

SIGN 164

Eating disorders

Quick reference guide

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This Quick Reference Guide provides a summary of the main recommendations in **SIGN 164 Eating disorders**.

Recommendations **R** are worded to indicate the strength of the supporting evidence. Good practice points ✓ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: www.sign.ac.uk.

Early intervention

R | **A pilot of an additional First Episode and Rapid Early intervention in Eating Disorders (FREED) service to complement existing eating disorders services may be considered. This would offer early intervention to young adults aged 16–25 with eating disorders of less than three years' duration.**

Support for family and carers

R | **Formal carer support should be offered to all carers. This could draw on materials from Expert Carers Helping Others (ECHO) self help or Collaborative Carer Workshops.**

✓ | Family and carer support can be provided without breaching patient confidentiality and should always be offered if carers are not involved in formal family work and signposted to families even if their loved one is not accessing services. Manuals are available for both clinicians and lay readers teaching the cognitive interpersonal skills used in ECHO and related models.

✓ | Clinical judgement on the applicability of ECHO self-help materials within the child and adolescent mental health service should be made on an individual basis. There may be some conflict between advice given to parents or carers using this model and advice provided by family-based therapies.

Achieving and maintaining recovery

R | **Refeeding to an optimised healthy weight (taking the patient's ethnicity and sex into consideration) should be offered routinely to all patients with anorexia nervosa, both as a life saving measure and also as an adjunct to achieving an optimised weight and to reduce relapse.**

R | **In acutely ill patients refer to MEED guideline to safely manage refeeding.**

✓ | Nutritional goals should be set on a patient-by-patient basis after a holistic assessment of the patient's general physical and psychological condition, taking into account the patient's ethnicity, biological sex, genetics, personal dietary requirements, sensory sensitivities and cultural beliefs. This should be guided by an experienced specialist eating disorder dietitian or suitably qualified alternative healthcare professional.

R | **Specialist-supervised exercise programmes should be offered to patients with anorexia nervosa as part of a comprehensive management programme, which includes a psychoeducation component.**

R | **Where appropriate (depending on cognitive function and patient's motivational status) the inclusion and integration of the treatment of dysfunctional exercise/activity should be considered as part of a multidisciplinary treatment programme.**

- R** | **Patients with anorexia nervosa participating in an exercise programme should be managed within a multidisciplinary team. Ideally, assessment and supervision should be carried out by a suitably qualified clinician, such as a specialist physiotherapist in eating disorders.**
- ✓ | Healthcare professionals should refer to the Safe Exercise at Every Stage (SEES) guideline to support adults with anorexia participating in an exercise programme.
 - ✓ | In the treatment of eating disorders in athletes and dancers a return to high levels of physical exercise carries risks which should be acknowledged and carefully addressed and monitored. There is specific guidance from Safe Exercise at Every Stage.

Severe comorbid and complex eating disorders

- ✓ | Alternative choices should be offered when first-line treatments are ineffective or unsuitable for those with moderate to severe comorbid psychiatric disorders. Choice of treatments should take into account therapeutic models that have an established evidence base in the treatment of comorbidities that have been shown to interfere with treatment outcomes in eating disorders (eg post-traumatic stress disorder, personality disorder, substance misuse). Assertive outreach that includes other input from psychiatric specialties and the Community Mental Health Team should be considered for those with an eating disorder and severe comorbid conditions.
- ✓ | Where a patient has an eating disorder and a personality disorder, different specialist services need to work closely together to prevent either gaps or conflicting goals in the work of each service. Transitions may also need to be sensitively managed.

Follow up

- ✓ | Patients may relapse after functional recovery if the recovery was dependent on one main support, such as therapy or medication. Care plans therefore need to take an individualised and holistic approach to ensure patients are equipped to maintain recovery.

Transition

- R** | **When a patient's age or geographical location necessitates a change of clinical team, the transition should be prepared, managed and followed up by clinicians in both services.**
- R** | **A clinician should be identified as transition co-ordinator to supervise the process for several months before and after the move, and to communicate with all parties.**
- R** | **A written transition plan should be drawn up in collaboration with patient, clinicians and carers, and copied to each party.**
- ✓ | Healthcare professionals should remember that serious illness in childhood and adolescence often causes people to miss out on the psychosocial and even physical progress experienced by their healthy peers, and can delay their ability to function independently from the support of family and other carers. Family involvement may be beneficial beyond the usual age where this seems appropriate.

Mental Health Act

- R** | Clinicians should consider whether the Mental Health (Care and Treatment) (Scotland) Act 2003 needs to be invoked when a patient (of any age) declines treatment. There may be a responsibility to provide compulsory treatment if there is a risk to the person's life or to prevent significant deterioration to health and wellbeing.

Delivering therapies remotely

- ✓ | The delivery of psychological assessments and treatment via videoconferencing could be offered as an adjunct or alternative to in-person sessions when there are barriers to accessing in-person sessions.

Therapies for children and adolescents with anorexia nervosa

- R** | Children and adolescents with anorexia nervosa should be offered family-based treatment.
- R** | Systemic family therapy, and augmented family-based treatment approaches could be considered for children and adolescents with anorexia nervosa where there are additional features such as severe obsessive-compulsive disorder or high levels of expressed emotion.
- R** | Adolescents with anorexia nervosa could be offered enhanced cognitive behavioural therapy (CBT-E as per Fairburn's model), at a dosage of 20–40 weekly sessions, or other forms of transdiagnostic CBT for eating disorders.

Therapies for children and adolescents with bulimia nervosa

- R** | Adolescents with bulimia nervosa should be offered cognitive behavioural therapy or family-based treatment adapted for bulimia nervosa.
- R** | If cognitive behavioural therapy or family-based treatment are not acceptable, psychodynamic therapy could be considered for adolescents with bulimia nervosa.
- R** | Fluoxetine (60 mg/day) may be considered in the treatment of patients with bulimia nervosa, aged 16–18, for short-term use along with the offer of psychological therapy, and with monitoring for suicidal, self-harming or aggressive behaviours, particularly at initiation.

Therapies for children and adolescents with binge eating disorder

- R** | Adolescents with binge eating disorder could be offered cognitive behavioural therapy, interpersonal psychotherapy or family-based interventions.
- R** | Pharmacological therapies should not be used in the management of children and adolescents with binge eating disorder.

Therapies for adults with anorexia nervosa

- R** | **Enhanced cognitive behavioural therapy for eating disorders or other forms of cognitive behavioural therapy should be used as first-line therapy for adults with anorexia nervosa.**
- R** | **If cognitive behavioural therapy is ineffective, unsuitable or unacceptable for adults with anorexia nervosa, other therapeutic approaches could be considered, such as interpersonal psychotherapy, the Maudsley Model of Anorexia Treatment, Specialist Supportive Clinical Management (SSCM), or focal psychodynamic therapy.**
- ✓ | Dialectical behaviour therapy is a transdiagnostic treatment regime showing greater validity for people with eating disorders with comorbidities including substance misuse disorder and borderline personality disorder (emotionally unstable personality disorder). This approach could, therefore, be considered instead of cognitive behavioural therapy for this complex group.
 - ✓ | Other therapies such as cognitive analytical therapy, schema therapy, mentalisation-based therapy, Radically Open Dialectical Behaviour Therapy, could be considered for patients with anorexia nervosa, as part of a clinical trial.
- R** | **Olanzapine may be offered to adults with anorexia nervosa to support recovery but should not be offered as the sole treatment.**
- ✓ | All low-weight patients should be monitored particularly closely when psychotropic drugs are prescribed. A baseline electrocardiogram and further monitoring can alert clinicians to avoidable dangers.
 - ✓ | Once the patient is weight restored general guidelines on the management of obsessional symptomatology and treatment for depression, anxiety and other conditions can be followed.
 - ✓ | Any other medication selected for the symptomatic treatment of anorexia nervosa and comorbid conditions should be carefully monitored and audited if possible. Patients should be entered into available research trials if they consent.
 - ✓ | There is no available evidence on the safest medication for rapid tranquilisation. Older antipsychotics should be avoided if possible because of potentially dangerous side effects. Olanzapine is commonly used in this situation, as it is reasonably well tolerated in patients with anorexia nervosa.

Therapies for adults with bulimia nervosa

- R** | **Cognitive behavioural therapy, preferably in the specially adapted format for eating disorders or bulimia nervosa, should be used as first-line therapy for adults with bulimia nervosa.**
- R** | **If cognitive behavioural therapy is ineffective, unsuitable or unacceptable in adults with bulimia nervosa other treatment options could be considered, such as, interpersonal therapy, integrative cognitive-affective therapy, or schema therapy. Mentalisation-based therapy may be considered if the patient has comorbid borderline personality disorder.**
- ✓ | Adjunctive therapeutic approaches could be considered to enhance outcomes of established treatments.
- R** | **Antidepressant medication should be considered as a short-term treatment for patients with bulimia nervosa or as an adjunct to psychological treatments.**
- R** | **When considering pharmacological treatment for patients with bulimia nervosa fluoxetine, usually at a dose of 60 mg daily, should be the first choice. If selective serotonin reuptake inhibitors are contraindicated other antidepressant medications could be considered.**

Therapies for adults with binge eating disorder

- R** | **Cognitive behavioural therapy or interpersonal psychotherapy should be considered for first-line therapy for adults with binge eating disorder.**
- R** | **If cognitive behavioural therapy or interpersonal psychotherapy are ineffective, unsuitable or unacceptable in adults with binge eating disorder other treatment options could be considered, such as dialectical-based therapy, integrative cognitive-affective therapy, brief strategic therapy or schema therapy.**
- ✓ | People with binge eating disorder should be made aware that the focus of cognitive behavioural therapy is on eliminating dieting due to its central role in increasing risk of binge eating. Therapies do not directly focus on weight loss but on addressing the factors that result in a person having a difficult relationship with food, regardless of their size.
Those who wish to lose weight (and this is deemed medically appropriate) need to be informed that it is a therapy which may not result in large reductions of BMI, but that interventions with a primary focus on BMI reduction are generally ineffective in achieving this aim in the longer term.
- ✓ | Adjunctive therapeutic approaches could be considered to enhance outcomes of established treatments.
- R** | **Medication is not recommended either as an alternative or as an adjunct to psychological treatment for patients with binge eating disorder.**
- ✓ | In patients with binge eating disorders medication should be considered in the treatment of comorbid conditions, with appropriate assessments of underlying risk factors, in particular cardiovascular and metabolic vulnerabilities.

Children, adolescents and adults with type 1 diabetes

- ✓ Assessment for the presence of eating disorders should be considered as part of the routine review of patients with type 1 diabetes.
- ✓ Healthcare professionals caring for people with diabetes and/or eating disorders should be aware of the common practice of insulin reduction to avoid weight gain. A high HbA1c level, recurrent diabetic ketoacidosis (DKA), poor engagement with healthcare, infrequent/absent self-blood glucose monitoring, omission of quick-acting insulin are frequently observed in people with type 1 diabetes and eating disorders.
- R Integrated intensive specialist care with the combined involvement of diabetes professionals and mental health professionals with experience in managing eating disorders is recommended to support people with type 1 diabetes and an eating disorder or compulsive insulin omission for weight control. Some patients may benefit from a specialist inpatient eating disorders service.**
- R Healthcare professionals should consider managing control of insulin administration alongside psychological interventions to address motivation, distress tolerance and to build trusting relationships with professional and lay carers.**

Bone mineral density

- R Weight restoration should be offered to patients, with low-weight anorexia, regardless of gender identity and age, as part of a holistic programme of treatment, to improve bone mineral density.**
- R Treatment with bisphosphonates or oestrogen to prevent loss of or restore bone mineral density and so reduce fracture risk should not be considered as treatment modalities on their own, but could be used as a supportive treatment. Benefits and risks should be discussed with the patient, and those who receive treatment should be closely monitored by experts in eating disorders and bone metabolism.**
- R Bisphosphonate treatment is not recommended for younger patients due to its teratogenic side effects and long half life.**
- ✓ The restoration of healthy nutrition will be reflected in normal body mass index. This is essential for optimal brain development and the health of other systems, such as the skeleton. Weight restoration is very difficult psychologically for patients. It is therefore essential that this is managed within a therapeutic setting ensuring that the holistic needs of the patient are met.
- ✓ Before starting any hormonal treatment for low bone mineral density in a patient with anorexia nervosa clinicians should seek advice from a paediatric, endocrinological or bone specialist and co-ordinate treatment with the eating disorders team.
- ✓ Men are also at risk of low bone mineral density but there is a lack of evidence on treatments other than weight restoration. Those who have persistent low bone mineral density should be referred to a specialist in bone metabolism in consultation with an eating disorder specialist.

Severe and enduring eating disorders

- R** | **Where active symptom-focused treatments have been exhausted either temporarily or in the medium-to-long term healthcare professionals may consider offering either adapted CBT-AN or adapted SSCM whilst monitoring risk and quality-of-life outcomes.**
- ✓ | When it has been agreed that symptom-challenging treatment should stop quality-of-life treatment should be continued and support offered to the patient's family and other carers. This should be supported by robust ongoing clinical reviews.
- ✓ | Patients who have disengaged from therapy should have the opportunity to change their mind, re-engage and discuss the options with an appropriately-trained healthcare professional.

Pregnancy and postnatal care

- R** | **During pregnancy and the postnatal period healthcare professionals should routinely sensitively enquire if the woman has a current or past history of eating disorder and be aware of potential barriers for disclosure.**
- R** | **Healthcare professionals should discuss with women who are pregnant how their eating disorder symptoms may change during the antenatal and postnatal period.**
- R** | **Healthcare professionals should be aware of the risk of relapse, particularly in the postnatal period.**
- ✓ | Referral to eating disorder services and/or perinatal mental health services should be considered for pregnant women with a current or past eating disorder.
- ✓ | Care planning with the extended multidisciplinary team (eg maternity staff, eating disorder service, perinatal mental health services, general practitioner, health visitor, family nurse partnership or other agencies if relevant such as children's services) should be considered for pregnant women with a current or past history of an eating disorder relevant to their presenting needs.
- R** | **Healthcare professionals providing care for women with a current or past eating disorder should consider assessing for depression and anxiety and offer evidence-based treatment as appropriate, alongside management of the eating disorder.**
- ✓ | All women of childbearing age should be given appropriate counselling on the balance of risks of untreated illness and of medication exposure during the different stages of pregnancy and postnatal period, taking into account breastfeeding. If possible discussions should start before conception.
- R** | **Healthcare professionals should consider enhanced screening for iron deficiency anaemia for pregnant women who have a history of anorexia nervosa.**

- ✓ Healthcare professionals should undertake an approximate assessment of the nutritional intake of a pregnant woman with a current or history of an eating disorder, taking into account prepregnancy BMI and, if possible, gestational weight gain. Should there be concerns about the patient's nutritional intake (either low or high), specialist eating disorder dietetic assessment, intervention and weight monitoring should be considered. Other appropriate multidisciplinary interventions (including support to manage any distress secondary to the eating disorder) should be provided if indicated.
- ✓ Healthcare professionals should be aware that cultural practices or pregnancy diets in minority ethnic communities may mask eating disorders.

R | Healthcare professionals should be aware that women with eating disorders may be at higher risk of obstetric complications.

- ✓ Women with eating disorders or a history of eating disorders with a low or high prepregnancy BMI or failure to gain gestational weight, may be considered for additional obstetric monitoring during pregnancy (such as foetal growth scans) to support and allow multidisciplinary intervention if indicated.
- ✓ Healthcare professionals may wish to consider offering preconceptual advice regarding optimising nutritional status and promoting recovery to women with eating disorders, where possible, prior to conception.
- ✓ Healthcare professionals should consider that infants of women with eating disorders (and their caregivers) may benefit from additional support with feeding, eating, social and emotional difficulties and should consider working collaboratively with health visiting staff and other parenting supports available locally.

Needs of diverse communities

- R** | **Sex differences and issues relating to gender identity should be sensitively considered by all healthcare professionals treating people with eating disorders.**
- R** | **Services should be designed so that all patients have equity of access to eating disorders services at all levels.**
- R** | **Delivery of tailor-made, individualised care plans should accommodate considerations of diversity.**
- ✓ | Where treatment services are specifically designed for the needs of a female-dominant group (particularly inpatient services) alternative services may be considered where there are mixed or more diverse communities.
- ✓ | Where male patients have to be treated within a female-dominated group alternative services may be considered where there are mixed or all-male communities. No patient should be deprived of a service because it is dominated by a majority group.
- ✓ | Where individuals are receiving treatment in specialist gender identity services, consideration of joint working and training between these services and eating disorder services may be of benefit.
- ✓ | Services should encourage staff diversity in terms of age, gender and ethnicity to provide a welcoming environment for every patient.

Training

- R** | **Teaching and training should be offered to all healthcare professionals to allow them to identify individuals with eating disorders, recognise potential variations in their profile of symptoms, and how diverse needs may impact treatment.**
- ✓ | It is recommended that clinicians providing treatment for eating disorders should maximise treatment fidelity through regular ongoing training and clinical supervision, and should use standardised outcome measures to monitor outcomes.
- ✓ | Healthcare professionals working with pregnant and postnatal women should have training, relevant to their role, in identifying and appropriately managing patients with eating disorders.

Sources of useful information

Beat

Helpline: 0808 801 0432

Email: scotlandhelp@beateatingdisorders.org.uk

www.beateatingdisorders.org.uk

CARED Scotland

www.caredscotland.co.uk

F.E.A.S.T.

www.feast-ed.org

MaleVoiced

www.Malevoiced.com

Mental Welfare Commission

Adviceline for personal queries: 0800 309 6809

Adviceline for professional queries: 0131 313 8777

Email: mwc.enquiries@nhs.scot

www.mwscot.org.uk

PEACE pathway

www.peacepathway.org

PEACE is a pathway for people with eating disorders and autism developed from clinical experience, to support autistic people an eating disorder, their loved ones and their clinicians.



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