

Eating Disorders in Scotland

Recommendations for Management and Treatment

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Background and acknowledgements

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. NHS QIS does this by setting standards, by monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

NHS QIS is grateful to the National Institute for Health and Clinical Excellence (NICE) for their kind permission to reproduce selected recommendations from NICE Guideline 9 on Eating Disorders.

NHS QIS gratefully acknowledges the work of the project group for overseeing the project from its inception to the publication of this report.

NHS QIS also gratefully acknowledges those who commented on the draft recommendations.

1 Introduction

This report makes recommendations for healthcare professionals in Scotland in identification, management and treatment of eating disorders in adults, adolescents and children. Recommendations are made for referral to specialist services.

The recommendations relate to tiers 0, 1, 2, and 3 of services for patients with an eating disorder set out in the Framework for Mental Health Services (2001)ⁱ. Location of specialist inpatient facilities (tier 4 of the Framework) is not addressed, as these are being reviewed by the Scottish Executive Health Department.

Prevalence estimates for the number of patients with eating disorders in Scotland are difficult to calculate given the likely numbers who do not seek medical help. It has been estimated that the annual incidence of anorexia nervosa is 8.1 per 100,000 population and incidence of bulimia nervosa is 11.4 per 100,000 populationⁱ. Approximately 90% of all cases present in womenⁱⁱⁱ. Further estimates suggest 30-50% of patients go on to experience long-term chronic problems^{iv}. Most general practitioners (GPs) see few patients with an eating disorder in any one year and as a result clear guidance for them and primary healthcare team members is required.

The recommendations were developed by a group of healthcare professionals and lay representatives from across Scotland, under the joint chairmanship of Dr Chris Freeman and Dr Harry Millar. Group membership is listed in Appendix 1. The group reviewed the National Institute of Health and Clinical Excellence (NICE) Guideline 9 on Eating Disorders^v and has incorporated those recommendations which are directly applicable to the Scottish context into this document. These are identified as NICE recommendations in the text. An explanation of the grading used for NICE recommendations is included in Appendix 2.

The evidence base for treatment of eating disorders varies by condition. For anorexia nervosa there is surprisingly little research. Only one area, family interventions, has a body of high quality evidence, focusing on children and adolescents. Therefore, the development group used current clinical best practice within NHSScotland to make consensus based recommendations for the management of anorexia nervosa. Bulimia nervosa and binge eating disorder both have substantial bodies of high quality evidence, allowing evidence based recommendations to be derived.

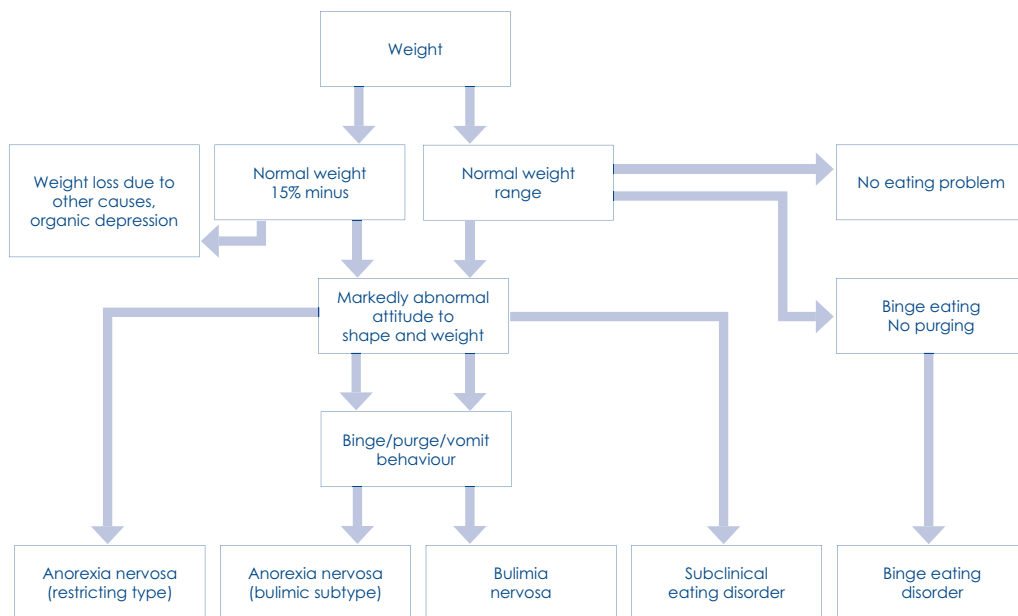
Eating disorders are a group of conditions related to body image disturbance and abnormal eating behaviour; these include anorexia nervosa, bulimia nervosa and atypical eating disorders (including binge eating disorder). The International Classification of Diseases^{vi} definitions of eating disorders are included in Appendix 3.

In eating disorders there is not just a disturbance of eating behaviour, but also a very characteristic abnormal thinking pattern characterised by an extreme preoccupation with body shape and weight, and body disparagement. An important distinction is between disorders that occur in people of at least normal body weight and those that occur in people of low body weight. Other conditions, including depression, anxiety, obsessional and personality disorders, often exist alongside eating disorders. Patients frequently move between the different categories of eating disorders. Figure 1 shows the relationship of eating disorders to each other.

For some people, compulsive activity is even more important than food restriction. This means that treatment needs to consider the meaning of exercise, as well as of eating and of body image, in people's lives. At low weight it can be physically as well as psychologically damaging to over-exercise and this can lead to:

- muscle breakdown
- damage to the heart
- damage to bones
- risk of accidents, and
- weakened immune system.

Figure One Diagnostic flow chart for anorexia nervosa, bulimia nervosa and binge eating disorders



Adapted from Freeman C^{vii}

For clarity, people with eating disorders are described as 'patients' throughout this report. It is acknowledged that some individuals may prefer to be described as users of services or people with eating disorders. A patient and carer version of the recommendations will be published in early 2007.

2 General principles for management of eating disorders

2.1 Individualised care and treatment

Care should be based on individual needs and not on arbitrary targets for weight gain or numbers of sessions of therapy. Assessment of motivation, comorbidity, severity and personal support are all important. Different patients presenting with similar symptoms and weight levels can have very different care needs and their treatment goals, duration and outcomes may differ greatly. The following vignettes illustrate the need for individualised care.

Patient one

A 24-year old self aware and motivated woman with a 2-year history of bulimia nervosa. She is well supported by her live-in partner and prior to referral to a specialist eating disorders service she had already reduced her binge eating frequency with the help of Internet contacts and a self-help book. She needed just 6 sessions of cognitive behaviour therapy (CBT) to eliminate her binge eating completely.

Patient two

A 35-year old single woman with a 20-year history of eating disorder. She suffered abuse in childhood and is in no current close relationships. She has a history of taking drug overdoses, self-cutting and of heavy alcohol consumption. Although she made some gains after 20 sessions of CBT there were no further gains after 10 more sessions. At that stage she was still bulimic but it was not the most serious problem behaviour. A longer term support and crisis management structure was negotiated with the help of the general adult psychiatry mental health team.

Recommendation

NHS QIS

Care and treatment should be tailored to the needs of the individual patient

2.2 The multidisciplinary model of care

Appropriate management of eating disorders requires input from a number of disciplines, working together in a co-ordinated manner. Core professions involved in the multi-disciplinary team are clinical

psychologists, psychiatrists, nurse therapists, other therapists and dieticians (Appendix 4 details the role of the dietician in eating disorders). Additionally, the team may include social workers, family therapists, occupational therapists, physiotherapists, art therapists, pharmacists and general physicians. Individual healthcare professionals should not work in isolation without adequate support. As eating disorders comprise psychological and physiological components, treatments should combine expertise in both, with health professionals understanding the nutritional and physiological effects these disorders can have.

Recommendation

NHS QIS

Care for individuals with eating disorders should be based on a multidisciplinary model

2.3 Management of physical aspects of an eating disorder

Although eating disorders are often managed within mental health services there are important physical manifestations that have to be considered. These may present to a variety of health professionals including midwives, obstetricians, dentists, diabetes specialists and primary care staff.

Recommendations

NICE 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(C)

NICE 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 (C)

NICE 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 (C)

NICE 1.1.4.4

Pregnant women with eating disorders require careful monitoring throughout the pregnancy and in the postpartum period (C)

NICE 1.1.4.5

Patients with an eating disorder who are vomiting should have regular dental reviews (C)

NICE 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) (C)

NICE 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 (C)

NHS QIS

Eating disorders teams should have close liaison with community dental services to ensure that patients with an eating disorder have access to appropriate dental services

2.4 Children and adolescents

Many of the recommendations made in this report apply equally to children and adolescents. There are also a number of special considerations in these groups.

Pre-pubertal children occasionally develop the classic eating disorders anorexia nervosa and bulimia nervosa. They may also show symptoms of eating difficulty secondary to other psychopathology such as emotional and behavioural disorders of childhood, obsessive compulsive disorders, autism spectrum disorders, phobias and refusal disorders. This report does not address the diagnosis and treatment of weight loss or food refusal in these disorders but they have to be considered in the differential diagnosis. Physical assessment is also important and may need the input of a specialist paediatrician and paediatric dietitian not only to clarify the diagnosis but also to assess the nutritional state of the patient taking account of their stage of development.

A central diagnostic feature for an eating disorder is whether the abnormal behaviour is based on over-evaluation of thinness or morbid fear of fatness but these may be difficult to elicit in younger patients. In anorexia nervosa and bulimia nervosa weight control is often achieved through overactivity including concealed exercise (see vignette). Bulimia nervosa was previously considered

to be a disorder of later onset, but is actually a disorder of later presentation. It commonly develops in adolescents and may have a better prognosis if treated early^{viii}.

Teenage anorexia

H went to a different secondary school from her group of friends and found it quite hard to settle, although she was studious and academically successful. By her second year she had become rather withdrawn but announced enthusiastically to her parents that she was starting a fitness programme. She took up solitary running and her parents heard the noises of sit-ups, press-ups and star jumps from her bedroom. She rejected 'unhealthy food' and was soon thin and scrawny. Her mother noticed with concern that her periods had still not started. Within months her weight was so low that her ribs protruded and she had spontaneous bruising but she still refused to eat breakfast until she had completed a morning run, and later walked two miles to school whatever the weather. Her worried parents insisted she see the family GP, but she refused. They were phoned at work by a worried guidance teacher after H fainted in the school toilet. The school doctor arranged an urgent appointment with a Child and Adolescent Psychiatrist and explained that the Scottish Mental Health Act would allow for compulsory treatment in view of the severity of the situation. Luckily this was not necessary – H accepted outpatient treatment when she learned that she would not be 'straitjacketed and fattened up.' After several months' treatment she was able to tolerate a slightly healthier weight, but she was 16 before her periods started.

It is important that healthcare professionals ascertain weight loss in children and adolescents by plotting both weight and height on growth charts wherever possible. Specific BMI is of limited value, as height may be stunted. Where previous height and weight information is not available, the use of parental indices may be helpful.

Recommendation

NHS QIS

Weight and height should be measured at intervals over time in children and adolescents presenting with an eating disorder and the results recorded on growth charts

Increasingly eating disorders are picked up in educational services. Healthcare professionals working in schools and guidance teachers need support to assess and manage risk in these children. This can

be achieved by close communication between those working in education and the child's general practitioner in consultation with child and adolescent mental health teams. Because of the serious implications of low weight in children, including failure to grow and retardation of puberty, specialist help should be sought early from child and adolescent mental health services.

Recommendation

NHS QIS

Individuals involved in school health should receive training in eating disorders and communication networks established with specialist teams

Young people with life threatening disease can be treated against their will. The Mental Health (Care and Treatment) (Scotland) Act 2003 applies to children and young people as well as adults. Occasionally the Children (Scotland) Act 1995 is more appropriate than the Mental Health Act when statutory treatment is required. This is covered further in Appendix 6.

2.5 Transition between services

Transition between services of patients with anorexia nervosa is difficult^{ix}. There is a need to ensure that contact with health services is maintained when patients move between services, such as adolescent to adult services, or move to another geographical area to attend university or take up employment. This requires arrangements to be in place to ensure minimisation of disruption to care and to avoid loss of contact. Liaison and reciprocal arrangements between specialist services is required and must not rely on referral via primary care as this can lead to unacceptable delays. This is particularly an issue for transition between adolescent and adult services. Services should work together to ensure that transition between services is achieved as smoothly as possible and at the optimum time to best meet the clinical needs of patients.

Recommendations

NHS QIS

There should be reciprocal arrangements between specialist services in different geographical areas in order to ensure no disruption of treatment and to avoid loss of contact with patients with eating disorders

NHS QIS

Close liaison should take place between adolescent and adult services to ensure transfer at an appropriate stage rather than at an arbitrary age cut-off

2.6 Information

There is a need for high quality information for patients, their carers and their families. A simple Internet search produces nearly 15 million hits for eating disorders. Examples of useful websites are given in Appendix 5.

Recommendation

NHS QIS

All healthcare professionals should be able to access and recommend high quality information and warn against dangerous information for patients and their families

2.7 Legal Framework

Eating disorders are recognised to be mental disorders under the terms of the Mental Health (Care and Treatment) (Scotland) Act 2003. The vast majority of treatment given for an eating disorder is given on an informal basis. This means that the practitioner has fully explained the treatment to the patient and the patient has agreed to accept it. If the patient does not wish to accept the treatment then they have the right to refuse it. There may be occasions however where the patient's decision-making abilities have become so impaired by their illness that they refuse treatment which could be of benefit to them. Very rarely it may be necessary for a doctor to consider giving treatment against the express wishes of the patient. This can only be done in certain circumstances and within a proper legal framework that provides safeguards for the patient. If a patient refuses treatment for their eating disorder it is possible under special circumstances for their doctor to proceed with nutrition by artificial means. In Scotland this is done by way of The Mental Health (Care and Treatment) (Scotland) Act 2003. This is addressed further in Appendix 6.

2.8 Confidentiality

Eating disorders can involve and affect families and carers in a profound way. These disorders often involve issues of medical safety and it would be unreasonable not to share risks with those in a caring role. Healthcare professionals need to be sensitive to this,

while maintaining the patient's confidentiality.

Rarely there are circumstances where, in the interests of patients, (eg when they are in a life threatening state and refusing treatment) it would be appropriate to breach confidentiality and involve carers without the consent of patients.

The Mental Welfare Commission has issued guidance on confidentiality. This is available at www.mwcscot.org.uk.

3 Role of the GP and the Primary Care Team

The first point of contact with health services for the majority of patients with an eating disorder is the primary care team. This may be direct, where patients seek help for their eating disorder, or indirect, where they seek help for other conditions. In addition, many parents or carers may seek advice from the primary care team about a family member. A survey of GPs in the south of England found that half of the GPs surveyed had seen at least one patient with an eating disorders during the past year and around a quarter of these cases were managed exclusively in primary care^x. There are some evolving mental health services within primary care in Scotland that may have a role in the management of patients with an eating disorder.

Any contact with the primary care team should be seen as an opportunity to engage the person with an eating disorder and attempts should be made to ensure that they will return in the future. This is not a simple process as many individuals with eating disorders do not wish to engage with health services and the assessment process itself may lead to non co-operation in the future.

The 2006 Quality and Outcomes Framework (QOF)^{xi} indicator MH8 requires that 'the practice can produce a register of people with schizophrenia, bipolar disease and other psychoses'. To facilitate regular review in eating disorder patients not being seen by other services, it would be helpful if practices could include patients with severe chronic eating disorders on such registers.

Recommendation

NHS QIS

Primary care teams should include patients with severe chronic eating disorders on their registers of people with severe and enduring mental illness

3.1 Opportunistic intervention

Common indirect presentations are anxiety, depression, gastrointestinal symptoms, menstrual symptoms or diabetic patients with poor diabetic control.

Recommendation

NICE 1.1.6.3

Young people with type 1 diabetes and poor treatment adherence

should be screened and assessed for an eating disorder (C)

Opportunistic questioning should start with questions that are non-threatening, for example, “when your mood alters does this have an effect on your sleeping or eating?” or “have there been any changes to your eating, appetite or weight?”. In some cases, young people may be unwilling to answer such questions when a parent is present. Young people should be offered an opportunity to discuss any health concerns or difficulties without the presence of their parents.

Further questions could clarify whether it is likely the patient has an eating disorder. The SCOFF^{xii} (see Figure 2) has been validated for use in patients with an eating disorder over the age of 18.

Figure 2: the SCOFF questionnaire

If patients score 2 or more positive answers then an eating disorder is likely

- Do you make yourself sick because you feel uncomfortably full?
- Do you worry you have lost control over how much you eat?
- Have you recently lost more than one stone in a 3-month period?
- Do you believe yourself to be fat when others say you are too thin?
- Would you say that food dominates your life?

From BMJ, 1999, 319, 1467-8^{xiii}

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Recommendation

NHS QIS

Opportunistic questioning in primary care should start with unthreatening questions and develop further using a recognised eating disorders questionnaire

3.2 Taking a history

Once it is established that it is likely that a patient has an eating disorder then further history taking is required. Some more detailed questioning is set out in the Lothian Care Pathway for Anorexia Nervosa (<http://www.anitt.org.uk/downloads/cpclinicians.pdf>). There should be some exploration of relevant family or personal factors. It is also important to look out for significant physical symptoms such as vomiting blood, bowel disturbance, weakness, dizziness, fainting, cold intolerance and dental problems. Throughout this process the priority

is to maintain a rapport and positively engage the patient in the process of evaluating their symptoms.

3.3 Physical examination

Healthcare professionals need to be sensitive to the extreme anxiety some patients have regarding their body weight and shape when approaching physical examination. If the patient is comfortable about it, weight and height should be measured and Body Mass Index (BMI) calculated. If the patient is resistant this should not be confronted at the first assessment appointment. Other basic examinations include pulse rate and rhythm and blood pressure. In underweight patients it is appropriate to look for evidence of poor peripheral circulation, low core body temperature and muscle weakness. More severely ill patients require a more comprehensive physical examination. In young people and children there must be an assessment of any developmental delay.

3.4 Investigations

Baseline investigations are helpful for assessing the severity of any eating disorder and useful when referring to secondary care. These should include:

- Biochemistry – urea and electrolytes, thyroid function tests, liver function tests, glucose
- Haematology – full blood count
- Electrocardiogram (ECG) – if there is hypokalaemia, bradycardia or a BMI < 16
- A baseline dual energy x-ray absorptiometry (DXA) scan in patients with anorexia nervosa. This should be repeated at least every two years until bone recovery has been achieved.

Recommendations

NHS QIS

Physical assessment, tailored to the severity of the illness, should be routinely performed in patients with eating disorders

NHS QIS

Very low weight (BMI < 15), rapid weight loss (more than 0.5 kg in a week), frequent vomiting (more than once per day) and severe laxative abuse necessitate frequent physical monitoring

NHS QIS

Baseline DXA scans should be carried out on all patients with anorexia nervosa

NHS QIS

DXA scans should be repeated in patients with anorexia nervosa every two years to monitor for further bone loss until bone recovery has been achieved

3.5 Risk assessment

Risk assessment should be broadly based, covering physical, psychological and social issues. This should assist primary care team members in identifying those for whom early intervention and referral would be most beneficial. The Lothian Care Pathway for Anorexia Nervosa has a useful scheme for assessing risk in anorexia nervosa (<http://www.anitt.org.uk/downloads/cpclinicians.pdf>).

3.6 Referral to specialist services

There are a number of key clinical features which suggest that referral to specialist services is indicated. Because children and young people have marked growth spurts, BMI alone is a less meaningful measure of emaciation. Reference to height and weight charts is the best way to assess the need for referral in this patient group.

Recommendations

NHS QIS

Referral to specialist services is indicated when the following clinical features are present.

Anorexia Nervosa

- continuing weight loss
- severe emaciation, eg BMI<16
- marked vomiting or laxative abuse
- physical complications, eg hypotension
- when primary care interventions have failed
- when depression is marked and/or a risk of self harm
- co-morbid conditions such as pregnancy or diabetes

Bulimia Nervosa

- symptoms severe and persistent
- duration longer than 6 months
- other dyscontrol behaviours, eg shoplifting, wrist cutting, overdoses
- when depression is marked
- when simple advice/diaries have failed
- rapid weight loss even if not yet satisfying criteria for anorexia nervosa

NHS QIS

Referral to specialist services is very strongly indicated when the following are present.

Anorexia Nervosa

- BMI < 13.0
- rate of weight loss continuing at >1 kg per week
- vomiting more frequently than once per day
- heavy laxative use
- prolongation of QTc interval or other significant ECG abnormality
- core temperature <34°C
- muscle weakness - unable to rise from a squat without use of arms for leverage
- pulse rate less than 40 per minute or systolic blood pressure (BP) less than 80 mm/Hg
- major abnormality of biochemistry or haematology
- signs of significant cognitive impairment

Bulimia nervosa

- persistent suicidal thinking
- persistent deliberate self-harm
- rapid weight loss although not yet satisfied criteria for anorexia nervosa
- major abnormality of biochemistry or haematology

3.7 Where to get further help

If a person with an eating disorder is unwilling to accept assessment or referral to secondary care services, the general practitioner should be able to seek advice and support from specialists in eating disorders. In addition, there are a number of websites, such as the Eating Disorders Association and ANITT, which provide help and support for general practitioners in this position (see Appendix 5).

Recommendations

NHS QIS

With illnesses that are severe and/or treatment resistant, GPs should seek specialist advice or referral

NHS QIS

Patients should be advised of all types of help and support available such as self-help groups and internet resources

4 Role of specialist services

The availability of specialist services varies across Scotland from dedicated eating disorders services to provision within general psychiatric and psychological services. The 2001 report of the Mental Health and Well Being Support Group^{xiv} found that provision was 'limited and patchy...much more needs to be done to create treatment protocols, clear referral pathways and a pattern of specialist inpatient provision in the NHS'. While there have been significant improvements across Scotland since 2001 and several NHS Boards have advanced plans for developing eating disorder services, provision across Scotland remains patchy^{xv}.

Recommendation

NHS QIS

Information on eating disorder services in Scotland should be easily accessible for healthcare professionals and patients

A 2006 report by the Scottish Public Services Ombudsman^{xvi} into the care of a young woman in Scotland made a number of comments and recommendations for the care of patients with eating disorders. These included comments on:

- the small but vitally important unmet need for adult in-patient and related mental health services for patients with an eating disorder
- a wider need for acute inpatient medical services with appropriate specialist knowledge and expertise in patients with eating disorders whose physical condition requires input
- the need for integration of such services with the relevant psychiatric, mental health and other appropriate medical services, and
- the shortfall in the level of knowledge about and awareness of the legal position, with respect to some treatments for eating disorders amongst health practitioners in primary and secondary care settings.

4.1 Anorexia Nervosa

Most patients with anorexia nervosa can be managed on an outpatient basis with a psychological component, medical monitoring and dietetic advice provided by a multidisciplinary team.

The initial aim of outpatient anorexia nervosa treatment is to

establish a therapeutic rapport with the patient, establish motivation for change and prevent further weight loss. The ultimate aim is to restore the patient to a healthy weight and to improve abnormal thinking about food, weight and shape as well as improving abnormal eating behaviour and other related abnormal behaviour. For patients with more chronic treatment resistant illnesses it may be more appropriate to aim to help to maintain a safe weight and to try to improve the patient's quality of life.

In children and adolescents the aims of treatment differ. Because weight gain is a crucial part of development, weight stabilisation is not an appropriate goal. Weight restoration should take priority over other educational and social needs. This can be achieved by increased calorie intake or reduced energy output.

4.1.1 Outpatient care

General supportive psychological care should be available to individuals with anorexia nervosa on an outpatient basis within any mental health service in Scotland, whether this is from a community mental health team or a dedicated specialised eating disorders service. Care should be tailored to the individual needs of the patient, taking account of any comorbidity, and arbitrary timescales should not be applied to care. Continuity of care is important for this group of patients to ensure that they remain in contact with health services. Care should be organised to achieve this continuity, wherever possible, and should continue beyond weight restoration. An integrated care pathway (ICP) for care in a general mental health setting would be useful to ensure care is co-ordinated.

The needs of families and carers should be considered and it may be appropriate to involve families in the therapeutic process. Formal family therapy may be indicated particularly in younger patients (see 4.1.6)

There should be clarity of responsibility for physical assessment and monitoring between primary care and mental health services to ensure that this happens at the right time and to reduce the chance of patients being lost to follow up.

Recommendations

NHS QIS

Integrated care pathways should be developed for the care of patients with anorexia nervosa

NHS QIS

Care for patients with anorexia nervosa should consist of:

- good general supportive care
- motivation enhancement alongside appropriate psychological treatments
- good medical management, and
- good nutritional care

NHS QIS

Responsibility for physical assessment and monitoring should be clarified between primary care and mental health services

4.1.2 Psychological treatments

A choice of psychological treatments, based on an individual psychological formulation, should be provided. Treatments should focus on motivational enhancement, eating behaviour and attitudes to weight and shape and on underlying psychosocial issues with the expectation of weight gain. All therapists involved in the care of patients with anorexia nervosa should have a good knowledge of all aspects of care.

Recommendation

NHS QIS

A choice of psychological treatments for anorexia nervosa should be available as part of mental health services in all areas

4.1.3 Pharmacological treatments

There are no drugs licensed specifically to treat the psychopathology of anorexia nervosa. However, some drugs may be indicated for associated psychological symptoms.

Mineral deficiencies may occur rarely in starvation states. Patients should be routinely monitored to ensure appropriate correction of these with mineral supplementation.

Recommendations

NICE1.2.3.1

Medication should not be used as the sole or primary treatment for anorexia nervosa (C)

NICE 1.2.3.2

Caution should be exercised in the use of medication for co morbid conditions such as depressive or obsessive – compulsive features as they may resolve with weight gain alone (C)

NICE 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 (C)

NICE 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 (C)

NICE 1.2.3.5

If the prescription of medication that may compromise cardiac functioning is essential, ECG monitoring should be undertaken (C)

NICE 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 (C)

NICE 1.2.4.2

Regular physical monitoring, and in some cases treatment with a multi-vitamin supplement in oral form, is recommended for people with anorexia nervosa during both inpatient and outpatient weight restoration (C)

NHS QIS

Mineral supplements may be required especially in the early stages of re-feeding for anorexia nervosa

4.1.4 Risk assessment

Body Mass Index should not be the sole assessment of the degree of risk. Other important variables are rate of weight loss, frequency of vomiting and laxative misuse, cardiovascular abnormalities such as bradycardia, hypotension and ECG abnormalities, low core body temperature, muscle weakness, cognitive impairment

and major abnormalities of biochemistry or haematology. Special considerations for children and adolescents are addressed in sections 2.5 and 3.5.

Regarding BMI the following gives a rough guide in adults:

Risk	BMI
Low – Moderate Risk	17.5 – 15
Moderate Risk	14.9 – 13
High Risk	<13
Very High Risk	<12

In addition to physical features of the anorexia nervosa other psychosocial factors need to be considered. These include severe depression and suicidality, alcohol and drug misuse and absence of social support. Comorbid conditions such as diabetes and pregnancy also need to be considered.

4.1.5 Intensive treatments (including assertive outreach, day programmes or inpatient care)

Intensive treatments need to be available for patients for whom routine outpatient care has not produced a satisfactory response. Services available vary throughout the country and in some places are only available to a limited extent, necessitating referral elsewhere for inpatient treatment. If admission is required to a general medical ward clear lines of communication should be maintained between these and specialist services. Each specialist service should include these in its operational policies.

Recommendations

NHS QIS

Patients with anorexia nervosa who require intensive treatment should have access to assertive outreach, day hospital care and inpatient care intensive treatment

NHS QIS

Admission to hospital should be considered when:

- the patient's condition is life threatening as a result of either starvation and/or purging and/or exercise and/or infection or other physical health problems
- a self-harming overdose is suspected. Relatively small overdoses are potentially life threatening in starvation
- inpatient treatment is required for treatment of a comorbid

condition such as psychosis, obsessive compulsive disorder (OCD) or severe depression

NHS QIS

Each specialist service should ensure that its operational policies include plans for clear communication between themselves and general medical services

NHS QIS

When patients are admitted for treatment of anorexia nervosa this should be at a setting which is as near home as possible to facilitate involvement of relatives and carers and to ensure close liaison and continuity with those involved in treatment before and after the inpatient phase of treatment.

Decisions to admit to hospital depend on support available at home and the patient's capacity to make best use of help from lay carers.

Inpatient units and intensive day services include some group experience in a highly structured, highly supportive and psycho-educational environment. Competitiveness between group members is a risk and needs to be energetically addressed.

Correcting the nutritional deficits in someone in a starvation state is a highly skilled medical task and requires detailed attention from doctors, dieticians and nurses with experience in managing re-feeding of starved patients and preventing complications such as re-feeding syndrome. Ideally this should include input from a consultant physician with a special interest in nutrition. It is essential to understand the importance of ensuring the satisfactory repair of cellular damage and avoid overloading the patient with potentially toxic nutrients before this repair process has been achieved.

Recommendation

NICE 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 (C)

4.1.6 Anorexia nervosa in children & adolescents

Because the majority of children and adolescents with anorexia

nervosa are living with their families, involvement of the family is the likeliest way in which to achieve benefit. There has been some high quality research that demonstrates that family interventions are useful not only in the treatment of anorexia nervosa in children and adolescents, but also in young adult sufferers.

Recommendations

NICE 1.2.2.13

Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa (B)

If intensive treatment is required for children or adolescents, then admission to a child or adolescent psychiatric inpatient or day patient unit with expertise in eating disorders should be arranged. General paediatric wards and, particularly, adult psychiatric wards should be avoided.

Recommendation

NHS QIS

Adolescent anorexia patients should be admitted to an adolescent unit which has experience of managing the condition

4.2 Bulimia Nervosa

Care for individuals with bulimia nervosa has a substantial evidence base. Evidence-based recommendations from the NICE guidelines are included in this section.

Most patients with bulimia nervosa can be managed on an outpatient basis with a psychological component. Some also require medication, medical monitoring and dietetic advice that is best provided by a multidisciplinary team. Care should be tailored to individuals rather than a rigid pattern of treatment.

4.2.1 Self help

There is good quality evidence to support the use of self-help programmes in bulimia nervosa.

Recommendations

NICE 1.3.1.1

As a possible first step, patients with bulimia nervosa should be encouraged to follow an evidence-based self-help programme (B)

NICE 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 (B)

4.2.2 Psychological treatments

There is good quality evidence to support the use of psychological treatments in bulimia nervosa. Again, care should be individualised and a choice of treatments made available wherever possible.

NICE 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 (A)

NHS QIS

Additional sessions of CBT should be offered if the patient is benefiting from the treatment and likely to make further progress

NICE 1.3.1.4

When people with bulimia nervosa have not responded to or do not want CBT, other psychological treatments should be considered (B)

NICE 1.3.1.5

Interpersonal psychotherapy (IPT) 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 (B)

NHS QIS

When co-morbidity is present in patients with bulimia nervosa other psychological treatments in addition to CBT may be considered

4.2.3 Pharmacological management

There is an evidence base for the anti-bulimic effects of SSRIs and other antidepressant drugs independent of their antidepressant properties. Fluoxetine (60mg) has a specific licence for bulimia nervosa in adults.

Recommendations

NICE 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 (B)

NICE 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 (B)

NICE 1.3.2.5

No drugs, other than antidepressants, are recommended for the treatment of bulimia nervosa (B)

4.2.4 Inpatient care

There is no evidence base supporting inpatient care to help recovery in bulimia nervosa. Clinical experience suggests that patients with bulimia nervosa will achieve improved control of binge eating in hospital but this rarely translates into sustained improvement out of hospital. However, a significant number of patients have additional problems such as low mood and repeated deliberate self-harm and these problems when combined with the eating disorder may necessitate hospital admission, often for short spells. These admissions are usually to a general psychiatric ward.

4.3 Atypical Eating Disorders, including binge eating disorder

There is little evidence to guide the management of atypical and other disorders (known also as eating disorders not otherwise specified, EDNOS). Some of these have eating disorder psychopathology that is severe, disabling and in many respects very similar to the psychopathology found in anorexia nervosa and bulimia nervosa. For these patients the treatment of the category of eating disorder that most closely resembles the patient's symptoms should be followed.

Many of these patients are overweight or obese and there will be valid medical reasons to consider helping the patient with weight loss. This merits a very careful assessment of how best to address the combined and possibly conflicting aims of weight loss, helping

with the psychopathology of the eating disorder and dealing with other psychological symptoms. This will be important for healthcare professionals dealing with obesity as well as for those treating eating disorders.

Recommendation

NHS QIS

Binge eating disorders should be covered in guidelines for management of obesity as well as within those for eating disorders

4.3.1 Self help

There is good quality evidence to support the use of self-help programmes in binge eating disorder.

Recommendations

NICE 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 (B)

NICE 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 (B)

4.3.2 Psychological treatments

There is good quality evidence to support the use of psychological treatments in binge eating disorder.

Recommendations

NICE 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 (A)

NICE 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 (B)

NICE 1.4.2.5

Patients should be informed that all psychological treatments for binge eating disorder have a limited effect on body weight (A)

NHS QIS

Psychological treatments for binge eating disorders should be provided as a group intervention where possible

4.3.3 Pharmacological treatments

There is good quality evidence on the use of pharmacological treatments in binge eating disorders.

Recommendations

NICE 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 (B)

NICE 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 (B)

5 Management of long-term eating disorders

A small but important group of patients do not respond to active treatment or fail to engage in treatment. Motivation for treatment may change and it can be difficult to ask for help again if you have turned it down several times before.

Individuals with chronic eating disorders are unlikely to make spontaneous contact with treatment services unless an arrangement is in place to promote this (see vignette). They can sometimes receive important or life saving treatment if they do.

Chronic 'multi-impulsive' eating disorder

D, an artist in her late thirties, had spent much of her teens in and out of hospital. She was treated for low weight anorexia nervosa by compulsory refeeding on several occasions, but rapidly lost weight each time she was discharged. Whenever she had the opportunity she resisted each period of weight gain by inducing vomiting, and demonstrated her distress by cutting herself and taking overdoses. She disclosed to staff that she had been abused by a friend of the family but later said she had 'made it all up'.

D had produced impressive paintings even in hospital and went to a prestigious Art School. Her family was concerned when they realised that she was maintaining an apparently normal weight mainly as a result of her alcohol intake. She had built up debts and was once arrested for shoplifting chocolate bars. She was awake and partying all night but slept by day, and eventually dropped out of Art School. She found she was suffering from chlamydia and was told it was likely she would not be able to have children. Her response to this was a massive overdose of paracetamol, resulting in further hospitalisation.

D was a difficult patient to care for – she suffered from severe symptoms of alcohol withdrawal, smoked in bed and took her own discharge against medical advice. By now her weight had dropped so that she was dangerously malnourished, but her psychiatrist was reluctant to admit her to a psychiatric ward – something that she also resisted. Over the years she forged a reasonable relationship with her GP, who monitored her weight and health when her rather chaotic appointment keeping allowed this.

She was treated successfully for tuberculosis and less successfully for osteoporosis, which was by now severe. However, she had survived decades of self-harm and malnutrition, and there was

evidence that her personality was ‘mellowing’. Her weight had stabilised somewhat, her substance abuse was less, and she was living with two fellow artists who also sold work to a local shop. The aim of monitoring is to maintain stability in the patient’s physical state and weight, even if low.

The aim of monitoring is to maintain stability in the patient’s physical state and weight, even if low.

It also is an opportunity to provide ongoing support to the patient and carers, to promote optimum social functioning and to make it easier for the patient to negotiate more active treatment.

Recommendations

NHS QIS

There should be a clear and preferably written agreement between the patient, the GP and the secondary care service about the nature and frequency of monitoring

NHS QIS

The following are recommended as the minimum for monitoring

- 1 Re-engagement in active treatment should be offered at each contact
- 2 Weight should be monitored six-monthly
- 3 Suicide risk and mental state should be assessed six-monthly
- 4 Routine blood tests should be checked annually
- 5 A physical examination should be done annually
- 6 A DXA bone scan should be done every two years to monitor bone density and identify osteoporosis
- 7 Annual dental checks for palatal dental erosion for patients who vomit or who chew and spit whatever their weight
- 8 The results of the monitoring should be discussed with the patient and used as one part of helping the patient develop motivation for change
- 9 Active medical treatment should be offered for physical complications where appropriate though often the most appropriate treatment will be re-nutrition and weight gain

Further information and an example of a monitoring record sheet are available in Module 8 of the ANITT Integrated Care Pathway www.anitt.org.uk.

6 Minimum data set

The following items should be collected at first contact with any eating disorder patient and repeated at regular intervals for patients in active treatment or being monitored.

Frequency of repetition will depend on the severity of the eating disorder. More severe and/or high-risk eating disorders may need extra information to be collected to assess risk accurately (see section 2).

The minimum data set shall, wherever possible, be communicated whenever a patient is referred to a different level of service.

Minimum Data Set for all Eating Disorders Patients																					
1	Height <input type="text"/> (in metres) 2 Weight <input type="text"/> (in kilos) = BMI <input type="text"/>																				
3	If patient refuses to be weighed, note this and rate: Emaciated <input type="checkbox"/> Very underweight <input type="checkbox"/> Moderately underweight <input type="checkbox"/> Normal weight range <input type="checkbox"/> Obesity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>																				
4	Weight trend (last 2 months): Rapidly falling <input type="checkbox"/> Slowly falling <input type="checkbox"/> Steady <input type="checkbox"/> Slowly rising <input type="checkbox"/> Rapidly Rising <input type="checkbox"/>																				
5	Duration of symptoms overall <input type="text"/> years/months this episode <input type="text"/> years/months																				
6	Menstrual Status: Primary amenorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No OR Current menstrual status Regular cycles <input type="checkbox"/> Irregular / chaotic <input type="checkbox"/> Oligomenorrhea <input type="checkbox"/> Secondary amenorrhea <input type="checkbox"/> Date of last cycle <input type="text"/>																				
7	Blood Pressure: Record if standing / sitting / lying Systolic <input type="text"/> Diastolic <input type="text"/>																				
8	Significant Complicating / risk factors: Excess Alcohol intake <input type="checkbox"/> Yes <input type="checkbox"/> No Drug Misuse <input type="checkbox"/> Yes <input type="checkbox"/> No Depressive Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Other (please specify) <input type="text"/>																				
9	Bingeing Behaviour: Record frequency per week <input type="text"/>																				
10	Purging Behaviour: Record Nature of purging <input type="text"/> Record frequency per week <input type="text"/>																				
11	Exercise: Is excessive exercise being used to promote weight loss? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes record frequency per week <input type="text"/>																				
12	Clinical Global Impression: <table border="1"> <thead> <tr> <th>CGI 1: Severity of Illness</th> <th>CGI 2: Global Improvement</th> </tr> </thead> <tbody> <tr> <td>Considering your total clinical experience with this particular population, how ill is the patient at this time?</td> <td>Rate total improvement since the start of treatment. Compared to his (her) condition, how much has he (she) changed?</td> </tr> <tr> <td>Score</td> <td>Score</td> </tr> <tr> <td>1. Normal / not at all ill <input type="checkbox"/></td> <td>1. Very much improved <input type="checkbox"/></td> </tr> <tr> <td>2. Borderline ill <input type="checkbox"/></td> <td>2. Much improved <input type="checkbox"/></td> </tr> <tr> <td>3. Mildly ill <input type="checkbox"/></td> <td>3. Minimally improved <input type="checkbox"/></td> </tr> <tr> <td>4. Moderately ill <input type="checkbox"/></td> <td>4. No change <input type="checkbox"/></td> </tr> <tr> <td>5. Markedly ill <input type="checkbox"/></td> <td>5. Minimally worse <input type="checkbox"/></td> </tr> <tr> <td>6. Severely ill <input type="checkbox"/></td> <td>6. Much worse <input type="checkbox"/></td> </tr> <tr> <td>7. Among the most extremely ill patients <input type="checkbox"/></td> <td>7. Very much worse <input type="checkbox"/></td> </tr> </tbody> </table>	CGI 1: Severity of Illness	CGI 2: Global Improvement	Considering your total clinical experience with this particular population, how ill is the patient at this time?	Rate total improvement since the start of treatment. Compared to his (her) condition, how much has he (she) changed?	Score	Score	1. Normal / not at all ill <input type="checkbox"/>	1. Very much improved <input type="checkbox"/>	2. Borderline ill <input type="checkbox"/>	2. Much improved <input type="checkbox"/>	3. Mildly ill <input type="checkbox"/>	3. Minimally improved <input type="checkbox"/>	4. Moderately ill <input type="checkbox"/>	4. No change <input type="checkbox"/>	5. Markedly ill <input type="checkbox"/>	5. Minimally worse <input type="checkbox"/>	6. Severely ill <input type="checkbox"/>	6. Much worse <input type="checkbox"/>	7. Among the most extremely ill patients <input type="checkbox"/>	7. Very much worse <input type="checkbox"/>
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7. Among the most extremely ill patients <input type="checkbox"/>	7. Very much worse <input type="checkbox"/>																				
13	Blood Tests: Minimum is Full Blood Count and U&Es <input type="text"/>																				

7 Resource implications

It is recognised that many of the recommendations made in this document do not reflect current practice across NHSScotland. Several boards have advanced plans for the development of eating disorders services and for managed clinical networks and training networks; in others this remains a challenge. During the consultation period for the draft recommendations a number of areas were identified as requiring either a different way of working or additional resources to implement. These are highlighted below.

7.1 Training and awareness raising

There is a requirement for training and awareness raising for NHS staff and those from other statutory bodies involved in mental health. This includes not only specialists but also GPs, practice nurses, other community based staff and mental health officers. Staff in other areas of medicine, such as gynaecology, who regularly deal with patients with eating disorders should also have access to appropriate training and awareness raising sessions. All Deaneries should ensure that GP registrars are appropriately trained in the management of eating disorders.

NHS Education for Scotland is developing a specific educational resource for use in both undergraduate and pre registration programmes on mental health themes including eating disorders.

Due to the age of onset of the majority of patients with eating disorders, there is also a requirement for awareness raising among school health services and guidance teachers.

7.2 DXA scanning

The ability of GPs to refer patients directly for a DXA varies among NHS Boards.

7.3 Staff with relevant experience in managing eating disorders

It is recognised that there are insufficient staff at present to provide comprehensive eating disorders services at both community and specialist level across NHSScotland. There are particular shortages of some staff groups, including clinical psychologists who are able to offer a wide range of psychological treatments, dietitians with specialised knowledge of nutritional requirements for patients with an eating disorder and mental health professionals trained in cognitive behavioural and family based therapy techniques.

7.4 Liaison between statutory and voluntary services

Many patients do not engage with statutory services. As a result, there is a need to ensure close liaison takes place between the statutory and voluntary sectors.

7.5 Inpatient provision

Adequate inpatient provision for children, adolescents and adults with eating disorders have been identified as an issue across NHSScotland. This is being addressed at a national level.

8 Glossary

The Anorexia Nervosa Intensive Treatment Team (ANITT)	The ANITT Team is a small, multi-disciplinary team that provides intensive treatment to people with low weight anorexia nervosa in Lothian who might otherwise have to be admitted to hospital.
biochemistry	The branch of medicine that is generally concerned with analysis of bodily fluids
cognitive behaviour therapy (CBT)	Discrete, time limited, structured psychological interventions, derived from the cognitive-behavioural model of affective disorders in which the patient: (1) works collaboratively with a therapist to identify the types and effects of thoughts, beliefs and interpretations on current symptoms, feelings states and/or problem areas; (2) develops skills to identify, monitor and then counteract problematic thoughts, beliefs and interpretations related to the target symptoms/problems; (3) learns a repertoire of coping skills appropriate to the target thoughts, beliefs and/or problem areas.
electrocardiogram (ECG)	A simple test that traces the electrical activity of the heart. Also known as an EKG
family interventions	Interventions organised around the structure and function of the family system and on how interpersonal relationships determine behaviour in both individuals and families
haematology	The branch of medicine that is concerned with blood and its disorders
incidence	The number of new cases of a condition per year
integrated care pathway (ICP)	An integrated care pathway is a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes.
National Institute of Clinical Excellence (NICE)	The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE produces guidance on health technologies and on clinical practice for the NHS in England and Wales.
NHS Quality Improvement Scotland (NHS QIS)	NHS Quality Improvement Scotland (NHS QIS) was established as a Special Health Board by the Scottish Executive in 2003, in order to act as the lead organisation in improving the quality of healthcare delivered by NHSScotland.
prevalence	The overall proportion of the population who suffer from a condition
prognosis	Prognosis refers to the possible outcomes of a disease and the frequency with which they can be expected to occur
QTc	The QT interval is a measure of the time between the start of the Q wave and the end of the T wave in the heart's electrical cycle on an ECG. The QT interval is dependent on the heart rate and has to be corrected, which is denoted by QTc.
Quality and Outcomes Framework (QOF)	The Quality and Outcomes Framework (QOF) is part of the new General Medical Services contract for general practices; it was introduced on 1 April 2004. The QOF provides financial rewards to general practices for the provision of high quality care. The QOF measures achievement against a scorecard of 146 indicators, plus three measures of depth of care. Practices score points on the basis of achievement against each indicator, up to a maximum of 1050 points.

Appendix 1: Group membership

Dr Chris Freeman	Psychiatry, Edinburgh (Co Chair)
Dr Harry Millar	Psychiatry, Aberdeen (Co Chair)
Alison Thomson	Nursing, Mental Welfare Commission for Scotland
Dr Fiona Simpson	Clinical Psychology, Edinburgh
Ian McDonald	Carer representative, Scottish Eating Disorders Interest Group (SEDIG)
Dr Jane Morris	Child & Adolescent Psychiatry, Edinburgh
Jane S Knox	Dietician, Aberdeen
Dr Jenny Bennison	GP, Royal College of General Practitioners Scotland, Edinburgh
Jo Rowbory	Medical Student, Dundee
Joyce Cormie	Public Partner, Fife
Katy Park	Nursing, Glasgow
Pauline Milne	Nursing, Aberdeen
Dr Sara Twaddle	NHS Quality Improvement Scotland (NHS QIS)
Dr Stephen Curran	Psychiatry, Perth
Susan Christie	Mental Health Officer, Aberdeen

Emma Jane Harrington provided administrative support to the working group

Appendix 2: NICE hierarchy of evidence and recommendations grading scheme^{xvii}

Level	Type of Evidence	Grade	Evidence
I	Evidence obtained from a single randomized controlled trial or a meta-analysis of randomized controlled trials	A	At least one randomized controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendations (evidence level I) without extrapolation
IIa	Evidence obtained from at least one well designed controlled study without randomisation	B	Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level I evidence.
IIb	Evidence obtained from at least one other well-designed quasi-experimental study		
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case-control studies		
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities	C	Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV) or extrapolated from level I or II evidence. This grading indicates that directly applicable clinical studies of good quality are absent or not readily available.

Appendix 3: Classification of eating disorders

The following table shows the classification of eating disorders by the International Classification of Diseases^{xviii}.

ICD10	Description
F50.0	Anorexia Nervosa
A disorder characterized by deliberate weight loss, induced and sustained by the patient. It occurs most commonly in adolescent girls and young women, but adolescent boys and young men may also be affected, as may children approaching puberty and older women. The disorder is associated with a specific psychopathology whereby a dread of fatness and flabbiness of body contour persists as an intrusive overvalued idea, and the patients impose a low weight threshold on themselves. There is undernutrition of varying severity with secondary endocrine and metabolic changes and disturbances of bodily function. The symptoms include restricted dietary choice, excessive exercise, induced vomiting and purgation, and use of appetite suppressants and diuretics.	
F50.1	Atypical anorexia nervosa
Disorders that fulfil some of the features of anorexia nervosa but in which the overall clinical picture does not justify that diagnosis. For instance, one of the key symptoms, such as amenorrhoea or marked dread of being fat, may be absent in the presence of marked weight loss and weight-reducing behaviour. This diagnosis should not be made in the presence of known physical disorders associated with weight loss.	
F50.2	Bulimia Nervosa
A syndrome characterized by repeated bouts of overeating and an excessive preoccupation with the control of body weight, leading to a pattern of overeating followed by vomiting or use of purgatives. This disorder shares many psychological features with anorexia nervosa, including an overconcern with body shape and weight. Repeated vomiting is likely to give rise to disturbances of body electrolytes and physical complications. There is often, but not always, a history of an earlier episode of anorexia nervosa, the interval ranging from a few months to several years.	
F50.3	Atypical bulimia nervosa
Disorders that fulfil some of the features of bulimia nervosa, but in which the overall clinical picture does not justify that diagnosis. For instance, there may be recurrent bouts of overeating and overuse of purgatives without significant weight change, or the typical overconcern about body shape and weight may be absent.	
F50.4	Overeating associated with other psychological disturbances
F50.5	Vomiting associated with other psychological disturbances
F50.8	Other eating disorders
F50.9	Eating disorder, unspecified
DSM-IV ^{xix} has a proposed category of Binge Eating Disorder which is similar to Bulimia Nervosa, but without compensatory behaviours. In ICD10 this would normally be subsumed into F50.3, F50.4, F50.8 or F50.9.	

Appendix 4: Role of the dietitian in the treatment of eating disorders

Introduction

As eating disorders comprise both psychological and physiological components, treatments should combine expertise in both with health professionals understanding the nutritional and physiological effects these disorders can have. Registered dietitians, registered with the Health Professions Council, have an essential role within multidisciplinary teams and are involved in the assessment, treatment and monitoring of patients with anorexia nervosa, bulimia nervosa and binge eating disorder. Dietetic input should be offered to both inpatients and outpatients as an adjunct to other treatments.

Why dietetics in eating disorders?

Dietitians are specialised in assessing nutritional requirements and are up to date in latest nutritional information, so can provide accurate and relevant information for patients including those with additional dietary requirements eg diabetes or food allergy.

As poor eating patterns and unhealthy views surrounding food are primarily symptoms of eating disorders, not the cause, dietary concerns can be addressed by a dietitian leaving other health professionals to deal with the underlying issues of the eating disorder.

A dietitian can:

- act as a specialist within a multi-disciplinary team
- act as a consultant to other health professionals advising on nutritional aspects of care, appropriate literature to use and providing training as required
- run nutrition education sessions for patients covering general topics with regards to nutrition and basic physiology
- act as a co-therapist in individual treatments, and in therapy groups where nutrition is a major component eg bulimia nervosa or overeaters groups
- have long-term individual contact with patients
- review patient eating diaries
- design and review nutrition plans for the patient
- monitor weight and amend nutritional plans as appropriate
- liaise with and support families and carers as required.

The role of the dietitian can be divided into 4 main areas:

Assessment

Dietetic assessment will vary depending on when the patient is being seen and what previous assessment has been carried out eg dietetic outpatient assessment will be different from the assessment carried out by a dietitian working in a specialist inpatient unit.

Dietetic assessment includes:

- current and previous dietary intake, eating habits and weight history
- other eating disorder behaviour eg purging, use of laxatives and diuretics
- history of weight reducing diets, including family history of dieting
- current nutritional knowledge and dietary rules eg kcalorie counting, times of eating, ritualistic behaviours, food combining, avoidance of fats and fatty foods
- activity level and exercise
- motivation to change and patient's aims of treatment
- calculation of nutritional requirements for weight maintenance and weight gain (if required)
- treatment plan

Nutrition education

Nutrition education can seem unnecessary and be overlooked for patients with eating disorders as their knowledge and interest in nutrition can seem vast. However this is a major part of the problem. Patients are often overly concerned with small aspects of nutrition such as kcalorie counting, avoiding fats or carbohydrates. This can result in completely distorted views on food and nutrition, and a diet deficient in many nutrients. For some this has been a result of their eating disorder, but for others their poor diets predate this. A dietitian can help a patient review their current dietary intake, question their dietary "rules" and provide more accurate information about nutrition and physiology to help them move towards a nutritionally adequate diet.

Recommendations

Ideally this involves the dietitian and patient working collaboratively to set realistic and achievable diet and weight goals. Goals for weight gain need to be slower for outpatient than for inpatient treatment. Recommendations should be backed up using results of nutritional analysis and calculations of nutritional requirements for weight maintenance and weight gain.

Note: A dietitian will only recommend the use of nasogastric feeding or use of supplementary drinks where this is absolutely necessary as a patient can quickly become reliant on these dietary props, preferring to use these rather than re-establishing a normal diet.

Support

Ultimately the role of a dietitian is to help patients learn to trust food again. When patients have followed restrictive or chaotic eating patterns for a period of time their beliefs about food and nutrition can become very distorted and rigid. Changing poor eating patterns is very difficult to do, even with very motivated patients. It inevitably means breaking numerous dietary “rules” and, as with other elements of treatment, involves risk and experimentation. A dietitian can be the best person to instil confidence in patients to make these changes.

How to access a dietitian

In Scotland there is a network for dietitians working with patients with eating disorders, called The Scottish Dietitians Eating Disorders Clinical Forum (SDEDCF).

Depending on their location, health professionals can refer patients to community dietitians or to dietitians working in secondary and tertiary healthcare settings. If the dietitian does not feel they have the necessary experience, they can liaise with a dietitian linked to the SDEDCF who will either recommend referral to a specialist dietitian or offer advice and support to the dietitian involved. It is essential that dietitians working with patients with eating disorders have appropriate clinical supervision and are not the only health professional involved with the patient.

Appendix 5: Internet resources

This report does not endorse any particular website, but the following contain comprehensive and sensible information.

- 1 www.edauk.com The Eating Disorders Association site has good information about the eating disorders network in the UK and details of local self-help and support groups.
- 2 www.sedig.members.beeb.net The Scottish Eating Disorders Interest Group website.
- 3 www.rcpsych.ac.uk The Royal College of Psychiatrists site offers leaflets in English and Chinese for patients, their families and friends and teachers, plus links to other organisations
- 4 www.healthscotland.com The site of NHS Health Scotland offers a number of leaflets on aspects of mental health and wellbeing, including eating disorders
- 5 www.iop.kcl.ac.uk The Institute of Psychiatry/Maudsley Hospital site has good information and downloadable PDFs on medical complications of eating disorders and is kept up to date with research development.
- 6 www.something-fishy.org is a very comprehensive site set up by a husband and wife team in America with a combination of good information, sufferers and carers stories and comments and it is regularly updated.
- 7 www.girlpower.gov is the US Department of Health and Human Services site directed particularly at adolescent young women.
- 8 www.bodywhys.ie is the eating disorders association of the Republic of Ireland and gives comprehensive information for Eire as well as good general information.
- 9 www.swedauk.org The Somerset and Wessex site shows what a local area can do with input from health, education and voluntary agencies.
- 10 www.nationaleatingdisorders.org The National Eating Disorders Organisation in the USA has a very comprehensive site and has a particularly good handout on “what should I say tips for talking to a friend who may be struggling with an eating disorder.”

- 11 www.anitt.org.uk The ANITT (Anorexia Nervosa Intensive Treatment Team) site has a detailed clinical pathway for anorexia nervosa that is downloadable in PDF format.
- 12 www.nice.org.uk Allows downloading of NICE Guidelines on eating and other disorders.

The American Psychiatric association has recently published a guideline on the treatment of patients with eating disorders (third edition). This can be downloaded free of charge from http://www.psych.org/psych_pract/treatg/pg/EatingDisorders3ePG_04-28-06.pdf.

There are also a large number of sites that advocate an eating disorder as a lifestyle choice and are strongly disapproving of treatment or any intervention. "Pro Ana" and "Pro Mia" refer to pro anorexic and pro bulimic sites respectively. Other sites promote extreme fasting for spiritual or cleansing reasons eg breatharianism.

Appendix 6: The legal situation in Scotland

The Mental Health (Care and Treatment) (Scotland) Act 2003

The Mental Health (Care and Treatment) (Scotland) Act 2003 is now largely in force. It is based on a set of guiding principles and as a general rule anyone who performs functions under the Act should act in accordance with these principles. These include:

- The present and past wishes and feelings of the patient
- The views of the patient's named person, carer, guardian or welfare attorney
- The importance of the patient participating as fully as possible;
- The importance of providing the maximum benefit to the patient
- The importance of providing appropriate services to the patient, and
- The needs and circumstances of the patient's carer.

The Act also sets out principles relating to the way in which the function must be discharged. These require the person discharging the function to do so in a way which, for example:

- Involves the minimum restriction on the freedom of the patient that appears to be necessary in the circumstances
- Encourages equal opportunities, and
- If the patient is a child, best secures their welfare.

A patient who is subject to a Short Term Order or a Compulsory Treatment Order can be given treatment without his or her consent if it is in accordance with rules set out in the Act that deal with medical treatment.

Feeding

Feeding against the will of the patient should be an intervention of last resort in the care and management of anorexia nervosa and other eating disorders. It may rarely also be necessary in the treatment of people with major mental illnesses or learning disability.

The Mental Health (Care and Treatment) (Scotland) Act 2003, Section 240, authorises the giving of nutrition by artificial means where the patient does not consent to the treatment.

The decision to proceed with artificial feeding without the person's consent is ethically complex and the decision to initiate or withdraw

treatment should always be made on an individual basis taking into consideration the potential benefits and disadvantages of imposing treatment. The primary purpose of artificial feeding without consent should be to save the patient's life or to prevent further serious deterioration of their physical condition.

The Code of Practice which accompanies the Act states that there is a difference between forcible feeding and artificial means of feeding someone for example through a nasogastric tube, an intravenous drip or directly into the stomach through a gastrostomy. These methods of nutrition bypass the patient's need to swallow food but forcible feeding involves using direct force to make an individual swallow food. Forcible feeding may involve methods such as forcibly pushing food into the individual's mouth or holding his or her mouth open to receive food. This type of forcible feeding is not authorised by the Act and the Code of Practice states it should never be used.

If artificial feeding without consent is being considered for any patient liable to compulsory treatment under the Act, the patient's responsible medical officer is required to arrange through the Mental Welfare Commission for a designated medical practitioner to examine the patient and consider whether the treatment should be authorised under the Act. A designated medical practitioner is an experienced, independent psychiatrist who considers and makes a judgement on the benefit to the patient of the treatment proposed. Where the patient is aged less than 18 years then either the responsible medical officer or the designated medical practitioner must be a specialist in child and adolescent psychiatry.

Both the patient's responsible medical officer and the designated medical practitioner must have regard to any valid Advance Statement made by the patient before making a decision about treatment. The Act enables a patient to make an Advance Statement and this is a written statement stating out how he or she would wish to be treated, or wish not to be treated, for mental disorder should his or her ability to make decisions about treatment for their mental disorder become significantly impaired as a result of their mental disorder. It is a requirement of the Act that the Advance Statement should be taken into account when decisions are being made about care and treatment. An Advance Statement cannot make a doctor do anything that is illegal or unethical and it cannot enforce the provision (or withdrawal) of particular services, medicines or treatments. If a decision is made which goes against an Advance Statement, the Act says that the person making the decision must record the reasons and give a copy of that record to the patient and others. (Section 276(8))

Children and young people

A child under the age of 18 years can be made subject to an emergency order, a short-term order or a compulsory treatment order in the same way as an adult. If it becomes apparent that it may be appropriate to grant such an order then special consideration should be given to the effects of detention on the child and to ensuring that all other options have been fully explored. There are some additional measures to those contained in the Mental Health Act that apply only to a child under 16. If a child has capacity to understand the issues concerning treatment and is refusing, a parent might seek an order from the court under the Children (Scotland) Act 1995 Part 1 authorising parental consent to treatment of the child. Alternatively a child's care may be subject to the supervision of the local authority, under the child protection regime contained in the Children (Scotland) Act 1995 Part 2. A children's hearing operating under this Part of the Act can be asked to attach a condition of treatment to a supervision requirement. This is only competent if there are grounds for invoking child protection measures, but it could be argued that the child is outwith parental control if not persuadable to agree to treatment under medical advice, or at risk of neglect if the parent is also refusing treatment against medical advice.

Conflicts of interest

Treatment is sometimes provided in private hospitals and there are special requirements for doctors to follow if they are considering detaining a patient on a short-term order or a compulsory treatment order in a private hospital. These are the Mental Health (Conflict of Interest) (Scotland) (No 2) Regulations. They state that doctors employed in a private hospital should not prepare the mental health reports that support an application for a compulsory treatment order detaining a patient in that hospital. If they did, this would be a conflict of interest. The same principle applies for a short-term order.

Any private hospital that cares for patients who are detained under the Act must be registered with the Care Commission as an independent healthcare service and is subject to regular announced and unannounced inspections by the Care Commission.

The Adults with Incapacity (Scotland) Act 2000

The Adults with Incapacity (Scotland) Act 2000 deals with issues relating to the personal welfare of an adult (aged over 16 years) as well as medical treatment. Informal patients who lack the capacity to make their own decisions about treatment may be given treatment for mental disorder under the Adults with Incapacity Act. However, the associated Code of Practice states that if the adult resists treatment then consideration should be given as to whether it would be appropriate that he or she be formally treated under the 2003 Act. The Adults with Incapacity Act prohibits the use of force or detention unless immediately necessary and does not authorise detention in hospital. Therefore, this Act can only authorise feeding by artificial means, if it does not involve the use of force.

Other considerations

The above has focused on feeding without the consent of the patient and treatment given under the Mental Health Act. It is important to point out though that consent should be sought for all patients prior to beginning any treatment programme and reviewed regularly to ensure they are continuing to give a valid consent.

Great care must always be taken to ensure that any treatment plan does not unnecessarily impinge on the patients' dignity and privacy nor make him or her feel stigmatised and degraded.

Patients have a right under Article 3 of the Human Rights Act 1998 to be protected from inhuman or degrading treatment. Whether the treatment was inhuman or degrading would depend upon the individual circumstances. Any treatment given must always be clinically justifiable and a proportionate response to the risk presented. People also have rights to liberty (Article 5) and to privacy (Article 8), such that any encroachment on those rights must be authorised by law. An encroachment on these rights in fact which has not been taken through the processes of law provided for in Mental Health, incapacity or other process of legislation or common law test (such as necessity) will be open to challenge under Articles 5 or 8.

In conclusion, this a very complex ethical area and the Mental Welfare Commission are planning on producing good practice guidelines to be published following consultation in 2007.

Further information and contacts

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Mental Health (Care and Treatment) (Scotland)Act 2003
The Stationery Office Ltd

Mental Health (Care and Treatment) (Scotland)Act 2003 Code of
Practice
Scottish Executive 2005

Mental Health Act topic guides have been produced by a
partnership that included the Scottish Executive Mental Health
Team, the Mental Welfare Commission and representatives from
service user and individual advocacy services. They are available
from the Scottish Executive website at www.scotland.gov.uk.

Appendix 7: References

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