

**Regional
Care Pathway
for the Treatment
of Eating Disorders**

Promoting Hope, Opportunity and Personal Control

PLEASE DON'T JUDGE ME

By Sabrina Hunter

Caring
for the
whole
person

Participating
and making
Connections

Personal
Strengths &
Goals

Hope and
Self
Determination

Please I ask that you don't judge me as I want to try and help you understand;
That when Anorexia crept into my life it was the last thing I had planned!

I was a carefree bubbly teenager, pre-occupied with loving life, dreams and fun;
I loved food and knew nothing of eating disorders; little did I know what my life would become

I remember slowly beginning to feel uneasy,
Every time food was within my sight;
When I ate the guilt would saturate me, until every mouthful became a fight

Years passed and I believed it was normal, ashamed to tell another living soul;
That I didn't believe I was worthy of food and my self-esteem lay crumpled on the floor

Eventually people started to notice and began questioning what was wrong;
For I was a scared broken shell of myself and all my love for life had gone

I assumed people would be critical, so ashamed of what they would say;
How would anyone understand the reason I was starving myself was because I felt unworthy and in turmoil everyday

I wasn't trying to hurt people, seek attention or be purposely vain;
Anorexia was my crutch to deal with stress, and mask all my trauma and pain

But instead of people judging me they listened were patient and kind;
I realised reaching out for help was crucial to help me understand the battle in my mind

The diagnosis Anorexia rung in my ears so shocked I nearly collapsed of the chair;
But for once there was a glimmer of hope; finally I wasn't alone in my despair

In time I have rebuilt my life and I use my strength to fight everyday;
I try to use all the experiences I have to help others in a positive way

So I can only ask when you hear the word 'eating disorder' that you will try to understand it's not a choice, because I have fought harder than you can imagine;
To be in recovery and find my voice!

Foreword

This care pathway provides a summary of the core interventions in the treatment and management of eating disorders. The clinical information provided is based on NICE Guideline CG9 (2004); and it is underpinned by the standards for mental health care set out in the Regional Mental Health Care Pathway (HSCB, 2014).

The care pathway outlines what people can expect if they are referred for treatment and provides summary of clinical advice derived from evidence based practice. It also includes information to assist people with self-care and accessing other supports before, during and after treatment.

The care pathway recognises that mental health care should have parity with physical health care in terms of priority and resources. Although aspects of this Care Pathway are challenging to implement immediately due to constraints on resources, it does commit health and social care services in Northern Ireland to make best use of existing resources, and to seek additional resource to address gaps in service provision.



Equality Statement



Equality

Diversity

Human
Rights

Alternative
Formats

In line with Section 75 of the Northern Ireland Act 1998, treatment for an eating disorder will be provided and available to all who require it irrespective of gender, ethnicity, political opinion, religious belief, disability, age, sexual orientation, and dependant, marital status. The services are designed to diagnose, treat and improve the wellbeing of all those people requiring mental health care.

Mental health services have a duty to each and every individual that they serve and must respect and protect their human rights. At the same time, mental health services also have a wide social duty to promote equality through the care it provides and in the way it provides care. This includes addressing the needs of those groups or sections of society who may be experiencing inequalities in health and wellbeing outcomes.

Alternative Formats

This care pathway can also be made available in alternative formats: large print, computer disk, Braille, audio tape or translation for anyone not fluent in English. Please contact the Communications Office at the Health and Social Care Board, www.hscboard.hscni.net.

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Part 1: The Care Pathway and Standards

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**Explain how
to access
services**

**Explain the
Steps
Involved**

**Promote
Working
Together**

**Support
Decision
Making**

1.1 Purpose and Aims of the Care Pathway

This care pathway is concerned with the identification, treatment and management of anorexia nervosa, bulimia nervosa, and associated atypical eating disorders. These disorders frequently emerge in adolescence or early adulthood, but are not unknown in younger children. Clinical interventions are similar irrespective of age; therefore the care pathway takes a life course approach, highlighting differences in emphasis or special considerations when treating children and young people.

The management of loss of appetite due to physical illness, psychogenic disturbance of appetite, or binge eating is not within the scope of this care pathway. Nor are problems with eating that can be developed by children such as food phobias, selective eating, and poor appetite. Clinicians treating such conditions should follow the relevant clinical guideline and/or condition-specific pathway.



1.2 What is an Eating Disorder?

An eating disorder is a disturbance of eating behaviour, along with a characteristic abnormal thinking pattern, an extreme preoccupation with body shape and weight, and body disparagement.

People can frequently move between the different categories of eating disorders, and experience other mental health conditions, including depression, anxiety, obsessional traits and personality disorders. Some of the behaviours associated with eating disorders can lead to serious physical health problems.

The defining features of all eating disorders are:

- a deviation from normal eating behaviour, for example severely restricting amounts or types of food eaten, over-eating or bingeing
- using other behaviours in an attempt to control weight, for example self-induced vomiting, taking laxatives or diuretics or excessive exercise
- problems with physical health and/or psychological functioning caused by disturbed eating or other weight control behaviours
- preoccupation and excessive concern with body shape, weight and eating
- often can present alongside other mental health disorders

Part 1: The Care Pathway and Standards

- **Anorexia Nervosa**

Anorexia Nervosa is a syndrome in which the individual maintains a low weight as a result of a preoccupation with body weight, construed either as a fear of fatness or pursuit of thinness. Weight loss is induced by avoiding “fattening” foods, sometimes supported by excessive exercising or self-induced purging. The individual’s perception is often at odds with the assessment of others and there can be a marked disturbance of body image and a strongly held conviction that weight control is desirable. Secondary features include social withdrawal, rigidity and obsessionality. The impact of the disorder can include adverse physical effects, social isolation, compromise of educational and employment plans, and poor self-care.

- **Bulimia Nervosa**

Bulimia Nervosa is characterised by recurrent episodes of binge eating followed by compensatory behaviours (self-induced vomiting, purging, fasting, over exercising, or a combination of these) in order to prevent weight gain. Binge eating is accompanied by a subjective feeling of loss of control over eating.

- **Atypical Eating Disorders**

An eating disorder described as atypical is one where some, but not all, of the features of anorexia or bulimia are present. In treatment terms the care pathway of an atypical disorder will follow that of the disorder it most closely resembles.

- **Physical Health**

Unchecked, the behaviours associated with eating disorders can significantly impact on the individual's physical health, including their dental health. There are particular risks and health problems for people who have an eating disorder and become pregnant, and those that have diabetes or other serious health conditions. The behaviours often associated with eating disorders can reduce the effectiveness of treatment for physical health problems.

- **Eating Disorders in Children and Adolescents**

The behaviours and thinking that are typical in adults experiencing anorexia nervosa or bulimia nervosa are the same for adolescents and children, and clinical interventions to address these are the same. However some of the physical indicators of eating disorder (such as low body mass index and amenorrhea), can be more difficult to identify depending on the age and developmental stage of the child. Therefore there may be more reliance on the psychological and behavioural factors in detecting the disorders in a child, with particular attention to the report of parents and carers.

Part 1: The Care Pathway and Standards



1.3 Who is the Pathway For?

- **General Practitioners**

Early identification of an eating disorder is critical, and intervention before harmful behaviours become entrenched can significantly reduce the level of serious physical and mental harm that can occur over time. Therefore this care pathway is aimed at GPs to support early identification and referral.

- **Physical and Mental Health Practitioners**

Eating disorder behaviours can seriously compromise an individual's physical health, and can impact on the effectiveness of interventions

addressing other physical and mental health conditions. Therefore the care pathway provides information relevant to clinicians providing medical or mental health care to someone with a co-morbid eating disorder.

- **People with an Eating Disorder and their Family and Friends**

The care pathway is for individuals experiencing an eating disorder and the people who care for them, including family members, close friends and other professionals such as teachers and youth workers. A separate guide for people using services and their family members is also available.



1.4 Recovery from Eating Disorders

Recovery includes achieving life goals and quality of life as well as a reduction in symptoms. It is highly personal; however with the right support many people recover completely or are able to manage their symptoms in a way which reduces the impact on their lives. As well as providing expert treatment Eating Disorder services will support individuals and their family members to “recover” aspects of their lives that may have been stalled or lost because of the onset of the disorder, and to live full and rewarding lives despite the symptoms of mental ill health.

Recovery Principles

Promote Hope and Self Determination

Eating disorder services will be optimistic about the opportunities for recovery and will support personal decision-making to help build the capacity of the individual to manage their own mental health and wellbeing.

Deliver Personalised Whole Person Centred Care

Eating disorder services will provide interventions which are known to work and will partner with the individual using the services to ensure their personal preferences, values, ambitions and goals are incorporated into their recovery plan.

Encourage Participation and Making Connection

Eating disorder services will support the individual in directing their own care and will help them strengthen family, social and community networks.

Focus on Personal Strengths

Eating disorder services will help the individual to develop a positive and solution focused approach and support them to maximise their personal strengths.

Support Children and Young People to Thrive

CAMHS eating disorder services will support children and young people in the continuation of their physical, social and emotional development.

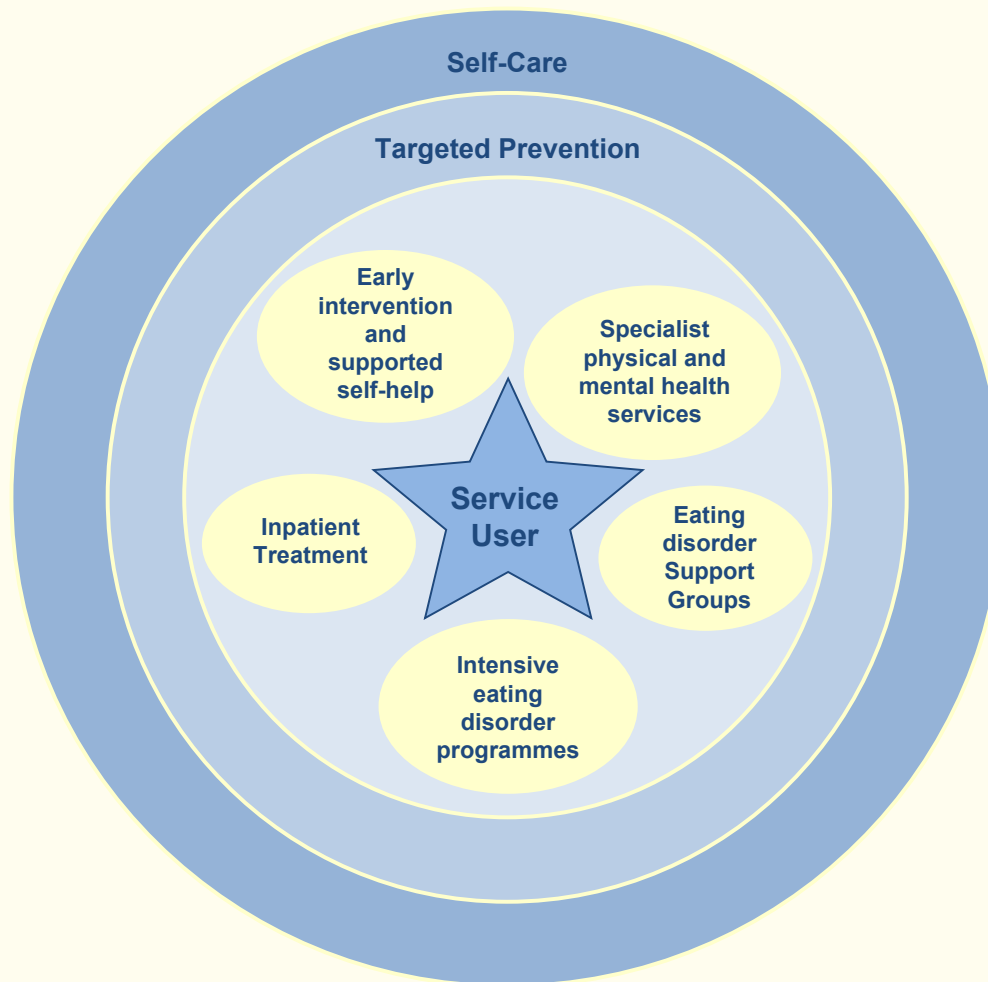


1.5 The Stepped Care Model

This care pathway is based on the stepped care model. This model describes different types and intensity of services (not the people who use the services). An individual can appropriately be using a range of services across the different steps at the same time, or move between services and steps as their needs change. The step care approach helps ensure that the person is referred to the right service, at the right time, and to professionals with the best skills to meet their needs at that time.

If an individual's need changes and a different level of support is required then the professionals working with the individual will explain the reasons and the benefits of any step up or step down or other change in service proposed. They will give relevant information, provide an opportunity to discuss any new treatment and assist the individual to consider the options. The Stepped Care model for eating disorder services is described in the diagram overleaf.

The Stepped Care Model for Eating Disorders



- **Self-Care**

Looking after your own health and wellbeing is fundamental. This includes making good lifestyle choices, and engaging with people and the world around you in a way that supports your physical health and emotional wellbeing. Good self-care includes seeking help if worrying symptoms appear, or behaviours seem out of control. Good self-care also includes engaging positively with the services offered and following your treatment plan and any professional advice you are given.

- **Targeted Prevention**

Targeted prevention for eating disorders are provided by voluntary and community organisations and self-help groups and include peer support groups, carer advocacy, and information and education programmes provided to schools, youth clubs and others used by people who may be vulnerable to developing an eating disorder.

- **Early Intervention and Supported Self-help**

Early intervention is activated when symptoms begin to become apparent. Interventions include psycho-education and supported self-help programmes that can prevent the development of a full blown eating disorder. Early intervention can be provided by specialist community and voluntary sector services or by staff from HSC Trusts trained in early intervention techniques.

- **Specialist Physical and Mental Health Services**

Specialist mental health services are usually required to respond to people experiencing a serious mental disorder or with complex needs associated with more than one disorder. The physical health problems that can result from the harmful compensatory behaviours associated

with eating disorders may also require specialist medical interventions. Because of the nature of eating disorders there is a high likelihood that an individual will require both medical and mental health interventions. In these circumstances the care pathway requires that practitioners work closely together to ensure the best care for the individual.

- **Specialist Eating Disorder Services**

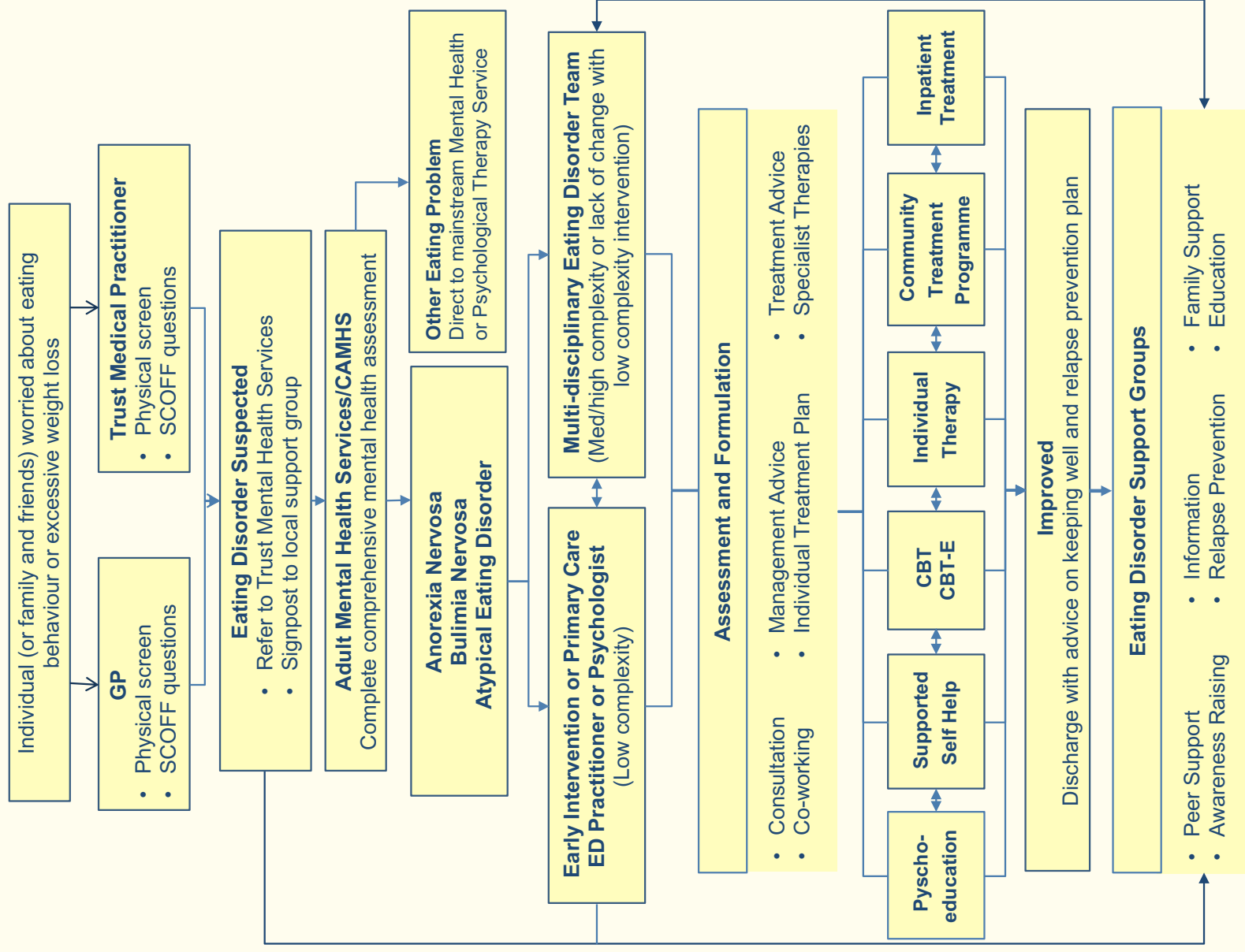
Specialist eating disorder services are usually provided in response to complex/ specific eating disorder need which requires an intensive programme of treatment by specialist practitioners. These services are usually provided by multi-disciplinary eating disorder teams, psychological therapy services, and specialist eating disorder practitioners working in community mental health teams or psychiatric inpatient units.

Specialist teams and practitioners also provide expert advice and support to colleagues treating patients with other physical or mental health conditions that may be made more complex because of the presence of an eating disorder.

- **High Intensity Mental Health Services**

High Intensity services are usually provided in response to complex needs that are seriously compromising a person's safety and health. With eating disorders this complexity is often due to the coexistence of other serious mental or physical illness. High intensity services include intensive day programmes and treatment in hospital. For a small number of people this may be provided in a specialist unit outside of Northern Ireland.

1.6 The Care Pathway at a Glance



1.7 The Care Pathway Explained



- **Early Identification**

Early identification and skilled intervention can significantly reduce the long term harm to an individual's mental and physical health. Anyone concerned about unexplained weight loss; their own eating behaviour; or parents worried about children or young people should see their GP as soon as possible.

Before referring to specialist mental health services the GP will want to carry out a thorough physical work up to rule out physical health conditions as the cause of any symptoms or weight loss. If there is no obvious physical cause the SCOFF questionnaire¹ can help identify a potential eating disorder. A score of 2 or more positive responses to the following questions would indicate that a fuller assessment for eating disorder is required.

SCOFF Questions

- Do you ever 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 three month period?
- Do you believe yourself to be fat when others say you are too thin?
- Would you say that food dominates your life?

However, some people with anorexia nervosa will deny even these behaviours and it is important to keep weight under review if an eating disorder is suspected.

The GP should refer for a mental health assessment as soon as the individual or parent of a child or young person under 18 acknowledges there is a likelihood of an eating disorder and agree to a referral.

¹ Morgan et al (2001) SCOFF Questionnaire



• Referral

Most referrals for assessment and treatment of an eating disorder will come from the patient's GP. Referrals may also be made by medical practitioners if an individual has presented for medical care, and eating disorder behaviours are suspected as an underlying cause. Referrals to specialist eating disorder practitioners or services can also be made internally from another mental health service.

New referrals will be routed through normal points of access for generic adult or child and adolescent mental health services in each of the Trusts. GPs can seek advice directly from specialist eating disorder practitioners or teams if required.

Referrers should provide individuals and families with interim advice and signpost to one of the voluntary sector organisations for information and support. (See Useful Information Section).

Referrers will be asked to identify the urgency of any referral. Individuals can expect to be seen within:

- 9 weeks for a routine referral
- 5 working days for referrals deemed urgent
- 24 hours for emergency referrals



- **Initial Assessment**

The initial assessment involves a structured conversation with a mental health practitioner who will ask about the symptoms and behaviour, and life experiences that may be influencing their behaviours and thinking. People under 18 years can usually expect to have their parents or legal guardians involved in the discussion. People over 18 years will be asked to identify family members or close friends who they want to be involved in the discussion.

When an eating disorder is present there are likely to be negative impacts on the individual's physical health if behaviours persist. Therefore the individual's physical health will be screened as part of the initial assessment.



- **Formulation and Diagnosis**

Formulation is a more in depth process whereby all the available information is drawn together in order to identify the individual's specific needs and circumstances, and identify possible reasons why these needs have arisen. It is done collaboratively with the service user and draws on the expertise of a range of professionals (the multi-disciplinary team). Formulation will also take into account the report of family members and the referrer, and draw upon psychological theory and research to better understand the situation and what interventions would be of most help to the individual.

Participating in the process of formulation in partnership with professionals can help the individual (and their family members) understand their needs and identify areas of their lives which may need to change. For children and young people it is particularly important that family members also gain understanding and insight through the formulation process.

A diagnosis is a clinical judgement that all the diagnostic criteria for a specific eating disorder are met. It is usually not helpful to have a diagnosis made in isolation from the formulation process.

If a diagnosis is made the clinician making it will explain it and what it may mean for the individual.



- **Health and Wellbeing Planning**

A Personal Wellbeing Plan (also sometimes called a care plan or a treatment plan) will be developed by the eating disorder practitioner in partnership with the individual and their parents (if the individual is under 18 years); and nominated family members or friends for an adult patient.

The plan will outline the mental health care that is being offered; any arrangements for working closely with practitioners monitoring or treating other conditions; and how family members or close friends are to be involved. The Personal Wellbeing Plan will also describe any agreements about maintaining personal safety and managing crisis.



- **Personal Safety Planning**

Eating Disorder services are required to complete screening and assessment of risk in line with regional guidelines for mental health services, and to work with individuals and their families (where appropriate) to develop plans to avoid or minimise the impact of any risk. People using eating disorder services can expect that eating disorder staff will:

- Openly discuss any issues which may have a significant impact on safety with the individual.
- Help them think through the risks for them personally and for family and/or other relevant other people.
- Assist each individual in treatment to develop their own personal safety plan.

Eating Disorder staff will always be mindful of the safety and wellbeing of children or adults at risk of abuse, and will take appropriate action if they are concerned about the safety of a child or an adult in need of protection.



- **Personalised Treatment**

The specific needs of individuals experiencing an eating disorder can be varied and complex, therefore care and treatment interventions need to be tailored to the specific need of the individual.

If a person is at the early stage of an eating disorder information and motivational support may be enough to help them get back to healthy eating. Most people referred will receive a psychological therapy, however if someone is very underweight and frail the initial focus may be on addressing physical health problems to get the person to the point where they are able to participate in psychological therapy. Sometimes another mental illness or disorder will have to be treated first. This would particularly be the case for someone misusing alcohol or other substances.

As well as psychological therapy individuals can expect to have regular physical health monitoring, body image sessions, advice and skills programmes about healthy eating and fitness, and support with self-care.

Family members will be offered advice and information so that they can support their loved one in their progress. Parents and siblings may be offered family therapy; and family members will be offered carers support in their own right.



• **Staying Engaged**

When an individual is referred for eating disorder services it is important that they keep all appointments, and if they cannot attend to let the service know well in advance. If an individual stops attending appointments without prior discussion with the eating disorder team they will not be automatically discharged. The eating disorder service will:

- Attempt to contact the individual directly, and if this fails, will contact the nominated person of an adult patient or parent of a patient under 18 years.
- Jointly consider the safety of the individual with the GP or other referrer, assess the potential risks, and agree the most appropriate follow up action.
- If an individual repeatedly and/or intermittently misses or cancels appointments, the eating disorder service will discuss the impact of this with them with a view to re-engaging the individual with treatment.



- **Transitions**

Transitioning from one service to another can occur when an individual's needs or circumstances change. Eating Disorder staff will work closely with the individual, their nominated family/friends and staff from other service areas to ensure that any transition occurs smoothly and continues to support the individual's recovery.

Moving between Community and Inpatient Service

People who experience an eating disorder can on occasion require inpatient treatment, usually if there is an acute and serious risk to their health or wellbeing. The admission could be to a general medical ward or a mental health ward. During any inpatient admission principal clinical responsibility will be with the inpatient consultant and multi-disciplinary team in the hospital. The eating disorder service will provide expert advice to the inpatient team where this is needed. On discharge from hospital clinical responsibility will normally be transferred back to the community Eating Disorder Team or specialist practitioner.

Moving between Northern Ireland Based Services and Specialist Units outside Northern Ireland

A small number of patients may be referred to a specialist eating disorder unit in the Republic of Ireland or mainland UK for a specific time-limited treatment. This usually occurs when it is deemed that a period of 24 hour specialist care is needed to progress full recovery, and local services cannot provide the specific treatment required. As for treatment in a local hospital, clinical responsibility will be with the specialist facility's consultant and multi-disciplinary team for the duration of the inpatient treatment. However the Northern Ireland clinician that made the referral will remain in close contact throughout the placement, monitor its effectiveness, and resume clinical responsibility for any on-going care and treatment needs when the patient returns to Northern Ireland.

If a patient decides not to return to Northern Ireland the local service will advise and assist them to access services in the locality where they decide to settle.

Moving from Children's to Adult Services

If the existence of an eating disorder is suspected in a young person (under 18 years) they will be referred to CAMH services. If they require on-going treatment after their 18th birthday there will be a planned transfer to adult services. If the young person is already in their 17th year when they are first referred, the CAMH and the Adult Eating Disorder teams will make a clinical decision as to the best treatment pathway for that individual.

Transition from one service to another can cause anxiety for the young person, their family members and carers. For parents in particular the change in legal status of their child can be challenging. Therefore good communication and robust planning, and involvement of the young person and their family members throughout the transition are essential. Specialist eating disorder teams will adhere to the agreed protocol for transfers from children's to adult mental health services.

Moving Between Trusts

If you move to live in another Trust area it is likely that your care will be transferred to the service covering your new address. This includes anyone previously being treated by health services provided in prison or juvenile justice centres.

The timing of the transfer will be based on the individual's clinical needs; and discussion and agreement between the two services and the individual concerned.

Moving from Direct Care to Self-Management

Throughout the individual's engagement with eating disorder services they will be asked to monitor their personal improvement in partnership with the multi-disciplinary team. This will help determine when they are ready for discharge from specialist care.

When discharge from specialist care is agreed staff will work with the individual to develop a relapse prevention plan; identify in what circumstances and how they can re-engage with services if they experience a setback; and the service user will be encouraged to remain involved in their local support group to sustain their on-going recovery.



1.7 Confidentiality and the Use of Information

Health services gather and record personal information for the purpose of providing safe and effective health and social care. Eating disorder services will respect this information, and will store it securely. Information will be shared with others in the multi-disciplinary team for the purpose of understanding the challenges the service user is facing and to develop care and treatment programmes to meet the individual's specific needs. Consent will be sought to share information with anyone outside of the services, with an explanation about what information is to be shared, why, and what the benefits are.

Consent will also be sought to share certain details about the service user's needs and treatment with family members or nominated friends when doing so would be beneficial to recovery.

Personal information will only be shared without consent where there is a legal obligation to do so and/or where it is considered necessary for the safety of the service user and/or others. In such circumstances agreement will be sought in the first instance and the service user will be informed about what information is being shared, with whom and why.

Health and social care professionals working with children and young people with eating disorder will abide by national guidelines, professional standards, their employer's policies, and legal requirements in respect of issues of confidentiality, capacity and consent for people under 18 years.

Eating disorder services routinely monitor the quality, safety and effectiveness of the services they provide. Adult Eating Disorder Services use the Eating Disorder Examination Questionnaire (EDE-Q) (Fairburn, 2008) for this purpose. Information from the questionnaires will be collated regionally and analysed to assist service development and improvement. Personal details will be removed prior to this process so that no individual service user can be identified.

Part 2: Clinical Interventions and Management of Eating Disorders

This section provides a summary of clinical guidelines provided by NICE (2004). If more detailed information is required the full guideline should be consulted.

2.1 Care Across all Eating Disorders

Service Area	Needs Indicators	Practice Recommendations
Primary Care and non-mental health settings Targeted identification and screening for suspected eating disorder in Primary Care and Non mental health settings	Patients consulting with weight concerns that are not overweight, or no medical cause identifiable for: • Low body mass index compared with age norms. • Women with menstrual disturbances or amenorrhoea. • Patients with gastrointestinal symptoms. • Patients with physical signs of starvation or repeated vomiting • Children with poor growth. • Young people with type 1 diabetes and poor adherence to treatment. • Mood disturbance or behavioural change such as social avoidance.	Screen for eating disorder using the SCOFF assessment tool When screening for eating disorders consider one or two simple questions for use with these specific target groups (for example, 'Do you think you have an eating problem?' and 'Do you worry excessively about your weight?'). People with eating disorders seeking help should be assessed and receive treatment at the earliest opportunity. Early treatment is particularly important for those with or at risk of severe emaciation and such patients should be prioritised for treatment.

Service Area	Needs Indicators	Practice Recommendations
Primary Care and non-mental health settings cont.	Poor dentition or other indicators of self-induced vomiting.	
	Initial indicators of eating disorder	Whenever possible engage and refer patients before they reach severe emaciation. This requires both early identification and intervention. Effective monitoring and engagement of patients at severely low weight, or with falling weight, should be a priority. GPs should take responsibility for the initial assessment and the initial coordination of care. This includes the determination of the need for emergency medical or psychiatric assessment.
	Laxative misuse and self-induced vomiting	Where laxative abuse is present, advise patients to gradually reduce laxative use and inform them that laxative use does not significantly reduce calorie absorption. Patients with an eating disorder who are vomiting should have regular dental reviews. Give patients with an eating disorder who are vomiting 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).

Service Area	Needs Indicators	Practice Recommendations
Secondary Care Assessing and coordinating care	People with eating disorder referred to secondary mental health care	Assessment of people with eating disorders should be comprehensive and include physical, psychological and social needs, and a comprehensive assessment of risk to self. Monitor the level of risk to the patient's mental and physical health as treatment progresses because it may increase, for example, following weight gain or at times of transition between services in cases of anorexia nervosa.
Shared Care	People with eating disorder in receipt of shared care between Primary and Secondary Care	Where management is shared between primary and secondary care, there should be clear agreement among individual healthcare professionals about the responsibility for monitoring patients with eating disorders. This agreement should be in writing and should be shared with the patient and, where appropriate, his or her family and carers.

Service Area	Needs Indicators	Practice Recommendations
All Services Providing good information and support	People with eating disorders and their family carers that are in need of support	Provide patients and carers with education and information on the nature, course and treatment of eating disorders. Healthcare professionals should acknowledge that many people with eating disorders are ambivalent about treatment. Healthcare professionals should also recognise the consequent demands and challenges this presents.
	Families and Carers in need of support	In addition to the provision of information, family and carers should be informed of self-help groups and support groups, and offered the opportunity to participate in such groups.

Service Area	Needs Indicators	Practice Recommendations
All Services Treatment for medical conditions	Compromised physical health conditions associated with maladaptive behaviours	Medical conditions that have derived from sustained maladaptive behaviours associated with eating disorders should be treated in accordance with the relevant NICE or other clinical guideline for that condition. Consultation with an Eating Disorder specialist should be sought if behaviours are likely to undermine treatment. Co-working should be considered for the treatment and management of long term medical problems.
	Osteoporosis and bone disorders	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.
	Diabetes	Treatment of both sub-threshold and clinical cases of an eating disorder in people with diabetes is essential because of the greatly increased physical risk in this group. 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.
Maternity Services	Pregnancy	Pregnant women with eating disorders require careful monitoring throughout the pregnancy and in the postpartum period.

Service Area	Needs Indicators	Practice Recommendations
Services for Children and Adolescents Additional considerations for Children and Adolescents	Carers and family members needs	Family members, including siblings, should normally be included in the treatment of children and adolescents with eating disorders. Interventions may include sharing of information, advice on behavioural management and facilitating communication.
	Children and adolescents with arrested growth	Closely monitor growth and development in children and adolescents. Where development is delayed or growth is stunted despite adequate nutrition, seek paediatric advice.
	Indicators of abuse or neglect	Healthcare professionals assessing children and adolescents with eating disorders should be alert to indicators of abuse (emotional, physical and sexual) and should remain so throughout treatment. For more information see the NICE pathway CG8 on when to suspect child maltreatment.
	Confidentiality for children and adolescents.	Healthcare professionals working with children and adolescents with eating disorders should familiarise themselves with professional and national guidelines and their employers' policies in the area of confidentiality. Parental rights and responsibilities in respect of providing care and safety for a child or adolescent should also be considered in this context.

2.2 Anorexia Nervosa

Service Area	Needs Indicators	Practice Recommendations
Primary Care and non-mental health settings Assessment	Weight loss or impeded growth with no other medical explanation	In anorexia nervosa, although weight and body mass index are important indicators they should not be considered the sole indicators of physical risk (as they are unreliable in adults and especially in children). In assessing whether a person has anorexia nervosa, pay attention to the overall clinical assessment (repeated over time), including rate of weight loss, growth rates in children, objective physical signs and appropriate laboratory tests.
Primary Care Management in primary care	Patient with enduring anorexia nervosa who has declined secondary mental health care.	Offer patients with enduring anorexia nervosa who are not under the care of a secondary care service an annual physical and mental health review by their GP.
Secondary Care Outpatient Treatment	Patients with Anorexia Nervosa	Most people with anorexia nervosa should be managed on an outpatient basis, with psychological treatment (with physical monitoring) provided by a healthcare professional competent to give it and to assess the physical risk of people with eating disorders. Outpatient psychological treatment for anorexia nervosa should normally be of at least 6 months' duration. If during outpatient psychological treatment there is significant deterioration, or the completion of an adequate course of outpatient psychological treatment does not lead to any significant improvement, consider more intensive forms of treatment (for example, a move from individual therapy to combined individual and family work; or daycare or inpatient care). Do not provide dietary counselling as the sole treatment for anorexia nervosa.

Service Area	Needs Indicators	Practice Recommendations
Secondary Care Outpatient Treatment	Psychological Therapies	Therapies to be considered for the psychological treatment of anorexia nervosa include cognitive analytic therapy, cognitive behaviour therapy, interpersonal psychotherapy, focal psychodynamic therapy and family interventions focused explicitly on eating disorders. Take into account patient and, where appropriate, carer preference in deciding which psychological treatment is to be offered. The aims of psychological treatment should be to reduce risk, to encourage weight gain and normal eating, to reduce other symptoms related to an eating disorder, and to facilitate psychological and physical recovery.
	Anorexia nervosa binge-purge subtype	Healthcare professionals managing patients with anorexia nervosa, especially those with the binge–purging subtype, should be aware of the increased risk of self-harm and suicide, particularly at times of transition between services or service settings.
	Post-hospitalisation psychological treatment	Following inpatient weight restoration, offer people with anorexia nervosa outpatient psychological treatment that focuses both on eating behaviour and attitudes to weight and shape, and on wider psychosocial issues, with regular monitoring of both physical and psychological risk. The length of outpatient psychological treatment and physical monitoring following inpatient weight restoration should typically be at least 12 months.

Service Area	Needs Indicators	Practice Recommendations
Secondary Care Outpatient Treatment	Pharmacological interventions	Do not use medication as the sole or primary treatment for anorexia nervosa. Exercise caution in the use of medication for comorbid conditions such as depressive or obsessive–compulsive features as they may resolve with weight gain alone. When using medication to treat people with anorexia nervosa, carefully consider and discuss with the patient the side effects of drug treatment (in particular, cardiac side effects) because of the compromised cardiovascular function of many people with anorexia nervosa. 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, avoid prescribing drugs with side effects that may compromise cardiac functioning. If the prescription of medication that may compromise cardiac functioning is essential, undertake ECG monitoring. Place an alert concerning the risk of side effects in the prescribing record of all patients with a diagnosis of anorexia nervosa.
	Refeeding as an outpatient	Most refeeding programmes should be supervised by the specialist eating disorder team on an outpatient basis as part of a programme that includes physical monitoring in combination with psychosocial interventions. Relevant physician advice should be sought when risks associated with biochemical imbalance or other associated physical health problems require to be monitored. Where there are high physical health risks refeeding in an inpatient setting should be considered.

Service Area	Needs Indicators	Practice Recommendations
Secondary Care Outpatient Treatment	Post-hospitalisation psychological treatment	Following inpatient weight restoration, offer people with anorexia nervosa outpatient psychological treatment that focuses both on eating behaviour and attitudes to weight and shape, and on wider psychosocial issues, with regular monitoring of both physical and psychological risk. The length of outpatient psychological treatment and physical monitoring following inpatient weight restoration should typically be at least 12 months.
	Managing weight gain	When treating most patients with anorexia nervosa, aim for an average weekly weight gain of 0.5–1 kg in inpatient settings and 0.5 kg in outpatient settings. The number of calories required for weight gain can vary considerable, but generally about 3500 to 7000 extra calories a week are required. Perform regular physical monitoring, and in some cases offer a multivitamin/ multimineral supplement in oral form or IV for people with anorexia nervosa during both inpatient and outpatient weight restoration. Do not use total parenteral nutrition for people with anorexia nervosa, unless there is significant gastrointestinal dysfunction.

Service Area	Needs Indicators	Practice Recommendations
Secondary Care Outpatient Treatment	Managing risk	Healthcare professionals should monitor physical risk in patients with anorexia nervosa. If this leads to the identification of increased physical risk, adjust the frequency of the monitoring and the nature of the investigations accordingly. Inform people with anorexia nervosa and their carers if the risk to their physical health is high. Consider the involvement of a physician or paediatrician with expertise in the treatment of medically at-risk patients with anorexia nervosa for all individuals who are medically at-risk. Do not use oestrogen administration to treat bone density problems in children and adolescents as this may lead to premature fusion of the epiphyses.
Maternity Services	Pregnant women with anorexia nervosa	Consider more intensive prenatal care for pregnant women with either current or remitted anorexia nervosa to ensure adequate prenatal nutrition and foetal development.
Inpatient Care	Patients whose disorder has not improved with appropriate outpatient treatment or for whom there is a significant risk of suicide or self harm.	Consider inpatient treatment or day patient treatment for people with anorexia nervosa whose disorder has not improved with appropriate outpatient treatment, or for whom there is a significant risk of suicide or severe self-harm.
	Moderate to high physical risk	Consider inpatient treatment for people with anorexia nervosa whose disorder is associated with high or moderate physical risk.

Service Area	Needs Indicators	Practice Recommendations
Inpatient Care	Maintenance of family and social relationships	Where inpatient management is required for people with anorexia nervosa, provide this within reasonable travelling distance to enable the involvement of relatives and carers in treatment, to maintain social and occupational links and to avoid difficulty in transition between primary and secondary care services. This is particularly important in the treatment of children and adolescents.
	Compulsory admission	Healthcare professionals without specialist experience of eating disorders, or in situations of uncertainty, should consider seeking advice from an appropriate specialist when contemplating a compulsory admission for a patient with anorexia nervosa, regardless of the age of the patient.
	Refeeding for people with additional serious medical complications; severely compromised physical health; or high risk co-morbid health conditions.	People that require refeeding with 24 hour medical supervision should be admitted to a setting that can provide the skilled implementation of refeeding with careful physical and biochemical monitoring (particularly in the first few days of refeeding), in combination with psychosocial interventions. The latter usually provided with advice and guidance, or in-reach by the specialist eating disorder team.
	Psychological aspects of inpatient care	For inpatients with anorexia nervosa, provide a structured symptom-focused treatment regimen with the expectation of weight gain in order to achieve weight restoration. It is important to carefully monitor the patient's physical status during refeeding. Provide psychological treatment that has a focus both on eating behaviour and attitudes to weight and shape, and on wider psychosocial issues with the expectation of weight gain. Do not use rigid inpatient behaviour modification programmes in the management of anorexia nervosa.

Service Area	Needs Indicators	Practice Recommendations
Services for Children and Adolescents	Feeding against the will of the patient	Feeding against the will of the patient should be an intervention of last resort in the care and management of anorexia nervosa. When making the decision to feed against the will of the patient, the legal basis for any such action must be clear. This should only be done in the context of the Mental Health (NI) Order 1986 or the Children (NI) Order 1995. Feeding against the will of the patient is a highly specialised procedure requiring expertise in the care and management of those with severe eating disorders and the physical complications associated with it.
Additional considerations for children and adolescents	Children and Adolescents with anorexia nervosa	Offer family interventions that directly address the eating disorder. Offer individual appointments with a healthcare professional separate from those with their family members or carers. Consider the therapeutic involvement of siblings and other family members in all cases because of the effects of anorexia nervosa on other family members. Balance the need for inpatient treatment and the need for urgent weight restoration alongside the educational and social needs of the young person.
	Children and adolescents with anorexia nervosa that have reached a healthy weight.	Healthcare professionals should ensure that children and adolescents with anorexia nervosa who have reached a healthy weight have the increased energy and necessary nutrients available in their diet to support further growth and development. In the nutritional management of children and adolescents with anorexia nervosa, include carers in any dietary education or meal planning.

Service Area	Needs Indicators	Practice Recommendations
Services for Children and Adolescents Additional considerations for children and adolescents	Children and young people with Anorexia Nervosa that require in-patient treatment	Admit children and adolescents with anorexia nervosa to age-appropriate facilities (with the potential for separate children and adolescent services), which have the capacity to provide appropriate educational and related activities.
	Children and young people with Anorexia Nervosa that refuse treatment	When a young person with anorexia nervosa refuses treatment that is deemed essential, consider the right of those with parental responsibility to override the young person's refusal; or using the Mental Health (NI) Order 1986. Avoid relying indefinitely on parental consent to treatment. Record the legal basis under which treatment is being carried out in the patient's case notes. For children and adolescents with anorexia nervosa, where issues of consent to treatment are highlighted, healthcare professionals should consider seeking a second opinion from an eating disorders specialist.
Services for Children and Adolescents Additional considerations for children and adolescents	Children and young people with Anorexia Nervosa whose parents / guardian refuse treatment. Medically at risk children and young people	If the patient with anorexia nervosa and those with parental responsibility refuse treatment, and treatment is deemed to be essential, seek legal advice in order to consider proceedings under the Children (NI) Order 1995. Consider the involvement of a physician or paediatrician with expertise in the treatment of medically at-risk patients with anorexia nervosa for all individuals who are medically at-risk. Do not use oestrogen administration to treat bone density problems in children and adolescents as this may lead to premature fusion of the epiphyses.

2.3 Bulimia Nervosa

Service Area	Needs Indicators	Practice Recommendations
Primary Care and non-mental health settings Early Intervention	Initial signs of bulimic behaviours	As a possible first step, encourage patients with bulimia nervosa to follow an evidence-based self-help programme as this may improve outcomes. This may be sufficient treatment for a limited subset of patients.
Secondary Care Outpatient treatment	Patients with bulimia nervosa	Treat the great majority of patients with bulimia nervosa in an outpatient setting. Healthcare professionals should be aware that patients with bulimia nervosa who have poor impulse control, notably substance misuse, may be less likely to respond to a standard programme of treatment. As a consequence treatment should be adapted to the problems presented.
	Require psychological interventions	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. Offer cognitive behaviour therapy for bulimia nervosa, a specifically adapted form of cognitive behaviour therapy, to adults with bulimia nervosa. The course of treatment should be for 16 to 20 sessions over 4 to 5 months. When people with bulimia nervosa have not responded to or do not want cognitive behaviour therapy, consider other psychological treatments. Consider interpersonal psychotherapy as an alternative to cognitive behaviour therapy, but inform patients that it takes 8–12 months to achieve results comparable with cognitive behaviour therapy.

Service Area	Needs Indicators	Practice Recommendations
Secondary Care Outpatient treatment	Require pharmacological interventions	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. Inform patients 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. Selective serotonin reuptake inhibitors (specifically fluoxetine) are the drugs of first choice for the treatment of bulimia nervosa in terms of acceptability, tolerability and reduction of symptoms. For people with bulimia nervosa, the effective dose of fluoxetine is higher than for depression (60 mg daily). No drugs, other than antidepressants, are recommended for the treatment of bulimia nervosa.
	Electrolyte disturbance associated with frequent vomiting or large quantities of laxatives.	Assess the fluid and electrolyte balance of patients with bulimia nervosa who are vomiting frequently or taking large quantities of laxatives (especially if they are also underweight). When electrolyte disturbance is detected, it is usually sufficient to focus on eliminating the behaviour responsible. In the small proportion of cases where supplementation is required to restore electrolyte balance, oral rather than intravenous administration is recommended, unless there are problems with gastrointestinal absorption.

Service Area	Needs Indicators	Practice Recommendations
Inpatient Care	People with bulimia nervosa at risk of suicide or severe self-harm.	For patients with bulimia nervosa who are at risk of suicide or severe self-harm, follow the clinical guidance for self-harm. Co-working with specialist self-harm or personality disorder services may be considered.
Child and Adolescent Services	Children and Adolescents with Bulimia Nervosa	Adolescents with bulimia nervosa may be treated with cognitive behaviour therapy for bulimia nervosa adapted as needed to suit their age, circumstances and level of development, and including the family as appropriate.

2.4 Atypical Eating Disorders

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

Part 3: Useful Information

This section includes useful contacts and other information for people experiencing an eating disorder, family carers and medical and other practitioners treating them.

3.1 Eating Disorder Support Groups

Eating Disorders Association NI Regional helpline; and carer and peer support groups for residents of Belfast and South Eastern Trust areas. Helpline: 02890235959 Web: www.eatingdisordersni.co.uk Email: edani@btconnect.com	Action for Eating Disorders Support groups for residents of Southern Trust area. Helpline: 02838347535 Web: www.adapteatingdistress.com Email: info@adapteatingdistress.com	The Laurence Trust On line information and resources for young men experiencing an eating disorder. Web: www.thelaurencetrust.co.uk Email: thelaurencetrust@hotmail.co.uk
Stamp-ED On line information and resources and carer and peer support groups for residents of Northern Trust area. Web: www.stamp-ED.co.uk	Defeat-ED Support groups for residents of Western Trust area. Tel: 02871320165	CARED Maudsley training for parents and carers. NB there is a charge for CARED training courses. Web: www.caredni.org Email: caringaboutrecovery@gmail.com

3.2 Statutory Eating Disorder Treatment Teams

Belfast / South Eastern Trust

- Adult Eating Disorder Service: Woodstock MH Resource Centre. Tel: 02895042900
- Eating Disorder Youth Service: Beechcroft. Tel: 02895042696

Northern Trust

- Adult Eating Disorder Service: The Villa at Holywell Hospital. Tel: 02894413307
- Child & Adolescent Eating Disorder Service: Alder House Tel: 02894424600

Southern Trust

- Adult Eating Disorder Service Trasna House in Lurgan. Tel: 02838311741
- Child & Adolescent Eating Disorder Service: Ceaderwood Buildings. Tel: 02838360680

Western Trust

- Adult Eating Disorder Service: Old Bridge House, Derry. Tel: 02871320165
- Child & Adolescent Eating Disorder Service: Woodlea House, Gransha Park.
Tel: 02882835990. Rivendell 02882835990

3.3 Helpful Resources

Belfast HSC Trust, Mind Matters: A Young Person's Guide to Child and Adolescent Mental Health Services in Northern Ireland, www.belfasttrust.hscni.net/pdf/Mind_Matters

Boyd, R (2014), Understanding Eating Problems, London: Mind

Bryant-Waugh, R. & Lask, B. (2013), Eating Disorders: A Parent's Guide. London: Routledge.

Eating Disorder Association NI (2016) Eating Disorders: A resource for Parents

Lock, J. & Le Grange, D. (2004) Help Your Teenager Beat an Eating Disorder, New York: Guilford Press.

Mental Health Foundation (2004) How to Talk to Your GP about Your Mental Health

Southern HSC Trust, Getting Help with Eating Disorders, www.southerntrust.hscni.net/Adult_Eating_Disorder_Services.

Southern HSC Trust, Self Help Guide: Eating Disorders, www.selfhelpguides.ntw.nhs.uk/southerntrust

Tait, L & Lester, H (2005) Encouraging User Involvement in Mental Health Services, in Advances in Psychiatric Treatment April 2005, 11(3) 168-175: Royal College of Psychiatrists

The New Maudsley Approach: A Resource for Professionals and Carers of People with Eating Disorders, www.thenewmaudsleyapproach.co.uk

Treasure, J, Smith, G & Crane, A. (2007), Skills-based Learning for Carers of a Loved One with an Eating Disorder: The New Maudsley Method: London: Routledge

3.4 The Scoff Questionnaire²

Early detection in patients with unexplained weight loss improves prognosis and may be aided by use of the SCOFF questionnaire, developed by John Morgan at Leeds Partnerships NHS Foundation Trust. This uses five simple screening questions and has been validated in specialist and primary care settings. It has a sensitivity of 100% and specificity of 90% for anorexia nervosa. Though not diagnostic, a score of 2 or more positive answers should raise your index of suspicion of a case, highlighting need for more detailed history as delineated below.

- Do you ever 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 three month period?
- Do you believe yourself to be fat when others say you are too thin?
- Would you say that food dominates your life?

However, some cases of anorexia nervosa deny even these symptoms and it is important to keep weight under review if the diagnosis is suspected.

² Morgan, J. et al (2002)

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- HSCB (July 2015) Protocol for the Transfer of Adult Mental Health Patients between Trusts.
- Morgan, J. et al (2002) The SCOFF Questionnaire and Clinical Interview for Eating Disorders in General Practice: Comparative Study, in BMJ 2002:325. www.bmj.com/contents/325/7367/755
- National Mental Health Development Unit, (2014), The Triangle of Care: Carer Included
- NICE Guidance CG9 (2004), Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders
- NICE Guidance CG136 (2011), Service User Experience in Adult Mental health Services
- Royal Colleges of Pathologists, Physicians and Psychiatrists (October 2014). MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa (2nd ed)
- Southern HSC Trust, Getting Help with Eating Disorders, www.southerntrust.hscni.net/Adult_Eating_Disorder_Services

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Promoting Hope, Opportunity and Personal Control

www.hscboard.hscni.net/mentalhealth/