

# Eating disorders

Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders

Issued: January 2004

**NICE clinical guideline 9**

[www.nice.org.uk/cg9](http://www.nice.org.uk/cg9)

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## Key priorities for implementation

The following recommendations have been identified as key priorities for implementation.

### Anorexia nervosa

- Most people with anorexia nervosa should be managed on an outpatient basis with psychological treatment provided by a service that is competent in giving that treatment and assessing the physical risk of people with eating disorders.
- People with anorexia nervosa requiring inpatient treatment should be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding) in combination with psychosocial interventions.
- Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa.

### Bulimia nervosa

- As a possible first step, patients with bulimia nervosa should be encouraged to follow an evidence-based self-help programme.
- As an alternative or additional first step to using an evidence-based self-help programme, adults with bulimia nervosa may be offered a trial of an antidepressant drug.
- Cognitive behaviour therapy for bulimia nervosa (CBT-BN), a specifically adapted form of CBT, should be offered to adults with bulimia nervosa. The course of treatment should be for 16 to 20 sessions over 4 to 5 months.
- Adolescents with bulimia nervosa may be treated with CBT-BN, adapted as needed to suit their age, circumstances and level of development, and including the family as appropriate.

### Atypical eating disorders

- In the absence of evidence to guide the management of atypical eating disorders (eating disorders not otherwise specified) other than binge eating disorder, it is recommended that the clinician considers following the guidance on the treatment of the eating problem that most closely resembles the individual patient's eating disorder.

- Cognitive behaviour therapy for binge eating disorder (CBT-BED), a specifically adapted form of CBT, should be offered to adults with binge eating disorder.

## **For all eating disorders**

- Family members, including siblings, should normally be included in the treatment of children and adolescents with eating disorders. Interventions may include sharing of information, advice on behavioural management and facilitating communication.

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# 1 Guidance

This guideline makes recommendations for the identification, treatment and management of anorexia nervosa, bulimia nervosa and atypical eating disorders (including binge eating disorder) in primary, secondary and tertiary care. The guideline applies to adults, adolescents and children aged 8 years and older.

## 1.1 Care across all conditions

### 1.1.1 Assessment and coordination of care

- 1.1.1.1 Assessment of people with eating disorders should be comprehensive and include physical, psychological and social needs, and a comprehensive assessment of risk to self.
- 1.1.1.2 The level of risk to the patient's mental and physical health should be monitored as treatment progresses because it may increase – for example, following weight change or at times of transition between services in cases of anorexia nervosa.
- 1.1.1.3 For people with eating disorders presenting in primary care, GPs should take responsibility for the initial assessment and the initial coordination of care. This includes the determination of the need for emergency medical or psychiatric assessment.
- 1.1.1.4 Where management is shared between primary and secondary care, there should be clear agreement among individual healthcare professionals on the responsibility for monitoring patients with eating disorders. This agreement should be in writing (where appropriate using the care programme approach) and should be shared with the patient and, where appropriate, his or her family and carers.

### 1.1.2 Providing good information and support

- 1.1.2.1 Patients and, where appropriate, carers should be provided with education and information on the nature, course and treatment of eating disorders.

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1.1.2.2 In addition to the provision of information, family and carers may be informed of self-help groups and support groups, and offered the opportunity to participate in such groups where they exist.

1.1.2.3 Healthcare professionals should acknowledge that many people with eating disorders are ambivalent about treatment. Healthcare professionals should also recognise the consequent demands and challenges this presents.

### **1.1.3 Getting help early**

1.1.3.1 People with eating disorders should be assessed and receive treatment at the earliest opportunity.

1.1.3.2 Early treatment is particularly important for those with or at risk of severe emaciation and such patients should be prioritised for treatment.

### **1.1.4 Management of physical aspects**

1.1.4.1 Where laxative abuse is present, patients should be advised to gradually reduce laxative use and informed that laxative use does not significantly reduce calorie absorption.

1.1.4.2 Treatment of both subthreshold and clinical cases of an eating disorder in people with diabetes is essential because of the greatly increased physical risk in this group.

1.1.4.3 People with type 1 diabetes and an eating disorder should have intensive regular physical monitoring because they are at high risk of retinopathy and other complications.

1.1.4.4 Pregnant women with eating disorders require careful monitoring throughout the pregnancy and in the postpartum period.

1.1.4.5 Patients with an eating disorder who are vomiting should have regular dental reviews.

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- 1.1.4.6 Patients with an eating disorder who are vomiting should be given appropriate advice on dental hygiene, which should include: avoiding brushing after vomiting; rinsing with a non-acid mouthwash after vomiting; and reducing an acid oral environment (for example, limiting acidic foods).
- 1.1.4.7 Healthcare professionals should advise people with eating disorders and osteoporosis or related bone disorders to refrain from physical activities that significantly increase the likelihood of falls.

### **1.1.5 Additional considerations for children and adolescents**

- 1.1.5.1 Family members, including siblings, should normally be included in the treatment of children and adolescents with eating disorders. Interventions may include sharing of information, advice on behavioural management and facilitating communication.
- 1.1.5.2 In children and adolescents with eating disorders, growth and development should be closely monitored. Where development is delayed or growth is stunted despite adequate nutrition, paediatric advice should be sought.
- 1.1.5.3 Healthcare professionals assessing children and adolescents with eating disorders should be alert to indicators of abuse (emotional, physical and sexual) and should remain so throughout treatment.
- 1.1.5.4 The right to confidentiality of children and adolescents with eating disorders should be respected.
- 1.1.5.5 Healthcare professionals working with children and adolescents with eating disorders should familiarise themselves with national guidelines and their employers' policies in the area of confidentiality.

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### **1.1.6 Identification and screening of eating disorders in primary care and non-mental health settings**

- 1.1.6.1 Target groups for screening should include young women with low body mass index (BMI) compared with age norms, patients consulting with weight concerns who are not overweight, women with menstrual disturbances or amenorrhoea, patients with gastrointestinal symptoms, patients with physical signs of starvation or repeated vomiting, and children with poor growth.
- 1.1.6.2 When screening for eating disorders one or two simple questions should be considered for use with specific target groups (for example, "Do you think you have an eating problem?" and "Do you worry excessively about your weight?").
- 1.1.6.3 Young people with type 1 diabetes and poor treatment adherence should be screened and assessed for the presence of an eating disorder.

## **1.2 Anorexia nervosa**

### **1.2.1 Assessment and management of anorexia nervosa in primary care**

- 1.2.1.1 In anorexia nervosa, although weight and BMI are important indicators they should not be considered the sole indicators of physical risk (as they are unreliable in adults and especially in children).
- 1.2.1.2 In assessing whether a person has anorexia nervosa, attention should be paid to the overall clinical assessment (repeated over time), including rate of weight loss, growth rates in children, objective physical signs and appropriate laboratory tests.
- 1.2.1.3 Patients with enduring anorexia nervosa not under the care of a secondary care service should be offered an annual physical and mental health review by their GP.

### **1.2.2 Psychological interventions for anorexia nervosa**

The delivery of psychological interventions should be accompanied by regular monitoring of a patient's physical state including weight and specific indicators of increased physical risk.



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### **Common elements of the psychological treatment of anorexia nervosa**

- 1.2.2.1 Therapies to be considered for the psychological treatment of anorexia nervosa include cognitive analytic therapy (CAT), cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT), focal psychodynamic therapy and family interventions focused explicitly on eating disorders.
- 1.2.2.2 Patient and, where appropriate, carer preference should be taken into account in deciding which psychological treatment is to be offered.
- 1.2.2.3 The aims of psychological treatment should be to reduce risk, to encourage weight gain and healthy eating, to reduce other symptoms related to an eating disorder, and to facilitate psychological and physical recovery.

### **Outpatient psychological treatments in first episode and later episodes**

- 1.2.2.4 Most people with anorexia nervosa should be managed on an outpatient basis, with psychological treatment (with physical monitoring) provided by a healthcare professional competent to give it and to assess the physical risk of people with eating disorders.
- 1.2.2.5 Outpatient psychological treatment for anorexia nervosa should normally be of at least 6 months' duration.
- 1.2.2.6 For patients with anorexia nervosa, if during outpatient psychological treatment there is significant deterioration, or the completion of an adequate course of outpatient psychological treatment does not lead to any significant improvement, more intensive forms of treatment (for example, a move from individual therapy to combined individual and family work; or day-care or inpatient care) should be considered.
- 1.2.2.7 Dietary counselling should not be provided as the sole treatment for anorexia nervosa.

### **Psychological aspects of inpatient care**

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- 1.2.2.8 For inpatients with anorexia nervosa, a structured symptom-focused treatment regimen with the expectation of weight gain should be provided in order to achieve weight restoration. It is important to carefully monitor the patient's physical status during refeeding.
- 1.2.2.9 Psychological treatment should be provided which has a focus both on eating behaviour and attitudes to weight and shape, and on wider psychosocial issues with the expectation of weight gain.
- 1.2.2.10 Rigid inpatient behaviour modification programmes should not be used in the management of anorexia nervosa.

### **Post-hospitalisation psychological treatment**

- 1.2.2.11 Following inpatient weight restoration, people with anorexia nervosa should be offered outpatient psychological treatment that focuses both on eating behaviour and attitudes to weight and shape, and on wider psychosocial issues, with regular monitoring of both physical and psychological risk.
- 1.2.2.12 The length of outpatient psychological treatment and physical monitoring following inpatient weight restoration should typically be at least 12 months.

### **Additional considerations for children and adolescents with anorexia nervosa**

- 1.2.2.13 Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa.
- 1.2.2.14 Children and adolescents with anorexia nervosa should be offered individual appointments with a healthcare professional separate from those with their family members or carers.
- 1.2.2.15 The therapeutic involvement of siblings and other family members should be considered in all cases because of the effects of anorexia nervosa on other family members.

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1.2.2.16 In children and adolescents with anorexia nervosa, the need for inpatient treatment and the need for urgent weight restoration should be balanced alongside the educational and social needs of the young person.

### **1.2.3 Pharmacological interventions for anorexia nervosa**

There is a very limited evidence base for the pharmacological treatment of anorexia nervosa. A range of drugs may be used in the treatment of comorbid conditions but caution should be exercised in their use given the physical vulnerability of many people with anorexia nervosa.

1.2.3.1 Medication should not be used as the sole or primary treatment for anorexia nervosa.

1.2.3.2 Caution should be exercised in the use of medication for comorbid conditions such as depressive or obsessive–compulsive features as they may resolve with weight gain alone.

1.2.3.3 When medication is used to treat people with anorexia nervosa, the side effects of drug treatment (in particular, cardiac side effects) should be carefully considered and discussed with the patient because of the compromised cardiovascular function of many people with anorexia nervosa.

1.2.3.4 Healthcare professionals should be aware of the risk of drugs that prolong the QTc interval on the ECG; for example, antipsychotics, tricyclic antidepressants, macrolide antibiotics, and some antihistamines. In patients with anorexia nervosa at risk of cardiac complications, the prescription of drugs with side effects that may compromise cardiac functioning should be avoided.

1.2.3.5 If the prescription of medication that may compromise cardiac functioning is essential, ECG monitoring should be undertaken.

1.2.3.6 All patients with a diagnosis of anorexia nervosa should have an alert placed in their prescribing record concerning the risk of side effects.

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## 1.2.4 Physical management of anorexia nervosa

Anorexia nervosa carries considerable risk of serious physical morbidity. Awareness of the risk, careful monitoring and, where appropriate, close liaison with an experienced physician are important in the management of the physical complications of anorexia nervosa.

### Managing weight gain

- 1.2.4.1 In most patients with anorexia nervosa, an average weekly weight gain of 0.5–1 kg in inpatient settings and 0.5 kg in outpatient settings should be an aim of treatment. This requires about 3500 to 7000 extra calories a week.
- 1.2.4.2 Regular physical monitoring, and in some cases treatment with a multi-vitamin/multi-mineral supplement in oral form, is recommended for people with anorexia nervosa during both inpatient and outpatient weight restoration.
- 1.2.4.3 Total parenteral nutrition should not be used for people with anorexia nervosa, unless there is significant gastrointestinal dysfunction.

### Managing risk

- 1.2.4.4 Healthcare professionals should monitor physical risk in patients with anorexia nervosa. If this leads to the identification of increased physical risk, the frequency of the monitoring and nature of the investigations should be adjusted accordingly.
- 1.2.4.5 People with anorexia nervosa and their carers should be informed if the risk to their physical health is high.
- 1.2.4.6 The involvement of a physician or paediatrician with expertise in the treatment of medically at-risk patients with anorexia nervosa should be considered for all individuals who are medically at-risk.
- 1.2.4.7 Pregnant women with either current or remitted anorexia nervosa should be considered for more intensive prenatal care to ensure adequate prenatal nutrition and fetal development.

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- 1.2.4.8 Oestrogen administration should not be used to treat bone density problems in children and adolescents as this may lead to premature fusion of the epiphyses.
- 1.2.4.9 Whenever possible patients should be engaged and treated before reaching severe emaciation. This requires both early identification and intervention. Effective monitoring and engagement of patients at severely low weight, or with falling weight, should be a priority.

### **Feeding against the will of the patient**

- 1.2.4.10 Feeding against the will of the patient should be an intervention of last resort in the care and management of anorexia nervosa.
- 1.2.4.11 Feeding against the will of the patient is a highly specialised procedure requiring expertise in the care and management of those with severe eating disorders and the physical complications associated with it. This should only be done in the context of the Mental Health Act 1983 or Children Act 1989.
- 1.2.4.12 When making the decision to feed against the will of the patient, the legal basis for any such action must be clear.

### **1.2.5 Service interventions for anorexia nervosa**

This section considers those aspects of the service system relevant to the treatment and management of anorexia nervosa.

- 1.2.5.1 Most people with anorexia nervosa should be treated on an outpatient basis.
- 1.2.5.2 Inpatient treatment or day patient treatment should be considered for people with anorexia nervosa whose disorder has not improved with appropriate outpatient treatment, or for whom there is a significant risk of suicide or severe self-harm.
- 1.2.5.3 Inpatient treatment should be considered for people with anorexia nervosa whose disorder is associated with high or moderate physical risk.

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- 1.2.5.4 Where inpatient management is required for people with anorexia nervosa, this should be provided within reasonable travelling distance to enable the involvement of relatives and carers in treatment, to maintain social and occupational links and to avoid difficulty in transition between primary and secondary care services. This is particularly important in the treatment of children and adolescents.
- 1.2.5.5 People with anorexia nervosa requiring inpatient treatment should be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding), in combination with psychosocial interventions.
- 1.2.5.6 Healthcare professionals without specialist experience of eating disorders, or in situations of uncertainty, should consider seeking advice from an appropriate specialist when contemplating a compulsory admission for a patient with anorexia nervosa, regardless of the age of the patient.
- 1.2.5.7 Healthcare professionals managing patients with anorexia nervosa, especially those with the binge–purging sub-type, should be aware of the increased risk of self-harm and suicide, particularly at times of transition between services or service settings.

## **1.2.6 Additional considerations for children and adolescents**

- 1.2.6.1 Healthcare professionals should ensure that children and adolescents with anorexia nervosa who have reached a healthy weight have the increased energy and necessary nutrients available in their diet to support further growth and development.
- 1.2.6.2 In the nutritional management of children and adolescents with anorexia nervosa, carers should be included in any dietary education or meal planning.
- 1.2.6.3 Admission of children and adolescents with anorexia nervosa should be to age-appropriate facilities (with the potential for separate children and adolescent services), which have the capacity to provide appropriate educational and related activities.

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- 1.2.6.4 When a young person with anorexia nervosa refuses treatment that is deemed essential, consideration should be given to the use of the Mental Health Act 1983 or the right of those with parental responsibility to override the young person's refusal.
- 1.2.6.5 Relying indefinitely on parental consent to treatment should be avoided. It is recommended that the legal basis under which treatment is being carried out should be recorded in the patient's case notes, and this is particularly important in the case of children and adolescents.
- 1.2.6.6 For children and adolescents with anorexia nervosa, where issues of consent to treatment are highlighted, healthcare professionals should consider seeking a second opinion from an eating disorders specialist.
- 1.2.6.7 If the patient with anorexia nervosa and those with parental responsibility refuse treatment, and treatment is deemed to be essential, legal advice should be sought in order to consider proceedings under the Children Act 1989.

## **1.3 Bulimia nervosa**

### **1.3.1 Psychological interventions for bulimia nervosa**

- 1.3.1.1 As a possible first step, patients with bulimia nervosa should be encouraged to follow an evidence-based self-help programme.
- 1.3.1.2 Healthcare professionals should consider providing direct encouragement and support to patients undertaking an evidence-based self-help programme as this may improve outcomes. This may be sufficient treatment for a limited subset of patients.
- 1.3.1.3 Cognitive behaviour therapy for bulimia nervosa (CBT-BN), a specifically adapted form of CBT, should be offered to adults with bulimia nervosa. The course of treatment should be for 16 to 20 sessions over 4 to 5 months.
- 1.3.1.4 When people with bulimia nervosa have not responded to or do not want CBT, other psychological treatments should be considered.

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1.3.1.5 Interpersonal psychotherapy should be considered as an alternative to CBT, but patients should be informed it takes 8–12 months to achieve results comparable with cognitive behaviour therapy.

### **1.3.2 Pharmacological interventions for bulimia nervosa**

1.3.2.1 As an alternative or additional first step to using an evidence-based self-help programme, adults with bulimia nervosa may be offered a trial of an antidepressant drug.

1.3.2.2 Patients should be informed that antidepressant drugs can reduce the frequency of binge eating and purging, but the long-term effects are unknown. Any beneficial effects will be rapidly apparent.

1.3.2.3 Selective serotonin reuptake inhibitors (SSRIs) (specifically fluoxetine) are the drugs of first choice for the treatment of bulimia nervosa in terms of acceptability, tolerability and reduction of symptoms.

1.3.2.4 For people with bulimia nervosa, the effective dose of fluoxetine is higher than for depression (60 mg daily).

1.3.2.5 No drugs, other than antidepressants, are recommended for the treatment of bulimia nervosa.

### **1.3.3 Management of physical aspects of bulimia nervosa**

Patients with bulimia nervosa can experience physical problems as a result of a range of behaviours associated with the condition. Awareness of the risks and careful monitoring should be a concern of all healthcare professionals working with people with this disorder.

1.3.3.1 Patients with bulimia nervosa who are vomiting frequently or taking large quantities of laxatives (especially if they are also underweight) should have their fluid and electrolyte balance assessed.



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1.3.3.2 When electrolyte disturbance is detected, it is usually sufficient to focus on eliminating the behaviour responsible. In the small proportion of cases where supplementation is required to restore electrolyte balance, oral rather than intravenous administration is recommended, unless there are problems with gastrointestinal absorption.

### **1.3.4 Service interventions for bulimia nervosa**

The great majority of patients with bulimia nervosa can be treated as outpatients. There is a very limited role for the inpatient treatment of bulimia nervosa. This is primarily concerned with the management of suicide risk or severe self-harm.

1.3.4.1 The great majority of patients with bulimia nervosa should be treated in an outpatient setting.

1.3.4.2 For patients with bulimia nervosa who are at risk of suicide or severe self-harm, admission as an inpatient or day patient, or the provision of more intensive outpatient care, should be considered.

1.3.4.3 Psychiatric admission for people with bulimia nervosa should normally be undertaken in a setting with experience of managing this disorder.

1.3.4.4 Healthcare professionals should be aware that patients with bulimia nervosa who have poor impulse control, notably substance misuse, may be less likely to respond to a standard programme of treatment. As a consequence treatment should be adapted to the problems presented.

### **1.3.5 Additional considerations for children and adolescents**

1.3.5.1 Adolescents with bulimia nervosa may be treated with CBT-BN adapted as needed to suit their age, circumstances and level of development, and including the family as appropriate.

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## 1.4 Atypical eating disorders including binge eating disorder

### 1.4.1 General treatment of atypical eating disorders

1.4.1.1 In the absence of evidence to guide the management of atypical eating disorders (also known as eating disorders not otherwise specified) other than binge eating disorder, it is recommended that the clinician considers following the guidance on the treatment of the eating problem that most closely resembles the individual patient's eating disorder.

### 1.4.2 Psychological treatments for binge eating disorder

1.4.2.1 As a possible first step, patients with binge eating disorder should be encouraged to follow an evidence-based self-help programme.

1.4.2.2 Healthcare professionals should consider providing direct encouragement and support to patients undertaking an evidence-based self-help programme as this may improve outcomes. This may be sufficient treatment for a limited subset of patients.

1.4.2.3 Cognitive behaviour therapy for binge eating disorder (CBT-BED), a specifically adapted form of CBT, should be offered to adults with binge eating disorder.

1.4.2.4 Other psychological treatments (interpersonal psychotherapy for binge eating disorder and modified dialectical behaviour therapy) may be offered to adults with persistent binge eating disorder.

1.4.2.5 Patients should be informed that all psychological treatments for binge eating disorder have a limited effect on body weight.

1.4.2.6 When providing psychological treatments for patients with binge eating disorder, consideration should be given to the provision of concurrent or consecutive interventions focusing on the management of any comorbid obesity.

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1.4.2.7 Suitably adapted psychological treatments should be offered to adolescents with persistent binge eating disorder.

### **1.4.3 Pharmacological interventions for binge eating disorder**

1.4.3.1 As an alternative or additional first step to using an evidence-based self-help programme, consideration should be given to offering a trial of an SSRI antidepressant drug to patients with binge eating disorder.

1.4.3.2 Patients with binge eating disorders should be informed that SSRIs can reduce binge eating, but the long-term effects are unknown. Antidepressant drug treatment may be sufficient treatment for a limited subset of patients.

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## 2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, following a period of consultation.

This guideline is relevant to people aged 8 years and over with anorexia nervosa, bulimia nervosa or related conditions, to their carers, and to all healthcare professionals involved in the help, treatment and care of people with eating disorders. These include:

- professional groups who share in the treatment and care for people with a diagnosis of an eating disorder, including psychiatrists, clinical psychologists, mental health nurses, community psychiatric nurses, social workers, practice nurses, secondary care medical staff, dietitians, dental, nursing and paramedical staff, occupational therapists, pharmacists, paediatricians, other physicians, general medical and dental practitioners, physiotherapists and family/other therapists
- professionals in other health and non-health sectors who may have direct contact with or are involved in the provision of health and other public services for those diagnosed with eating disorders, which may include prison doctors, the police, and professionals who work in the criminal justice and education sectors
- those with responsibility for planning services for people with a diagnosis of an eating disorder and their carers, including directors of public health, NHS trust managers and managers in primary care trusts.

The guidance does not specifically address:

- the diagnosis or treatment of people with eating disorders in the context of a separate physical or other primary mental disorder of which a disorder of eating is a symptom
- the practice of other professionals such as A&E staff and those who work in education sectors
- the management of the wider range of eating disturbances typically occurring in children (for example, food avoidance emotional disorder).

Although this guideline addresses the issue of identifying eating disorders, it has not made evidence-based recommendations in this regard nor has it referred to evidence regarding primary prevention or assessment.

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## 3 Implementation in the NHS

### 3.1 In general

Local health communities should review their existing practice in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders (core interventions) against this guideline. The review should consider the resources required to implement the recommendations set out in [Section 1](#), the people and processes involved and the timeline over which full implementation is envisaged. It is in the interests of patients that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly. This guideline should be used in conjunction with the [National Service Framework for Mental Health](#).

### 3.2 Audit

Suggested audit criteria are listed in [Appendix D](#). These can be used as the basis for local clinical audit, at the discretion of those in practice.

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## 4 Research recommendations

The following research recommendations have been identified to address gaps in the evidence base.

- Adequately powered efficacy studies of specific treatments and services for people with anorexia nervosa are needed.
- Efficacy studies of the treatment of atypical eating disorders (eating disorders not otherwise specified) are needed.
- Efficacy studies of the treatment of adolescents with bulimia nervosa, and non-responders to cognitive behaviour therapy are needed.
- Effectiveness studies of the treatment of bulimia nervosa in adults are needed.
- Patient and carer satisfaction is an important outcome and may influence treatment approaches. It should be considered a routine outcome in research.
- Further research is needed to assess the validity of screening instruments in primary care.

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## 5 Full guideline

The National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Mental Health. The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The full guideline [Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders](#) is published by the National Collaborating Centre for Mental Health.

The members of the Guideline Development Group are listed in [Appendix B](#). Information about the independent Guideline Review Panel is given in [Appendix C](#).

There is more information about [how NICE clinical guidelines are developed](#) on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is [available](#).



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## 6 Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

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## Appendix A: Grading scheme

The recommendations in this guideline were graded according to the quality of the evidence they were based on. The gradings are available in the [full guideline](#) and are not shown in this web version.

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## Appendix B: The Guideline Development Group

**Professor Simon Gowers (Chair)**

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**Ms Susan Ringwood**

Chief Executive, Eating Disorders Association (December 2002–January 2004)

**Dr Ulrike Schmidt**

Senior Lecturer in Eating Disorders, Eating Disorders Unit, Institute of Psychiatry

## **National Collaborating Centre for Mental Health Staff**

**Dr Catherine Pettinari** , Senior Project Manager

**Dr Craig Whittington** , Senior Systematic Reviewer

**Dr Judit Simon** , Health Economist

**Ms Heather Wilder** , Information Scientist

**Ms Ellen Boddington** , Research Assistant

**Mr Lawrence Howells** , Research Assistant

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## Appendix C: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The Panel includes experts on guideline methodology, healthcare professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel were as follows.

**Dr Chaand Nagpaul**

GP, Stanmore

**Dr Marcia Kelson**

Director, Patient Involvement Unit for NICE, College of Health, London

**Mr John Seddon**

Patient Representative

**Professor Kenneth Wilson**

Professor of Psychiatry of Old Age and Honorary Consultant Psychiatrist, Cheshire and Wirral Partnership NHS Trust

**Professor Shirley Reynolds**

Professor of Clinical Psychology, School of Medicine, Health Policy and Practice University of East Anglia, Norwich

**Dr Roger Paxton**

R&D Director, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust

## **Appendix D: Technical detail on the criteria for audit**

The [full guideline](#) contains the technical detail on the criteria for audit.

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## About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Mental Health. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in [The guidelines manual](#).

We have produced a [summary for patients and carers](#). Tools to help you put the guideline into practice and information about the evidence it is based on are also [available](#).

### Changes since publication

March 2012: minor maintenance.

### Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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