or restrictive eating practices (such as dieting when they are underweight) that are worrying them, their family members or carers, or professionals
 - family members or carers report a change in eating behaviour
 - social withdrawal, particularly from situations that involve food
 - other mental health problems

- a disproportionate concern about their weight or shape (for example, concerns about weight gain as a side effect of contraceptive medication)
- problems managing a chronic illness that affects diet, such as diabetes or coeliac disease
- menstrual or other endocrine disturbances, or unexplained gastrointestinal symptoms
- physical signs of:
 - malnutrition, including poor circulation, dizziness, palpitations, fainting or pallor
 - compensatory behaviours, including laxative or diet pill misuse, vomiting or excessive exercise
- abdominal pain that is associated with vomiting or restrictions in diet, and that cannot be fully explained by a medical condition
- unexplained electrolyte imbalance or hypoglycaemia
- atypical dental wear (such as erosion)
- whether they take part in activities associated with a high risk of eating disorders (for example, professional sport, fashion, dance, or modelling).

1.2.7 Be aware that, in addition to the points in recommendation 1.2.6, children and young people with an eating disorder may also present with faltering growth (for example, a low weight or height for their age) or delayed puberty.

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

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

- their physical health, including checking for any physical effects of malnutrition or compensatory behaviours such as vomiting
- the presence of mental health problems commonly associated with eating disorders, including depression, anxiety, self-harm and obsessive compulsive disorder
- the possibility of alcohol or substance misuse

- the need for emergency care in people whose physical health is compromised or who have a suicide risk.

Referral

1.2.10 If an eating disorder is suspected after an initial assessment, refer immediately to a community-based, age-appropriate eating disorder service for further assessment or treatment.

1.3 *Treating anorexia nervosa*

1.3.1 Provide support and care for all people with anorexia nervosa in contact with specialist services, whether or not they are having a specific intervention.

Support should:

- include psychoeducation about the disorder
- include monitoring of weight, mental and physical health, and any risk factors
- be multidisciplinary and coordinated between services
- involve the person's family members or carers (as appropriate).

1.3.2 When treating anorexia nervosa, be aware that:

- helping people to reach a healthy body weight or BMI for their age is a key goal **and**
- weight gain is key in supporting other psychological, physical and quality of life changes that are needed for improvement or recovery.

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

Psychological treatment for anorexia nervosa in adults

1.3.4 For adults with anorexia nervosa, consider one of:

- individual eating-disorder-focused cognitive behavioural therapy (CBT-ED)
- Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)
- specialist supportive clinical management (SSCM).

Explain to the person what the treatments involve to help them choose which they would prefer.

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

- typically consist of up to 40 sessions over 40 weeks, with twice-weekly sessions in the first 2 or 3 weeks
- aim to reduce the risk to physical health and any other symptoms of the eating disorder
- encourage healthy eating and reaching a healthy body weight
- cover nutrition, cognitive restructuring, mood regulation, social skills, body image concern, self-esteem, and relapse prevention
- create a personalised treatment plan based on the processes that appear to be maintaining the eating problem
- explain the risks of malnutrition and being underweight
- enhance self-efficacy
- include self-monitoring of dietary intake and associated thoughts and feelings
- include homework, to help the person practice in their daily life what they have learned.

1.3.6 MANTRA for adults with anorexia nervosa should:

- typically consist of 20 sessions, with:
 - weekly sessions for the first 10 weeks, and a flexible schedule after this
 - up to 10 extra sessions for people with complex problems
- base treatment on the MANTRA workbook
- motivate the person and encourage them to work with the practitioner
- be flexible in how the modules of MANTRA are delivered and emphasised
- when the person is ready, cover nutrition, symptom management, and behaviour change

- encourage the person to develop a 'non-anorexic identity'
- involve family members or carers to help the person:
 - understand their condition and the problems it causes and the link to the wider social context
 - change their behaviour.

1.3.7 SSCM for adults with anorexia nervosa should:

- typically consist of 20 or more weekly sessions (depending on severity)
- assess, identify, and regularly review key problems
- aim to develop a positive relationship between the person and the practitioner
- aim to help people recognise the link between their symptoms and their abnormal eating behaviour
- aim to restore weight
- provide psychoeducation, and nutritional education and advice
- include physical health monitoring
- establish a weight range goal
- encourage reaching a healthy body weight and healthy eating
- allow the person to decide what else should be included as part of their therapy.

1.3.8 If individual CBT-ED, MANTRA, or SSCM is unacceptable, contraindicated or ineffective for adults with anorexia nervosa, consider:

- one of these 3 treatments that the person has not had before or
- eating-disorder-focused focal psychodynamic therapy (FPT).

1.3.9 FPT for adults with anorexia nervosa should:

- typically consist of up to 40 sessions over 40 weeks

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

Psychological treatment for anorexia nervosa in children and young people

1.3.10 Consider anorexia-nervosa-focused family therapy for children and young people (FT-AN), delivered as single-family therapy or a combination of single- and multi-family therapy. Give children and young people the option to have some single-family sessions:

- separately from their family members or carers and
- together with their family members or carers.

1.3.11 FT-AN for children and young people with anorexia nervosa should:

- typically consist of 18–20 sessions over 1 year
- review the needs of the person 4 weeks after treatment begins and then every 3 months, to establish how regular sessions should be and how long treatment should last
- emphasise the role of the family in helping the person to recover

- not blame the person or their family members or carers
- include psychoeducation about nutrition and the effects of malnutrition
- early in treatment, support the parents or carers to take a central role in helping the person manage their eating, and emphasise that this is a temporary role
- in the first phase, aim to establish a good therapeutic alliance with the person, their parents or carers and other family members
- in the second phase, support the person (with help from their parents or carers) to establish a level of independence appropriate for their level of development
- in the final phase:
 - focus on plans for when treatment ends (including any concerns the person and their family have) and on relapse prevention
 - address how the person can get support if treatment is stopped.

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

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

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

1.3.15 If FT-AN is unacceptable, contraindicated or ineffective for children or young people with anorexia nervosa, consider individual CBT-ED or adolescent-focused psychotherapy for anorexia nervosa (AFP-AN).

1.3.16 Individual CBT-ED for children and young people with anorexia nervosa should:

- typically consist of up to 40 sessions over 40 weeks, with:
 - twice-weekly sessions in the first 2 or 3 weeks
 - 8–12 additional brief family sessions with the person and their parents or carers (as appropriate)

- in family sessions and in individual sessions, include psychoeducation about nutrition and the effects of malnutrition
- in family sessions:
 - identify anything in the person's home life that could make it difficult for them to change their behaviour, and find ways to address this
 - discuss meal plans
- aim to reduce the risk to physical health and any other symptoms of the eating disorder
- encourage reaching a healthy body weight and healthy eating
- cover nutrition, relapse prevention, cognitive restructuring, mood regulation, social skills, body image concern and self-esteem
- create a personalised treatment plan based on the processes that appear to be maintaining the eating problem
- take into account the person's specific development needs
- explain the risks of malnutrition and being underweight
- enhance self-efficacy
- include self-monitoring of dietary intake and associated thoughts and feelings
- include homework, to help the person practice what they have learned in their daily life
- address how the person can get support if treatment is stopped.

1.3.17 AFP-AN for children and young people should:

- typically consist of 32–40 individual sessions over 12–18 months, with:
 - more regular sessions early on, to help the person build a relationship with the practitioner and motivate them to change their behaviour
 - 8–12 additional family sessions with the person and their parents or carers (as appropriate)

- review the needs of the person 4 weeks after treatment begins and then every 3 months, to establish how regular sessions should be and how long treatment should last
- in family sessions and in individual sessions, include psychoeducation about nutrition and the effects of malnutrition
- focus on the person's self-image, emotions and interpersonal processes, and how these affect their eating disorder
- develop a formulation of the person's psychological issues and how they use anorexic behaviour as a coping strategy
- address fears about weight gain, and emphasise that weight gain and healthy eating is a critical part of therapy
- find alternative strategies for the person to manage stress
- in later stages of treatment, explore issues of identity and build independence
- towards end of treatment, focus on transferring the therapy experience to situations in everyday life
- in family sessions, help parents or carers support the person to change their behaviour
- address how the person can get support if treatment is stopped.

People with anorexia nervosa who are not having treatment

1.3.18 For people with anorexia who are not having treatment (for example because it has not helped or because they have declined it) and who do not have severe or complex problems:

- discharge them to primary care
- tell them they can ask their GP to refer them again for treatment at any time.

1.3.19 For people with anorexia who have declined or do not want treatment and who have severe or complex problems, eating disorder services should provide support as covered in recommendation 1.3.1.

Dietary advice for people with anorexia nervosa

- 1.3.20 Only offer dietary counselling as part of a multidisciplinary approach.
- 1.3.21 Encourage people with anorexia nervosa to take an age-appropriate oral multi-vitamin and multi-mineral supplement until their diet includes enough to meet their dietary reference values.
- 1.3.22 Include family members or carers (as appropriate) in any dietary education or meal planning for children and young people with anorexia nervosa who are having therapy on their own.
- 1.3.23 Offer supplementary dietary advice to children and young people with anorexia nervosa and their family or carers (as appropriate) to help them meet their dietary needs for growth and development (particularly during puberty).

Medication for anorexia nervosa

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

1.4 *Treating binge eating disorder*

Psychological treatment for binge eating disorder in adults

- 1.4.1 Explain to people with binge eating disorder that psychological treatments aimed at treating binge eating have a limited effect on body weight and that weight loss is not a therapy target in itself. Refer to the NICE guideline on [obesity identification, assessment and management](#) for guidance on weight loss and bariatric surgery.
- 1.4.2 Offer a binge-eating-disorder-focused guided self-help programme to adults with binge eating disorder.
- 1.4.3 Binge-eating-disorder-focused guided self-help programmes for adults should:
- use cognitive behavioural self-help materials
 - focus on adherence to the self-help programme

- supplement the self-help programme with brief supportive sessions (for example, 4 to 9 sessions lasting 20 minutes each over 16 weeks, running weekly at first)
- focus exclusively on helping the person follow the programme.

1.4.4 If guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks, offer group eating-disorder-focused cognitive behavioural therapy (CBT-ED).

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

- typically consist of 16 weekly 90-minute group sessions over 4 months
- focus on psychoeducation, self-monitoring of the eating behaviour and helping the person analyse their problems and goals
- include making a daily food intake plan and identifying binge eating cues
- include body exposure training and helping the person to identify and change negative beliefs about their body
- help with avoiding relapses and coping with current and future risks and triggers.

1.4.6 If group CBT-ED is not available or the person declines it, consider individual CBT-ED for adults with binge eating disorder.

1.4.7 Individual CBT-ED for adults with binge eating disorder should:

- typically consist of 16–20 sessions
- develop a formulation of the person's psychological issues, to determine how dietary and emotional factors contribute to their binge eating
- based on the formulation:
 - advise people to eat regular meals and snacks to avoid feeling hungry
 - address the emotional triggers for their binge eating, using cognitive restructuring, behavioural experiments and exposure
- include weekly monitoring of binge eating behaviours, dietary intake and weight
- share the weight record with the person

- address body-image issues if present
- explain to the person that although CBT-ED does not aim at weight loss, stopping binge eating can have this effect in the long term
- advise the person not to try to lose weight (for example by dieting) during treatment, because this is likely to trigger binge eating.

Psychological treatment for binge eating disorder in children and young people

- 1.4.8 For children and young people with binge eating disorder, offer the same treatments recommended for adults with binge eating disorder.

Medication for binge eating disorder

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

1.5 *Treating bulimia nervosa*

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

Psychological treatment for bulimia nervosa in adults

- 1.5.2 Consider bulimia-nervosa-focused guided self-help for adults with bulimia nervosa.
- 1.5.3 Bulimia-nervosa-focused guided self-help programmes for adults with bulimia nervosa should:
- use cognitive behavioural self-help materials for eating disorders
 - supplement the self-help programme with brief supportive sessions (for example 4 to 9 sessions lasting 20 minutes each over 16 weeks, running weekly at first).
- 1.5.4 If bulimia-nervosa-focused guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks of treatment, consider individual eating-disorder-focused cognitive behavioural therapy (CBT-ED).
- 1.5.5 Individual CBT-ED for adults with bulimia nervosa should:

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

Psychological treatment for bulimia nervosa in children and young people

1.5.6 Offer bulimia-nervosa-focused family therapy (FT-BN) to children and young people with bulimia nervosa.

1.5.7 FT-BN for children and young people with bulimia nervosa should:

- typically consist of 18–20 sessions over 6 months
- establish a good therapeutic relationship with the person and their family members or carers
- support and encourage the family to help the person recover
- not blame the person, their family members or carers
- include information about:
 - regulating body weight
 - dieting
 - the adverse effects of attempting to control weight with self-induced vomiting, laxatives or other compensatory behaviours

- use a collaborative approach between the parents and the young person to establish regular eating patterns and minimise compensatory behaviours
- include regular meetings with the person on their own throughout the treatment
- include self-monitoring of bulimic behaviours and discussions with family members or carers
- in later phases of treatment, support the person and their family members or carers to establish a level of independence appropriate for their level of development
- in the final phase of treatment, focus on plans for when treatment ends (including any concerns the person and their family have) and on relapse prevention.

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

1.5.9 If FT-BN is unacceptable, contraindicated or ineffective, consider individual eating-disorder-focused cognitive behavioural therapy (CBT-ED) for children and young people with bulimia nervosa.

1.5.10 Individual CBT-ED for children and young people with bulimia nervosa should:

- typically consist of 18 sessions over 6 months, with more frequent sessions early in treatment
- include up to 4 additional sessions with parents or carers
- initially focus on the role bulimia nervosa plays in the person's life and on building motivation to change
- provide psychoeducation about eating disorders and how symptoms are maintained, while encouraging the person to gradually establish regular eating habits
- develop a case formulation with the person
- teach the person to monitor their thoughts, feelings and behaviours
- set goals and encourage the person to address problematic thoughts, beliefs and behaviours with problem-solving
- use relapse prevention strategies to prepare for and mitigate potential future setbacks

- in sessions with parents and carers, provide education about eating disorders, identify family factors that stop the person from changing their behaviour, and discuss how the family can support the person's recovery.

Medication for bulimia nervosa

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

1.6 *Treating other specified feeding and eating disorders (OSFED)*

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

1.7 *Physical therapy for any eating disorder*

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

1.8 *Physical and mental health comorbidities*

1.8.1 Eating disorder specialists and other healthcare teams should collaborate to support effective treatment of physical or mental health comorbidities in people with an eating disorder.

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

Diabetes

1.8.3 For people with an eating disorder and diabetes, the eating disorder and diabetes teams should:

- collaborate to explain the importance of physical health monitoring to the person
- agree who has responsibility for monitoring physical health
- collaborate on managing mental and physical health comorbidities

- use a low threshold for monitoring blood glucose and blood ketones
- use outcome measurements to monitor the effectiveness of treatments for each condition and the potential impact they have on each other.

1.8.4 When treating eating disorders in people with diabetes:

- explain to the person (and if needed their diabetes team) that they may need to monitor their blood glucose and blood ketones more closely during treatment
- consider involving their family members and carers (as appropriate) in treatment to help them with blood glucose control.

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

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

- a gradual increase in the amount of carbohydrates in their diet (if medically safe), so that insulin can be started at a lower dose
- a gradual increase in insulin doses to avoid a rapid drop in blood glucose levels, which can increase the risk of retinopathy and neuropathy
- adjusted total glycaemic load and carbohydrate distribution to meet their individual needs and prevent rapid weight gain
- psychoeducation about the problems caused by misuse of diabetes medication
- diabetes educational interventions, if the person has any gaps in their knowledge.

1.8.7 For people with suspected hypoglycaemia, test blood glucose:

- before all supervised meals and snacks
- when using the hypoglycaemia treatment algorithm
- after correction doses.

- 1.8.8 For people with suspected hyperglycaemia or hypoglycaemia, and people with normal blood glucose levels who are misusing insulin, healthcare professionals should test for blood ketones:
- when using the hypoglycaemia treatment algorithm
 - after correction doses.
- 1.8.9 For people with bulimia nervosa and diabetes, consider monitoring of:
- glucose toxicity
 - insulin resistance
 - ketoacidosis
 - oedema.
- 1.8.10 When diabetes control is challenging:
- do not attempt to rapidly treat hyperglycaemia (for example with increased insulin doses), because this increases the risk of retinopathy and neuropathy
 - regularly monitor blood potassium levels
 - do not stop insulin altogether, because this puts the person at high risk of diabetic ketoacidosis.
- 1.8.11 For more guidance on managing diabetes, including on [fluid replacement in children and young people with diabetic ketoacidosis](#), refer to the NICE guidelines on [type 1 and type 2 diabetes in children and young people](#), [type 1 diabetes in adults](#), and [type 2 diabetes in adults](#).

Comorbid mental health problems

- 1.8.12 When deciding which order to treat an eating disorder and a comorbid mental health condition (in parallel, as part of the same treatment plan or one after the other), take the following into account:
- the severity and complexity of the eating disorder and comorbidity
 - the person's level of functioning

- the preferences of the person with the eating disorder and (if appropriate) those of their family members or carers.

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

Medication risk management

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

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

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

1.8.17 Offer ECG monitoring for people with an eating disorder who are taking medication that could compromise cardiac functioning (including medication that could cause electrolyte imbalance, bradycardia below 40 beats per minute, hypokalaemia, or a prolonged QT interval).

Substance or medication misuse

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

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

Growth and development

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

1.9 *Conception and pregnancy for women with eating disorders*

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

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

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

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

1.9.3 For women who are pregnant or in the perinatal period and have an eating disorder:

- offer treatment for their eating disorder as covered in sections 1.3–1.6
- provide monitoring and education as recommended in the NICE guideline on [antenatal and postnatal mental health](#).

1.9.4 For guidance on providing advice to pregnant women about healthy eating and feeding their baby, see the NICE guideline on [maternal and child nutrition](#).

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

1.10 *Physical health assessment, monitoring and management for eating disorders*

Physical health assessment and monitoring for all eating disorders

- 1.10.1 Assess fluid and electrolyte balance in people with an eating disorder who are believed to be engaging in compensatory behaviours, such as vomiting, taking laxatives or diuretics, or water loading.
- 1.10.2 Assess whether ECG monitoring is needed in people with an eating disorder, based on the following risk factors:
- rapid weight loss
 - excessive exercise
 - severe purging behaviours, such as laxative or diuretic use or vomiting
 - bradycardia
 - hypotension
 - excessive caffeine (including from energy drinks)
 - prescribed or non-prescribed medications
 - muscular weakness
 - electrolyte imbalance
 - previous abnormal heart rhythm.

Management for all eating disorders

- 1.10.3 Provide acute medical care (including emergency admission) for people with an eating disorder who have severe electrolyte imbalance, severe malnutrition, severe dehydration or signs of incipient organ failure.

- 1.10.4 For people with an eating disorder who need supplements to restore electrolyte balance, offer these orally unless the person has problems with gastrointestinal absorption or the electrolyte disturbance is severe.
- 1.10.5 For people with an eating disorder and continued unexplained electrolyte imbalance, assess whether it could be caused by another condition.
- 1.10.6 Encourage people with an eating disorder who are vomiting to:
- have regular dental and medical reviews
 - avoid brushing teeth immediately after vomiting
 - rinse with non-acid mouthwash after vomiting
 - avoid highly acidic foods and drinks.
- 1.10.7 Advise people with an eating disorder who are misusing laxatives or diuretics:
- that laxatives and diuretics do not reduce calorie absorption and so do not help with weight loss
 - to gradually reduce and stop laxative or diuretic use.
- 1.10.8 Advise people with an eating disorder who are exercising excessively to stop doing so.
- 1.10.9 For guidance on identifying, assessing and managing overweight and obesity, see the NICE guideline on [obesity](#).

Assessment and monitoring of physical health in anorexia nervosa

- 1.10.10 GPs should offer a physical and mental health review at least annually to people with anorexia nervosa who are not receiving ongoing treatment for their eating disorder. The review should include:
- weight or BMI (adjusted for age if appropriate)
 - blood pressure
 - relevant blood tests

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

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

Low bone mineral density in people with anorexia nervosa

1.10.12 Bone mineral density results should be interpreted and explained to people with anorexia nervosa by a professional with the knowledge and competencies to do this.

1.10.13 Before deciding whether to measure bone density, discuss with the person and their family members or carers why it could be useful.

1.10.14 Explain to people with anorexia nervosa that the main way of preventing and treating low bone mineral density is reaching and maintaining a healthy body weight or BMI for their age.

1.10.15 Consider a bone mineral density scan:

- after 1 year of underweight in children and young people, or earlier if they have bone pain or recurrent fractures
- after 2 years of underweight in adults, or earlier if they have bone pain or recurrent fractures.

1.10.16 Use measures of bone density that correct for bone size (such as bone mineral apparent density [BMAD]) in children and young people with faltering growth.

1.10.17 Consider repeat bone mineral density scans in people with ongoing persistent underweight, especially when using or deciding whether to use hormonal treatment.

- 1.10.18 Do not repeat bone mineral density scans for people with anorexia nervosa more frequently than once per year, unless they develop bone pain or recurrent fractures.
- 1.10.19 Do not routinely offer oral or transdermal oestrogen therapy to treat low bone mineral density in children or young people with anorexia nervosa.
- 1.10.20 Seek specialist paediatric or endocrinological advice before starting any hormonal treatment for low bone mineral density. Coordinate any treatment with the eating disorders team.
- 1.10.21 Consider transdermal 17- β -estradiol (with cyclic progesterone) for young women (13–17 years) with anorexia nervosa who have long-term low body weight and low bone mineral density with a bone age over 15.
- 1.10.22 Consider incremental physiological doses of oestrogen in young women (13–17 years) with anorexia nervosa who have delayed puberty, long-term low body weight and low bone mineral density with a bone age under 15.
- 1.10.23 Consider bisphosphonates for women (18 years and over) with anorexia nervosa who have long-term low body weight and low bone mineral density. Discuss the benefits and risks (including risk of teratogenic effects) with women before starting treatment.
- 1.10.24 Advise people with anorexia nervosa and osteoporosis or related bone disorders to avoid high-impact physical activities and activities that significantly increase the chance of falls or fractures.
- 1.10.25 For guidance on osteoporosis risk assessment, see the NICE guideline on [assessing the risk of fragility fractures in osteoporosis](#).

1.11 *Inpatient and day patient treatment*

- 1.11.1 Admit people with an eating disorder whose physical health is severely compromised to a medical inpatient or day patient service for medical stabilisation and to initiate refeeding, if these cannot be done in an outpatient setting.

- 1.11.2 Do not use an absolute weight or BMI threshold when deciding whether to admit people with an eating disorder to day patient or inpatient care.
- 1.11.3 When deciding whether day patient or inpatient care is most appropriate, take the following into account:
- The person's BMI or weight, and whether these can be safely managed in a day patient service or whether the rate of weight loss (for example more than 1 kg a week) means they need inpatient care.
 - Whether inpatient care is needed to actively monitor medical risk parameters such as blood tests, physical observations and ECG (for example bradycardia below 40 beats per minute or a prolonged QT interval) that have values or rates of change in the concern or alert ranges: refer to Box 1 in Management of Really Sick Patients with Anorexia Nervosa ([MARSIPAN](#)), or Guidance 1 and 2 in [junior MARSIPAN](#).
 - The person's current physical health and whether this is significantly declining.
 - Whether the parents or carers of children and young people can support them and keep them from significant harm as a day patient.
- 1.11.4 When reviewing the need for inpatient care as part of an integrated treatment programme for a person with an eating disorder:
- do not use inpatient care solely to provide psychological treatment for eating disorders
 - do not discharge people solely because they have reached a healthy weight.
- 1.11.5 For people with an eating disorder and acute mental health risk (such as significant suicide risk), consider psychiatric crisis care or psychiatric inpatient care.
- 1.11.6 Children, young people and adults with an eating disorder who are admitted to day patient or inpatient care should be cared for in age-appropriate facilities (for example, paediatric wards or adolescent mental health services). These should be near to their home, and have the capacity to provide appropriate educational activities during extended admissions.

1.11.7 When a person is admitted to inpatient care for medical stabilisation, specialist eating disorder or liaison psychiatry services should:

- keep in contact with the inpatient team to advise on care and management, both during the admission and when planning discharge
- keep the person's family members or carers involved
- consider starting or continuing psychological treatments for the eating disorder.

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

Refeeding

1.11.9 Ensure that staff of day patient, inpatient, or acute services who treat eating disorders are trained to recognise the symptoms of refeeding syndrome and how to manage it.

1.11.10 Use a standard operating procedure for refeeding that emphasises the need to avoid under-nutrition and refeeding syndrome. Refer to existing national guidance, such as [MARSIPAN](#) and [junior MARSIPAN](#).

Care planning and discharge from inpatient care

1.11.11 Develop a care plan for each person with an eating disorder who is admitted to inpatient care. The care plan should:

- give clear objectives and outcomes for the admission
- be developed in collaboration with the person, their family members or carers (as appropriate), and the community-based eating disorder service
- set out how they will be discharged, how they will move back to community-based care, and what this care should be.

1.11.12 Whether or not the person is medically stable, within 1 month of admission review with them, their parents or carers (as appropriate) and the referring team, whether inpatient care should be continued or stepped down to a less intensive setting.

1.11.13 As part of the review:

- assess whether enough progress has been made towards the objectives agreed at admission
- agree a schedule for further reviews, with reviews happening at least monthly
- take into account the risk that people with an eating disorder can become institutionalised by a long admission, and that a lack of change in their condition could indicate that inpatient treatment is harmful
- consider seeking an independent second opinion if healthcare professionals have different views about the benefit of continued inpatient care.

1.12 *Using the Mental Health Act and compulsory treatment*

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

1.12.2 If a child or young person lacks capacity, their physical health is at serious risk and they do not consent to treatment, ask their parents or carers to consent on their behalf and if necessary, use an appropriate legal framework for compulsory treatment (such as the Mental Health Act 1983/2007 or the Children Act 1989).

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

Terms used in this guideline

Children

Aged 0–12 years.

Young people

Aged 13–17 years.

Adults

Aged 18 years and over.

Context

Eating disorders are defined by the negative beliefs and behaviours they cause people to have about themselves and their eating, body shape and weight. They can cause people to adopt restricted eating, binge eating and compensatory behaviours (such as vomiting and excessive exercise). The emotional and physical consequences of these beliefs and behaviours maintain the disorder and result in a high mortality rate from malnutrition, suicide and physical issues (such as electrolyte imbalances). This is most common in people with anorexia nervosa. There are also other physical complications (such as osteoporosis) and psychiatric comorbidities (such as anxiety disorders) that affect the wellbeing and recovery of people with an eating disorder and raise the cost of treatment.

Using figures for UK hospital admissions from 2012 to 2013, the eating disorders charity BEAT estimated that there were over 725,000 people with an eating disorder in the UK, approximately 90% of whom were female. However, recent community-based epidemiological studies suggest that as many as 25% of people with an eating disorder are male. Eating disorders most commonly start in adolescence, but can also start during childhood or adulthood. About 15% of people with an eating disorder have anorexia nervosa, which is also more common in younger people. Most people with an eating disorder meet diagnostic criteria for bulimia nervosa, binge eating disorder, or other specified feeding and eating disorder (OSFED). Each disorder is associated with poor quality of life, social isolation, and a substantial impact for family members and carers. Eating disorders are long-lasting conditions if they are not treated.

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

Recommendations for research

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

1 Psychological treatments for binge eating disorder

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

Compare the clinical and cost effectiveness of individual eating-disorder-focused CBT-ED with guided self-help and group CBT-ED for children and young people with binge eating disorder.

Why this is important

There is little evidence on psychological treatments for people with binge eating disorder. The studies that have been published have not always provided remission outcomes or adequate definitions of remission. While there is some evidence for guided self-help and individual CBT-ED, only one study was identified for individual CBT-ED and no remission data were available. It is also unclear if individual CBT-ED is more effective than guided self-help or group CBT-ED (especially for people that find these treatments ineffective).

There is also no evidence on treatments for children and very little for young people. One study was found on individual CBT-ED for young people, but only 26 participants were included in the data for remission. 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, the efficacy of eating disorder-focused family therapy could also be compared with individual CBT-ED and different kinds of self-help (such as internet self-help or guided self-help). Primary outcome measures could include:

- remission
- binge eating
- compensatory behaviours.

There should be at least a 1-year follow up. Qualitative data could also be collected on the service user's and (if appropriate) their family members' or carers' experience of the treatment. Mediating and moderating factors that have an effect on treatment effectiveness should also be measured, so that treatment barriers can be addressed and positive factors can be promoted.

2 Duration and intensity of psychological treatment

What is the effectiveness of treating eating disorders with psychological treatments of reduced duration and reduced intensity, compared with standard treatment?

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. People may be able to achieve remission with a smaller number of sessions or over a shorter period of time.

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

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

There should be at least a 1-year follow up. Mediating and moderating factors that have an effect on treatment effectiveness should also be measured, so that treatment barriers can be addressed and positive factors can be promoted.

3 Predictors of acute physical risk

What clinical and biochemical markers are the best predictors of acute physical risk for people with eating disorders?

Why this is important

Medical conditions such as bradycardia, hypotension and hypothermia are common in people who are underweight because of an eating disorder. Key markers of medical instability due to underweight such as pulse rate, blood pressure, and degree of underweight are commonly used as indications of risk in people with eating disorders. A number of internationally used risk frameworks are based on these markers and are important in decision-making for people with eating disorders (in particular when deciding whether to admit someone, whether to use compulsory care, and how to provide nutrition). The medical markers of acute risk are used throughout this guideline.

Despite their importance, almost all of the conventional risk frameworks are based on consensus with little validation. There is also a shortage of information on the physical factors most associated with mortality in eating disorders. Validated tools (such as Acute Physiology and Chronic Health Evaluation [APACHE] scores) are central to risk prediction in other areas of medical care, and it would be very useful to have a tool like this for eating disorders. Research is therefore needed to validate the range of individual clinical and biochemical markers, both individually and collectively, as predictors for physical harm (including death).

4 Treating an eating disorder in people with a comorbidity

What is the impact of comorbidities on treatment outcomes for eating disorders, and what approaches are effective in managing these comorbidities?

Why this is important

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

This is a complex area and likely to depend on the severity of the comorbidity and the eating disorder. There is limited evidence and randomised controlled trials are needed. For example, a trial could randomise people with an eating disorder and the same comorbidity (such as type 1 diabetes) to either a modified eating disorder therapy or a non-modified eating disorder therapy. Primary outcome measures may include:

- remission
- binge eating
- compensatory behaviours
- weight or BMI (for studies of anorexia nervosa)
- critical outcomes relating to the specific comorbidity.

There should be at least a 1-year follow up. Mediating and moderating factors that have an effect on treatment effectiveness should also be measured, so that treatment barriers can be addressed and positive factors can be promoted.

5 Maintaining benefits after successful treatment of anorexia nervosa

What factors (including comorbidities, personal, social and demographic factors, treatment type, and subsequent relapse prevention interventions) are associated with continued benefit after successful treatment for anorexia nervosa?

Why this is important

There is a wide range of treatments available for anorexia nervosa. However, they are often ineffective, and even when they are successful there is a high risk of relapse. It is not clear which factors reduce the risk of relapse after successful treatment, or what benefit people receive from further treatment to prevent relapse. There is also little evidence on effective relapse prevention strategies for people in remission.

A series of studies should be done to identify the factors associated with an enduring response to treatment, and to test interventions specifically aimed at preventing relapse in people in remission. Primary outcome measures may include:

- time to relapse
- weight or BMI.

Update information

May 2017

This guideline is a full update of NICE guideline CG9 (published January 2004) and replaces it.

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Accreditation

