Eating disorders: recognition and treatment

Consultation on draft guideline - Stakeholder comments table
09 December 2016–20 January 2017

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Organisation name	Document	Page No	Line No	Comments	Developer's response
1.	SH	Association for Cognitive Analytic Therapy (ACAT)	General	General	General	It is concerning to ACAT that CAT seems to have lost its identity as an individual approach despite being in the existing guidance: see points 2-4 below.	Thank you for your comment. The evidence considered by the Committee included studies that used CAT as well as numerous other studies published since the 2004 guideline. The Committee concluded that the evidence for other therapies was better than that for CAT.
2.	SH	Association for Cognitive Analytic Therapy (ACAT)	General	General	General	CAT has a long history across the UK as an individual approach for working with people with anorexia nervosa including, for example, the Cambridge and Peterborough NHS Foundation Trust Eating Disorders Service, the Cornwall Partnership NHS Foundation Trust and an extensive case series of patients from the Bethlem and Maudsley Hospitals. In Mersey Care NHS Foundation Trust CAT has recently been developed as a group intervention for mixed eating disorder patients and for patients post-bariatric surgery. CAT is widely seen as an acceptable and valid approach for patients unresponsive to previous treatments and for those with more complex relational and personality based problems. In a review of the evidence base, CAT has been shown to have a large effect size (0.83: CI: 0.66 – 1.00) across a	Thank you for your comment. The evidence considered by the Committee included studies that used CAT as well as numerous other studies published since the 2004 guideline. The Committee concluded that the evidence for other therapies was better than that for CAT. In the review of the evidence for CAT that you mention (Ryle et al. 2014), only two articles were identified that used an eating disorder sample (Dare 2001, Treasure 1995) both of which were included in the review presented in this guideline. As such, the other studies identified in Ryle 2014 (and included in the quoted meta-analysis) would not have been included in this review. Regarding the development of further work at workshops and conferences, the Committee decided to restrict attention to published studies and so the work you refer to would at this stage not be included.

						range of complex conditions (including anorexia) in routine clinical settings (Ryle A, Kellett S, Hepple J and Calvert R (2014) Cognitive Analytic Therapy (CAT) at Thirty. Advances in Psychiatric Treatment 20, 258-268.) Evidence also suggests that CAT has advantages compared with CBT in terms of client engagement, acceptability and treatment completion. ACAT is aware of the evidence of only modest improvements in people with anorexia receiving individual psychological therapies and has been seeking to develop the CAT model to more specifically target the relational patterns presented by people with anorexia. Work on this has been presented at workshops and conferences in the UK and in Greece and will soon be published as a theoretical development of the CAT model with the hope of developing a more effective treatment approach that can be researched.	
3.	SH	Anorexia and Bulimia Care	General	General	General	ABC considers the recommendations cover the issues well, and that they offer a breadth of important evidence. One important challenge we have found from working with service users and their family members is GPs putting into practice the recommendations regarding medical reviews for patients with eating disorders (and discussion with carers of younger patients). This is due to the difficulty patients experience getting appointments. Although this affects patients with any health issue, this is	Thank you for your comment.

						particularly difficult for eating disorder patients, due to the anxiety and shame they feel, which in turn reinforces the belief that they do not need or deserve medical care. ABC co-writing with RCGP, the first online course for eating disorders, suggests a series of booked appointments and practice managers being made aware of the medical and emotional needs of patients with eating disorders, and also their carers.	
4.	SH	British Psychological Society	General	General	General	<u>References</u> British Psychological Society (2011). *Good Practice Guidelines on the Use of Psychological Formulation.* Leicester: The British Psychological Society. Dalle Grave, R., Calugi, S., Conti, M., Doll, H. & Fairburn, C.G. (2013). Inpatient cognitive behaviour therapy for anorexia nervosa: A randomised controlled trial. *Psychotherapy and Psychosomatics*, 82, 390-398. Fairburn, C.G., Cooper, Z. & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: a "transdiagnostic" theory and treatment. *Behaviour Research and Therapy*, 41, 509-528. Simpson, S. (2012). Schema Therapy for Eating Disorders: A case study illustration of the mode approach. In: M. van Vreeswijk, J. Broersen & M. Nadort (Eds.), *The Wiley-Blackwell Handbook of*	Thank you for the references provided. Dalle Grave 2013 and Fairburn 2003 were already included in the guideline. The remaining provided references are not relevant to the evidence reviews as they are not RCTs.

						Schema Therapy: Theory, Research and Practice. Wiley: Chichester, UK. Simpson, S.G., Morrow, E., van Vreeswijk, M. & Reid, C. (2010). Group schema therapy for eating disorders: A pilot study. *Frontiers in Psychology*, 1, 182. Tchanturia, K. (Ed.). (2015). *Brief group psychotherapy for eating disorders: Inpatient protocols.* London: Routledge. Waller, G., Kennerley, H. & Ohanian, V. (2007). Schema-focused cognitive behavioral therapy with eating disorders. In: L. P. Riso, P. L. du Toit, D. J. Stein, & J. E. Young (Eds)., *Cognitive schemas and core beliefs in psychiatric disorders: A scientist-practitioner guide.* (pp. 139-175). New York: American Psychological Association.	
5.	SH	College of Mental Health Pharmacy	General	General	General	*General comment:* *This guideline seem fair and rational and is an improvement on the previous one.* *I could find no mention of the value of an echocardiogram.*	Thank you for your comment in support of the guideline. No mention of an echocardiogram was made as the committee deemed the use of other measures (such as ECG monitoring) to be more important.
6.	SH	Cardiff and Vale University Health Board	General	General	General	Refeeding syndrome'. Point 89. Standard regimes should be used with caution and only if a die titian is not available to provide an immediate plan, as current intake of the individual needs to be accurately calculated and this should be undertaken by an appropriately trained and specialist Dietitian who has nutritional analysis skills. The	Thank you for your comment. The recommendation made is in line with MARSIPAN, which recommends that staff (which may include dietitians) are appropriately trained. Indeed, reference is made to MARSIPAN and Junior MARSIPAN in the recommendations on refeeding and an electronic link to them is provided in the document.

						interpretation and application of MARSIPAN is critical to reducing risk of adverse effects or mortality	
7.	SH	RCGP	General	General	General	A thoughtful and undogmatic approach of an apparently man-made problem with no agreed aetiology-	Thank you for your comment.
8.	SH	RCGP	General	General	General	It would be helpful to have more detail on the epidemiology, and natural history as well as the relative effectiveness of different interventions. It seems a disease which peaks and then largely "burns itself out" and sometimes the best option is simply to support the person and family until it does so.	Thank you for your comment. The guideline is not intended as a textbook but as an evidence-based guideline for healthcare practitioners and time constraints dictated that not every issue of interest could be addressed. Regarding the effectiveness of different interventions, the full guideline includes reviews of the evidence for psychological, pharmacological, physical and other types of interventions.
9.	SH	RCGP	General	General	General	General – useful approach to management, covers the range of issues that we might expect	Thank you for your comment.
10.	SH	Royal College of Nursing	General	General	General	The Royal College of Nursing welcomes the update of this guideline. The RCN invited members who care for and have knowledge of caring for people with eating disorders to comment and review this guideline of its behalf. The comments below reflect the views of our reviewers.	Thank you for your comment.
11.	SH	Royal College of Nursing	General	General	General	We would have liked to see more nursing representation in terms of the professionals contributing to the development of these guidelines, particularly those with inpatient experience.	Thank you for your comment. It is recognised that nurses are vitally important in providing care for people with eating disorders. Note that one of the Committee members was a mental health nurse and fully engaged in the decision making process.
12.	SH	Royal College of Nursing	General	General	General		Thank you for your comment. This guideline is not intended to be a textbook

						There does not seem to be enough detail in the guidelines about inpatient treatment or much detail about day patient treatment at all.	and inpatient and day treatment is discussed in the chapters about the coordination of care, and compulsory treatment.
13.	SH	Royal College of Nursing	General	General		There is nothing about the length of stay for inpatients or the types of psychological interventions offered, when to admit, when to discharge.	Thank you for your comment. Several of the recommendations have been amended to address these issues. For example, although no specific limit is put on the length of inpatient stay, the committee have recommended that a review occur within 1 month of inpatient admission to determine whether inpatient care should continue or stepped down to less intensive setting; it is also made clear that inpatient treatment should only occur when the person with the eating disorder is at medical risk and that it should be avoided if possible.
14.	SH	Royal College of Nursing	General	General	General	There is nothing about naso – gastric feeding and compulsory treatment and the role of the nurse in this.	Thank you for your comment. It is not the standard practice of NICE to single out a particular professional group. The recommendation regarding refeeding specifies that the relevant inpatient staff (who may or may not be a nurse) is trained to recognise and manage refeeding syndrome, and that refeeding itself should follow existing national guidance. Similarly in the case of compulsory treatment, although the recommendations do not specify who must make the decision to deliver a feeding intervention against the patient's consent, such a decision will typically (although not always) legally require a Section 12 doctor, a registered medical practitioner (e.g. a GP), and an approved

							mental health professional. In the latter case, this may or may not be a nurse.
15.	SH	Royal College of Nursing	General	General	General	In terms of outpatient treatment for anorexia nervosa which is very often delivered nationally by nurses and nurse led teams, there is nothing about psycho - social interventions, motivational interventions and medical monitoring i.e. clinical management.	Thank you for your comment. The chapter on the treatment and management of anorexia nervosa in the full guideline considered all published RCTs on psychological interventions including psychosocial and motivation interventions, as well as studies on specialist supportive clinical management (SSCM). The recommendations in the short guideline also have a section on medical/health management.
16.	SH	Royal College of Nursing	General	General	General	The majority of patients referred into eating disorders services now in the NHS are complex and with co-morbid presentations, as others go to Improving Access to Psychological Therapies (IAPT) Services first. There is very little detail in the guideline about the management of personality disorder which is by far the most widespread co-morbidity.	Thank you for your comment. A search was performed as part of the evidence review for RCTs investigating how treatments should be modified in the presence of a physical or mental comorbidity. Although no appropriate studies on personality disorders were identified, the Committee agreed that the role of comorbidities was an area that needed research and therefore provided a research recommendation to this effect. In the absence of appropriate evidence, the committee has recommended that healthcare professionals consult the appropriate NICE guidelines if relevant, or else use clinical judgment.
17.	SH	Royal College of Nursing	General	General	General	Manualised treatment for complex and low weight patients is not helpful as it is too rigid an approach for difficult to engage individuals.	Thank you for your comment. Manuals provide a guidance structure to the delivery of an intervention. In all cases the application of a manual requires clinical judgement and this would be expected to be the case for people who are difficult to engage (e.g. those with low weight and complex problems).

18.	SH	Royal College of Nursing	General	General	General	It should be noted that focal psychodynamic therapy is rarely available in NHS Out Patient Services.	Thank you for your comment, we agree.
19.	SH	British Dental Association	General	General	Section 1.3–1.8	Dental erosion is linked to frequent vomiting and to dietary sources of acids. Advice should be included for patients/carers and non-dental health professionals on: - diet in relation to oral health - minimising the effects of frequent vomiting (for example, use of fluoride mouthrinses and optimal toothbrushing practices) - the importance of visiting the dentist regularly.	Thank you for your comment. Unfortunately the literature search for dental interventions for eating disorders for the physical complications review yielded a very limited evidence base, predominantly consisting of case studies and anecdotal evidence. The Committee therefore decided not to provide detailed recommendations regarding dental erosion beyond the advice that practitioners should look for it, particularly in relation to vomiting.
20.	SH	Association of School and College Leaders (ASCL)	Full	General	General	The intended audience of the document is not clear, but at 900+ pages it will not be of value to anyone who is not a full-time mental health practitioner. There are a number of references to education, but if there is to be any communication with education professionals this document is not suitable.	Thank you for your comment. The full and short NICE Guideline are both intended as a practical guidelines for healthcare professionals. A version of the guideline named 'Information for the public' is intended for people without specialist medical knowledge and will be available for download via the NICE website.
21.	SH	Barnet Enfield and Haringey Mental Health Trust	Full	General	General	We are really disappointed about the limited range of recommendations for psychological intervention to work with this challenging and often hard to treat client population.	Thank you for your comment. After further discussion, the Committee decided to revise and broaden their recommendations regarding psychological interventions. In particular, the recommendations for adult anorexia nervosa have been amended to consider MANTRA and SSCM in addition to individual CBT-ED as first-line options to reflect the fact that there is evidence of no difference between these therapies; the Committee recognised that implementing the provision of focal

							psychodynamic therapy could have significant cost implications for services and partly for this reason revised their recommendation to include it as a second-line alternative treatment if CBT-ED, MANTRA and SSCM prove unacceptable or ineffective, or are contraindicated. The recommendations for young people with bulimia nervosa have been amended to consider individual CBT-ED as a second-line alternative to family therapy (rather than guided self-help) due to (i) the reclassification by the committee of the guided self-help arm in Schmidt et al. 2007 as a form of individual CBT-ED and (ii) to allow for the provision of individual psychological treatment. The recommendations for adults with BED have also been amended to add individual CBT-ED as a third-line option after guided self-help and group CBT-ED because the committee recognised that it may be difficult to recruit sufficient numbers of people to form a group and that some form of individual therapy should be considered.
22.	SH	Barnet Enfield and Haringey Mental Health Trust	Full	General	General	We are concerned that, despite the clear documentation that much of the research on which the recommendations are based are low and very low quality, the recommendations for psychological interventions for anorexia, bulimia and binge-eating disorder appear to be very prescriptive. We acknowledge that the words “consider” and “offer” are used to demonstrate weaker vs stronger	Thank you for your comment. The wording of the recommendations is required to follow the methods outlined in "Developing NICE guidelines: the manual". As such, the recommendations use 'offer' and 'consider' as indicators of their level of certainty in line with NICE's preferred methods. As can be observed, the majority of the recommendations use the word 'consider' rather than 'offer' reflecting the fact that there is some

						evidence, we feel that a clearer distinction is needed.	uncertainty regarding them due to the low or very low quality of the evidence.
23.	SH	Barnet Enfield and Haringey Mental Health Trust	Full	General	General	As the recommendations for psychological intervention are based on low and very low quality RCTs, we feel that the guidelines should acknowledge the need for more research in a range of different modalities and not just furthering the research in CBT-E and Focal Psychodynamic Psychotherapy.	Thank you for your comment. The recommendations for adult anorexia nervosa have been revised to include CBT-ED, MANTRA and SSCM as first-line options with focal psychodynamic therapy (FPT) now recommended as a second-line option. This recommendation was amended to reflect the facts that (i) there is evidence of no difference between these therapies, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. Only two of the research recommendations (see full guideline) specify the treatments that should be the subject of research and as such, they do not discriminate between treatments that should or should not be researched.
24.	SH	Barnet Enfield and Haringey Mental Health Trust	Full	General	General	As these recommendations are based on low and very low quality RCTs, we feel that the guidelines should make a reference to emerging research in different fields such as Compassion Focussed Therapy, Radically Open Dialectic Behavioural Therapy, Schema Therapy, and Dialectic Behavioural Therapy.	Thank you for your comment. The NICE guidelines are based on the best available evidence to guide decision making in health, public health and social care and are updated periodically to reflect the changing evidence base. As such, if studies using these therapies were to be conducted they would of course be considered in any future update to the guideline.
25.	SH	Barnet Enfield and Haringey Mental Health Trust	Full	General	General	The recommendations for psychological interventions appear to be targeting a group of patients that are motivated and ready to make changes. We feel that more could be said to acknowledge those with severe and enduring eating disorders and recommendations made	Thank you for your comment. The Committee recognised that some people may have had an eating disorder for a long time, that it may be severe, and that it can be difficult to conduct studies in this difficult to treat group. However, there was little evidence in relation to this

						for the need for further research with this client group.	group, and the Committee took the view that there was no accepted nor acceptable definition of SEED available in the literature. As such, the Committee was of the view that the same treatment should be offered to people with eating disorders regardless of the severity, and therefore it would not be appropriate to develop a research recommendation for a putative group whose existence they were sceptical of.
26.	SH	Barnet Enfield and Haringey Mental Health Trust	Full	General	General	Although declarations of interest have been made by the committee members, it is not clear the steps that the committee took to ensure that their recommendations were not unduly influenced by their preferred practice and any personal financial gain.	Thank you for your comment. The methodology section (Chapter 3.3) emphasises that when Committee members had a conflict of interest (for example, were authors of paper or manuals) they were required to either withdraw completely or partly for the relevant parts of the discussion. A sentence has been added to make clear that they were sometimes consulted for points of clarification only during the Committee's decision making but did not play a role in it.
27.	SH	BEAT	Full	General	General	We welcome the reference to stigma as a potential barrier to identification of eating disorders in recommendation 1.1.1, but believe that a separate section on stigma in the full guideline would help to communicate its importance to commissioners and health professionals.	Thank you for your comment. Whilst the Committee recommended that healthcare professionals should be aware that people with an eating disorder may be vulnerable to stigma, describing and commenting on the stigma that may be felt, both generally regarding mental health and specifically regarding eating disorders, is beyond the scope of this guideline.
28.	SH	BEAT	Full	General	General	We welcome the reference to early intervention on page 17, but believe that a separate section on early intervention in the full guideline would help to	Thank you for your comment. Whilst there was not a review question which concentrated specifically on the efficacy of early intervention, the chapter on the

						communicate its importance to commissioners and health professionals. This should include some strong opposition to the use of Body Mass Index (BMI) and/or weight-based thresholds to determine whether or not patients are able to access (specialist) treatment.	identification and assessment of eating disorders is relevant to this topic. Referral to services given identification of an eating disorder is discussed in the chapter on the coordination of care. Regarding the use of BMI/weight, it is emphasised that it should not be used as the sole criterion to determine whether treatment should be offered nor whether to admit to day- or in- patient care.
29.	SH	British Psychological Society	Full	General	General	Overall, The Society welcomes this thorough document, which provides comprehensive guidance around the management of eating disorders. It is useful that recommendations have been specified in relation to important areas such as supervision and outcomes monitoring, coordination of care, and the need for monitoring of physical health in people receiving psychological interventions. The guidance also acknowledges significant advances in the evidence base since publication of the previous NICE guideline (e.g. studies on Cognitive Behaviour Therapy – Enhanced / CBT-E, the effectiveness of CBT in routine clinical settings, and the Maudsley Model of Anorexia Nervosa Treatment for Adults / MANTRA).	Thank you for your comment and your support for this guideline.
30.	SH	British Psychological Society	Full	General	General	There were concerns about use of NICE evidence criteria on a technically weak evidence base and then drawing on informed expert opinion in the absence of medium to high quality evidence, rather than considering other forms of published research and clinical evidence more	Thank you for your comment. There are limitations to the quality of evidence, however standard NICE procedures - including GRADE, which is a well-respected method of assessing quality by experts worldwide - have been used, to evaluate the evidence and this has

						carefully. We identified problems with the use of NICE criteria for judging the quality of the evidence base, especially regarding complex and protracted psychological interventions which are not always amenable to rigorous controlled trials, and the exclusion of studies that did not meet rigorous quality criteria for example in terms of type of outcome. This NICE evidence process may be premature in the context of a technically weak evidence base. (See also comments 5-10).	informed the recommendations. The issues you raise in other comments have been responded to as appropriate. It should also be noted that the evidence was not only limited to RCTs and that observational studies were sometimes included (especially in cases where RCTs may be difficult to conduct, see e.g. reviews on coordination of care or refeeding). Please also note that a significant number of research recommendations have been made that are designed to address the limitations in the current evidence base.
31.	SH	British Psychological Society	Full	General	General	The Society has concerns that the research recommendations made are very specific and limited and do not acknowledge the limitations that still exist within the evidence base for treatments for adults with eating disorders in general and anorexia nervosa in particular (despite this limited evidence base being acknowledged within the committee notations on the guidance). Recommendations for further research in the 2004 guidance made reference to the need for 'further adequately powered studies of specific treatments and services for people with Anorexia Nervosa' and we believe that a similar broad recommendation should be included in this updated guidance in relation to all eating disorders. Given the levels of quality and uncertainty regarding treatment of other eating disorders the recommendation should also be made for the same research to be conducted in relation to other	Thank you for your comment. Although more research is needed in many areas, a broad call for research would be too general. The Committee has made a number of further specific research recommendations that were considered to be of urgent national priority relative to the extant evidence.

						disorders, as well as further studies of differences in outcome between eating disorders of different degrees of chronicity and studies of longer term outcome.	
32.	SH	British Psychological Society	Full	General	General	We are concerned that the focus of the outcome evidence is primarily on BMI and weight gain by end of treatment as opposed to longer term follow up outcomes. Most studies did not have a suitable follow up period of time. The real challenge for clinicians in the field is enabling patients to maintain and improve weight gain alongside developing effective responses to distress that are not based on weight loss. For these reasons, we have reservations regarding the methodology used to evaluate the evidence for effective treatment for anorexia nervosa. Consequently, the recommendations made have similar limitations. E.g.: "In adults, individual CBT for eating disorders was more effective at improving body weight and remission versus any other intervention but there was some uncertainty. At 12 months follow-up, the benefits of CBT-ED on body weight and remission were no longer evident. The guideline also leans too far in empowering distal professionals and academics and disempowering people with eating disorders in the limitations regarding the assumptions about important or valuable outcomes. Some other outcomes that may be of value,	Thank you for your comment. The Committee recognised the dearth of evidence regarding the types of treatments that are efficacious for eating disorders and that very few studies have sufficient or the same follow up times. Given the profusion of outcomes in the literature, the Committee chose outcomes for which firstly, there would be at least some comparable data available and secondly, would be useful in deciding between competing interventions. Similarly, regarding the issue of the duration of follow up, the variety in follow up times used in the literature would have made it extremely difficult to evaluate the efficacy of the evaluated interventions. Regarding the comment asserting that people with eating disorders were disempowered in the choice of critical and important outcomes: it should be noted that the Committee included two people with experience of an eating disorder, both of whom played an active role in the evaluation of the evidence. Regarding the view that distal professionals have been too empowered, a wide range of professionals involved in providing treatment and care for people with eating disorders were on the Committee. Whilst it is not practical for every type of

						likely from therapy but hard to evidence include preventative effects (preventing deterioration, maintenance, avoiding admission), because it is hard to distinguish in somebody who's situation is relatively stable whether that is fostering unhealthy dependence or actively addressing problem factors thus preventing deterioration, and also a range of subjective, qualitative experience related to wellbeing and functioning.	professional to be represented on the Committee, the selection of the Committee is transparent in line with the aim of NICE guidelines to provide evidence-based guidance to healthcare professionals and the scope of the relevant guideline. Finally, although the outcomes listed maybe of value, as stated, they are hard to measure. Such outcomes (qualitative data in particular) can be extremely useful in guiding practice. However, evaluating such data was outside the scope of this guideline.
33.	SH	British Psychological Society	Full	General	General	We are concerned that despite using a hard line approach to evaluating evidence and making recommendations based on this source of evidence, the committee freely discusses principles (i.e. not evidence) and makes recommendations that are based on their discussions and opinions without reference to the evidence. This approach is inconsistent and methodologically unsound. As there is very little sound evidence, received clinical wisdom is acceptable but should not be based on the opinions of a limited number of people. E.g. *"The committee had an in-depth discussion about…it was agreed that …" "the committee agreed it was important to say up to 40 sessions…"*	Thank you for your comment. It is recognised that high quality evidence based on RCTs is not always available to guide the guideline committee in developing recommendations. In these circumstances, the committee used informal consensus methods to develop them. As such, the multidisciplinary committee drew on the best available evidence identified through the systematic review that was directly related to the relevant population and interventions as specified in the protocol, as well as other evidence and their own knowledge and experience to develop the recommendations. This approach is in line with the agreed procedure set out in *Developing NICE guidelines: the manual*, which is available for download on the NICE website. In some cases, the Committee decided when drafting the review protocols to include observational studies where they believed they could add value given their knowledge of the extant evidence base (especially for

							questions where it would be difficult or unethical to conduct RCTs such as coordination of care). The approach outlined in the various review protocols was agreed by NICE and therefore followed by the developers. As stakeholders, other interested bodies have the opportunity to comment on, critique, and influence the final guideline itself. Whilst not all types of professional and non-professionals with an interest in eating disorders are represented on the Committee, there were 19 expert, non-expert and lay members, who in accordance with NICE policy provide a broad range of experience and opinion on which to reliably base decisions and recommendations.
34.	SH	The British Dietetic Association	Full	general	general	Numerous typos, references repeated alongside each other and Americanising words in some parts. Recommendation 112 is repeated a number of times.	Thank you for your comment. The typos and references have been amended throughout the guideline. The recommendation is repeated because it applies to each eating disorder (see individual chapters) however this has now been revised.
35.	SH	The British Dietetic Association	Full	general	general	Dietitian is spelt incorrectly throughout the whole document.	Thank you for your comment. The text has been amended throughout the guideline.
36.	SH	The British Dietetic Association	Full	general	general	Worrying bias in sections 6.2, 6.3 and 7.2 as members of the NICE guidelines group wrote the manuals that are being recommended (CBT-ED and MANTRA). I appreciate bias and conflicts of interest are likely to have been considered throughout this process, but I cannot see any discussion of it within the guidelines, and for transparency, I think it needs to be documented.	Thank you for your comment. The actions set out in Appendix B (declarations of interest) at consultation were not fully accurate and the NGA apologises for this error. Where studies or manuals were discussed that involved one of the committee members, they did not participate in decision making and only answered questions on points of clarification. They did not play a role in

							the committee's decision making. The appendix has now been updated accordingly. It should be noted that the recommendations themselves, apart from MANTRA (which has been now recommended as a first-line option for adult anorexia nervosa) do not identify any particular manual as the manual of choice.
37.	SH	British Society of Gastroenterology	Full	General	General	NICE are to be congratulated on the thorough and exhaustive literature search and systematic appraisal of the evidence. It is clear however that virtually the entire evidence base features a quality of evidence (GRADE) that is either low or very low. Therefore no more than a handful of analyses even reach the 'moderate grade'. There is by necessity no good quality evidence on which to base recommendations and the entire document is the opinion of the expert panel. We are concerned that there is unintentional bias in some of the recommendations. There is a bias for example towards CBT therapies particularly for anorexia nervosa when the quality of the evidence is poor. There are statements that particular CBT manuals should be followed and not deviated from. Many of the CBT manuals mentioned have either been, written by or promoted by, members of the committee. We cannot find a table listing potential conflicts of interest. Treatment manuals are marketed commercially. If CBT therapies are mentioned in the guidance, than any involvement in their writing and	Thank you for your comment. Whilst there may be limitations in the use of GRADE, standard NICE practice requires its use, as detailed in *Developing NICE guidelines: the manual*. It is recognised that high quality evidence based on RCTs is not always available to guide the guideline committee in developing recommendations. Generally, when conducting the reviews, the relevant protocols were followed. In some cases, the Committee decided when drafting the review protocols to include observational studies where they believed they could add value given their knowledge of the extant evidence base (especially for questions where it would be difficult or unethical to conduct RCTs such as coordination of care). The approach outlined in the various review protocols was agreed by NICE and therefore followed by the developers. When no evidence of the appropriate design was identified, the committee used informal consensus methods to develop them. As such, the multidisciplinary committee drew on best available evidence identified through the systematic review that was directly

						publication by members of the committee must be stated	related to the relevant population and interventions, as well as other evidence and their own knowledge and experience to develop the recommendations. This approach is in line with the agreed procedure set out in *Developing NICE guidelines: the manual*, which is available for download on the NICE website. Although it is true that the recommendations are developed by the Committee members, public consultation is an opportunity for registered and non-registered stakeholders alike to raise detailed concerns regarding their content which is taken into consideration. The actions set out in Appendix B (declarations of interest) at consultation were not fully accurate and the NGA apologises for this error. Where studies or manuals were discussed that involved one of the committee members, they did not participate in decision making and only answered questions on points of clarification. They did not play a role in the committee's decision making. The appendix has now been updated accordingly. It should be noted that the recommendations do not identify any particular manual with the exception of MANTRA (which has now been recommended as a first-line option treatment for adult anorexia nervosa along with CBT-ED and SSCM). As appears to be indicated, high quality evidence free from bias in the study of mental health is particularly difficult to come by for a variety of reasons (such as

							variety of the difficulty of conducting RCTs, extant measures, high dropout rate, the use of self-report, poor reporting) regardless of whether GRADE or some other quality assessment tool is used. This does not show, however, that the recommendations are 'just' the opinion of the Committee as there can be a high degree of uncertainty regarding the precise estimate of an effect without there being uncertainty of the effect itself (that is, we can be almost certain that treatment A is effective versus treatment B but uncertain as to *how* effective it is). Regarding the use of manuals in the delivery of treatment, whilst they provide a common structure on which to base therapy, it should always be the case that clinicians use their judgement and are responsive to the needs of the individual with the eating disorder rather than uncritically adhering to the printed words of the page.
38.	SH	British Society of Gastroenterology	Full	General	General	The areas likely to have the biggest impact on practice would be: Firstly recommending that patients with anorexia nervosa and extreme malnutrition are looked after by Clinicians with an interest in Nutrition and and experience in managing eating disorder patients. The care of patients will be greatly improved if the MARSIPAN guidelines were followed more closely. In general it provides far more practical information about managing acutely ill patients with anorexia nervosa than the current NICE guideline. NICE should	Thank you for your comment. Generally, please note the recommendations have been substantially revised. Reference to MARSIPAN is made in several recommendations. Regarding the definition of inpatient care, given the variety of services available across the country, the Committee felt that it would not be appropriate to further specify its composition. However, it should be noted that the Committee have made several recommendations that make explicit (1) the right of every person with an eating disorder to have equal access to treatment regardless of where they live,

						recommend much more clearly that MARSIPAN represents the best practical approach to care. It is true that MARSIPAN also suffers from a lack of evidence and can be regarded as the opinion of experts, but in this respect it does not differ from the draft NICE guidelines. As the guideline is imprecise about what is meant by 'inpatient care' the role of Specialist Eating Disorder Units is not recognised and the advice in places seems contradictory. Whilst it is not suggested that all patients with anorexia nervosa should be admitted to Specialist Eating Disorder Units, they are the only psychiatric facility that tends to be able to carry out nasogastric feeding safely. The NICE Guidance should be much more active in suggesting that all patients should have access to an SEDU within reasonable geographical distance. The guidance does not recognise the importance of Nutrition Specialists or Eating Disorder Specialists working together and developing local protocols and guidelines so that the transfer of patients between different facilities occurs smoothly and coherently. Recommendations: The formation of more specialised Eating Disorder Units and joint working with Physicians with nutritional interest would have some financial implications. However, the cost of patients being	(2) the need that all staff involved in refeeding should be adequately trained in the recognition and management of refeeding syndrome, and (3) the need for healthcare professionals to work together to ensure adequate coordination of care, care planning and discharge from inpatient care (if appropriate). Regarding Managed Clinical Networks, no relevant evidence was identified in the evidence review.

						looked after in the private sector is extremely high and experience of working with Managed Clinical Networks in Scotland suggests that this cost can be lowered significantly. The example of Managed Clinical Networks is not discussed in the guidance and should be examined in more detail. The issues that would perhaps help the users implement change and overcome challenges would be compulsory reporting of any death related to an eating disorder. This would show up local variation and would make the public more aware of geographical differences. It would also force commissioners and Health Boards to examine the provision of Specialist Care.	
39.	SH	Interpersonal Psychotherapy UK (IPTUK)	Full	general	general	Specialist Eating Disorder Services in 2getherNHS Trust, Leicestershire Partnership NHS Trust have offered to offer their experiences to the panel. Contact julia.fox-clinch@nhs.net and Debbie.Whight@leicspart.nhs.uk	Thank you for your comment and your offer of support for this guideline.
40.	SH	Manchester Metropolitan University	Full	General	General	References to support my comments above Davis, N. J. (2014). Transcranial stimulation of the developing brain: a plea for extreme caution. *Frontiers in Human Neuroscience*, *8*, 600. Davis, N. J., & van Koningsbruggen, M. (2013). "Non-invasive" brain stimulation is not non-invasive.	Thank you for your comment and references provided. However, none of the references were for RCTs and so they were not included in the review.

						Frontiers in systems neuroscience, *7*, 76. Maslen, H., Pugh, J., & Savulescu, J. (2015). The ethics of deep brain stimulation for the treatment of anorexia nervosa. *Neuroethics*, *8*(3), 215-230. Val-Laillet, D., Aarts, E., Weber, B., Ferrari, M., Quaresima, V., Stoeckel, L. E., ... & Stice, E. (2015). Neuroimaging and neuromodulation approaches to study eating behavior and prevent and treat eating disorders and obesity. *NeuroImage: Clinical*, *8*, 1-31. Widdows, K. C., & Davis, N. J. (2014). Ethical considerations in using brain stimulation to treat eating disorders. *Frontiers in behavioral neuroscience*, *8,* 351.	
41.	SH	Mental Health Foundation	Full	General	General	We are concerned that at 989 pages long (including appendices), the guidance is too long and therefore inaccessible for most health professionals, especially when this is compared with 261 pages published in the 2004 guidance.	Thank you for your comment. There has been substantially more research published in the 12 or so years since the publication of the last guideline. A short version of the guideline detailing the recommendations only is available for download from the NICE website. A version of the guideline named 'Information for the public' is intended for people without specialist medical knowledge and will be available for download via the NICE website.

42.	SH	Mental Health Foundation	Full	General	General	The use of the word 'suffer' or 'sufferers' should be removed from all guidance on eating disorders, and mental health more generally, as it reinforces the pervasive stigma. Below are examples of its use in the full guidance. Page 17 line 8 ('Those who suffer from eating disorders') and 14 ('loved ones also suffer as a result of the eating disorder'). Page 24 line 10 and 16 ('male sufferers'). Page 26 line 7 ('Sufferers are able to keep the problem secret for many years'). Page 33 line 42 ('direct financial burden to sufferers and carers'). Page 106 line 25 ('challenging for sufferers and families to manage') We would suggest using 'those living with' or 'people with lived experience'.	Thank you for your comment. The text has been amended throughout the guideline.
43.	SH	Mental Health Foundation	Full	General	General	We would like to draw attention to the interchanging use of EDNOS and OSFED; this needs to be consistent throughout the guidance. As OSFED is used in the DSM, we would like to see this as the only reference in the recommendations; this would also ensure the guidance is in line with the most up to date literature.	Thank you for your comment. Although the Committee recognised that DSM-V has recently changed its diagnostic categories to the current OSFED designation, it was felt that to only use this would be misleading as they are not co-extensive and that the majority of the published research used the EDNOS category of DSM-IV.

						Although NICE recognise the terms are used interchangeably, we argue it would be more transparent to both address the interchangeableness but to them chose one and use it consistently.	
44.	SH	Scottish Eating Disorder Interest Group	Full	General	General	The Scottish Eating Disorder Interest Group welcome a number of recommendations in the draft NICE guideline for eating disorders, particularly the clear consideration of the role of carers and family and advice pertaining to the full range of eating disorder presentations. However, we would like to note some concerns regarding any clinical guidance or recommendations which are predominantly based around one therapeutic modality e.g. CBT. SEDIG is strongly in favour of evidence based practice, but also the need for treatment choice for service users instead of a one size fits all approach. While we acknowledge the need for more research into stepped care models, this will take a number of years to develop. Clinicians, commissioners and service users need support and guidance for alternative or secondary therapeutic modalities based on the current evidence base. Such advice has been present in previous NICE guidance e.g. highlighting psychological therapies such as IPT-BN where equivalent levels of remission to CBT were met at longer term follow up. We would welcome such guidance from the expert group to support clinicians, service users and their families, in making informed decisions	Thank you for your comment. The Committee has revised its initial recommendations to include other types of therapies. In particular, the recommendations for adult anorexia nervosa have been amended to consider MANTRA and SSCM in addition to individual CBT-ED as first-line options to reflect the fact that there is evidence of no difference between these therapies; the Committee recognised that implementing the provision of focal psychodynamic therapy could have significant cost implications for services and partly for this reason revised their recommendation to include it as a second-line alternative treatment if CBT-ED, MANTRA and SSCM prove unacceptable or ineffective, or are contraindicated. The recommendations for young people with bulimia nervosa have been amended to consider individual CBT-ED as a second-line alternative to family therapy (rather than guided self-help) due to (i) the reclassification by the committee of the guided self-help arm in Schmidt et al. 2007 as a form of individual CBT-ED and (ii) to allow for the provision of individual psychological treatment. The recommendations for adults with BED have also been amended to add

						and have concerns that without this, the clinical utility of these guidelines is hugely reduced.	individual CBT-ED as a third-line option after guided self-help and group CBT-ED because the committee recognised that it may be difficult to recruit sufficient numbers of people to form a group and that some form of individual therapy should be considered.
45.	SH	Scottish Eating Disorder Interest Group	Full	General	General	While we welcome the use of robust systematic review methodology, we are unclear why some methodological information was unable to be obtained as part of the risk of bias ratings, when the authors of some of these studies were an active part of the expert group. Taking into account the poor research quality across the board, we would have thought that clarification of this information would have been sought to support a more robust risk of bias assessment.	Thank you for your comment. While it is true that some of the research on which the recommendations are based was authored or co-authored by members of the Committee, methodological information regarding the design of the trial (in particular information necessary to evaluate risk of bias) was gleaned solely from the published evidence. This was to avoid studies completed by committee members being given undue advantage over other studies.
46.	SH	Somerset Partnership NHS Foundation Trust	Full	General	General	Evidence contained within Table. 71 (page 204) and Table. 168 (pages 419-422) refers to two interventions entitled 'CBT-ED. 1' and 'CBT-ED.2'. The following papers are cited as presenting evidence using these interventions; Dalle Grace 2012; Bulik 1998/McIntosh 2011; Fairburn 2009; Wilson 1991. Although a comment is made that the difference between these interventions relates to a 'variation in content', it seems unclear from the information provided the exact nature of these variations. We have been unable to locate these references in Section 11 (page 929) of the guidance in order to gain a clearer understanding. As the guidance currently cites a CBT	Thank you for your comment. The missing references have now been included.

						approach as first line in many of the eating disorder presentations, it would be helpful to know the exact CBT interventions which have proved effective.	
47.	SH	Somerset Partnership NHS Foundation Trust	Full	General	General	These guidelines have provided a helpful and thorough review of much of the available evidence regarding the treatments available for eating disorders. However, as a specialist service, we feel that they do not fully reflect our experience of working with this client population. In particular, our experience is that the complexity arising from high levels of both physical and psychiatric comorbidity (noted on pages 27-28) often poses significant challenges to the delivery and effectiveness of the interventions identified. In practice, we find a flexible, multidisciplinary team approach critical in meeting these challenges, and adapting manualised approaches accordingly to meet our clients' needs. Whilst we accept that this stance is in part reflected in the research recommendations (p.988, l.13), and is also mentioned on p.844, we are concerned that this need for clinical flexibility and a skilled, multidisciplinary approach in these circumstances is not sufficiently highlighted.	Thank you for your comment. Whilst physical and/or psychiatric comorbidities are common in people with eating disorders, very little evidence was found on how treatments for primary eating disorders might be modified in light of such secondary comorbidities (especially psychiatric ones); please note that the issue of how to treat people with a particular condition where the eating disorder is a secondary comorbidity was outside the scope of this guideline (please refer to the relevant NICE guidelines). Regarding the use of manuals, clinicians should not blindly apply the manual and it should always be the case that they both use their judgement in delivering a manual-based intervention and are sensitive to the needs of the individual with the eating disorder.
48.	SH	South Staffordshire and Shropshire NHS Foundation Trust	Full	General	General	We were surprised to see that CFT was not mentioned when initial studies seem to be showing promise with those patients who have a fear lack of self-compassion and we are piloting this approach with our severe and enduring	Thank you for your comment. Unfortunately, no comparative trials (which are the most reliable types of evidence for evaluating the effectiveness of an intervention) of compassion focused therapy for eating disorders were

						patients for whom “treatment as usual” does not seem effective.	identified and were therefore not included in the review.
49.	SH	South Staffordshire and Shropshire NHS Foundation Trust	Full	General	General	We were wondering why avoidant restrictive food intake wasn’t covered given that it is now included in the DSM V as we are now receiving referrals for this sub group of eating disorders.	Thank you for your comment. Avoidant restrictive food intake, which was not classified as an eating disorder in the DSM-IV and ICD-10, was outside the scope of the guideline and therefore not included.
50.	SH	The Tuke Centre, part of The Retreat, York	Full	General	General	There is a big gap between evidence (largely poor /very poor) and recommendations made.	Thank you for your comment. Please note that the recommendations have been substantially revised. It is recognised that the majority of outcomes on which the recommendations are based were rated in GRADE as 'very low' or 'low' quality. However GRADE ratings have a particular technical significance as they take into account factors such as risk of bias, sample size, uncertainty of the effect estimate and publication bias. When making their recommendations, the Committee discussed and evaluated the available data according to the effect estimates, GRADE ratings and other features (such as idiosyncrasies in the studies not easily captured in GRADE) in order to produce them. Where there was insufficient evidence on which to base their recommendations, the Committee used their expert knowledge and experience to develop them (see the LETR sections in the full guideline for further details). The recommendations use 'offer' and 'consider' as indicators of their level of certainty in line with NICE's preferred methods (See *Developing NICE guidelines: the manual*). As can be observed, the majority of the recommendations use the word 'consider'

							rather than 'offer' reflecting the fact that there is some uncertainty regarding them due to the low or very low quality of the evidence.
51.	SH	The Tuke Centre, part of The Retreat, York	Full	General	General	There is clear conflict of interest in places. E.g. A committee member being the author of the manual which is recommended for all EDs despite poor evidence.	Thank you for your comment. The actions set out in Appendix B (declarations of interest) at consultation were not fully accurate and the NGA apologises for this error. Where studies or manuals were discussed that involved one of the committee members, they did not participate in decision making and only answered questions on points of clarification. They did not play a role in the committee's decision making. The appendix has now been updated accordingly. It should be noted that the recommendations themselves do not identify any particular manual (with the exception of MANTRA, which has now been recommended as a first-line option for adult anorexia nervosa, in addition to CBT-ED and SSCM). These recommendations were amended to reflect the fact that there is evidence of no difference between these therapies, and there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision.
52.	SH	The Tuke Centre, part of The Retreat, York	Full	General	General	The apparent conclusion that some evidence however poor is better that none although this rule appears to be applied arbitrarily e.g. Just as little evidence for IPT as CBT-E for AN but IPT not even mentioned as second line	Thank you for your comment. Please note that the recommendations for the treatment of adult anorexia nervosa have been revised to include MANTRA and SSCM in addition to CBT-ED as first line options, and focal psychodynamic therapy as second line option. These

						treatment in short version.	recommendations were amended to reflect the fact that there is evidence of no difference between these therapies, and there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision, The Committee did not recommend IPT because although there is evidence of no difference between IPT and CBT or SSCM (McIntosh 2005/Carter 2011) at end of treatment and long-term follow up, this was the only study identified that compared IPT with other interventions. By contrast, there were several studies that examined the use of CBT-ED versus other interventions (e.g. Dalle Grave 2013, Hall 1987, McIntosh 2005/Carter 2011, Pike 2003, Touyz 2013, Zipfel 2014). Hence, the Committee were more convinced overall that CBT-ED was effective. Similarly, there were several studies that examined the effectiveness of MANTRA and/or SSCM (Macintosh 2005/Carter 2011, Schmidt 2012, Schmidt 2015, Touyz 2013, Treasure 1995).
53.	SH	The Tuke Centre, part of The Retreat, York	Full	General	General	There is very little written re-inpatient or day patient care. I still can't find it in the long version. In the short version the points appear to indicate that patients should only be admitted if they are physically compromised or suicidal. The implication (although this is not clearly stated) is that once the risk is eliminated they should be discharged within four weeks although later on it does say that patients should not discharged just	Thank you for your comment. Due to wide regional variation in the structure of healthcare services, and the lack of comparative trials amongst the various types of inpatient scenarios, the Committee did not feel that they could specify further the type of inpatient setting in which treatment should be provided. Note that treatment in an inpatient setting is discussed in the sections on the treatment of physical

						because they have reached a healthy weight.	complications and compulsory treatment. For discussion of different settings (e.g. inpatient vs day care) please see chapter 5.
54.	SH	The Tuke Centre, part of The Retreat, York	Full	General	General	These guidelines will form the basis of commissioning for EDs. Commissioners will look to them for guidance. As they stand they are confusing and contradictory and yet prescriptive and reductionist at the same time. We still don't know what helps people to recover from eating disorders and that is the message that is missing. As it stands the guideline tells us that, for adults, CBT-ED for all EDs or brief focal PT (just for AN) are the gold standard treatments. The guideline does not say what to do if they don't work.	Thank you for your comment. The recommendations have been revised to include CBT-ED, MANTRA and SSCM as first-line interventions, and focal psychodynamic therapy as a second line intervention. These recommendations were amended to reflect the fact that there is evidence of no difference between these therapies, and there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision.
55.	SH	The Tuke Centre, part of The Retreat, York	Full	General	General	Comorbidities are extremely common. Estimated rates of Personality Disorder in ED patient populations: 30%. A brief mention but no guidance. Same with autism spectrum disorders.	Thank you for your comment. The Committee recognised that comorbidities are extremely common but, due to the lack of trials examining how eating disorder treatments should be modified in light of a comorbidity, did not feel it appropriate to offer explicit guidance. However, a research recommendation calling for such research was made.
56.	SH	The Tuke Centre, part of The Retreat, York	Full	General	General	Section on coordination of care is good.	Thank you for your comment
57.	SH	The Tuke Centre, part of The Retreat, York	Full	General	General	The point made re- no absolute weight or BMI threshold for admission is good.	Thank you for your comment
58.	SH	The Tuke Centre, part of The Retreat, York	Full	General	General	Guidance on osteoporosis is good.	Thank you for your comment

59.	SH	The Tuke Centre, part of The Retreat, York	Full	General	General	Dietitian is spelt incorrectly throughout the whole document.	Thank you for your comment. The text has been amended throughout the guideline.
60.	SH	NHS Greater Glasgow and Clyde	Full	General	General	Should we be including guidance on driving from the DVLA document (2016)? This is particularly important for patients at low weight or high physical instability.	Thank you for your comment however this issue is outside the scope of the guideline.
61.	SH	British Society of Gastroenterology	Full	6	Lines 25–27	Professionals who assess and treat eating disorders should be competent to do this for the age group they care for. What is meant by 'competent'?	Thank you for your comment. It is a requirement for all practitioners working within the NHS or any healthcare system to be trained according to the relevant standards in the interventions and procedures they are delivering to the persons in their care.
62.	SH	British Psychological Society	Full	17-20	1, 20	In a departure from previous guidelines the revision includes a preface including a strong editorial stance, a literature review and important and explicit empirical claims. We are uncertain whether the preface to the NICE guideline is the best place for an article of this type and consistent with their scope. A lack of continuity results as in contrast to the main guideline, it is not clear how the committee determined what were the most important developments in the field between 2004 and 2016, how the literature search was conducted, how the strength of the evidence was assessed for the empirical claims and how the evidence was weighed to obtain the consensus statement, which are strengths of the main guideline. We recommend that the format of the introduction to the document be reviewed, and that the short guidelines be harmonised more closely with the introduction of the full guidelines.	Thank you for your comment. In the drafting of the introduction, the Committee felt that much of the potential content of the introduction was still appropriate for inclusion somewhere in the guideline. The committee took the view that, rather than undertaking a major revision of introduction, it was preferable to provide a preface. Please note that some changes (including the addition of references) to the preface have been made. Please also note the short guideline has been substantially revised and it is hoped that it is more in harmony with the full guideline.

63.	SH	British Psychological Society	Full	17	36-47	The Society has concerns that the evidence base for the maintaining factors is not cited, and that individual/idiosyncratic maintaining factors are not acknowledged (only those applying at the group/cluster level) and that evidence based interpersonal and environmental factors may be missing from the list. We recommend that the evidence be cited, or the content be removed or that it be presented more cautiously as a set of provisional potential maintaining factors of which there may be others. Arguing that they are the maintaining factors are empirically grounded because they are manipulated in effective treatment is reasonable but not strong because the treatment studies were not designed or powered specifically to test some maintaining factors and exclude other hypotheses regarding mechanism of change and the factors are confounded in the absence of dismantling studies.	Thank you for your comment. The list is not intended to be exhaustive and the sentence has been amended to make this clear.
64.	SH	BEAT	Full	17	4-5	The use of the phrase "prevalence rate" is unusual as it is ambiguous and is not a commonly used epidemiological term. Was this sentence intended to refer to incidence? If the intention was to say that the 'prevalence' of eating disorders has been "relatively stable" over time then given the lack of evidence around prevalence in the UK, there isn't sufficient evidence to support such a claim.	Thank you for your comment. The word 'rate' as been deleted and references have been included.
65.	SH	BEAT	Full	17	16-17	If citing this source the guideline should be clear that this 90% figure relates to	Thank you for your comment. The text has been amended to clarify this point.

						cases presenting in some clinical samples, and is not a reliable estimate for the total prevalence of eating disorders in males in the community.	
66.	SH	College of Occupational Therapists	Full	17	46-47	**1.** We are concerned that occupational behaviours are not included in the list of behaviours that maintain the eating disorders. We believe that it is important to clearly identify common occupational behaviours that maintain eating disorders so they are effectively addressed during treatment. We therefore recommend that occupational behaviours are included in line 46-47 as below – *(see recommended inclusions in red italics)* • Behaviours that maintain the problem (avoidance of food, purging behaviours, body checking , *avoidance of adaptive self-care, productivity, leisure and rest activities including eating with others, adaptive meal preparation, social or body-centric activities or other anxiety-provoking activities of daily living*) **2.** We are concerned that the draft guideline minimises the importance of identifying common impairments to occupational participation and performance experienced by people with eating disorders. o We regard terms such as 'general functioning' and 'return	Thank you for your comment. The list of maintaining factors is not intended to be exhaustive and we consider that several of the suggested additions to the list are covered by those already there. For example, anxiety is already mentioned, whilst avoidance of eating with others may plausibly be included under 'social isolation' or 'behaviours that maintain the problem'. Regarding the use of the term 'general functioning' and 'return to normal activities...': it is a widely used term in the literature and many of the available measures (such as SF-36) have several subscales intended to assess people's general functioning/quality of life in a variety of specific ways related to people's everyday lives.

						to normal activities and self-efficacy' used throughout this guideline as too vague and lacking in important detail. ○ We therefore request that terms such as 'general functioning' and 'return to normal functioning' are re-defined as *participation in adaptive self-care, productivity, leisure and rest activities* throughout the guideline.	
67.	SH	North Essex Partnership NHS Foundation Trust	Full	17	11	Risk of early death statement needs a reference	Thank you for your comment. A reference has been included.
68.	SH	North Essex Partnership NHS Foundation Trust	Full	17	17	Please specify what criteria is being used (I assume ICD-10 yet ARFID is mentioned on page 19 (which is from DSM)	Thank you for your comment. The estimate for the UK, which uses data for hospital admissions from 2012-2013, uses the ICD-10 classification system.
69.	SH	BEAT	Full	17	19	The remaining comments on the Full guideline are solely concerning typographical errors. Typographical error - the word "of" has been used instead of "or".	Thank you for your comment, this has been amended as suggested.
70.	SH	NHS Greater Glasgow and Clyde	Full	17	19	Used 'of' instead of 'or'	Thank you for your comment, this has been amended as suggested.
71.	SH	Mental Health Foundation	Full	17	16 & 17	More up to date references are available than Fairburn and Harrison, 2003, which is cited for the point that, 'About 90% of cases in the UK are female and most are of normal weight or above (only 17 about 15-20% meet criteria for anorexia nervosa)'. For example, evidence from Beat (2015) cited on line 11 of the same	Thank you for your comment. A reference to Beat (2015) has been added. The Committee declined to cite Hudson 2007 in this context because it does not use full diagnosis as a criteria for bulimia nervosa and was not conducted in a UK context.

						page could be used instead as a more up to date reference. The guidance does not reflect the fact the cited figure has been disputed; prevalence rates among males are argued to be significantly higher at 25% (Hudson, Hiripi, Pope & Kessler, 2007).	
72.	SH	BEAT	Full	18	26-31	This paragraph is not suitably worded. It is important that all users of the guideline understand that - even if a clear neurobiological underpinning to Anorexia nervosa or any other eating disorder is identified - neurobiology is not destiny and the way the brain functions can be altered with nutrition, psychological therapy and a supportive environment.	Thank you for your comment. The text has been amended to emphasise that interventions can affect the physical health, cognitive, emotional and interpersonal outcomes of people with eating disorders.
73.	SH	BEAT	Full	18	43-45	This is an understandable rationale, however we are concerned about the risk that the narrower focus of this guideline could restrict the development of new and potentially effective psychotherapies in future, by limiting research funding and opportunities for the development of 'practice-based evidence'. To mitigate this risk, we ask that a research recommendation be included to encourage the continued development of other or new psychotherapies which may yet prove to be highly effective for patients with eating disorders. It is also important that the guideline is reviewed regularly so that the recommendations can be modified if necessary to reflect any new developments in the evidence-base which may occur for other therapies (for example regarding Radically Open-	Thank you for your comment. A number of recommendations were made regarding further treatments for eating disorders, which are not limited to current interventions that might be dealt with in this guideline and that have some empirical support.

						Dialectical Behaviour Therapy (RO-DBT)).	
74.	SH	College of Occupational Therapists	Full	18	24-26	We are concerned that occupational aspects are not included in the list of benefits of nutritional restoration We believe that it is important to specify that nutritional restoration maximises the opportunity for improved occupational participation and performance. We therefore recommend that occupational factors are included in lines 24-26 as below – • 'Its impact is: biological (e.g. resumption of menstruation and repair of bone structure; cognitive (e.g. flexibility of thought); emotional (e.g. stabilisation of mood); interpersonal (e.g. restoration of social skills) *and occupational (e.g. improved participation in adaptive self-care, productivity, leisure and rest activities).'*	Thank you for your comment. The text has been amended to take away the implication that the impact of nutritional restoration is limited to *only* biological, emotional and interpersonal benefits.
75.	SH	BEAT	Full	18	30-31	The statement that "…clinicians, should not regard anorexia nervosa as a 'diagnosis of despair'" does not go far enough. There is an important opportunity here to refute some healthcare professionals unfounded and dangerous negative views about prognosis in a more decisive way. Instead the guideline should make a clear statement that recovery or remission is possible and that a sense of hope can be incredibly powerful to that endeavour.	Thank you for your comment. The text has been amended to emphasise that such a diagnosis is certainly not one of despair. The committee declined to include a further statement as suggested.

76.	SH	NHS Greater Glasgow and Clyde	Full	18	19	Doesn't specify what the acronym ARFID is	Thank you for your comment, this has been added to the abbreviations list.
77.	SH	NHS Greater Glasgow and Clyde	Full	19	30-39	References repeated twice after information	Thank you for your comment. The references have all been fixed.
78.	SH	British Psychological Society	Full	19	40-47	We have concerns that the language with which 'therapist drift' is described is too basic. We share the committee's concern that evidence based therapies are not consistently available and the preliminary evidence to suggest that this may be in part due to avoidance of effective approaches due to unjustified obstacles that can be addressed, for example by high quality training and supervision. The recommended therapy approaches are among the best first line options and should be rapidly available to anybody who wants and needs them. However, we are concerned at an implicit assumption that 'therapist drift' is the only reason different choices get made and whether the evidence shows that in all cases. The wishes and needs of people with eating disorders also need to be considered.	Thank you for your comment. The text has been amended to remove the implication that therapist drift is the only reason that "different choices get made".
79.	SH	British Psychological Society	Full	19 20	6-8 and 1-3	We are concerned that this statement is too 'black and white' and unqualified, and has problematic logical consequences. Given the variety of outcomes associated with even the best treatments the implication is the guidelines recommend treatments causing widespread harm, whilst other approaches not recommended are nevertheless effective for some people, thus the guidelines	Thank you for your comment. It is not clear which sentences you are referring to as the sentence on p. 19 is a statement regarding some of the studies that will be reviewed, whilst the sentence on p. 20 is a statement that the use of therapies for which there is no robust evidence can be both costly and harmful. The evaluation of the quality of the studies included in this guideline uses

						proscribe against preventing harm. The dichotomous approach to a continuum of strength of evidence noted above creates this unintended implication. We recommend that the statement be made more cautiously with an acknowledgement that more evidence is needed regarding the rates at which these outcomes occur in different therapies (perhaps they should be important or critical outcomes in future studies).	the GRADE system for intervention reviews, which is in line with standard NICE practice. It should be noted that the committee has developed several research recommendations concerning what they believe to be the most important unresolved topics, in particular where there is a conspicuous lack of evidence.
80.	SH	British Psychological Society	Full	19	20-21	Given the risks of pathologising overweight individuals, we recommend that here and elsewhere it be made clear that obesity is not only excluded because it is the subject of other guidelines, but also, crucially, because it is not of itself an eating disorder or a psychiatric disorder of any kind, although some people with obesity also have eating disorders.	Thank you for your comment. The text has been amended throughout the guideline to make it clear that obesity without an eating disorder is not a psychiatric disorder.
81.	SH	BEAT	Full	19	19	Typographical error - the reference has been duplicated.	Thank you for your comment. The references have all been fixed.
82.	SH	North Essex Partnership NHS Foundation Trust	Full	19	22	I would have expected to see reference to the House et al (2012) study here	Thank you for your comment. The reference, and a bullet point noting that specialist outpatient eating services have lower rates of case identification has been added in response to your comment.
83.	SH	BEAT	Full	19	26	Typographical error with reference	Thank you for your comment. The references have all been fixed.
84.	SH	NHS Greater Glasgow and Clyde	Full	19	26	Waller et al reference not dated	Thank you for your comment, this has been amended to include the date.
85.	SH	BEAT	Full	19	30-31;33-35; 38	Typographical errors with references	Thank you for your comment. The references have all been fixed.

86.	SH	BEAT	Full	19	41; 43-44	Typographical error with references	Thank you for your comment. The references have all been fixed.
87.	SH	British Society of Gastroenterology	Full	19	27–39	Evidence of treatment delivery. The repeated assertion that there are 'evidence based' therapies needs to be defined more carefully. None of the evidence contained within the NICE guidance reaches particularly strong levels. Most is ranked low or very low. In this context it would be useful to define more clearly what is meant by 'evidence based' therapy. The fact that they are referred to as 'evidence based' may give them a preferential position in the mind of the reader, but there are other therapies such as drug therapies, which are dismissed because there is a poor evidence base.	Thank you for your comment. The term 'evidence-based' is widely used and although, as noted, the evidence for the recommended interventions is often rated as 'low' is 'very low', these GRADE ratings have a specific technical meaning that take into account a variety of factors such as risk of bias, sample size, uncertainty of the effect estimate, and publication bias. This is referenced in the methods chapter of the full guideline. With regards to pharmacological interventions, the Committee did not recommend any for the treatment of any eating disorder because there was little evidence that they (alone or in combination with psychological interventions) were particularly effective, the risk of adverse events, and/or their cost.
88.	SH	British Society of Gastroenterology	Full	19	40–47	This paragraph contains jargon such as 'therapist drift'. Whilst this may be a term recognised by Psychiatrists its precise meaning to other Clinicians may not be clear. It is commented that 'Clinicians commonly dismiss evidence based practice as not relevant to their clinical setting and therefore routinely employ unevidenced therapeutic approaches'. The guideline as a whole seems to suggest that the evidence quality for <u>all</u> treatments is extremely poor in eating disorders. The precise meaning of this paragraph therefore needs to be spelt out in more detail.	Thank you for your comment. The term has been explained after its use in the introduction.

89.	SH	College of Occupational Therapists	Full	20	21	**1.** We are concerned that guideline committee did not include an Occupational Therapist and that no national or international Occupational Therapy expert was asked to contribute. ○ We are therefore very concerned that the wealth of occupation-focussed expert opinion generated over the last 50 years has been completely overlooked depriving patients, carers and other professionals of the benefits of occupation-focussed knowledge and specialist application to eating disorders. ○ Without occupation-focussed expert opinion inclusions we believe the guideline cannot claim true equal opportunities for all professionals involved in treating people with eating disorders and true multi-disciplinary representation. For example, we are surprised that Dentistry has been represented on the committee despite the fact that dentists have very limited contact with people with eating in comparison to Occupational Therapists. **2.** We are concerned about the total absence of clearly identified occupation-focussed interventions within the guideline.	Thank you for your comment. Advertisement for membership of the Committee, complete with relevant role description and person specification was made public. The composition of the Committee was determined by the scope of the guideline, which was subject to consultation. In determining the composition of the group, the selection process was carefully conducted to ensure that the group was (i) broadly representative consisting of both professionals and non-professionals, and (ii) of a size that would enable effective group discussions. Both these aims were met in our selection of 20 individuals. Extending the membership further would have likely made the discussion and consideration of evidence considerably more difficult. In any case, as you are aware, the guideline and the recommendations contained therein are open and subject to stakeholder comments and it would be expected that concerned individuals/groups would bring their experience to bear in commenting on them. Such stakeholder comments are an essential and invaluable part of crafting NICE guidelines and have a significant impact on their final form. Regarding your provided references, given the systematic nature of the NICE process in researching and writing guidelines, it would not be appropriate to include them as a matter of course, especially given that there do not appear to be any RCTs (which were specified in the majority of the protocols) that

						○ We define 'occupation-focussed' interventions as interventions that enable people to carry out activities they need, want or are expected to do in their daily life' *(College of Occupations Therapists Professional standards for Occupational Therapy Practice, 2017).* ○ Occupation-focussed interventions for people with eating disorders include psychoeducational, experiential, creative, social and recreational activity-based interventions that improve self-efficacy and participation in adaptive eating, meal preparation, self-care, productivity, leisure and rest activities and independent activities of daily living. ○ We therefore request the guideline includes the best available evidence for occupation-focussed interventions by including the range of expert opinion additions provided in this contribution (see recommendations). **3.** We are concerned that Occupational Therapy is cited only once within the full and short guidelines as part of a study (Crisp 1991) - see table on page 110.	examine the efficacy of occupation-focussed interventions in the treatment of eating disorders. In particular, five of the studies you cite (Kong et al. 2005; Olmsted et al., 2002; Tantilllo et al., 2009; Williamson et al., 2001; Zeek 2004/2011) were included in the review of coordination of care. Of the remaining studies you cite: Rummel-Kluge et al. (2013) was a questionnaire-based study of healthcare professionals (and not service users) who work in a general psychiatric hospital setting (and only 6 professionals that work in eating disorder services). It thus would not have been included in any of the reviews. Lock et al. (2012) does not have a comparison group and so would not have been included in the review on nutritional interventions; Quiles-Cestari & Rebeiro (2012) compares anorexia nervosa group with healthy controls, so would not have been included; there is no clear intervention in Rymaszewska et al . (2012), so this would not have been included; Elliot et al. (2012) and Lock & Pepin (2011) are narrative reviews, and so would not have been included in any of the reviews in this guideline. Finally, it was not possible to obtain Gogarty & Brangan (2004).

						○ We acknowledge that Occupational Therapy interventions are not yet supported by high quality evidence, but we argue that this is due to the lack of funded research opportunities. We therefore assert the need to include the best available evidence for occupation-focussed interventions that seek to enable people with eating disorders to participate in adaptive self-care, productivity, leisure and rest activities via experiential activity involving graded exposure. ○ Patients repeatedly commend the utility and efficacy of occupation-focussed interventions. They are particularly valued by lower functioning inpatients and day patients including those with under-developed independent living skills or significant psycho-social impairments including autism, learning disability or physical disabilities. ○ Many patients fail to achieve occupational self-efficacy through purely psychologically-focused interventions alone. They need specialist support to 'do the doing' by experts in	

						practical, experiential enablement via activity-based interventions. o For example: a low quality empirically validated study by Rummel-Kluge, Kluge & Kissling (2013) explores the frequency & relevance of psycho-education in German eating disorder services for adults and concludes that service users rank Occupational Therapy interventions as 2nd most relevant therapy, despite the lack of high quality evidence. **4.** We are concerned that the 'best available' evidence for occupation-focussed interventions has not been included in the guideline and we would recommend the following is included: a) Eating and meal preparation group for adult inpatient and day-patients Evidence for this includes: o A naturalistic pilot study that demonstrates the effectiveness of an experiential Occupational Therapy Meal Preparation Group for inpatients & day patients. This paper explains the methodology and provides an outcome tool -	

						the Eating and Meal Preparation Skills Assessment (Lock, Williams, Bamford & Lacey, 2012) o Cooking cited in three studies (Kong 2005 on page 111, Zeek 2004 and 2011 on page 118) o Meal planning is cited in Williamson et al 2001, page 156 o Interventions including meals and daily living skills is cited as efficacious (Tantillo 2009) (on page 117) b) Lifestyle interventions for adult and adolescent inpatients and day-patients No specific outcome study exists for these occupation-focussed interventions but there are studies that allude to their benefits plus several expert opinion papers suggesting they are efficacious. For instance: o Williamson et al cites the efficacy of 'activity therapy' (2001) (see page 156) o Olmsted (2002) cites the efficacy of experiential interventions (see page 116)	

						○ Tantillo (2009) cites the importance of case management intervention to improve problem-solving and daily living skills, support groups, meals, and transportation to appointments/events in the community ○ Quiles-Cestari LM & Rebeiro RP (2012) cites the impaired occupational roles of women with anorexia nervosa. ○ *Gogarty & Brangan (2004) explores the impact of eating disorders on occupational performance.* ○ Elliot, Michelle L. (2012) explores the figured world of eating disorders: Occupation of illness ○ Rymaszewska J & Mazurek J (2012) The social and occupational functioning of outpatients from mental health services *Advances in Clinical and Experimental Medicine March April 2012 vol/iss 21/2 215-223) 1899-5276* ○ The importance of lifestyle and daily living skill	

						interventions and occupation-focussed intervention for young people are cited in Lock & Pepin (2011)	
90.	SH	British Society of Gastroenterology	Full	23	General	The introduction has a very useful statement about eating disorders and the current knowledge base.	Thank you for your comment and your support for the guideline.
91.	SH	BEAT	Full	23	28-35	It would strengthen this section if the issue of comorbidities could be included and the issue of the increased costs to the NHS which are incurred when treatment is not offered early (or delivered effectively).	Thank you for your comment. The economic costs associated with eating disorders are considered in Chapter 2, section 'The use of health service resources'.
92.	SH	BEAT	Full	23	10-12	A source should be included to support this statement: "The majority of individuals with eating disorders (80-85%) are not underweight…"	Thank you for your comment. A reference has been inserted as requested.
93.	SH	BEAT	Full	23	44-45	Here the guideline should stress that the decision of which approach to take (from family-based to focussed on the individual as agent of change) should be based on the developmental stage of the young person and should not be determined solely by whether they have reached the age of 18 or not, as is frequently the case in practice.	Thank you for your comment. A sentence has been inserted earlier in this paragraph to stress that the treatment should be sensitive to both the age and developmental level of the person.
94.	SH	College of Occupational Therapists	Full	23	6-7	We recommend the sentence should be amended to include occupational impairments (see red italic section below) 'The relevant behaviours include, restriction of dietary intake: overeating with a sense of loss or control: *impaired participation in adaptive self-care, productivity, leisure and rest activities* plus compensatory behaviours (e.g. vomiting, exercise, laxative abuse)'.	Thank you for your comment. Impaired participation in adaptive self-care, productivity, leisure and rest activities, unlike those listed in the main text, are not specific to eating disorders in a diagnostic context (though may be a consequence of engaging in the relevant behaviours). Hence, it would not be appropriate to include the suggested

							phrases in a paragraph about the definition of an eating disorder.
95.	SH	BEAT	Full	24	19-27	The guideline should be clear in its wording when the epidemiological sources it is citing refer to cases identified by health services/professionals as opposed to those within the community. For example, lines 26-27 would be more accurately written as "The incidence of anorexia nervosa (identified by GPs) in the UK appears to have remained stable over the past decade, with a peak age of onset (when identified) of 15-19 years" (Micali et al., 2013).	Thank you for your comment. The text has been amended to make clear that the source of the estimate is from health professionals.
96.	SH	BEAT	Full	24	20-22	Typographical error with references	Thank you for your comment. All references have been fixed.
97.	SH	BEAT	Full	24	19-20	The van Hoeken et al (2003) source which has been cited here generated these point prevalence estimates by calculating averages from several studies conducted in various countries. Therefore, the wording used should reflect that these estimates are not derived directly from studies of the UK population. It is important that the lack of epidemiological evidence about eating disorders in the UK population is highlighted to policy makers and funders to help support efforts to rectify this.	Thank you for your comment. The text has been amended to reflect that the estimate pertains to Western Europe and the US.
98.	SH	British Society of Gastroenterology	Full	24	Line 1	GP's, Eating Disorder Specialists, Paediatricians, Psychiatrists or Cardiologists should assess whether ECG monitoring is needing. In practical terms Cardiologists are virtually never involved. It should	Thank you for your comment. The recommendation has been amended to remain neutral as to who should conduct ECG monitoring.

						perhaps read General Physician or General Internal Medicine Specialist.	
99.	SH	BEAT	Full	24	32	The van Hoeken et al (2003) study which has been cited here generated these point prevalence estimates by calculating averages from several studies conducted in various countries. Therefore, the wording used should reflect that these estimates are not derived directly from studies of the UK population. It is important that the lack of epidemiological evidence about eating disorders in the UK population is highlighted to policy makers and funders to help support efforts to rectify this.	Thank you for your comment. The text has been amended to reflect that the estimate pertains to Western Europe and the US.
100.	SH	BEAT	Full	24	32	These percentages should only be cited as applying to younger people (e.g. Under 35s as the King's Fund did when it cited them in its 'Paying the Price' report), because only a few of the studies included in the van Hoeken et al (2003) meta-analysis (which this source presumably draws on), included patients of 35 years or older.	Thank you for your comment. The text has been amended in response to your comment.
101.	SH	BEAT	Full	24	32	This 0.1% estimate for males has been contradicted by studies which have been published since the van Hoeken et. al. (2003) review. Most notably 25% of the people with lifetime experience of Bulimia nervosa identified by Hudson et al (2007) were male. A review of community-based epidemiological studies by Sweeting et al (2015) suggests that the prevalence of eating disorders in males may be as high as 25%.	Thank you for your comment. A sentence indicating that the prevalence may be higher than previously thought, has been added. An alternative reference has been added. The Committee declined to include Hudson (2007) as it is does not use full diagnosis as a criteria for bulimia nervosa and was not conducted in a UK context.
102.	SH	BEAT	Full	24	43	The Preti et. al. (2009) paper which has been cited here generated these lifetime prevalence estimates through a study	Thank you for your comment. The text has been amended to reflect that the estimate pertains to Europe.

						conducted in a group of European countries (which did not include the UK or any part of the UK). Therefore, the wording used here should reflect that these estimates are not derived from studies of the UK population. It is important that the lack of epidemiological evidence about eating disorders in the UK population is highlighted to policy makers and funders to help support efforts to rectify this.	
103.	SH	BEAT	Full	24	43	This reference should be (Preti et al., 2009)	Thank you for your comment, this has been amended.
104.	SH	Anorexia and Bulimia Care	Full	24	25–26	'It is also relatively rare among middle-aged and 26 elderly women (Lapid 2010).' Could recent research led by Dr Nadia Micali, be considered? Please refer to the link below and the research paper, in the hope that it may further illuminate your findings into the instances of eating disorders among middle-aged women. http://www.bristol.ac.uk/news/2017/january/eating-disorders.html Research paper: 'Lifetime and 12-month prevalence of eating disorders amongst women in mid-life; a population-based study of diagnoses and risk factors; Micali, N. et al, 2016'	Thank you for your comment. The reference has been included as requested.
105.	SH	BEAT	Full	25	2-4	It would be clearer to readers if this section explained that due to the relatively recent introduction of Diagnostic and Statistical Manual of Mental Disorders 5 (DSM5) there is	Thank you for your comment. The text has been amended to make clear that the prevalence of OSFED is less clear given its relatively recent introduction.

						limited evidence about the epidemiology of Other Specified Feeding and Eating Disorders (OSFED). Then it could go on to cite the studies which have included Eating Disorders Not Otherwise Specified (EDNOS), including Micali et al. (2013) and Le Grange et al. (2012), with less risk of confusion.	
106.	SH	BEAT	Full	25	4-6	The use of the word "They" in line 4, conflates Other Specified Feeding and Eating Disorders (OSFED) and Eating Disorder Not Otherwise Specified (EDNOS), despite them being categories from different diagnostic eras and so may confuse some readers. Whilst the Fairburn and Harrison (2003) study cited suggests that EDNOS was the largest single category of cases of eating disorders (at least in clinical practice), we do not have sufficient evidence to establish whether this will remain to be the case for OSFED.	Thank you for your comment. The text has been amended to avoid ambiguity.
107.	SH	BEAT	Full	25	4-6	Typographical error with references	Thank you for your comment. All references have been fixed.
108.	SH	BEAT	Full	25	6-7	The lifetime prevalence estimates for Eating Disorder Not Otherwise Specified (EDNOS) cited in Le Grange et al (2012) only apply to samples conducted in the USA. Therefore, the wording used here should reflect that these estimates are not derived from studies of the UK population. It is important that the lack of epidemiological evidence about eating disorders in the UK population is highlighted to policy makers and funders to help support efforts to rectify this.	Thank you for your comment. The text has been amended to reflect that the estimate pertains to the USA only.

109.	SH	British Psychological Society	Full	25	45-46	Many problems in service transitions occur due to lack of clarity regarding the phenomenology of binge eating. We recommend that the full diagnostic criteria (DSM5) be used here for an objective binge eating episode to foster greater understanding.	Thank you for your comment. The introduction section is not intended to be a textbook statement on the diagnostic criteria for bulimia nervosa. No amendment was made as the current statement was considered to be sufficient.
110.	SH	Anorexia and Bulimia Care	Full	25	25	We believe it may be important to specify how often binges and purges occur in cases of Bulimia Nervosa in this introductory section. You later specify that binges occur at least once a week for 3 months, and we think this could be included on page 25.	Thank you for your comment. The introduction section is not intended to be a textbook statement on the diagnostic criteria for bulimia nervosa. No amendment was made as the current statement was considered to be sufficient.
111.	SH	NHS Greater Glasgow and Clyde	Full	25	28	There needs to be a comma after “individual loses”	Thank you for your comment. The sentence has been edited for clarity.
112.	SH	BEAT	Full	25	36	This section should also mention the over-valuation of shape, as for some sufferers this is a key concern.	Thank you for your comment. The introduction section is not intended to be a textbook statement on the diagnostic criteria for bulimia nervosa. No amendment was made as the current statement was considered to be sufficient.
113.	SH	BEAT	Full	26	32-49	The description of 'Atypical eating disorders' in section 2.6 makes no mention of those who may have a disorder which more closely resembles the diagnosis of Binge eating disorder and instead creates the impression that this section only includes people with so-called Atypical Anorexia nervosa or Atypical bulimia nervosa. There is no mention of 'Night eating syndrome' despite this being one of the subtypes of	Thank you for your comment. The text has been amended to make clear that atypical BED, purging disorder and night eating syndrome are now considered in DSM-V to be atypical eating disorders.

						Other Specified Feeding and Eating Disorders (OSFED) in Diagnostic and Statistical Manual of Mental Disorders 5 (DSM5) and only a brief reference is made to purging disorder.	
114.	SH	BEAT	Full	26	7-9	Suggest changing to "Sufferers are often able to keep the problem secret for many years, as their appearance is usually unremarkable and they can often eat normally in public". This would avoid generalisation and the inaccurate implication that there are no physical signs that can sometimes help with the identification of bulimia nervosa.	Thank you for your comment. The text has been amended in response to your comment.
115.	SH	BEAT	Full	26	23-25	Again, epidemiological information has been included, without sources being cited and despite the previous section being about epidemiology.	Thank you for your comment, references have now been included.
116.	SH	BEAT	Full	26	32-34	In DSM5 – Other Specified Feeding and Eating Disorders (OSFED), whilst still a rather broad attempt at a 'residual diagnosis', includes a number of specified sub-categories and so the conflation of OSFED with Eating Disorder Not Otherwise Specified (EDNOS) in this section is misleading.	Thank you for your comment, this has been amended.
117.	SH	BEAT	Full	26	9-10	Other factors beyond shame can also be significant barriers to help-seeking. As well as the possibility of sufferers feeling ashamed, this should also mention concerns about stigma/stigmatising reactions from others (including healthcare professionals), low self-esteem and people not being aware that help is available.	Thank you for your comment. The text has been amended.
118.	SH	BEAT	Full	26	30-31	The inclusion of "(eating disorders not otherwise specified)" may be misleading, especially since the title of the relevant	Thank you for your comment, the title of the section has been amended.

						section in the recommendations was 'Treating other specified feeding and eating disorders (OSFED)'.	
119.	SH	BEAT	Full	26	45-46	If the exclusion of Avoidant Restrictive Food Intake Disorder (ARFID) is to be detailed here, then it would make sense to also specify the fact that this guideline does not cover the conditions of pica or rumination disorder either.	Thank you for your comment, the text has been amended as suggested.
120.	SH	BEAT	Full	26	5	This should also mention over-exercise and misuse of diuretics as potential forms of compensatory behaviour which may be adopted by people with bulimia nervosa.	Thank you for your comment. The text has been amended to make clear that vomiting is just one of the compensatory behaviours that people with bulimia nervosa can engage in.
121.	SH	BEAT	Full	26	12	Typographical error - delete the word 'has'.	Thank you for your comment. The text has been amended.
122.	SH	BEAT	Full	26	13	Was any evidence used to inform the line that "Most cases are in their 20s and about 1 in 10 is male"? The guideline shouldn't make such statements without supporting evidence being cited. Whilst clinical samples suggest a 10% share as male, this is not supported by community-based epidemiological studies. Most notably 25% of the people with lifetime experience of bulimia nervosa identified by Hudson et al (2007) were male. Also, this seems out of place given that the preceding section (2.2) was on Epidemiology.	Thank you for your comment. This sentence has been removed.
123.	SH	Anorexia and Bulimia Care	Full	26	16	Perhaps a slight grammar correction could the addition of the word 'of' in the phrase 'accompanying sense loss of control'.	Thank you for your comment. The sentence has been amended for sense.
124.	SH	BEAT	Full	26	16	Typographical error - the word 'of' has been missed out.	Thank you for your comment. The sentence has been amended for sense.

125.	SH	BEAT	Full	26	47	No sources are cited for the line "Most people with an atypical eating disorder are female and in their 20s" and again this seems to overlap with the topic of section 2.2.	Thank you for your comment. This sentence has been removed.
126.	SH	BEAT	Full	26	48	Conversely many people who experience an Atypical eating disorder may go on to meet the diagnostic criteria for anorexia nervosa, bulimia nervosa or binge eating disorder.	Thank you for your comment. The text has been amended to reflect the fact that people with an atypical eating disorder can of course go on to develop a typical eating disorder.
127.	SH	BEAT	Full	26; 27	49; 1	The line "The atypical eating disorders are as impairing as bulimia nervosa..." is a generalisation which implies that atypical eating disorders never cause as much impairment as anorexia nervosa, which is incorrect. This statement also implies that there is evidence to support the view of a clear and consistent hierarchy of impairment between the different eating disorder diagnoses (e.g. an individual with anorexia nervosa is always more severely ill than any other individual with bulimia nervosa). It's important that simplistic misconceptions about the relative severity of the different eating disorders are not inadvertently reinforced by the guideline.	Thank you for your comment, the text has been amended to provide a more general statement.
128.	SH	BEAT	Full	27	1-2	The fact that Atypical eating disorders are also common in those with other primary mental health diagnoses is mentioned, although this is also true for the other eating disorders and so perhaps this should be added to those sections too if it is going to be included here.	Thank you for your comment. This sentence has been removed.
129.	SH	BEAT	Full	27	8-9	Error in the sentence structure or wording - possibly the word 'and' has been used where 'or' was meant.	Thank you for your comment, this sentence has now been revised.

130.	SH	BEAT	Full	27	10-11	This sentence is not clear that acute physical complications can result from someone who experiences rapid weight loss at a time when they are not 'underweight'. It should also add that acute complications can also arise in people with an eating disorder who are not underweight and who have not experienced rapid weight loss as a result of bingeing and compensatory behaviours.	Thank you for your comment, the text has been amended to be clearer.
131.	SH	BEAT	Full	27	7-8	Since excessive exercise is a form of compensatory behaviour should be included in the brackets on line 7?	Thank you for your comment, the text has been amended to be clearer.
132.	SH	BEAT	Full	27	18	Typographical error - "…anaemia and a higher the risk of stroke"	Thank you for your comment, this has been revised in line with your comment.
133.	SH	Anorexia and Bulimia Care	Full	27	After line 31	We think it may be important to include the medical dangers of water loading on the brain, in cases of AN.	Thank you for your comment. No amendment was made as the list of physical complications is not intended to be exhaustive and the current statement was considered to be sufficient.
134.	SH	Anorexia and Bulimia Care	Full	27	37	We are advised by the RCGP that self-induced vomiting causes a risk of heart attack and wonder if this should be included before mention of tooth enamel decay. It may also be useful to note oesophageal bleeding before more minor affects to teeth?	Thank you for your comment. No amendment was made as the list of physical complications is not intended to be exhaustive and the current statement was considered to be sufficient.
135.	SH	BEAT	Full	27	42	The phrase "the bulimic group" is pejorative and should be changed to "…patients with bulimia nervosa..." or similar.	Thank you for your comment. The text has been amended as suggested.
136.	SH	BEAT	Full	27-28	3-47; 1-13	The physical consequences of laxative and diuretic misuse and over-exercise have not been specified here.	Thank you for your comment. No amendment was made as the list of physical complications is not intended to be exhaustive and the current statement was considered to be sufficient.

137.	SH	Anorexia and Bulimia Care	Full	28	31	We suggest adding 'especially for Anorexia Nervosa' after the mention of 'perfectionist personality traits' as the research we aware of suggests that perfectionism is more likely to affect those with AN.	Thank you for your comment. As this section on psychiatric comorbidities is intended to be a brief overview of the kinds of disorders or behaviours that have been associated with eating disorders and not a narrative review of the literature, no amendment was made as the current statement was considered to be sufficient.
138.	SH	Somerset Partnership NHS Foundation Trust	Full	28	37	We were a little confused by this statement, which seems to suggest that effective eating disorder treatment often also addresses any underlying personality disorder presentation. We were unclear regarding the evidence-base for this statement, but our clinical practice suggests that this is a rather bold global assertion, and likely depends on both the individual concerned and the nature of the ED intervention.	Thank you for your comment. As the assertion applies to personality-*level* comorbidities (such as those listed) and not explicitly to personality *disorder* comorbidities, the text was considered to be clear and no amendment was made.
139.	SH	BEAT	Full	29	22	The pathways are being standardised for patients up to and including the age of 18.	Thank you for your comment. The text has been amended to include people aged 18 and under.
140.	SH	North Essex Partnership NHS Foundation Trust	Full	29	28	If it is true that dentists are often the first to recognise eating problems then it needs a reference	Thank you for your comment. The text has been amended to make clear that dentists are often the first to notice due to the fact that people who attend dentists often do so frequently. References have been added to the full guideline to support this statement.
141.	SH	BEAT	Full	29	37	The word "patient" should be replaced with "patients".	Thank you for your comment, this has been revised as suggested.
142.	SH	BEAT	Full	29	43	Typographical error - reference duplicated	Thank you for your comment. All references have been fixed.
143.	SH	British Psychological Society	Full	30	27-36	Outcomes of inpatient treatment are to be interpreted with utmost caution because of the severe limitations of research designs permitting strong	Thank you for your comment. The Committee was sensitive to the difficulties of interpreting evidence from studies performed in an inpatient and/or

						conclusions of any kind. There is contrary evidence of better BMI on discharge predicting reduced risk of relapse and readmission, and greater levels of weight gain in inpatient versus other settings, some of which is cited. We recommend that the guideline distinguish between first admission for non-chronic Anorexia Nervosa and make a research recommendation for more studies to compare longer voluntary admissions against alternative models of care for this group. It is also possible that iatrogenic effects of admission may be mitigated by having separate treatment settings and pathways for motivated and less chronic clients in intense settings as personal communication says is tried in New Zealand for inpatients and parts of the UK for day patients. This may maximise positive and reduce negative group effects.	compulsory treatment setting, especially given that participants in such a setting are more likely to need refeeding and other treatment for physical complications than those in an outpatient setting. Regarding research recommendations, whilst it is undoubtedly important that more research is conducted in this area regarding the effect of settings and severity of illness on outcomes such as remission, the Committee felt that other issues were more of a priority in terms of research.
144.	SH	British Society of Gastroenterology	Full	30	27 - 36	Throughout the guidance the term 'inpatient care' is used imprecisely. It is sometimes difficult to know whether the guidance refers to 'inpatient care' in an acute psychiatric hospital, inpatient care in a Specialist Eating Disorder Unit or inpatient care in an Acute Medical Facility such as a General Hospital. When considering Acute Medical Care there is very little nuance about whether the patient should be on a General Medical Ward, a ward with specialist expertise in nutrition, run by a Gastroenterologist with a nutritional interest, or a High	Thank you for your comment. Due to wide regional variation in the structure of healthcare services, and the lack of comparative trials amongst the various types of inpatient scenarios, the Committee did not feel that they could specify further the type of inpatient setting in which treatment should be provided.

						Dependency Unit. The only specialist groups referred to are Diabetologists, Paediatricians and Cardiologists. The MARSIPAN report makes it clear that Acute Medical Inpatient Treatment should be directed to Physicians with a specialist interest in nutrition and preferably experience in dealing with Eating Disorders. BAPEN and the BSG would welcome this point being made more clearly.	
145.	SH	College of Occupational Therapists	Full	30	18-24	As mentioned above we are concerned about the absence of the best available evidence for occupation-focussed interventions within the guideline in regards to confusion expressed related to treatment diversity and the great variety of therapeutic choices (interventions) and the underuse of evidence-based therapies o Whist the guideline's strict adherence to high quality evidence is praise-worthy we are concerned that this strict approach leads to a treatment bias towards interventions provided by clinicians with funded time to develop high quality evidence for them. Given there has been no funded research time for Occupational Therapy for over a decade and extremely little before that, we assert the lack of equal opportunity for occupation-focussed interventions within the guideline and the consequential	Thank you for your comment. The principal aim of the guideline is to provide evidence-based guidance to healthcare professionals and the funding of specific research questions or treatments is beyond the scope of this guideline.

						deprivation of interventions that patients deem to have face validity and utility.	
146.	SH	BEAT	Full	30	25-26	This will apply for patients up to and including the age of 18.	Thank you for your comment. The text has been amended to include people aged 18 and under.
147.	SH	BEAT	Full	30	27	Should this be given a larger font as it seems to be intended to act as the heading for a sub section within section 2.9?	Thank you for your comment, the subsection has been removed and therefore the headline will remain as it is.
148.	SH	BEAT	Full	30	33	Typographical error - replace "hour" with 'hours'.	Thank you for your comment, this has been revised as suggested.
149.	SH	Anorexia and Bulimia Care	Full	30	27–36	It might be constructive to add the following quote to the discussion, even though it is later mentioned on page 106: 'As there are a limited number of beds in England, patients may be admitted to units 23 geographically distant from home and from their community specialist or general services.'	Thank you for your comment. The text has been amended although added to Chapter 2.9 ('Variation in existing provision') rather than the place suggested.
150.	SH	North Essex Partnership NHS Foundation Trust	Full	30	350	Should it be clearer that EMDR might be appropriate in the context of comorbid PTSD?	Thank you for your comment. No RCTs were identified that examined the use of EMDR in an eating disorder population with comorbid PTSD. For guidance on the treatment of PTSD, please see the 2005 CG26 NICE guideline 'Post-traumatic stress disorder', which is due to be updated in September 2018.
151.	SH	British Society of Gastroenterology	Full	31	35-51	Tube Feeding Line 47-51 suggests that there is evidence that early weight restoration has an impact on outcome but no evidence is sited.	Thank you for your comment. The introduction is intended as a broad overview of the full guideline and is not intended to supplement the evidence reviews that appear in later chapters. Please see the review on physical complications for details about the evidence supporting the

							recommendations regarding tube feeding.
152.	SH	BEAT	Full	31	38	Has the word 'Care' been omitted here before "quality commission…"?	Thank you for your comment, this has been revised as suggested.
153.	SH	BEAT	Full	31	38	Typographical error - "adults in UK" should be "adults in the UK".	Thank you for your comment, this has been revised as suggested.
154.	SH	BEAT	Full	31	39	What clinical guidance is available on this topic? If relevant guidance is available, then it would be useful to cite it here.	Thank you for your comment. The introduction is intended as a broad overview of the full guideline and is not intended to supplement the evidence reviews that appear in later chapters. Please see the review on physical complications for details about the evidence supporting the recommendations regarding tube feeding.
155.	SH	The British Dietetic Association	Full	32	6-10	There is a statement made that nasogastric feeding may be superior to oral feeding with patients with binge/purge symptoms. However, this does not seem to have been reviewed in the nutritional intervention sections and there have been no recommendations made. If the guidelines are going to make a statement such as this, which has big implications on practise, surely the evidence needed to be examined and a recommendation made?	Thank you for your comment. Evidence regarding the efficacy of nasogastric feeding is reviewed in the chapter on the management of long- and short-term complications.
156.	SH	BEAT	Full	32	8-10	Typographical error - Duplication of references	Thank you for your comment. All references have been fixed.
157.	SH	BEAT	Full	32	15	Typographical error - insert the word 'an' before "eating disorder".	Thank you for your comment, this has been revised as suggested.
158.	SH	BEAT	Full	32	16; 19-20	Typographical error - Duplication of references	Thank you for your comment. All references have been fixed.
159.	SH	British Society of Gastroenterology	Full	32	11–21	The evidence supporting statements in this paragraph is poor. They are discussed in far more detail in Marsipan.	Thank you for your comment. This is an introduction and not intended to be a detailed defence of the guideline nor the

						It is not possible to discuss the rate of refeeding without stratifying patients according to risk. In patients with extreme malnutrition i.e BMI less than 12, refeeding should be undertaken by a Physician with a specialist interest in nutrition, and lower feeding rates may be appropriate. The most important issue is to monitor patients closely, to step feeding up to reach target levels, protect the patient from anorexic behaviours and to keep the patient under close observation until target nutritional intake has been achieved. It is failure to reach targets and nutritional intakes that lead to underfeeding rather than necessarily starting at a low rate. The evidence base in this area is extremely poor and the advice should be amended to reflect this. Once again BAPEN and the BSG would welcome a greater emphasis being placed on the importance of refeeding being conducted by a Physician with a Specialist interest in nutrition.	recommendations. Please note that MARSIPAN is recommended in the inpatient section of the chapter on the coordination of care and in the refeeding section of the chapter on physical complications and these should consulted for the rationale underlying the recommendations.
160.	SH	NHS Greater Glasgow and Clyde	Full	32	39	Home leave is (include “an”) important	Thank you for your comment, this has been revised as suggested.
161.	SH	British Society of Gastroenterology	Full	32	35–42	We agree entirely with the comments made that ‘it is challenging to develop a strong evidence base regarding interventions in an inpatient setting and randomisation to different forms of treatment’. Once again the term ‘inpatient’ should be more closely defined. The whole section on inpatient care seems a little unbalanced. There is a detailed discussion of the history of inpatient care going back to Sir William	Thank you for your comment. Please note that the recommendations regarding inpatient care and providing support have been substantially revised. The sections on the history of inpatient treatment and theoretical background have been deleted. The LETRs have also been substantially revised to make clearer the decision making process. The committee decided not to further define 'inpatient treatment' given the wide variation in the

						Gull in the 19th Century. The relevance of this is dubious. The theoretical background to inpatient care is extremely subjective, is written in a rather didactic way and is not supported by a single evidence source. The difficulty of writing guidance when the evidence base of such a low quality is recognised but where matters are simply the opinions of experts this needs to be more clearly stated. The document in general seems to favour outpatient treatment over inpatient treatment. What is meant by inpatient treatment seems to vary in different sections of the document. There is a failure to define whether it means General Psychiatric Care or Specialist Eating Disorder Units. There is a recognition that Specialist Eating Disorder Units may be an appropriate form of care if Outpatient treatment has broken down. On reading the document commissioners might draw the conclusion that there is no merit in supporting any form of inpatient facility for patients with severe restrictive anorexia nervosa. In reality Specialist Eating Disorder Units or Medical Inpatient Facilities are often the only safe way of refeeding extremely ill patients or controlling anorexic behaviour and providing the supportive care that prepares patients for more specific therapies such as family based therapy or cognitive behaviour therapy. As there is virtually no hard evidence on which to base decisions the alternative view point	structure of services across the country and the difficulties doing so would give rise to. The evidence regarding whether inpatient treatment provided benefit over other settings was clear and the Committee agreed that inpatient treatment should be avoided if possible and should only be used for medical stabilisation and refeeding. Regarding the treatment of people with severe anorexia nervosa, the committee was generally agreed that they should be offered the same treatments as less severe cases and that there was scant (if any) evidence that treatment needed to be substantially altered due to severity or duration of illness. Regarding support, there was no evidence to suggest that support could only effectively be provided in an inpatient setting. Regarding cost benefits, the committee took this into account but did not solely base their decision on the fact that inpatient care is much more expensive than outpatient care. Indeed, the evidence from both RCTs and comparative observational studies was almost unequivocal in showing the inpatient care provides no additional benefit compared to other settings (e.g. day care or outpatient settings).

						to Outpatient therapy needs to be stated more strongly. In addition simply comparing cost benefit is not always helpful, as patients admitted to Specialist Eating Disorder Units for inpatient treatment, tend to be nutritionally and psychologically much more ill than those managed in an outpatient setting. A greater sense of balance and a recognition of alternative views in the light of a poor evidence base is required.	
162.	SH	BEAT	Full	33	7-20	No sources are cited for the data presented in this section.	Thank you for your comment. The text has been edited and substantially revised.
163.	SH	BEAT	Full	33	22-25	No sources have been cited here.	Thank you for your comment. Some references have been added.
164.	SH	BEAT	Full	33	5	Typographical error - reference	Thank you for your comment. All references have been fixed.
165.	SH	NHS Greater Glasgow and Clyde	Full	33	11	Sentence after bracket doesn't link to sentence before brackets	Thank you for your comment. The sentence has been amended for clarity.
166.	SH	BEAT	Full	33	27;30	Typographical error - references duplicated	Thank you for your comment. All references have been fixed.
167.	SH	BEAT	Full	34	23-24	This is confusingly worded.	Thank you for your comment, the text has been amended to make it clearer.
168.	SH	BEAT	Full	34	14	Typographical error - delete the word 'the'.	Thank you for your comment, this has been revised as suggested.
169.	SH	BEAT	Full	35	21-31	It would be helpful if this section could highlight that early access to evidence-based therapy is likely to significantly reduce the long-term costs to the healthcare system associated with eating disorders.	Thank you for your comment. This section summarises published studies reporting economic costs associated with eating disorders. Although early access to evidence-based therapy is likely to significantly reduce the long-term costs to the healthcare system, the systematic literature review of economic evidence did not identify studies that reported the cost savings to the health care system

							associated with early access to evidence-based therapies for eating disorders.
170.	SH	BEAT	Full	35	22-31	This conclusion is poorly written.	Thank you for your comment, the text has been amended.
171.	SH	BEAT	Full	35	12-20	This could be strengthened with a statement to say that the wide range of physical and psychiatric comorbidities associated with eating disorders means that the costs incurred to the health system are substantially greater than just the costs incurred by services which provide treatment for eating disorders.	Thank you for your comment. This section summarises published studies reporting economic costs associated with eating disorders. Although the management of physical and psychiatric comorbidities associated with eating disorders is likely to have a significant financial consequences to the health care system, the systematic literature review of economic evidence did not identify studies that reported such economic consequences. The Committee discussions pertaining to the management of comorbidities and associated economic considerations are discussed in the Linking Evidence to Recommendations tables in the relevant sections of the full guideline.
172.	SH	BEAT	Full	35	4-5	The part which says "(including anorexia nervosa and bulimia patients)" is pejorative and should be reworded, for example to "… (including patients with anorexia nervosa or bulimia nervosa) …"	Thank you for your comment, the text has been amended.
173.	SH	BEAT	Full	35	22	Remove "eating-disordered" as this is pejorative - it could instead read '...per patient with an eating disorder...'.	Thank you for your comment, the text has been amended.
174.	SH	BEAT	Full	35	23	Typographical error - Duplication: "per annum year".	Thank you for your comment. All references have been fixed.
175.	SH	BEAT	Full	35	24	Typographical error - replace the first use of "disorder" with "disorders".	Thank you for your comment, this has been revised to ‘an eating disorder’.
176.	SH	BEAT	Full	35	24	Typographical error - replace "do" with "does".	Thank you for your comment, this has been revised as suggested.

177.	SH	NHS Greater Glasgow and Clyde	Full	35	24	Cost refers to people with eating disorder... – should read “disorders”	Thank you for your comment, this has been revised as suggested.
178.	SH	BEAT	Full	35	28	Typographical error - Add in commas.	Thank you for your comment, this has been revised for clarity.
179.	SH	Anorexia and Bulimia Care	Full	35	12–20	Perhaps the mention of the severe distress caused to parents and carers is insufficient, and needs elaborating to highlight the positive impact of supportive parents and carers. GPs and other health professionals may be grateful for this insight, to help reduce the effects of eating disorders on the whole family. Could the emotional cost to parents and carers be included earlier, perhaps following the information about economic costs? This research may be helpful and potentially included: Carers of anorexic patients have reported similar experiences in terms of the difficulties experienced to those of carers of adults with psychosis and higher levels of psychological distress. 2001 Psychological distress Treasure J, Murphy T, Szmukler G, Todd G, Gavan K, Joyce J. The experience of caregiving for severe mental illness: a comparison between anorexia nervosa and psychosis. Soc Psychiatry Psychiatr Epidemiol 2001; 36(7):343-347. Carers of people with ED reported significantly less well-being than carers of other patient groups, such as carers of	Thank you for your comment and the references. However, none of the suggested references report the economic consequences for parents and carers of people with eating disorders. Nevertheless, the BEAT (2015) study that is included in this section reports the indirect financial burden on sufferers and carers. Also, the Committee discussions pertaining to the support of parents and carers, and the associated economic considerations are discussed in the Linking Evidence to Recommendations tables in the relevant sections of the full guideline.

						people with brain injury and of people with dementia. Specifically, poorer social functioning was reported.2015 Psychological distress Linacre, S, Heywood-Everett, S, Sharma, V, & Hill, AJ 2015, 'Comparing carer wellbeing: implications for eating disorders', *Mental Health Review Journal*, vol. 20, no. 2, pp. 105-118. Available from: 10.1108/MHRJ-12-2014-0046. [21 September 2016] 'The interventions most frequently needed according to the carers were 'counselling and support' (90.7 per cent), 'family sessions' (90.6 per cent), 'individual psychoeducation' (87.5 per cent), 'printed information material' (84.4 per cent) and 'psychoeducational groups' (81.2 per cent) 'More than 59 per cent of the carers of patients with AN or BN stated to feel depressed, and burned out or to feel physically or mentally ill' Over three quarters of carers repoted not having enough information on relapses and their prevention' (78.1 per cent) The study found a great need for self-help support for families. Graap, Holmer, et al. "The needs of carers of patients with anorexia and bulimia nervosa." *European Eating Disorders Review* 16.1 (2008): 21-29.	

180.	SH	North Essex Partnership NHS Foundation Trust	Full	38	35	I think that NICE guideline NG43 (transition) should be included in the list	Thank you for your comment. A reference to this guideline has been added in this section and in the recommendations.
181.	SH	BEAT	Full	38	37	This list should include the NICE Guideline on transitions between Child and adolescent to adult mental health services [NG43].	Thank you for your comment. A reference to this guideline has been added in this section and in the recommendations.
182.	SH	College of Occupational Therapists	Full	40	31	As in comment 2 we are concerned that no national expert in OT was approached to develop the guideline	Thank you for your comment. The committee constituency was reviewed during the consultation on the scope during which registered stakeholders were able to comment. In forming any guideline committee, there is a limit to the number of professionals that can be included. In developing the scope and appointing the Committee members, careful consideration was given to the composition of the panel, including the range of professionals involved in it. On this basis, the decision was made that an Occupational Therapist would not be included on the committee. Stakeholder consultation, however, provides the opportunity for expert occupational therapists to be included in the guideline.
183.	SH	College of Occupational Therapists	Full	41	6	Re: What is really important to service user? We recommend that the phrase 'Return to work/social functioning/quality of life' – is changed to; '*'improved ability to participate in adaptive self-care, productivity, leisure and rest activities with improved social functioning and quality of life.'*	Thank you for your comment. The text you refer to is in a table provided as an example of how a review question should be formulated in the PICO format to ensure that it is clearly framed and realistically answerable. The text has therefore not been amended according to your suggestion.

184.	SH	College of Occupational Therapists	Full	58	27-28	From evidence to recommendations As in comment 1 we recommend that an Occupational Therapy expert opinion is included throughout this guideline to authentically 'take into account'…current clinical practice and requirements to prevent discrimination and authentically promote equality (line 20-28)	Thank you for your comment. The inclusion of expert opinion from occupational therapists without due process at this stage would undermine the Committee- and evidence-based nature of NICE guideline development. Stakeholder consultation, however, provides the opportunity for expert occupational therapists to be included in the guideline. In forming any guideline committee, there is a limit to the number of professionals that can be included. In developing the scope and appointing the Committee members, careful consideration was given to the composition of the panel, including the range of professionals involved in it. On this basis, the decision was made that an Occupational Therapist would not be included on the committee.
185.	SH	College of Occupational Therapists	Full	60	5-6	We recommend that these lines include occupational aspects hence re-worded as follows: Common ED Behaviours include extreme dieting, '*over controlled', 'out of control' and socially inappropriate eating, avoiding feared foods, avoiding commensal eating, meal preparation plus impaired participation in adaptive self-care, productivity or leisure activities including social or body-centric activities* ''	Thank you for your comment. The list in the introduction is not intended to be exhaustive.
186.	SH	College of Occupational Therapists	Full	101	Green Table item 4.	Under list headed 'Think about the possibility of an eating disorder with one or more of the following: include:	Thank you for your comment. The list is intended to delineate the most important features that the Committee - after much discussion and deliberation, and in

						Avoidance of social eating and participation adaptive self-care, productivity, leisure and rest activities especially if they include social eating.	accordance with NICE process - that healthcare professionals should be sensitive to. The Committee believe that the essence of your suggested insertion is already captured and therefore declined to add it.
187.	SH	BEAT	Full	105	17	Can this be more strongly worded? For example, "ideally under" could be replaced with "using".	Thank you for your comment. The text has been amended.
188.	SH	BEAT	Full	106	23-30	This should be reworded to form a strong statement in support of a right for patients and carers to receive inpatient treatment (relatively) close to home - given the context where often patients are sent many hundreds of miles from home. It should also highlight that this distance often presents problems in the coordination of care between the inpatient service and the community/outpatient service back home.	Thank you for your comment. The Committee recommended that people with an eating disorder should have equal access to treatment regardless of, among other things, where they live (See recommendation 9 in full guideline). It is therefore hope that this addresses your concerns.
189.	SH	BEAT	Full	106	12-17	This should state that services providing eating disorders treatment should be able to accept referrals from GPs who are outside of their 'catchment area' so that people (including students) can join the waiting list before they move.	Thank you for your comment. The Committee declined to include your specific suggestion in the introduction to the chapter. The importance of referral without delay is captured in recommendation 24 (in full guideline). It is outside the scope of the guideline to comment on waiting lists.
190.	SH	BEAT	Full	106	33	Typographical error - "MARISPAN" should be changed to 'MARSIPAN'.	Thank you for your comment. The text has been amended.
191.	SH	BEAT	Full	106	34	Typographical errors - references.	Thank you for your comment. All references have been fixed.
192.	SH	BEAT	Full	106	36	We recommend inserting: "(including death)" after "poor outcome" to highlight the severity of the risks involved when the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) guidelines are not followed.	Thank you for your comment. The text has been amended.

193.	SH	College of Occupational Therapists	Full	107	3	We recommend the table which includes the important outcome of 'General functioning by return to normal activities' – is re-worded to specify *healthy adaptive self-care work, study leisure and rest activities.*	Thank you for your comment. The text you refer to is embedded in a table detailing the protocol for the relevant evidence review and it would not be appropriate at this stage of the guideline to amend it. Note that the phrase 'general functioning…' is a widely-used term in the literature and that many of the available measures (e.g. SF-36) assess the kinds of everyday behaviours that your suggested phrases describe.
194.	SH	North Essex Partnership NHS Foundation Trust	Full	160	17	Why is (CAMHS) in this heading which appears to relate to adults?	Thank you for your comment, this has been amended.
195.	SH	Oxford Health NHS Foundation Trust	Full	160 & 162	17, 28 & 23/24	These statements refer to 'general outpatient (CAMHS) for adults' which is confusing as adults don't receive treatment in CAMHS. Can the committee make it clearer that they mean 'general adult mental health services'?	Thank you for your comment, this has been amended.
196.	SH	North Essex Partnership NHS Foundation Trust	Full	162	23	Why is the word "adults" in this heading which relates to CAM HS	Thank you for your comment, this has been amended.
197.	SH	British Psychological Society	Full	168	Recommendation 12	Given the challenges inherent in people accessing and completing appropriate treatment the guidelines recommend whole age specialist outpatient services so that transitions do not interrupt treatment at key stages of illness, which is to be welcomed. We recommend that the committee also make a recommendation about continuity of inpatient treatment. Currently different units are commissioned for child and adult inpatient treatment and patients have been required to transfer on reaching age 18. The trust that develops between patients and units and the	Thank you for your comment. The recommendations have been substantially revised. In particular, it has been explicitly stated that child and adults services should follow NICE guidance on transition between these services but that interventions should be tailored to the individual's age and level of development. Students have also been explicitly mentioned in the context of specifying that services should be coordinated in different places and at different times of the year.

						knowledge and holistic understanding of the young person is lost at a crucial stage of eating disorder recovery with potentially very harmful and costly outcome. We recommend a guideline that young people be able to complete treatment episodes after age 18 in the same young people's unit if they are already inpatients when they are 18. Further, when young people attend university, this can be a key time of risk as well as recovery opportunity. Currently in some areas specialist services are only permitted to see patients registered with a GP in the same area. However, it would be better if both therapy and GP medical oversight could be continuous and the most effective and practicable arrangements may involve doing one or both in either the home or university area or one in one area and the other in the other. Moreover we have had anecdotal cases where moving one's registered GP has resulted in coming under a different CCG with different policies with negative impact on continuity of care. We recommend that the care plans for people with eating disorders at university be permitted to be flexible regarding which responsibility sits where so long as they are clearly specified and allocated without unnecessary rigid CCG policy application.	

198.	SH	North Essex Partnership NHS Foundation Trust	Full	180 (& 973)	2 & (43)	What is “bulimic behaviours” meaning in terms of a standardised measure?	Thank you for your comment. The reference to bulimic behaviours has been removed.
199.	SH	BEAT	Full	181	n/a	This page includes the sentence: "Given the concerns surrounding nonadherence, the committee agreed it is important that healthcare professionals monitor adherence throughout the treatment. The committee said the following methods could be used: recordings, external audits and general scrutiny." According to the recommendations the methods cited here were actually suggested to help monitor the competence of professionals. Has a mistake been made here in mixing up competence and treatment adherence? If so it would be useful if the committee could suggest methods of monitoring treatment adherence too.	Thank you for your comment. The text has been changed to distinguish between therapist competence and adherence to a treatment manual, on the one hand, and the adherence of the person receiving treatment to the treatment itself.
200.	SH	British Psychological Society	Full	181	28-29	In practice, there is problematic variation in what supervision is considered adequate, depending upon the local composition of the multidisciplinary team. We recommend the guideline clarify that whatever other management or case management supervision is in place that practitioners have access to clinical supervision in the specific therapeutic models delivered from supervisors with appropriate qualification/experience, as well as generic supervision.	Thank you for your comment. The relevant recommendation and discussion has been revised to emphasize that professionals treating people with eating disorders should receive appropriate clinical supervision.
201.	SH	Oxford Health NHS Foundation Trust	Full	186	Recs 38 & 39	In Health Monitoring of all Eating Disorders’ delete ‘eating disorder specialist’ as it is not appropriate for a psychological therapist to assess the cause of unexplained electrolyte	Thank you for your comment. The text has been amended to specify that a medical professional should assess and treat the person with electrolyte imbalance.

						imbalance or to offer supplements for this.	
202.	SH	Barnet Enfield and Haringey Mental Health Trust	Full	189	1	We are worried that offering an annual physical and mental health review to people with anorexia who are not receiving on-going treatment for anorexia is too infrequent for many of the patients we see that have disengaged from services. We feel that GPs should be encouraged to review these patients more frequently.	Thank you for your comment. GPs would be expected to be sensitive to the individual needs/desires of the person with the eating disorder depending on the severity of the condition when offering reviews. The recommendation specifies that GPs should offer a physical and mental health review at least annually, implying that this is the minimum frequency and that if a GP deems it appropriate such a review can occur more frequently.
203.	SH	Anorexia and Bulimia Care	Full	189 This comment is also relevant to page 975.	44 31	Regarding the quote: 'GPs should offer a physical and mental health review at least annually to people with anorexia nervosa who are not receiving ongoing treatment for their eating disorder. The review should include: weight or BMI blood pressure relevant blood tests mood any problems with daily functioning assessment of risk (related to both physical and mental health) an ECG, for people with purging behaviours and/or significant weight changes discussion of treatment options.' ABC suggests that health reviews should occur more frequently than once a year, particularly for individuals with a low BMI, and those awaiting outpatient services and following discharge from services. According to the RCGP 'Regular medical monitoring, including monitoring of any further weight loss for	Thank you for your comment. GPs would be expected to be sensitive to the individual needs/desires of the person with the eating disorder depending on the severity of the condition when offering reviews. The recommendation specifies that GPs should offer a physical and mental health review at least annually, implying that this is the minimum frequency and that if a GP deems it appropriate such a review can occur more frequently.

						those with AN, while specialist services are awaited and even when patients are engaged with specialist services. It is important to be aware of the risks of the patient's condition changing whilst referrals are awaited and also of things being missed by specialist teams and situations destabilising at service transitions e.g. from CAMHS to adult services. Frequency of monitoring will depend on a number of factors including BMI, pre-existing health conditions and abnormalities on previous results. If in doubt get specialist advice and support. Don't forget the need to monitor mental state and wellbeing alongside physical parameters.'	
204.	SH	British Society of Gastroenterology	Full	189	Section 44	Health monitoring for anorexia nervosa. The call for GP's to offer physical and mental health review at least annually is welcomed by both the BSG and BAPEN.	Thank you for your comment.
205.	SH	Oxford Health NHS Foundation Trust	Full	189 & 976	1 & 1-3	Recommendation 45 recommends monitoring of physical and mental health for patients with 'AN receiving psychological interventions'. In the notes below the committee justify not specifying whom does this as they believe it should be an agreed plan between primary care and specialists, with clarity on who takes responsibility. We suggest rephrasing the recommendation to state this 'A *clear plan and specified responsibility needs to be agreed between primary care and specialist ED teams to monitor the*	Thank you for your comment. The recommendations regarding monitoring of physical and mental health of anorexia nervosa have been substantially revised and are now included in a section on physical health management, monitoring and management of eating disorders (see recommendations 40-50 in full guideline). Whilst the committee did not wish to specify who should take responsibility, a recommendation was made for all eating disorders in the general principles section at the

						physical and mental health of people with AN receiving psychological interventions'.	beginning of the short guideline that services should ensure that they are well coordinated.
206.	SH	British Society of Gastroenterology	Full	190	Section 46	Please define more carefully exactly what is meant by an inpatient setting.	Thank you for your comment. Due to wide regional variation in the structure of healthcare services, and the lack of comparative trials amongst the various types of inpatient scenarios, the Committee did not feel that they could specify further the type of inpatient setting in which treatment should be provided.
207.	SH	The British Dietetic Association	Full	190 & 196	1 & 1	Some parts seem contradictory as recommendation 49 points out that inpatient admissions are for medical stabilisation and refeeding i.e. short admissions, but then weight restoration is talked about as if this is the goal of admission in recommendation 56 and in other parts of the guidelines.	Thank you for your comment. Note that the recommendations for inpatient and day care treatment, as well as those on discharge planning, have been substantially revised. The recommendation regarding medical stabilisation/refeeding specifies the issues that should be thought about when considering whether to admit the person with an eating disorder to inpatient or day patient care. The subsequent recommendation makes clear that reaching a healthy weight should not be the sole criteria for discharge.
208.	SH	British Psychological Society	Full	191	N/A	The guidance recommends that if someone is admitted to hospital due to physical health problems caused by an eating disorder, psychological treatments should be started or continued if appropriate. However, there is a lack of research evidence to inform decision-making around the psychological interventions that may be appropriate in inpatient settings (although there are some promising areas of development,	Thank you for your comment. The Committee recognised the dearth of evidence regarding the types of psychological treatments that are efficacious in an inpatient setting but, given their recommendation that inpatient treatment should be avoided if possible (recommendation 25, full guideline), decided that other areas of research should take priority.

						e.g. Dalle Grave et al., 2013; Tchanturia, 2015). It would be helpful for a research recommendation to be made around exploring which psychological interventions may be most beneficial during inpatient admissions for eating disorders (within both adult and child and adolescent populations).	
209.	SH	British Society of Gastroenterology	Full	191	Section 50	'A person is admitted for physical health problems caused by an eating disorder. Start or continue psychological treatments for the eating disorder if appropriate'. Again this needs to be defined more carefully. In patients with extreme low weight i.e BMI less than 12, there is no evidence that the patient would be in a fit state to start psychological therapy. There is also evidence that psychological therapies are largely ineffective in patients with BMI's who are below 15. This statement is therefore unclear and needs much closer definition. The blanket statement in 51 'do not use inpatient care solely to provide psychological treatment for eating disorders. Needs greater explanation. What other treatments are of proven benefit. Is inpatient treatment therefore only to be used if some form of refeeding is being carried out? Greater clarity is required.	Thank you for your comment. Please note that the recommendations regarding inpatient care and refeeding have been substantially revised. In particular, the recommendation regarding the use of psychological treatment has been revised to make clear that it should be considered. As with the use of any treatment, clinicians should use their judgment in conjunction with informed patient choice to determine if it is appropriate. Regarding the recommendation that inpatient care should not be used as the only location with which to provide psychological treatment, the recommendations are clear that once a person has been medically stabilised, they should be discharged from inpatient care. Note also that the recommendations to include sections on care planning and discharge from inpatient care have been substantially revised. The evidence regarding effective psychological treatments in an inpatient setting was extremely sparse and the Committee agreed that there was insufficient evidence to recommend a particular intervention.

210.	SH	British Society of Gastroenterology	Full	196	Section 53-56	Emphasising the need for review after discharge is welcomed. In particular emphasising that weight is not the only criteria for discharge is also useful.	Thank you for your comment and support for this guideline.
211.	SH	BEAT	Full	196	1	The guideline lacks detail on this critically important topic. Why was discharge planning for after inpatient care omitted from the scope and thus the evidence review?	Thank you for your comment. The recommendations have been substantially revised. In particular, a section on care planning and discharge from inpatient care has been added to ensure that the person with the eating disorder (and the family/carers if appropriate) is crucially involved in the development of a care plan that has clear objectives and outcomes, and specifies the discharge process and transition to community-based care.
212.	SH	The British Dietetic Association	Full	196	1	It is excellent that a review is recommended in the inpatient unit after 4 weeks of admission and that non-adherence is thought about (recommendations 54 and 55), but it would be helpful if regular 4-6 week reviews were recommended so adherence could continue to be thought about as well as other treatment options.	Thank you for your comment. The relevant recommendations have been amended to specify that as part of the review, a schedule for further review on - at a minimum - a monthly basis should be agreed.
213.	SH	The Tuke Centre, part of The Retreat, York	Full	196	1	It is excellent that a review is recommended in the inpatient unit after 4 weeks of admission and that non-adherence is thought about (recommendations 54 and 55), but it would be helpful if regular 4-6 week reviews were recommended so adherence could continue to be thought about as well as other treatment options.	Thank you for your comment. The relevant recommendations have been amended to specify that as part of the review, a schedule for further review on - at a minimum - a monthly basis should be agreed.
214.	SH	Anorexia and Bulimia Care	Full	200	8	Slight grammar correction, perhaps remove the apostrophe from ‘it’s’.	Thank you for your comment. The text has been amended.

215.	SH	BEAT	Full	200	9	Grammatical error - "young people years" should be changed - perhaps replaced with 'adolescence'.	Thank you for your comment. The text has been amended.
216.	SH	North Essex Partnership NHS Foundation Trust	Full	201		Family Therapy nor Family Based Therapy appear in the list of interventions yet are mentioned later	Thank you for your comment. The list is not intended to be exhaustive. That said, 'Family' appears under 'mode of delivery' in the specification of the population that is of interest to the review.
217.	SH	College of Occupational Therapists	Full	201	39	Interventions and important outcomes We are concerned there is no mention of Occupational Therapy despite important outcomes in the Clinical Review Protocol summary including general functioning measured by normal activities. We recommend interventions should include Occupational Therapy and important outcomes should be re-worded as *improved participation in adaptive self-care, productivity, leisure and rest activities.*	Thank you for your comment. The term 'general functioning', is widely used in the literature and there are several well-known measures (e.g. SF-36) that assess a person's functioning/quality of life with respect to a wide variety of everyday activities. Moreover, the table to which reference is made is the protocol for the relevant evidence review and cannot be changed at this stage of guideline development.
218.	SH	Association for Cognitive Analytic Therapy (ACAT)	Full	201	Table 70	CAT is not listed as a putative psychological intervention despite being represented in two included RCTs (Treasure 1995, Dare 2001),being present in the existing NICE guidance and having substantial clinical representation across the UK in the NHS and private sector (see 7 below)..	Thank you for your comment. As detailed in the protocol, the list of interventions was not intended to be an exhaustive. As noted, the two studies were included and evaluated in the evidence review for psychological treatments for anorexia nervosa under the comparison 'Psychodynamic therapy vs another intervention'.
219.	SH	Somerset Partnership NHS Foundation Trust	Full	201 415 845	Table 70 Table 167 Table 342	CAT has been used in the Adult Eating Disorders Service of this Trust for a number of years and has been seen as beneficial by therapists and sufferers. Therefore it is very concerning that Cognitive Analytic Therapy (CAT) is no	Thank you for your comment. The Committee acknowledged that their recommendations might be difficult for some service providers to implement, especially given their substantial differences across the country. The

						longer listed as one of the therapies appropriate for this client group. It seems premature that therapy options should be narrowed down to only two, when no single intervention especially for anorexia seems to have a complete answer as yet. It also seems premature to assume that focal psychodynamic therapy is superior, when the evidence base for any therapies improving outcomes is very weak, with a dearth of robust research. It is also noted that the guidelines seem to conflate psychodynamic therapy and CAT in reference to research (Dare et al., 2001; Treasure et al., 1995). It is feared that the exclusion of CAT by these Guidelines could lead to it no longer being funded by commissioners for this client group, leading to a narrowing of treatment options available. This would seem to be regrettable both in terms of existing clinical services providing CAT for ED, and in terms of stifling research into refining this and other therapies by further developing the evidence base. We were also concerned that limited but emerging evidence regarding the use of group-based Compassion Focussed Therapy as an adjunctive treatment for eating disorders (AN, BN and OFSED) may have been overlooked, particularly as there is limited other evidence presented in relation to the use of group-based interventions (Gale et., 2014, Kelly et al., 2016).	recommended psychological interventions for anorexia nervosa have been revised to include MANTRA and SSCM as first-line treatments in light of the fact that there is evidence of no difference between these treatments. Furthermore, focal psychodynamic therapy is now recommended as a second-line option in recognition of the fact that implementing it may have significant cost implications for some services and that the manual is not yet published in English. Whilst the Committee recognised that there are differences between the therapies used in Dare et al. 2001 (CAT and general focal psychoanalytic psychotherapy) and Treasure et al. 1995 (CAT), they agreed that they were sufficiently similar to each other to be categorised as (general) psychodynamic therapy. Lastly, the cited studies on compassion-focussed therapy were not comparative and so would not have been included in the evidence review for psychological interventions for anorexia nervosa.

220.	SH	Association for Cognitive Analytic Therapy (ACAT)	Full	204	Table 71	In Table 71, Dare 2001 is listed as Psychodynamic General X 2 vs Psychiatric counselling Family therapy. In fact the trial looked at: (a) a year of focal psychoanalytic psychotherapy; (b) 7 months of cognitive analytic therapy (CAT); (c) family therapy for 1 year — and (d) low contact, 'routine' treatment for 1 year (control).	Thank you for your comment. The Committee thought that focal psychoanalytic psychotherapy and cognitive-analytic therapy were sufficiently similar to be classified as (general) psychodynamic therapy. The table text has been amended to clarify this.
221.	SH	Association for Cognitive Analytic Therapy (ACAT)	Full	205	Table 71	Similarly, Treasure1995 is listed as comparing SSCM with Psychodynamic General. The paper is actually entitled: 'A pilot study of a randomised trial of cognitive analytical therapy vs educational behavioral therapy for adult anorexia nervosa'.	Thank you for your comment. The Committee thought that cognitive-analytic therapy could be broadly classed as a type of psychodynamic therapy. The lead author of the paper, who was a member of the Committee, confirmed and agreed that it would be appropriate to classify educational behavioural therapy as an SSCM intervention.
222.	SH	Association for Cognitive Analytic Therapy (ACAT)	Full	218	Table 78	In footnote 5 relating to Dare 2001 CAT, is referred to as 'focal psychodynamic CAT'. CAT is not a subdivision of focal psychodynamic therapy.	Thank you for your comment, the text has been amended.
223.	SH	Nottinghamshire Healthcare NHS Foundation Trust	Full	269	General	There is much confusion regarding the various models of family therapy for Eating disorders, for example Locke's Family-based Treatment and Maudsley FT-AN. I wonder if more could be done to be more explicit about the models or the shared principles within the models.	Thank you for your comment. The Committee thought that although there are differences between (Lock's) Family-based treatment and (Maudsley-based) Family Therapy, they share sufficiently similar features to enable coherent comparisons between these types of therapies ('family therapy') and other interventions (e.g. other family interventions such as day workshops, or other psychological interventions). This guideline is intended to provide healthcare professionals with an action- and evidence-based description of current best practice. Professionals interested in the similarities and

							differences between (Lock & le Grange's) Family-based Treatment and (Maudesley-based) Family Therapy should consult the relevant literature.
224.	SH	College of Occupational Therapists	Full	270	Green Table item 60	We recommend the below recommendation is included: *Consider experiential eating, meal preparation, lifestyle and independent living skill interventions as an adjunct to CBT-ED for adults with anorexia nervosa with significant psycho-social impairments or disabilities*	Thank you for your comment. In line with the NICE development process, the recommendations have been written by the Committee, ideally on the basis of high quality published evidence (e.g. RCTs). The review of psychological treatments for anorexia nervosa only considered published RCTs and the recommendations for it were based on the considered evidence. In the absence of any RCTs on the efficacy of adjunctive occupational therapy to CBT-ED, it would not be appropriate to include the suggested amendment in the recommendation.
225.	SH	Barnet Enfield and Haringey Mental Health Trust	Full	270	5	We are concerned that the committee identified that helping people "reach a healthy body weight or BMI for their age" is a key goal for treatment of anorexia. The committee is also clear that focal psychodynamic therapy does not appear to improve BMI at the end of treatment or weight at follow-up. Therefore, it is unclear why it is this has been put forward as a recommendation despite clinicians being asked to "consider" instead of "offer" this treatment option. We agree with the committee's acknowledgement that few clinicians in the NHS are trained in this modality and it will also take time and financial investment to train clinicians in this modality to a standard that would be needed to provide this intervention.	Thank you for your comment. The Committee recognised that their recommendation of focal psychodynamic therapy might have significant financial and other implications for some service providers. Regarding the key goals of treatment for anorexia nervosa, the Committee considered reaching a healthy body weight as critical since a refusal to maintain a low body weight (relative to age, gender etc.) is one of its defining features. Regarding the recommendations for psychological interventions for anorexia nervosa, the Committee has revised these to include MANTRA and SSCM as first-line interventions, and focal psychodynamic therapy as a second-line treatment. These recommendations were amended

						Additionally, arranging suitable supervision for newly trained clinicians will also need to be considered.	to reflect the fact that there is evidence of no difference between these therapies, and there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. The evidence considered by the Committee showed that focal psychodynamic therapy was *no better nor worse* than CBT-ED and 'optimum' treatment as usual. The use of 'offer' and 'consider' in recommendations is in accordance with NICE's methods as detailed in 'Developing NICE guidelines: the manual' and are intended to reflect the level of certainty provided by the evidence. For example, 'offer' is used to indicate a high degree of certainty (e.g. where the benefits clearly outweigh the harms), whilst 'consider' indicates a lower degree of certainty (e.g. where there is a balance between benefits and harms to be thought about). As such, recommendations that are based on only one study are likely to use 'consider' unless there is convincing evidence (e.g. large sample size, low risk of bias, large effect size).
226.	SH	Association for Cognitive Analytic Therapy (ACAT)	Full	270	59	ACAT is uncertain about the rationale behind recommending eating disorder-focused focal psychodynamic therapy as one of only two therapies to be considered as first line individual approaches for adults with anorexia nervosa. This recommendation seems to be over-stating the superiority of eating disorder-focused focal psychodynamic therapy over other therapies with a	Thank you for your comment. The Committee has revised their recommendations for psychological interventions for anorexia nervosa to include MANTRA and SSCM as first-line interventions, and focal psychodynamic therapy as a second-line therapy. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between these therapies,

						developing evidence base. The evidence base in this whole area is unfortunately weak with little evidence of any particular therapy improving outcomes significantly more than any other. This recommendation could have a damaging effect on the diversity of therapies available (and so patient and carer choice), the morale of patients and clinical staff engaged in this work and the opportunity for promising therapies to go on to develop their clinical models and evidence base further in the hope of moving toward a more effective treatment for anorexia. ACAT would like to see a recommendation that other therapies with promise (including CAT) can be considered, especially for patients who have not responded adequately to previous interventions, as a combination treatment or for patients who have co-existing personality or relational problems.	and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. Regarding CAT, the evidence suggested that the recommended interventions are superior.
227.	SH	British Society of Gastroenterology	Full	270	Section 57–60	Does any group of individual psychological interventions with or without a Pharmacological intervention cause benefit or harm. Individual CBTE programs are defined as 'key treatment' although there does not seem to be particularly strong evidence, based on the what is presented.	Thank you for your comment. The recommendations regarding treatments for anorexia nervosa have been revised to include MANTRA and SSCM as first-line treatments in addition to CBT-ED, and focal psychodynamic as second-line treatment.
228.	SH	Somerset Partnership NHS Foundation Trust	Full	270	Statement 59, 60	We felt that the strength of the recommendations for the specified psychological therapies (and, perhaps moreover, implied exclusion of others)	Thank you for your comment. The Committee has revised their recommendations for psychological interventions for anorexia nervosa to

						seems at odds with both the strength and quality of the evidence presented in the Clinical Evidence Statements (6.3.11.1). In particular in relation to CBT-ED, the recommendation does not appear consistent with the observation that "…At 12 months follow up, the benefits of CBT-ED on body weight and remission were no longer evident." (p. 271). Further, we were concerned that eating disorder psychopathology was not considered a critical outcome measure. By way of example, the CBT-E model of anorexia conceptualises this psychopathology as core to its maintenance, and thus failure to address this would likely leave patients highly vulnerable to relapse (see Fairburn, 2008).	include MANTRA and SSCM as first-line interventions, and focal psychodynamic therapy as a second-line therapy. These recommendations were amended to reflect the fact that there is evidence of no difference between these therapies, and there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. Given the time constraints in producing this guideline, the committee had to prioritise the outcomes on which to primarily base their decision making, especially given the substantial profusion of different eating disorder psychopathology measures and outcomes reported in the literature.
229.	SH	BEAT	Full	270-271	5-	Why was Interpersonal Psychotherapy (IPT) not included in the recommendations, since according to page 271 of the full guideline, the evidence reviewed suggested similar outcomes to CBT-ED in terms of Body Mass Index (BMI) and some elements of psychopathology at long term follow up?	Thank you for your comment. Please note that the recommendations for the treatment of adult anorexia nervosa have been revised to include MANTRA and SSCM in addition to CBT-ED as first line options, and focal psychodynamic therapy as second line option. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between these therapies, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. The Committee did not recommend IPT because although there is evidence of no difference between IPT and CBT or SSCM (McIntosh 2005/Carter 2011) at end of treatment and long-term follow up, this was the only study identified that

							compared IPT with other interventions. By contrast, there were several studies that examined the use of CBT-ED versus other interventions (e.g. Dalle Grave 2013, Hall 1987, McIntosh 2005/Carter 2011, Pike 2003, Touyz 2013, Zipfel 2014). Hence, the Committee were more convinced overall that CBT-ED was effective. Similarly, there were several studies that examined the effectiveness of MANTRA and/or SSCM (Macintosh 2005/Carter 2011, Schmidt 2012, Schmidt 2015, Touyz 2013, Treasure 1995).
230.	SH	British Psychological Society	Full	General e.g. 271	General	It is difficult empirically to distinguish, amongst people who are stable for a period of time, cases for whom treatment is active regarding vulnerability factors and which is preventing deterioration (or admission) and/or promoting quality of life, versus cases for whom treatment is merely ineffective. Experience recently shows a correlated decrease in community health and social care in general and in some areas for eating disorders, and an increase in need for inpatient treatment of eating disorders. We recommend that the guidelines are cautious in recommending what services should not when there is ambiguity and gaps in the evidence base as there is for severe and enduring eating disorders but instead recommend further research and rigorous mechanisms of clinical governance around treatment of severe and enduring eating disorders	Thank you for your comment. The Committee recognised that some people may have an eating disorder for a long time and that it may be severe, and that furthermore it can be difficult to conduct studies in this difficult to treat group. However, (i) there was little evidence using this group, and the Committee (ii) thought that there was no accepted nor acceptable definition of SEED available in the literature, and (iii) did not wish their recommendations to be driven by this subgroup of patients.
231.	SH	Barnet Enfield and Haringey	Full	273	1	The committee has recommended that clinicians follow a focal psychodynamic	Thank you for your comment. The Committee has revised its

		Mental Health Trust				manual specific to eating disorders. We appreciate that the committee acknowledges that, at present, the only available manual is in German, and despite there being plans for it to be published in English this year, we are concerned about a recommendation to use this manual in anticipation of its publication.	recommendations for psychological interventions for anorexia nervosa. These recommendations were amended to reflect the fact that there is evidence of no difference between these therapies, and there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. An English language version of the manual is due to be published by Hogrefe Publishers later this year. Training for FPT for eating disorders currently consists in a 2-day intensive workshop, though presupposes at least basic training in general psychodynamic therapy.
232.	SH	British Society of Gastroenterology	Full	273	Section 61	Section on eating disorder 'focal psycho dynamic therapy' programs is jargon ridden. The meaning of this section is very unclear to those without specific psychiatric or psycho-therapeutic training. It is also very specific about the number of sessions and weeks that should be used for therapy when again the evidence base is of low grade. Is this justifiable? In general the guidance contains a lot of jargon without adequate explanation of what the therapies consist of particular for lay readers or those who have no psychiatric training.	Thank you for your comment. The Full Guideline is intended to aid health and social care staff in their practice, rather than for the general interest of a non-professional audience. The recommended length of sessions and duration of treatment was based on the studies considered.
233.	SH	British Psychological Society	Full	274		We are concerned that in the instance of comorbidity of eating disorder and other psychiatric comorbidity the conceptualisation of the 'ideal' research study is problematic. It would be better to acknowledge than to bypass it. This is because the psychiatric symptoms are found within diagnostic	Thank you for your comment. The Committee recognised the importance of research on treatments for people with a diagnosis of an eating disorder and a psychiatric comorbidity and provided a research recommendation for this very reason. However, it was outside the scope of the guideline to examine

						categories at the syndrome level with imperfect reliability and validity hence each symptom can be multiply determined at the population and individual levels as well as having idiosyncratic and individual meanings and functions. In the case of psychiatric comorbidity of each eating disorder (X) with each comorbid disorder (Y), beyond the 'ideal' study mentioned, we would really like to know whether it is better to treat X alone, Y alone, sequentially X then Y or Y then X or X and Y together in a combined/adapted therapy. Given the likelihood also of subgroups and mediators and moderators (e.g. OCD that preceded weight loss is likely to differ from OCD that occurred peri- or post-AN, food avoidance driven by fear of weight gain alone is likely to differ from food avoidance that is simultaneously avoidant of triggering PTSD re-experiencing symptoms for which food or eating is an associative cue, that binge or purge behaviour in the context of multi-impulsive/borderline problems and 'plastic' with other risky behaviour is likely to differ from the same behaviour outside that context etc.) this is a massive research programme. Also there may be risks associated with treating one disorder in the context of another without reference to the individual formulation of the connections between problems. We know that there is a high level of comorbidity in eating disorders as well as mortality and anecdotally untoward incidents have involved people with	treatments that primarily targeted the psychiatric comorbidity as these are covered by other NICE guidelines. Nevertheless, it would be expected that clinicians are sensitive to the individual needs of the person with the eating disorder and that the role of any psychiatric comorbidities is carefully considered when providing an eating disorder intervention. The importance of representing the views of people with eating disorders (and their carers) in designing and providing therapy was recognised but this was outside the scope of the guideline. This may be addressed in future NICE guidelines.

						comorbid problems being treated for eating disorders alone; however there is little systematic analysis of investigations or reporting of adverse events in trials to examine whether, whilst in general improvement in one problem is associated with improvement in others, at the individual level change in one problem could lead to predicable change in risk related to another pointing to need for adapted or combined treatments for some individuals. We recommend that the guideline make a research recommendation for more high quality studies of treatment of comorbid problems as described above as well as avoiding making any strong proscriptions about handling of psychiatric comorbidity under the current state of knowledge for most combinations of disorders. Later in the guideline (p844) potentially useful studies to this important question (randomising patients with eating disorder and mental health comorbidity to different treatments) were excluded because they did not address the more limited question of adapting eating disorder treatment. This is a pity as with hindsight a wider question may have been helpful; this could be addressed in a future guideline revision. Further, when the committee commendably recommend that treatment for eating disorder not be denied as a matter of routine or policy on the basis of comorbidity, this should not require therapists to treat eating disorder in a standard way regardless of comorbidity if	

						assessment indicates it is likely to be either impossible or also unduly risky. Given the inherent uncertainty around therapy for comorbid problems we would appreciate in particular the views of individuals with eating disorders and their carers and representative organisations on how linked problems should be addressed in therapy.	
234.	SH	The Association for Family Therapy and Systemic Practice in the UK	Full	279	Trade-off between net health benefits and resource use	In the full guidelines it is written that the committee consider that family therapy would be facilitated by a band 7 worker. AFT recommends that family therapy is facilitated by a qualified family therapist, who could be band 7, but also usefully could be of higher band according to the level of clinical experience and expertise indicated by the clinical need.	Thank you for your comment. The text has been amended to make clear that the reference to a band 7 worker was for illustrative purposes regarding costs of treatment.
235.	SH	Leicestershire Partnership NHS Trust	Full	282	General	The full guidance states on 282 that "instead of offering adult focal psychodynamic therapy for young people, the committee agreed to offer the age-appropriate version of adolescent (young people)". However, there isn't a specific model for adolescent focussed ED therapy?	Thank you for your comment. The recommendations have been revised to include a description of adolescent-focused individual therapy.
236.	SH	Nottinghamshire Healthcare NHS Foundation Trust	Full	283	Table 105	From looking at this table from my own professional experience I think that family based treatment, family day workshops, multifamily group therapy are all very affective in providing interventions for carers. Family based treatment provides not only effective support for carers, but offer effective treatment for the young person physical a psychological health perspective	Thank you for your comment. The interventions listed in the protocol were not intended as an exhaustive list of relevant interventions. Compassion focussed therapy was not included in the review due to the fact that no comparative studies were identified during the literature search.

						Also we offer a parents support group, which in an informal group, but is an affective support for the parents that we work with. I'm unable to see parents support group in the table as an intervention, could this be added? Also within the table under other considerations, it highlights the importance for to consider alternative therapy for someone with anorexia. I think this is essential. And should always be discussion after assessment about treatment options. CBT ED is good alternative. Has there been consideration of compassion focused therapy as an individual treatment?	
237.	SH	Nottinghamshire Healthcare NHS Foundation Trust	Full	304	6.4.4.1 6.4.4.2 6.4.4.3	I would agree with the evidence that has been found regarding there is no evidence to suggest that self-help, is more effective than usual treatments or that it has an impact of WFH or BMI. I wonder if that questions levels of insight people have into this illness and level of motivation and the impact these factors have on treatment. Within practice it has been my experience that both carers and young people need a lot of guidance within their treatment, on a regular basis, especially in the early stages of treatment, and therefore self-help initially for young people would not be affective in my professional opinion. It could be useful in later stages of someone's treatment I do think, self-help for carers as well been regularly seen by a clinician where	Thank you for your comment and support for the guideline.

						they can reflect on what they have learnt with someone that can offer support, could be useful	
238.	SH	Nottinghamshire Healthcare NHS Foundation Trust	Full	306	6.4.4.8	Interested that web based self-help showed no difference in enabling positive experience of care giving. I would question how affective web based treatment is in practice. Is guided self-offering more structure and support, which may impact on it's effectiveness	Thank you for your comment and support for the guideline.
239.	SH	Nottinghamshire Healthcare NHS Foundation Trust	Full	307	21, 69, 70	I agree with this statement. I think in practice more can be done to make sure we are thinking about carers needs. Although we ask these questions, in sometimes gets diluted because we are concentrating on the young person carer. What may be helpful is what is being suggested which is an assessment for them on their own which identifies their needs within the service. I also agree that written information for carers who cannot attend should be given. This is important and essential I think to implement this affectively in practice, specialist CAMHS Ed Teams need to be funded well, have experienced staff and are able to implement a number of different treatment interventions for carers. Currently I'm unsure if this does not happen if these guideline of more specific considerations for carers can be followed affectively	Thank you for your comment and support for the guideline.

240.	SH	Nottinghamshire Healthcare NHS Foundation Trust	Full	309	Other considerations	I agree with the last paragraph of this section, in regards to all the considerations that should thought about when considering affective treatment for carers and how and why they should be involved or not. I think in practice to really consider this need will require a longer assessment period before acting on treatment, which currently does not happen due resources and pressure treating a young person quickly	Thank you for your comment and support for the guideline.
241.	SH	Nottinghamshire Healthcare NHS Foundation Trust	Full	309	Other considerations	As practitioners we see the stress and burden on families who are caring for young people with an eating disorder. This is emotional and financial and importance of working with other agencies to support families who may require information on benefits, family services practitioners	Thank you for your comment and support for the guideline.
242.	SH	Nottinghamshire Healthcare NHS Foundation Trust	Full	309	Other considerations	To be able to complete a full individual assessment for families own needs this would require more resources. A group for siblings could be very beneficial which again would require funding to be properly implemented. Our Team will be doing a sibling focus/ feed back group to identify more of	Thank you for your comment and support for the guideline.
243.	SH	The Association for Family Therapy and Systemic Practice in the UK	Full	316		Re dietary counselling for anorexia nervosa, the recommendations include: 73. Include family members or carers (as appropriate) in any dietary education or meal planning for children and young people with anorexia nervosa who are	Thank you for your comment. The recommendation has been revised to remove the implication.

						having therapy on their own. 74. Offer individualised supplementary dietary advice to children and young people with anorexia nervosa and their parents or carers (if appropriate) to help them meet their nutritional needs for growth and development (particularly during puberty). Point 74 could imply additional individual sessions with a young person which appears to contradict Point 73.	
244.	SH	The British Dietetic Association	Full	316	N/A	In the recommendation points for the section on dietary counselling for anorexia nervosa, it does not say who will be delivering the dietary advice. Could it say the likely person is a dietitian in this part as you have said in the discussion?	Thank you for your comment. A recommendation to this effect has been inserted.
245.	SH	Cardiff and Vale University Health Board	Full	317		'Other considerations'. 1 Query whether the word 'nutritionist' should say Dietitian. Please note that a nutritionist is not qualified to comment on clinical issues. A registered die titian is a regulated professional registered with HCPC who will have undergone extensive training to provide guidance and advice direct to patients on clinical	Thank you for your comment. The text has been amended in line with your comment.

						matters concerning nutrition. A nutritionist is not a protected title and should never provide clinical advice. 2. A 'therapist' is not a protected title and therefore the skill set will vary significantly. It is not appropriate for dietetic advice to be provided by unqualified individuals in such a nutritionally vulnerable client group. This should be provided by a suitably qualified member of staff. This skill set is held by specialist dietitians only.	
246.	SH	The British Dietetic Association	Full	317	1	In the 'other consideration' section of 'dietary counselling for anorexia nervosa' (page 317), it states the nutritionist on the committee, and this is completely incorrect as it was a dietitian on the committee. It is important that the difference between a nutritionist and dietitian is not confused. Also, in the last paragraph of this section, it again refers to the health professional delivering the dietary advice is likely to be a nutritionist, and this should say dietitian.	Thank you for your comment. The text has been amended in line with your comment.
247.	SH	The Tuke Centre, part of The Retreat, York	Full	317	1	In the 'other consideration' section of 'dietary counselling for anorexia nervosa' (page 317), it states the nutritionist on the committee, and this is completely incorrect as it was a dietitian on the committee. It is important that the difference between a nutritionist and dietitian is not confused. Also, in the last paragraph of this section, it again refers to the health professional delivering the dietary advice is likely to be a nutritionist, and this should say dietitian.	Thank you for your comment. The text has been amended in line with your comment.

248.	SH	Somerset Partnership NHS Foundation Trust	Full	317	8	With reference to the following: "The committee agreed that the evidence was not strong enough to recommend nutritional counselling as the sole treatment for adults with anorexia nervosa. However, they highlighted that dietary advice and counselling are an integral part of CBT-ED, SSCM, MANTRA and family therapy, so it is not generally needed if the person is receiving therapy." The guidance appears to be expecting and committing psychology practitioners to being the only nutrition advisors. This is not a role they are qualified to undertake. Individuals with eating disorders can be at risk of re-feeding syndrome, frequently have co-morbidities eg coeliac disease, food intolerance, can be pregnant. Dietitians are the only regulated practitioners trained in medical conditions and nutrition best practice, registered with the HCPC. So a dietitian with specialist training in eating disorders should be a part of every eating disorders team.	Thank you for your comment. The text has been amended in line with your comment.
249.	SH	Somerset Partnership NHS Foundation Trust	full	317	16 from bottom of page	The statement "The health professional, most likely a nutritionist" should be replaced with 'dietitian'. Dietitians are the only profession registered with the HCPC qualified in medical conditions and nutrition. Anybody can call themselves a nutritionist, so if this was left in guidance it could be seen to be condoning the use of unqualified, unregulated individuals. Nutritionist should be replaced throughout the document with dietitian.	Thank you for your comment. The text has been amended in line with your comment.

250.	SH	Oxford Health NHS Foundation Trust	Full	398	Rec 82	Regarding the suggestion to consider treatment with biphosphonates for osteoporosis in long term low weight patients over 18, we suggest specifying the need to liaise with an ED specialist before prescribing as some GPs tends to prescribe even in patients without necessarily a long-term history of ED. Also, often they do not offer enough information for the patient to be able to make an informed decision on this.	Thank you for your comment. The recommendation is clear that prescribing bisphosphonates to women with anorexia nervosa should only be considered in those who have long-term body weight and low bone mineral density. A new recommendation has been inserted at the beginning of this section to emphasise that bone mineral density results should be interpreted by a trained professional.
251.	SH	Cardiff and Vale University Health Board	Full	403		Point 88. . If a dietician is involved in the refeeding process the risk of refeeding is minimised as a Dietitian is suitably qualified to assess, manage and minimise the risk of this occurring. Other professionals are unable to accurately assess risk, devise feeding regimes for oral or artificial routes. This should only be undertaken by a specialist die titian with expertise in the area of re-feeding. Other health professionals should not undertake this without dietetic input. MARSIPAN offers guidance about a range of starting energy prescriptions but unless a dietitian is able to devise a meal plan or feeding regimen there are real risks of under or over feeding. The interpretation and application of MARSIPAN is critical to reducing risk of adverse effects or mortality	Thank you for your comment. The recommendation made is in line with MARSIPAN, which recommends that staff (which may include dietitians) are appropriately trained. Indeed, reference is made to MARSIPAN and Junior MARSIPAN in the recommendations on refeeding and provide an electronic link to them in the document.
252.	SH	Cardiff and Vale University Health Board	Full	404 –405		Re 'Trade off..''. If a dietician is involved in the refeeding process the risk of refeeding is minimised as a Dietitian is suitably qualified to assess, manage and minimise the risk of this occurring. Other professionals are unable to accurately	Thank you for your comment. The recommendation made is in line with MARSIPAN, which recommends that staff (which may include dietitians) are appropriately trained. Indeed, reference is made to MARSIPAN and Junior

						assess risk, devise feeding regimes for oral or artificial routes. This should only be undertaken by a specialist die titian with expertise in the area of re-feeding. Other health professionals should not undertake this without dietetic input. MARSIPAN offers guidance about a range of starting energy prescriptions but unless a dietitian is able to devise a meal plan or feeding regimen there are real risks of under or over feeding. The interpretation and application of MARSIPAN is critical to reducing risk of adverse effects or mortality	MARSIPAN in the recommendations on refeeding and provide an electronic link to them in the document.
253.	SH	British Psychological Society	Full	406 844	Section 6.9 10-16	The specific research recommendation is made to test shorter forms of evidence-based therapies. This is to be welcomed for reasons of potential to improve cost-effectiveness and access. However, elsewhere in the guideline in many places in the weighing of costs, risks and benefits, initial costs are accepted and justified based even if the probability of their impact is limited or uncertain because the known and extremely high costs of chronic or untreated eating disorders justifies erring on the side of caution. Several of these decisions are in favour of resources comparable to or larger than the putative additional four to ten sessions of therapy reflected in the difference between extant therapies and the short form. Therefore a high threshold of evidence for cost effectiveness and safety will necessary before the shorter form be recommended instead of the longer form (as opposed to as an alternative option). We	Thank you for your comment. Your support for interventions of shorter duration is welcomed. The comments on methodology would be for research funding bodies to decide upon, drawing on the appropriate methodological and health economic expertise.

						recommend that the research recommendation regarding short forms be expanded to recommend: - Replication by independent clinics and in sufficient numbers for meta-analysis; - Evidence of effectiveness at long term follow up in studies powered to detect small effects, and mediating and moderating factors; - Adequate monitoring and reporting of adverse events.	
254.	SH	College of Occupational Therapists	Full	407	Table 166	We are concerned there is no mention of Occupational Therapy despite important outcomes in the Clinical review protocol summary including general functioning measured by normal activities – which we have recommended should be re-worded as *improved participation in adaptive self-care, productivity, leisure and rest activities* Important outcomes: We recommend important outcomes that include eating behaviours – needs to make recommendations on best available evidence of nursing and OT General functioning and return to normal activities should be re-worded as '*General social and occupational functioning and return to healthy adaptive meaningful self-care, work or study, leisure and rest activities'.*	Thank you for your comment. This table is the protocol for the evidence review and cannot be amended at this stage. Unfortunately no RCT studies were identified that examined the efficacy of occupational therapy interventions in the treatment of eating disorders.
255.	SH	The British Dietetic Association	Full	410, 618, 838 & 904	1	Recommendations 101, 121, 143 and 158 for diabetes recommends a low carbohydrate diet. This is not evidence	Thank you for your comment. The recommendations have been revised. A specific recommendation regarding blood

						based and not what is done in practise either when working with individuals with an eating disorder or someone with type I diabetes. At this stage feeding the individual is critical otherwise you will be underfeeding. Therefore, routine refeeding should be carried out and insulin doses adjusted accordingly. Also, it would be helpful if there was a recommendation made for measuring ketone levels if an individual with diabetes feels unwell, has an infection or has repeated high blood glucose levels to check for ketoacidosis.	ketones has been inserted and the reference to a low carbohydrate diet has been removed.
256.	SH	The Tuke Centre, part of The Retreat, York	Full	410, 618, 838 & 904	1	Recommendations 101, 121, 143 and 158 for diabetes recommends a low carbohydrate diet. This is not evidence based and not what is done in practise either when working with individuals with an eating disorder or someone with type I diabetes. At this stage feeding the individual is critical otherwise you will be underfeeding. Therefore, routine refeeding should be carried out and insulin doses adjusted accordingly. Also, it would be helpful if there was a recommendation made for measuring ketone levels if an individual with diabetes feels unwell, has an infection or has repeated high blood glucose levels to check for ketoacidosis.	Thank you for your comment. The recommendations have been revised. A recommendation specifically concerning ketones has been added, whilst the reference to a low carbohydrate diet has been removed.
257.	SH	Diabetes UK	Full	410	General	Diabulimia should be considered separately to anorexia or bulimia and it's severity assessed by HbA1c and frequency of DKA admissions. We are concerned that BMI alone may not	Thank you for your comment. The recommendations have been revised to emphasise that eating disorder and diabetes teams should work closely in caring for the person and treating each

						adequately assess how severe the problem is. There needs to be more detail on the medical management of diabulimia including reference to glucose toxicity, insulin resistance and oedema. Correct management of these issues is crucial to effective treatment. It must be made absolutely clear that diabulimia is best managed with diabetes and mental health professionals working together to address both physical and psychological needs.	problem. Specific reference to people with diabetes and bulimia nervosa has also been included, as suggested, and some guidance on how to treat it.
258.	SH	Diabetics with Eating Disorders	Full	410	General	Firstly, I would like to say how pleased we are, as the only organisation in the UK that deals solely with those who have type 1 diabetes and an eating disorder, to see these guidelines updated to address EDs in T1 and insulin omission. This having been said we (the charity and our members) have a number of concerns. It is important to note that in Type 1 severity should be measured or at least heavily informed by HBA1c and that must be made clear, HBA1c/ DKA frequency is the immediate risk factor and by separating EDs into just AN and BN, T1s are also being divided by BMI. BMI is less of a risk factor for death in those with T1 than HBA1c. Also by saying a T1 is AN, is that via restricting or via insulin omission? The implications both biologically and psychologically are massive. I am also concerned to see that	Thank you for your comment. The recommendations have been revised. The committee has added some comments regarding HbA1c to the relevant LETR. Regarding the use of the term 'diabulimia', the committee considered your suggestion, but as it is not a diagnostic term, declined to use it. A recommendation regarding diabetes and bulimia nervosa has been added.

						issues those caring for T1EDs (Type1 Eating Disorder) such as Insulin Resistance, Glucotoxicity and Oedema are not highlighted as treatment effects. This obviously has practice implications. There are countless papers showing that standard ED treatment doesn't work: This would suggest that a new paradigm is at least warranted. There are also countless papers showing that in T1s, diabetes specific aspects are important to the development of Eating Disorders so of course standard treatment needs modified, at least in the instance of T1D. It seems that NICE has half recognised this by stating that insulin restriction must be addresses, but that only is half the story. (See the specialist editions of Diabetes Care 2002, 2008) Also I haven't seen the term Diabulimia used once in this document and given that's what 98% of those who omit insulin call themselves (Allan 2015, Journal of Diabetes Nursing) HCPs should be aware that patients may present with this terminology.	
259.	SH	Diabetics with Eating Disorders	Full	411	general	DAFNE: In the immediate treatment plan it is far more important that T1EDs have access to appropriate psychological care than a dafne course. Our members have consistently reported that DAFNE attendance during an ED phase is at best unhelpful and at worse incredibly triggering, being around other T1s who have much better control, having to face	Thank you for your comment. The recommendations have been revised. In particular, reference to DAFNE in the recommendations has been removed.

						diabetes etc etc. There is a place for DAFNE down the line but not during active omission of insulin	
260.	SH	Diabetics with Eating Disorders	Full	411	general	'education about the problems caused by misuse of diabetes medication': This could seriously backfire, many of our members state that overemphasis of complications from health care professionals contributed to the development of their eating disorder in the first place. Of course, education is important but the idea that most of them aren't already acutely aware of the damage they're doing to themselves is wrong. It is probably more important that they understand the checks they need to have and the implications of them, than justifying what may be perceieved as yet more finger wagging.	Thank you for your comment. The recommendations have been revised and in particular, the point about the need for education has been amended.
261.	SH	BEAT	Full	415	25-26	The van Hoeken et al (2003) source which has been cited here generated these point prevalence estimates by calculating averages from several studies conducted in various countries. Therefore, the wording used should reflect that these estimates are not derived directly/solely from studies of the UK population. It is important that the lack of epidemiological evidence about eating disorders in the UK population is highlighted to policy makers and funders to help support efforts to rectify this.	Thank you for your comment. The text has been amended to reflect that the estimate pertains to Western Europe and the US.
262.	SH	BEAT	Full	415	25-26	These percentages should only be cited as applying to younger people (e.g. Under 35s as the King's Fund did when it cited them in its 'Paying the Price' report), because only a few of the studies	Thank you for your comment. The text has been amended in line with your comment.

						included in the van Hoeken et al. (2003) meta-analysis (which this source presumably draws on), included patients of 35 years or older. It is important that the lack of epidemiological evidence about eating disorders in the UK population is highlighted to policy makers and funders to help support efforts to rectify this.	
263.	SH	BEAT	Full	415	25-26	This 0.1% of cases are males estimate has been contradicted by studies which have been published since the van Hoeken et al. (2003) review. Most notably 25% of the people with lifetime experience of Bulimia nervosa identified by Hudson et al (2007) were male. A review of community-based epidemiological studies by Sweeting et al (2015) suggests that the prevalence of eating disorders in males may be as high as 25%.	Thank you for your comment. A sentence indicating that the prevalence may be higher than previously thought, has been added. An alternative reference has been added. The Committee declined to include Hudson (2007) as it is does not use full diagnosis as a criteria for bulimia nervosa and was not conducted in a UK context.
264.	SH	NHS Greater Glasgow and Clyde	Full	505	16 & 17	Sentence structure doesn't make sense	Thank you for your comment. The text has been amended for clarity.
265.			Full Short	527 981 15	9-10 37 9	There is a recommendation of twice weekly appointments in initial phase of CBT-ED for BN. This is a component of CBT-E (Fairburn, 2008) as tested in randomised trials, but not other manual based approaches (e.g. Waller et al, 2007). Uncontrolled effectiveness studies of 'amalgam' therapy combining the manuals report acceptable levels of engagement and outcome (Turner et al, 2015; Waller et al, 2014) comparable to RCT trials. The reports are unclear regarding frequency of appointments but personal communications suggested it	Thank you for your comment. The Committee made a more general research recommendation regarding the optimum duration of psychological treatments.

						may have been once weekly for at least some participants. There are practical obstacles for some people with eating disorders and services to provide twice weekly sessions. The differential requirements for time, money and ability to travel from patients may differentially impact on people with protected characteristics, as well as therapists working part time hours. Therefore whilst one would usually parsimoniously recommend adherence only to manuals used in trials, in this case we would instead make a research recommendation for trials of once versus twice weekly formats in phase one of CBT-E to establish whether the benefits outweigh the costs.	
266.	SH	Somerset Partnership NHS Foundation Trust	Full	529		In reference to the statement: "DBT, group emotional and mind training, group support, general self-help (versus another intervention), did not measure any critical outcomes." Whilst we appreciate that focus has to be kept on interventions which meet the critical outcomes, we fear that this fails to recognise the potentially important role of ancillary interventions, such as DBT, in equipping clients with the necessary skills to engage with them. This is particularly the case when working with clients who may be struggling with high levels of distress, and feel unable to make changes to their eating without	Thank you for your comment. Given the wide scope of the guideline, the time allotted to develop it, and the profusion of outcomes reported in the literature, it was necessary to choose outcomes (such as remission) that were the most critical and important for the Committee on which they could base their decision making.

						having the necessary skills to manage this distress.	
267.	SH	Manchester Metropolitan University	Full	533		The physical interventions listed in Table 216 include two neuromodulation techniques: transcranial magnetic stimulation (TMS) and deep brain stimulation (DBS). The review of the evidence does not include a review of transcranial direct current stimulation (tDCS), which is a technique in which mild electric current is delivered across the scalp. Some of this electric energy passes across the skull and affects brain function. NICE has already issued Interventional Procedures Guidance on tDCS for depression (IPG530). tDCS has so far shown promise in improving eating-related behaviour (see Table 4 of Val-Laillet et al., 2015). I suggest that the guideline incudes reference to tDCS.	Thank you for your comment. Val-Laillet et al. 2015, whilst interesting, is not systematic and would not normally be included in the evidence reviews. Nevertheless, the additional RCTs identified in Table 4 of the review article (in particular those examining tDCS) did not meet the inclusion criteria for the relevant evidence review (e.g. they were conducted using a non-eating disordered population or had a small sample size).
268.	SH	British Psychological Society	Full	533	1-3	We are highly concerned that the recommendations for CBT-ED and Focal Psychodynamic Psychotherapy have significant commercial implications, particularly when coupled with the recommendation that these therapies should not be delivered without a treatment manual. Some members of the committee have interests in these models of psychotherapy, clinically and potentially commercially. Therefore there is a significant conflict of interest inherent in the recommendations made by NICE, which is particularly marked in the context of only two models of psychotherapy being recommended. This conflict of interest has been acknowledged, but not discussed further.	Thank you for your comment. The Committee acknowledged that their recommendations might have significant financial and other implications for some service providers. Please note that, the therapies recommended for the treatment of anorexia nervosa have been changed to include CBT-ED, MANTRA and SSCM as first line therapies, whilst focal psychodynamic psychotherapy is now recommended as a second-line therapy. These recommendations were amended to reflect the fact that there is evidence of no difference between these therapies, and there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision.

						Given the significance of this potential conflict in the context of the recommendations made, it raises questions about the acceptability of the recommendations made by the draft document. (Appendix B "Declarations of interest" is not included in the draft).	The actions set out in Appendix B (declarations of interest) at consultation were not fully accurate and the NGA apologises for this error. Where studies or manuals were discussed that involved one of the committee members, they did not participate in decision making and only answered questions on points of clarification. They did not play a role in the committee's decision making. The appendix has now been updated accordingly.
269.	SH	Cardiff and Vale University Health Board	Full	552		Other considerations. As above Dietitians are the only registered clinicians who hold the necessary skills and qualifications to deliver clinical dietetic advice .	Thank you for your comment. The text has been amended to refer to a dietitian rather than a nutritionist as suggested, and to nutritional counselling rather than dietary counselling. This avoids the implication that the therapist providing CBT-ED, for example, is providing *dietary* advice.
270.	SH	Somerset Partnership NHS Foundation Trust	full	552		The guidance would be expecting and committing psychology practitioners to being the only nutrition advisors, which again raises the concerns noted in comment 6. Then "Usually this is delivered by the therapist and sometimes in collaboration with a dietician." Correctly refers to a dietitian (unlike p317 see comment 7 above). The term dietitian and nutritionist are not interchangeable. Dietitians (the regulated profession) rather than nutritionists (unregulated) would be the professional qualified to advise on nutrition.	Thank you for your comment. The text has been amended to refer to a dietitian rather than a nutritionist as suggested, and to nutritional counselling rather than dietary counselling. This avoids the implication that the therapist providing CBT-ED, for example, is providing *dietary* advice.

271.	SH	Manchester Metropolitan University	Full	564	12	Section 7.5.6 discusses the harms of neuromodulation. At present we do not have good, principled methods to set dosage for TMS or tDCS. TMS and tDCS work by delivering energy to the external surface of the head. Some of this energy reaches the brain, and changes its activity. These techniques are sometimes called 'non-invasive', although I believe this term to be misleading (Davis & van Koningsbruggen, 2013). At present our best method to determine an appropriate level of energy is to model the induced field using computational methods. However these methods may be unreliable when the person's head anatomy differs from the norm, such as in young people or people with eating disorders, whose skull may be thinner and whose protective fatty layers may be reduced (Davis, 2014; Widdows & Davis, 2014). Excessive stimulation may lead to mild skin lesions, or even to seizure.	Thank you for your comment. It should be noted that the Committee made a recommendation not to offer physical therapies such as tMS. The section referred to - "Trade-off between clinical benefits and harms" - describes the benefits and harms of the interventions considered in the context of the relevant identified studies, rather than more generally. As you may understand, given a document of this length intended to describe current best practice, it would neither be practical nor desirable to discuss the potential benefits and harms of every intervention considered but not recommended.
272.	SH	Manchester Metropolitan University	Full	564	12	A harm not discussed in Section 7.5.6 involves informed consent. I and others have raised concerns about the ability of people with eating disorders to consent to neuromodulation procedure. I suggest that the uncertainty around the effect of TMS, tDCS and DBS on people with eating disorders mean that it is not currently possible to advise people with certainty on the potential risks of the procedure (Widdows & Davis, 2014). Maslen et al. (2015) raise wider ethical concerns with the mode of action of DBS for anorexia nervosa, and what aspect of the person's behaviour, personality or	Thank you for your comment. It should be noted that the Committee made a recommendation not to offer physical therapies such as tMS. The section referred to - "Trade-off between clinical benefits and harms" - describes the benefits and harms of the interventions considered in the context of the relevant identified studies, rather than more generally. As you may understand, given a document of this length intended to describe current best practice, it would neither be practical nor desirable to discuss the potential benefits and harms of every intervention considered but not

						identity might be modulated by the procedure.	recommended. More general issues of consent are mentioned and discussed in the chapter on the coordination of care and compulsory treatment,
273.	SH	College of Occupational Therapists	Full	611	Table 7.7.6	Under Outcomes for People with Bulimia Nervosa include: *'Participation in adaptive solitary eating and meal preparation, social eating and self-care, productivity leisure and rest activities*	Thank you for your comment. The table describes the outcomes, which are specified in the protocol, that the Committee considered to be the most important in assessing the relevant interventions. It would therefore not be appropriate to amend the outcomes as suggested at this stage of guideline development.
274.	SH	Diabetics with Eating Disorders	Full	618	general	118. Agree between the eating disorder and diabetes teams who has responsibility for monitoring the physical health of people with an eating disorder and diabetes: This is worrying as many ED units do not understand the intricacies of type 1 diabetes. We have had patients on ED wards who have been administered the wrong insulin, been tested at the wrong times, been denied sugar when in Hypos (not in the meal plan), been denied water when in DKA (no extra fluid allowed) been left in DKA (don't understand correction doses) The Diabetes Team MUST be responsible for the medical management of patient or at the very least the diabetes regimen.	Thank you for your comment. Please note that the committee made a number of revisions on the management of diabetes for people with eating disorders, including a strong emphasis on the importance of collaboration between teams and some clarity regarding the division of labour between them.
275.	SH	NHS Greater Glasgow and Clyde	Full	621	N/A	"Family members may also need to care for someone if they hyper or phyo?" – Should be hypo not phyo	Thank you for your comment. The text has been amended in line with your comment.
276.	SH	NHS Greater Glasgow and Clyde	Full	622	N/A	Celiac is used instead of coeliac (Coeliac is the spelling used by the NHS websites)	Thank you for your comment, this has been revised throughout the guideline.

277.	SH	NHS Greater Glasgow and Clyde	Full	622	N/A	Irritable bowel disease – Do they mean irritable bowel syndrome or inflammatory bowel disease? You don't get irritable bowel disease	Thank you for your comment. The text has been amended.
278.	SH	BEAT	Full	625	10-11	No sources are cited for this statement about the epidemiology of Binge Eating Disorder (BED).	Thank you for your comment. Some references have been added.
279.	SH	BEAT	Full	625	7	Typographical error - "binges occur may occur…".	Thank you for your comment, this has been revised as suggested.
280.	SH	NHS Greater Glasgow and Clyde	Full	708	27	Sentence says "effective bingeing" whereas it should be "effective on bingeing"	Thank you for your comment, this has been revised as suggested.
281.	SH	College of Occupational Therapists	Full	724	Table 276	Under outcomes change 'general functioning' to: *'Participation in adaptive solitary eating and meal preparation, social eating and self-care, productivity leisure and rest activities*	Thank you for your comment. The table is the protocol for the relevant review. It would therefore not be appropriate to amend the outcomes as suggested at this stage of guideline development. It should be noted that these aspects of functioning are covered by measures of quality of life and general functioning measures.
282.	SH	Cardiff and Vale University Health Board	Full	815		'First paragraph' plus 'Trade off'.... As per the above comments. It is concerning that it has been recommended that any therapist can provide dietetic and nutrition information. This should be provided by an appropriately qualified clinician in line with all other professionals who should not work outside of scope of practice by provision of dietetic advice if they are not appropriately trained.	Thank you for your comment. The text has been amended to refer to a dietitian rather than a nutritionist as suggested, and to nutritional counselling rather than dietary counselling. This avoids the implication that the therapist providing CBT-ED, for example, is providing *dietary* advice.
283.	SH	Somerset Partnership NHS Foundation Trust	full	815		The guidance would be expecting and committing psychology practitioners to being the only nutrition advisors, which again raises the concerns noted in comment 6.	Thank you for your comment. The text has been amended to refer to a dietitian rather than a nutritionist as suggested, and to nutritional counselling rather than dietary counselling. This avoids the implication that the therapist providing

							CBT-ED, for example, is providing *dietary* advice.
284.	SH	BEAT	Full	828	n/a	There doesn't appear to be sufficient evidence to justify a 'do not offer' recommendation regarding yoga.	Thank you for your comment. The recommendation not to offer yoga as a treatment for binge eating disorder, and more generally for any eating disorder, was made on the basis that there was evidence that it had no effect on any of the critical outcomes and that it was therefore likely to be not cost effective.
285.	SH	BEAT	Full	845	15-17	This hasn't mentioned Purging disorder and Night Eating Syndrome.	Thank you for your comment. The text has been amended.
286.	SH	BEAT	Full	845	25-27	This should also add that many people may have an atypical eating disorder and then go on to meet the diagnostic criteria for either anorexia nervosa, bulimia nervosa or binge eating disorder.	Thank you for your comment. The text has been amended to reflect the fact that people with an atypical eating disorder can of course go on to develop a typical eating disorder.
287.	SH	BEAT	Full	845	22-23	This should be edited to make it clear that "Persistent and extreme dieting" is not experienced by everyone who has an atypical eating disorder given the fact that one of the subtypes of Other Specified Feeding and Eating Disorders (OSFED) is 'binge eating disorder (of lower frequency or duration)'.	Thank you for your comment. The text has been amended to make this clearer.
288.	SH	BEAT	Full	845	12	Typographical error - delete 'a'.	Thank you for your comment, unfortunately the page and line numbers given do not correspond with the comment and we are therefore unable to respond.
289.	SH	BEAT	Full	845	13-14; 20-21; 27; 29-30	Typographical errors - references.	Thank you for your comment, the references have been corrected throughout the guideline.
290.	SH	BEAT	Full	845	25	No source/s have been cited to support this statement.	Thank you for your comment. Some references have been added.
291.	SH	BEAT	Full	845	30	Typographical error - replace "that" with 'than'.	Thank you for your comment, the text has been amended for clarity.

292.	SH	BEAT	Full	845-847	All	Using both the terms Eating Disorder Not Otherwise Specified (EDNOS) and Other Specified Feeding and Eating Disorders (OSFED) seems like it will only add to the confusion. Wouldn't it be simpler to adopt and use the term OSFED given the fact that this is the most contemporary?	Thank you for the comment. As the majority of the relevant evidence used the DSM-IV category of EDNOS the Committee thought it was important to use the term as it is not co-extensive with the relatively new category of OSFED. It would therefore be misleading to just use the OSFED category.
293.	SH	Somerset Partnership NHS Foundation Trust	Full	875	Table 354	We were a little confused by the inclusion of Eye Movement Desensitization and Reprocessing Therapy (EMDR) within the analysis of physical rather than psychological interventions. Further, it is included in Table 354 but not mentioned in Table 353. In addition, references in 9.5.6 (p.886), p.979 (line 23), p. 982 (line 41), p.984 (line 37), p.986 (line 5) all refer simply to "Eye Movement Desensitization" rather than Eye Movement Desensitization and Reprocessing Therapy, which could be confusing to readers.	Thank you for your comment. This was a mistake and should not have been included in the evidence review for physical interventions. However, the study would not have been included in the review for psychological interventions and was therefore excluded.
294.	SH	College of Occupational Therapists	full	926		Under references include: o Elliot, Michelle L. (2012) Figured world of eating disorders: Occupation of illness. *Canadian Journal of Occupational Therapy vol 79 (1) Feb 2012* o Gogarty O & Brangan J (2004). The lived body experience of women with eating disorders: A phenomenological study of the perceived impact of body image disturbance on occupational performance. *Irish journal of Occupational therapy 33 (2) 11-9*	Thank you for the references, which have been checked. Rummel-Kluge et al. (2013) was a questionnaire-based study of healthcare professionals who work in a general psychiatric hospital setting (and not solely eating disorder services). It thus would not have been included in any of the reviews. Lock et al. (2012) does not have a comparison group and so would not have been included in the review on nutritional interventions; Quiles-Cestari & Rebeiro (2012) compares anorexia nervosa group with healthy controls, so would not have been included; there is no clear intervention in Rymaszewska et al . (2012), so this

						○ Quiles-Cestari LM & Rebeiro RP (2012) The Occupational roles of women with anorexia nervosa. *Revista Latino-Americano de Enfermagen 04 2012 vol/iss 20/2 (1-2) 0104-1169:2012 Apr)* ○ Lock LC, Williams HA, Bamford B & Lacey JH (2012) The St George's Eating Disorders Service Meal Preparation Group for Inpatients and Day Patients Pursuing Full Recovery: A Pilot Study, *European Eating Disorders Review Volume 20 p218-224* ○ Lock LC & Pepin G (2011) Eating Disorders, Chapter 10, (p 123-139) in: *Occupational Therapy in Mental Health: a vision for participation* Edited by Catana Brown & Virginnia C Stoffel Pub: F.A. Davis Philadelphia – (2nd edition in press) ○ Rummel-Kluge C, Kluge M & Kissling W (2013) Frequency and relevance of Psycho-education in psychiatric diagnoses: Results of two surveys five years apart in German-speaking European countries *BMC Psychiatry June 2013, vol/iss 13/?, 1471-244x (18.June 2013)*	would not have been included; Elliot et al. (2012) and Lock & Pepin (2011) are narrative reviews, and so would not have been included in any of the reviews in this guideline. Finally, it was not possible to obtain Gogarty & Brangan (2004).

						○ Rymaszewska J & Mazurek J (2012) The social and occupational functioning of outpatients from mental health services *Advances in Clinical and Experimental Medicine March April 2012 vol/iss 21/2 215-223) 1899-5276*	
295.	SH	BEAT	Full	942	32	Le Grange et al (2012) isn't listed in the references section.	Thank you for your comment. The text has been amended in line with your comment.
296.	SH	BEAT	Full	945	34	This reference has been given a different publication year on page 818.	Thank you for your comment. The text has been amended in line with your comment.
297.	SH	BEAT	Full	954	16	Reference is missing the place of publication.	Thank you for your comment. The text has been amended in line with your comment.
298.	SH	College of Occupational Therapists	Full	969		Include OT in list of abbreviations defined as Occupational Therapy	Thank you for your comment the abbreviation is not needed as it is used in this guideline.
299.	SH	Oxford Health NHS Foundation Trust	Full	971—987	Recommendations	Using a combination of 'Numbering' and Bullet points for the 164 Recommendations in the Full (Short) version will complicate auditing because it would be possible to be complaint with some bullet points of a recommendation but not with all bullet points of the specific recommendation. It would therefore be better for auditing purposes if the bullets points could be replaced by numbering e.g. 1.1, 1.2. 1.3. for each of the recommendations as this will enable auditors to report that a service is for example complaint with recommendation 9.1 and 9.2 but that the service is not complaint with recommendation 9.3 and 9.4.	Thank you for your comment, the recommendations are presented in the standard NICE format and cannot be changed.

300.	SH	North Essex Partnership NHS Foundation Trust	Full	971	9&38	Lines are repeated	Thank you for your comment, this has been revised to remove the duplicate sentence.
301.	SH	British Psychological Society	Full	975	31	We were concerned about the lack of clarity regarding which responsibilities for physical health monitoring should reside with GPs when individuals are also under specialist services, because this could result in gaps of service provision.	Thank you for your comment. The recommendations for health monitoring have been substantially revised to cover physical health assessment, monitoring and management of eating disorders and the reference to who should conduct the relevant assessments has been removed. Please also note that there is a recommendation in the general principles section that services are well coordinated, as well as some new recommendations regarding care planning and discharge from inpatient care.
302.	SH	South Staffordshire and Shropshire NHS Foundation Trust	Full	978	4	We are concerned that we currently offer CAT, IPT and systemic therapy for our outpatient sufferers of both anorexia nervosa and bulimia nervosa but that these therapy models are not mentioned as options in the new guidelines. We have experienced positive outcomes when working within these models (we would be happy to share our experiences)	Thank you for your comment. In the review of the evidence there were other therapies that the Committee decided were better supported by the evidence.
303.	SH	South Staffordshire and Shropshire NHS Foundation Trust	Full	979	22	The guidance stated that “no physical therapies should be used in the treatment of eating disorders” We have started to “augment” CAT therapy with EMDR and were hoping to include yoga specifically developed for anorexia in our inpatient programme and so to rule this option out would be a missed opportunity for those staff trained in these areas.	Thank you for your comment. This guideline is intended to characterise current best practice based on a systematic review of the evidence. Overall, the evidence based on RCT studies for the efficacy of physical interventions in the treatment of eating disorders (generally and specific) generally showed no difference on critical and important outcomes.

304.	SH	Cardiff and Vale University Health Board	Full	980		'Refeeding syndrome'. Point 88. If a dietician is involved in the refeeding process the risk of refeeding is minimised as a Dietitian is suitably qualified to assess, manage and minimise the risk of this occurring. Other professionals are unable to accurately assess risk, devise feeding regimes for oral or artificial routes. This should only be undertaken by a specialist die titian with expertise in the area of re-feeding. Other health professionals should not undertake this without dietetic input. The interpretation and application of MARSIPAN is critical to reducing risk of adverse effects or mortality	Thank you for your comment. The recommendation made is in line with MARSIPAN, which recommends that staff (which may include dietitians) are appropriately trained. Indeed, reference is made to MARSIPAN and Junior MARSIPAN in the recommendations on refeeding and provide an electronic link to them in the document.
305.	SH	Cardiff and Vale University Health Board	Full	980		Point 98. A die titian is physical health trained and is uniquely positioned to support the monitoring of diabetes and a co existing eating disorder	Thank you for your comment. Please note that the recommendations have been revised. Unless the context requires it, particular types of professional that should or should not be responsible for care of an individual with the relevant condition are not specified. In this particular case, it has been emphasised that eating disorder and diabetes teams (which may or may not include a dietitian) that care for individuals with diabetes and an eating disorder should closely collaborate and agree who has responsibility.
306.	SH	British Psychological Society	Full Short	982 16	35	We recognise that the evidence base supports the use of FBT as first line intervention for young people with Bulimia. However, given the established evidence base for CBT-ED for Bulimia in adults – we recommend that this also be included alongside guided self-help as a secondary option to consider for older	Thank you for your comment. The recommendations have been revised to include family therapy as first-line and CBT-ED as second-line therapy because the Committee decided to reclassify one arm of a study (Schmidt et al. 2007) as a form of CBT-ED (rather than as guided self-help).

						children / young adults. Experience in services suggests that this can be effective and acceptable and widens choice.	
307.	SH	Somerset Partnership NHS Foundation Trust	Full	988		Further research regarding the structure and configuration of community-based specialist eating disorder services would be helpful.	Thank you for your comment. The Committee acknowledged your suggestion but agreed that it was not a priority given the limited evidence on the effect of treatment.
308.	SH	BEAT	Full	988	7-12	Why have these research recommendations not been included in the 'Short version' document or Appendix G? Is this because these two research recommendations are deemed to be of a lower priority, as that is the implication? Their exclusion from these documents may lead to them being neglected in comparison, as we have not been provided with the same level of detail on the committee's deliberations. This has also made it impossible to comment in the same level of detail on these recommendations as we have been able to do for the others.	Thank you for your comment. NICE requires that the Committee pick 5 research recommendations that they consider to be of highest national priority for inclusion in the short guideline. The remaining research recommendations appear in the full guideline.
309.	SH	BEAT	Full	988	1	Given the considerable gaps in the research which has been conducted to date, we would like to argue that some additional research recommendations are warranted. The limited extent of UK epidemiological research into eating disorders means that we are left to try to extrapolate estimates for the prevalence of eating disorders in young people from studies conducted in other countries. Without reliable estimates of prevalence, it will be impossible to adequately plan initiatives aimed at increased help-	Thank you for your comment. Whilst the Committee recognised the importance of epidemiology in this area, they agreed that the national priority should be to develop effective interventions.

						seeking and treatment services. A research recommendation would be warranted such as: 'Conduct research aimed at estimating the prevalence of eating disorders in the community in the UK?'.	
310.	SH	BEAT	Full	988	1	When the guideline made recommendations for more than one form of psychotherapy for an eating disorder (see Recommendations 1.2.14 and 1.2.18), the committee were not able to make recommendations about 'what works for whom' (mediating and moderating factors). This suggests that a research recommendation is required to help address this gap in the evidence-base, such as: 'Are there certain patient characteristics or symptom patterns at assessment which can predict treatment outcome from those psychotherapies recommended in the guideline?'. A recent systematic review of predictors, mediators and moderators of CBT for eating disorders published in the European Eating Disorders Review found that "...it is unclear how and for whom this treatment works." (Linardon et al, 2016).	Thank you for your comment. It was agreed that establishing the factors that influence treatment efficacy is vitally important and the research recommendations have been amended to specify that mediating and moderating factors should be measured.
311.	SH	BEAT	Full	988	1	Given the high proportion of patients who do not complete a course of the treatments recommended in the draft guideline, a research recommendation should be made: 'Which elements of care can contribute best to helping patients to engage and complete a course of psychotherapy?'.	Thank you for your comment. A number of research recommendations have been made which address this important issue within the development of novel treatments (for example, in anorexia nervosa) and changes to the delivery of treatment (for example, regarding the intensity and duration of treatment).
312.	SH	BEAT	Full	988	1	Compared to other health conditions, there is a paucity of research evidence	Thank you for your comment. The Committee have adopted this research

						concerning peer support for people affected by eating disorders. Therefore, a research recommendation should be added to 'Investigate the clinical and cost-effectiveness of peer-support interventions for patients with eating disorders and their carers'.	recommendation and it is included in the full guideline (please see relevant LETR in Chapter 6.3 of the full guideline).
313.	SH	BEAT	Full	988	1	Since a significant proportion of patients who receive a course of one of the current evidence-based therapies still do not meet recovery criteria at the end of their treatment or follow up, a further research recommendation should be made, perhaps using similar wording to the following: 'Investigate the clinical and cost-effectiveness of psychotherapies not recommended in the guideline, such as Radically-Open Dialectical Behaviour Therapy (RO-DBT), Interpersonal Psychotherapy (IPT) and Cognitive Analytic Therapy (CAT), amongst others'. This would also help to support those eating disorders services who are engaged in developing new forms of treatment through research and 'practice-based evidence'.	Thank you for your comment. A number of research recommendations have been made which address this important issue within the development of novel treatments (for example, in anorexia nervosa) and changes to the delivery of treatment (for example, regarding the intensity and duration of treatment).
314.	SH	BEAT	Full	988	1	Whilst some important research is ongoing in this area, a research recommendation should be added: 'Evaluate the clinical and cost-effectiveness of early intervention in the treatment of eating disorders'. Strong evidence concerning the cost-effectiveness of investing in early intervention and access to treatment will be very important for campaigners (such as Beat), particularly given the financial	Thank you for your comment. The Committee declined to include the suggested research recommendation as they considered other areas for research to be of greater priority for this guideline.

						pressures on commissioners and mental health trusts.	
315.	SH	BEAT	Full	988	1	Another research recommendation could seek to address the deficit of research on the impact of care pathways and service models (in comparison to treatment approaches): 'What is the impact of different care pathways and service models on treatment effectiveness?'	Thank you for your comment. The committee acknowledges your suggestion but believe that it not a research priority given the limited evidence on the effectiveness of current treatments for eating disorders.
316.	SH	The Association for Family Therapy and Systemic Practice in the UK	Full	988	7–9	We welcome the research recommendations, particularly the consideration of whether the current guideline recommendations are effective in improving symptoms and remission rates for men. We would suggest that research recommendation 3, for further research into the effectiveness of adapted treatments for those with anorexia nervosa who are not responding to treatment, includes an evaluation of the involvement of carers and family members where possible and does not exclusively focus on individually focused aspects of these treatments.	Thank you for your comment, the committee revised the research recommendations and these have been updated within the guideline.
317.	SH	Age UK	Full & Short	General	General	The full draft guideline sets out on p37 that adults will be covered. While we understand this applies to all people aged over 18, Age UK believes that older people - who are an ever growing cohort of individuals with increasing numbers experiencing eating disorders - should be explicitly covered in this guidance. There are only two incidences when older people are specifically mentioned: p.24 of the full draft guideline, with reference to	Thank you for your comment. Most of the Committee's discussions were centred around the evidence identified and unfortunately no evidence was found on older people. Nevertheless the recommendations are still relevant to older people. "Age" has been added to the general principles section at the beginning of the guideline to emphasise that all people have the right to equal access to treatments.

						binge eating being more common with older individuals, and p.23 of the full draft guideline regarding 'the natural course of eating disorders'. The section on 'The natural course of eating disorders' mentions that cases can start at an older age and individuals can battle with eating disorders for decades. Age UK is concerned that there is not adequate information highlighting the fact that older people can relapse or indeed develop an eating disorder particularly when they experience a difficult transition later in life such as retirement or bereavement. Yet we know from our experiences with working closely with older people and their carers, and as part of the Malnutrition Task Force, that weight loss in an older person who has a history of eating disorders is often not seen as a relapse but merely a false assumption that it is a natural consequence of ageing. Similarly, weight loss and malnutrition in later life are often not identified or treated seriously. We believe the guideline could do more to address the ongoing lack of awareness and support in our health and care system for older people with eating disorders and nutritional issues. When malnutrition occurs among older individuals and is exacerbated with a previous eating disorder, Age UK believes that there is little acknowledgment of this previous diagnosis or adequate support offered for	

						individuals and their carers. The impact of this guideline could be strengthened by explicitly recognising eating orders as an important issue that affects older people, as well as younger age groups.	
318.	SH	British Psychological Society	Full & Short	General	General	The Society has concerns that the guidelines focus on only two main types of psychological therapy, when others may also be appropriate. Additionally there is a problem that there is a scarcity of therapists in eating disorders, and those available will need to use the skills they actually have. Moreover, the evidence is not up to showing definitely that some therapeutic approaches are superior to others. As some of the other comments below illustrate, focus on two types of intervention was felt to be too prescriptive.	Thank you for your comment. The recommendations on psychological therapy are evidence based and any therapies omitted either lacked the quality or effect size needed for the Committee to feel confident recommending. Without knowing specifics of which therapies you believe should be considered it is difficult for us to make any further comments.
319.	SH	British Psychological Society	Full & Short	General	General	We are concerned that the delayed release of the draft guidelines has resulted in inadequate consultation. External parties including our organisation had made plans to respond during November and early December including an AGM to discuss the draft given its importance and time was also lost to the Christmas holidays. We recommend that after revision a further round of formal consulatation occur.	Thank you for your comment. The consultation period was the standard 6 weeks required by the NICE guidelines manual and very few stakeholders expressed any concern with the deadline for comments. NICE and the NGA showed as much flexibility as they could to those that did, and extending the deadline for consultation would have delayed the whole project unduly. . Stakeholders were notified as soon as the delay was known. Unfortunately it will not be possible to have another version sent out for consultation.
320.	SH	British Psychological Society	Full & Short	General	General	The Society shares the committee's concern regarding the lack of consistent rapid availability of evidence based therapies for eating disorders from	Thank you for your comment. The guidance regarding what the psychological therapies should include is based on the limited evidence available

						competent, well trained and supervised clinicians and the widespread suffering and cost that results from this inconsistency. We welcome the committee's recognition of the limitations and low quality of evidence that currently exists regarding treatment for all the eating disorders, and for anorexia nervosa in particular, as reflected in the repeated rigorous evaluations of evidence quality and associated uncertainty. We are concerned that the limited range of alternative therapy approaches listed for consideration is overly proscriptive given the relatively limited evidence base. We support the relative weighting of the evidence and the associated rank ordering of interventions. However, we are concerned about the interpretation of the evidence base in some respects. On the whole it is generally weak, with studies rated mostly as methodologically of low or very low quality, evidence on questions deriving from small numbers of studies and showing effects and differences between treatments that are often small or uncertain. There is a concerning dearth in particular of replications by independent clinics. The concern is that the evidence is then interpreted dichotomously to proscribe a very limited number of options which we feel does not well reflect the more continuous and generally weak nature of the strength of the evidence for therapy approaches. Meanwhile other empirical	and the Committee's experience. The Committee had concerns that non-specific eating disorder treatments were being offered and it was agreed that for this reason it was important to outline what should be included in the treatment. The Committee agreed that remission should not be included as an outcome if changes were measured for less than a 2-week period, since assessment of a shorter duration would be unlikely to represent a real change in behaviour. Some of the evidence was assessed as being low or very low quality using GRADE methodology. The Committee considered the evidence available in addition to their own experience to generate recommendations to ensure access to treatment is available for people with eating disorders. The recommendations are different to those made in the previous guideline, but all evidence from the old guideline was included in this recent version in addition to new evidence. If any therapies are no longer recommended it is a result of new evidence adding more weight to the therapies ultimately recommended and this being supported by the cost-effectiveness analysis.

						evidence which is not given weight includes: • Excluded trials which, whilst relatively weaker, are not so distant from the included trials in quality and strength of the evidence that they warrant complete disregard; some were excluded because of the way outcomes were reported, which might give undue weight to the views on the committee regarding the definition of important, critical or meaningful as against the views of treated individual with eating disorder given that some of these excluded or unweighted studies nevertheless report on hard and significant outcomes; it might also bias towards studies conducted by committee members since they would have made the decisions on critical outcomes in the studies and guidelines; • Evidence regarding presenting symptoms and problems that derives from basic process research (for example into emotional change, behaviour change, motivation etc.) and from evidence bases for symptoms in other disorders which may be comorbid; • Evidence of functional relationships of symptoms with other variables derived from	

						longitudinal and cross sectional assessment of a person's problems and N=1 tests of hypotheses regarding individual and idiosyncratic maintaining factors; For example a sufferer of an eating disorder, who for whatever reasons found the first recommended treatments for bulimia nervosa unsuitable or unacceptable, would have no guidance to distinguish whether IPT or homeopathy would be the better next option. There is a conflation in the document of the concepts of 'empirically supported' and 'evidence based' clinical interventions and an argument that the latter is best conceptualised as the synthesis of the former along with related evidence, clinical judgment and formulation and patient preference in within a context of informed consent (Becker, 2016) We are concerned that the recommendations are essentially for two models of psychotherapy for adults with anorexia nervosa (CBT for EDs, or Focal Psychodynamic Psychotherapy). There is some concern that this implies that recommendations made in the previous NICE guidance should now not be followed – despite a lack of comparison studies between the now recommended treatments and the different psychological interventions cited in previous guidance. We recommend that the guideline rather than attempt to be overly proscriptive	

						instead say that service should have first and second line therapies available to all people with eating disorders who want them, and services should consider offering a choice of therapy, and consider, all else being equal, a preference for a first line option ahead of a second line option, and a second line option ahead of another tested option (i.e. those with weaker but extant evidence currently entirely omitted from the guideline) and should offer patients informed choice based on information on the relative strength of the evidence and their preferences after collaborative clinical assessment. This would be a better representation of the state of the evidence and its implications given the problems identified in the preface and a better balance of professional interpretation of the evidence base with people with eating disorder's autonomy and informed choice. Given the scientific limitations we would welcome in particular the views of people suffering from eating disorders and carers on what options should be on offer.	
321.	SH	Leicestershire Partnership NHS Trust	Full & Short	General	General	Overall most of the evidence on which the guidance is drawn is of very low or low quality. With the exception of FBT which is moderate, most other treatments were of low quality so we are unsure as to the rationale for using CBT-E or guided self-help for adolescents in particularly, especially when Focal	Thank you for your comment. Other study designs were excluded since RCT evidence was available. This is a standard practice in NICE guidelines. Second line treatments were offered for all eating disorders and 3rd and 4th line for AN.

						Psychodynamic Psychotherapy is recommended as a treatment option for adults (as noted in the draft guidance). It needs to be made clearer that the guidance is based on existing evidence from RCTs and that absence of RCTs does not mean that other treatment options are not effective. Some treatment models are in a better position for RCTs to be conducted, so other treatments should not necessarily be penalised on this basis alone (practice based evidence is also important and worth considering). In the light of no good evidence (very low or low), all possible options should be listed with the caveat that more research is required to examine their effectiveness, as opposed to excluding them entirely. Excluding the scope for second line treatments, particularly for BN (which were included in the previous guidance and no subsequent evidence to undermine their efficacy has been produced) will perpetuate a cycle where the first line treatments gather a stronger evidence base by virtue of their inclusion and use in practice at the expense of other models. Limiting the opportunities for continued research for other treatments with some promising, albeit limited studies cannot be good in the long term for the treatment of eating disorders. Instead it rather perpetuates a self-fulfilling prophesy of 'one truth'.	

322.	SH	Oxford Health NHS Foundation Trust	Full & Short	General	General	We feel that the 6-week consultation period over the Christmas holiday was too short to allow stakeholders to comment sufficiently on the Guidelines. The majority of our feedback therefore focussed on the short version. It is also assumed that any changes in the short version will be cross-referenced with the recommendations (p. 971-987) in the full version.	Thank you for your comment. Recommendations in the short version of the guideline are replicated in the full guideline.
323.	SH	Oxford Health NHS Foundation Trust	Full & Short	General	General	Finally, we would like to thank the Committee for producing these important Guidelines which will determine how people with eating disorders and their families/carers are assessed, treated and monitored for many years in the UK. It is therefore paramount that the Guidelines accurately reflect the evidence-base and make recommendations on how to support the full spectrum of patients where there are gaps in the research and limits in the evidence-base.	Thank you for your comment and support for this guideline.
324.	SH	NHS Greater Glasgow and Clyde	Full & Short	General	General	Dietitian is spelled incorrectly throughout the document.	Thank you for your comment. The text has been amended.
325.	SH	Cwm Taf Health Board	Full & Short	General	General	We are aware that psychological interventions are notoriously difficult to obtain meaningful RCT evidence for, especially when the intervention is not manualised, making it difficult to provide evidence for the effectiveness of all interventions to the standard that NICE bases their guidelines on. However, the previous guideline included recommendations which were graded based different levels of evidence. This meant that less scientifically robust evidence could also be included with an	Thank you for your comment. Other study designs were excluded since RCT evidence was available. This is a standard practice in NICE guidelines.

						acknowledgement that it was not 'gold standard' but still provided useful information for services and clinicians. I am hoping that it will be possible to include 'lower level' recommendations for some of the interventions discussed in comment 2, as many are currently being used in eating disorder services throughout the UK, with a recommendation that more research is needed.	
326.	SH	Oxford Health NHS Foundation Trust	Full & Short	8	6	1.2.2 We suggest using the term 'malnutrition' rather than 'starvation' throughout the documents (both the short and full guidelines). By using the word starvation, there is a risk that it implies a patient choice rather than the result of an illness. Furthermore, eating disorders result in varying levels of malnutrition (from underweight to overweight, and severe vitamin deficiencies). It would help directing non-specialists to use existing tools to assess the severity of malnutrition. The BAPEN MUST tool is easily available on their website and it is widely used by the NHS: http://www.bapen.org.uk/screening-and-must/must-calculator; http://www.bapen.org.uk/pdfs/must/must_full.pdf. This would be particularly helpful for GPs and acute hospitals, but also for self-screening for patients. It would also improve patient safety, as the level of malnutrition is one of the most important risk indicators. This is recognised by the DSM-5: the level of malnutrition is a severity indicator for anorexia nervosa	Thank you for your comment. The text has been amended. The Committee declined to include reference to the BAPEN MUST tool as the assessment of malnutrition is covered by MARSIPAN.

						(mild >BMI 17, moderate: BMI 16-16.99, severe BMI 15-15.99, extreme BMI <15). Raising awareness of this would be very helpful. It would also be helpful to note that there are no RCTs of psychological treatment of patients with extreme malnutrition (BMI<15).	
327.	SH	Oxford Health NHS Foundation Trust	Full & Short	10	11	1.2.14 It would be helpful to note that that there are no RCTs for the psychological treatment of extremely malnourished patients (BMI <15) with anorexia nervosa, or patients with severe psychiatric comorbidities, so any advice for the most severe patients needs to be tentative. The evidence for eating disorder specific focal psychodynamic therapy is based on one trial. This psychotherapy was specifically designed for that trial and it is very different from current UK practice. The manual is not available in English. Before it is recommended as first line treatment, replication studies in the UK would be needed. It would be better to phrase this more cautiously. Regarding the recommendation that 'Eating-disorder-focused focal psychodynamic therapy programmes for adults with anorexia nervosa should: 'use a focal psychodynamic manual specific to eating disorders' the committee noted that an English manual will be available in 2017 and as far we know there are no English training programmes available yet. In practice it might take several years to train a sufficient number of therapists to deliver FPT across the UK. It is also	Thank you for your comment. The Committee also noted your same concerns about recommending this new therapy to the UK. Please note that the recommendations for the treatment of adult anorexia nervosa have been substantially revised with CBT-ED, MANTRA, and SSCM now recommended as first-line options, and eating-disorder focussed focal psychodynamic therapy (FPT) now recommended as a possible second-line option. This was because there was evidence of no difference between CBT-ED, MANTRA and SSCM; The Committee changed their recommendation for FPT in recognition of the fact (see relevant LETR) that an investment in training may be needed locally before focal psychodynamic therapy can be provided and that the English version of the manual has not yet been published. Nevertheless, the evidence on people with anorexia nervosa was very limited and of those identified, eating-disorder-focused focal psychodynamic therapy was one of the most effective. So it was agreed to recommend it whilst acknowledging the caveats.

						unclear what the minimum training requirements and minimum accreditation levels of FPT therapists in the UK would need to be in future. If FPT therapists for example need to be accredited psychodynamic psychotherapists (with additional FPT training) then it would require recruitment of new staff or training of existing staff members in psychodynamic psychotherapy (which is a lengthy and expensive training course). We are therefore concerned that this recommendation in the short version without a caveat will set unrealistic expectations for patients, carers and commissioners that FPT should be immediately available on the NHS. We wonder therefore whether the committee would consider a rephrase of the recommendations and that FPT should be offered when the training manual and relevant training programmes have been made available in English and when UK psychological therapists have been adequately trained.	
328.	SH	Oxford Health NHS Foundation Trust	Full & Short	10	28	1.2.16 The recommendation of using manualised psychodynamic therapy for AN is based on one German study, with significant methodological shortcomings. The manual was specifically developed for the study to mirror CBT-E in terms of frequency and structure to help with double blinding, but at the expense of treatment fidelity. Furthermore, the way the authors defined remission was unusual: BMI 17 is malnourished state	Thank you for your comment. The remission definition was a PSR score (psychiatric status rating scale) of 1 or 2 and a BMI greater than 17·5 kg/m2. The Committee also noted your concerns but concluded on balance that it should be recommended. The Committee also decided to revise their recommendations for the treatment of adult anorexia nervosa to also include MANTRA and SSCM as recommended first-line

						and would meet DSM-5 criteria for anorexia nervosa, making the main findings of this study questionable. There is a real concern that this treatment does not address weight and malnutrition.	therapies because there is evidence of no difference between these therapies, and focal psychodynamic therapy for eating disorders as there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision.
329.	SH	Oxford Health NHS Foundation Trust	Full & Short	11	3	1.2.16 Psychoeducation is part of CBT-E but not part of focal psychodynamic therapy (not described in the ANTOP trial) so presumably this is an error here.	Thank you for your comment. The text has been amended.
330.	SH	Oxford Health NHS Foundation Trust	Full & Short	11 (Short)	26, 27	1.2.18 The recommendation for AN-focussed family therapy to be delivered either as single OR multi-family therapy is misleading and does not follow from the results of the main paper quoted for this recommendation (Eisler et al., 2016). In this paper SFT is compared with SFT plus MFT (the number of single family therapy sessions was not significantly different between the two groups 18.5 vs 19 outpatient sessions) and showed that the combination could be more effective than single family therapy for AN. The recommendation in the NICE Guidelines needs to accurately reflect this result.	Thank you for your comment. The main text and recommendation have been amended to make clear that multifamily therapy should be offered in addition to family therapy.
331.	SH	Oxford Health NHS Foundation Trust	Full & Short	14	18 +	There is nothing about the management of patients with anorexia nervosa in acute hospitals. We regard this as a major omission. Whilst there are no RCTs on this, patients with anorexia nervosa often first present to A&E and frequently inappropriately discharged without any treatment for their extreme malnutrition with potentially life threatening consequences. The full guidance makes reference to the MARSIPAN guidance –	Thank you for your comment. Reference is made to MARSIPAN in regard of treatment of malnutrition by refeeding in both the short and full guidelines.

						but it would be essential to include this in the short guidance too. This would help acute hospitals to raise awareness and improve training. A reference for the NICE Nutrition support guidelines would be extremely helpful. https://www.nice.org.uk/guidance/cg32/resources/nutrition-support-for-adults-oral-nutrition-support-enteral-tube-feeding-and-parenteral-nutrition-975383198917	
332.	SH	Oxford Health NHS Foundation Trust	Full & Short	16 (Short)	24	We find it surprising that CBT–ED is not recommended at least as a second line treatment for bulimia nervosa. This is inconsistent with other topics in the guidelines where the recommendations for young people have drawn on the evidence for adults where there is a lack of a clear evidence base in young people. There is overwhelming evidence for the use of CBT- ED in adults with bulimia nervosa. Most BN patients are over 16 and therefore appropriate to be considered for an intervention researched in adults. The full guidelines state (p535) that CBT-ED is not being recommended due to lack of data in adolescents and the high costings noted in adults. However, there is no mention of the clinical effectiveness data in adults which is substantial. Moreover, the failure to recommend CBT- ED is based on a single study (le Grange et al., 2015) with 53 adolescent patients undertaking this intervention (US sample). In this study (which compared a family-based approach with CBT-ED) there was no significant difference between the two groups at 12-month follow-up and the	Thank you for your comment. The recommendation has been revised to recommend CBT-ED as a second-line treatment to family therapy.

						authors themselves suggest CBT-ED is a viable alternative to FBT for families who would prefer a largely individual treatment or where families are not available.	
333.	SH	Oxford Health NHS Foundation Trust	Full & Short	18	18	There is no mention of Rumination disorder, which is included amongst eating disorders in the DSM-5.	Thank you for your comment. Rumination disorder was not included in the scope of the guideline as people with feeding disorders were excluded.
334.	SH	Oxford Health NHS Foundation Trust	Full & Short	25	3	1.11.1 Medical stabilisation needs to be carefully defined as it is open to widely different interpretations (one Australian study used a discharge BMI of 17.5, whilst in many acute NHS hospitals it only means iv replacement of electrolytes). Furthermore, without careful explanation and aftercare, many patients are falsely reassured by the term: a patient who is discharged from hospital with a BMI of 15 is still extremely malnourished and will continue deteriorating without ongoing weight restoration as part of outpatient treatment.	Thank you for your comment. There are a number of ways that medical stabilisation can be classified, which may reflect the paucity of extant evidence, differences in practices in individual units, and the nature of the current medical problems faced with severe eating disorders. In view of these considerations, the Committee decided that it was not possible to arrive at a single, unproblematic classification of medical stabilisation. In view of this, the Committee decided to make an explicit research recommendation concerned with elucidating the most informative physical parameters in the risk management of people with anorexia nervosa.
335.	SH	British Psychological Society	Full & short, particularly the Short	General	General	For CBT-ED there is significant evidence that many patients may benefit from this. However, engagement in CBT can be an issue for patients suffering from anorexia nervosa, because CBT-ED requires patients to accept at the point of engagement that weight gain is an essential outcome of treatment. Consequently, (i) persuading patients to accept this model of treatment can be a	Thank you for your comment. The Committee has revised its initial recommendations to recommend MANTRA and SSCM as alternative first-line treatments to CBT-ED. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between these therapies, and (ii) there is as yet no English manual for FPT and some services may incur

						problem for a significant number of patients; and (ii) it is important that a range of treatments is available. We are concerned that NICE recommends only one alternative to CBT-ED, and this model of therapy (Focal Psychodynamic Psychotherapy) has been around for a short length of time, has not been widely researched outside its centre of origin, and is not widely available. At one point it is described as not particularly effective: *"Focal psychodynamic general therapy appeared to improve remission rates but not BMI compared with any other intervention at the end of treatment. Other outcomes, including EDI total, general psychopathology and all-cause mortality were no different at the end of treatment…..at 26 to 32 months follow-up….no difference was found in weight….."* It will be challenging for services to be sufficiently engaging of the full range of patients with anorexia nervosa if limited to CBT-ED alone.	significant costs when implementing its provision.
336.	SH	Association of School and College Leaders (ASCL)	Short	General	General	The intended audience of the document is also not clear. It is more accessible than the full version, but if there is to be any communication with education professionals this document is still not suitable.	Thank you for your comment. This document is targeted towards healthcare professionals. There is also a short version of the guideline that lists the recommendations, context, and research recommendations. A version for the public titled 'Information for the public', written for those without specialist medical knowledge, is also published by NICE. Both will be available for download from the NICE website.
337.	SH	Barnet Enfield and Haringey	Short	General	General	We feel that the vast majority of people will read the short guidelines due to time limitations. As such, we feel it is	Thank you for your comment. The wording of recommendations is required to follow the methods outlined in

		Mental Health Trust				important to indicate on the short guidelines, the quality of research on which the recommendations are based on. We do not feel that the use of the words “consider” and “offer” is enough guidance and another way of indicating the quality of the research should be found.	"Developing NICE guidelines: the manual".
338.	SH	BEAT	Short	General	General	Beat is a national UK eating disorders charity. We exist to end the pain and suffering caused by these serious mental illnesses, and are a champion, guide and friend to all affected by them. Beat’s response to this consultation has incorporated the views and experience of seven members of staff including our Medical Advisor (Dr Richard Sly) and six of our supporters and service-users. We are pleased that the NICE guideline for eating disorders is being updated and we welcome this chance to influence its recommendations and other content. Whilst we welcome that recommendation 1.2.9 highlights the need for rapid referral when an eating disorder is suspected, the importance of the patient being able to receive treatment quickly after this referral, rather than sitting on a waiting list for many months, has not been covered, as it should have been, in this set of recommendations. Recommendation 1.1.3.1 in the 2004 Guideline stated that "People with eating disorders should be assessed and receive treatment at the earliest opportunity".	Thank you for your comment. As noted, the importance of referral without delay is captured in the recommendation. It is outside the scope of the guideline to comment on waiting lists.

339.	SH	BEAT	Short	General	General	We appreciate the need to have a way to denote the relative strength of recommendations, however it is problematic when this leads to a situation where there are certain patients for whom there are no confidently worded recommendations (on their psychological therapy) at all. In both the section on psychological treatment for adults with anorexia nervosa and the equivalent section for adults with bulimia nervosa, all the recommended treatments are introduced as treatments which the professional should 'consider' providing. This may be interpreted (by a non-specialist reader at least) that access to treatment for these patients is not important, especially since most readers are unlikely to read (or find) the explanation in the 'Developing NICE guidelines: the manual' document of what NICE actually means when it uses the word 'consider'. It is important that language is used which reflects the principle that all patients with an eating disorder should be entitled to access treatment. Even if there is less cost-effectiveness evidence for some of the interventions recommended for eating disorders (when compared to interventions for some of the other conditions which NICE have produced guidelines for), we argue that no patients should be left without a strong recommendation, regarding their access to psychological therapy. These weaker recommendations risk contradicting principle 3 of NICE's 'Social value	Thank you for your comment. The wording of recommendations in the short guideline is required to follow the methods outlined in "Developing NICE guidelines: the manual". In particular, the words 'offer' and 'consider' are intended to indicate the level of certainty that the evidence provides, where the former indicates a high degree of certainty (e.g. where the benefits clearly outweigh the harms) and the latter indicates a lower degree of certainty (e.g. where there is a balance between benefits and harms to be thought about). Hence, the lack of 'strong' recommendations regarding treatment of adult anorexia or bulimia nervosa reflects the uncertainty of the evidence base. Please note that the Committee have explicitly recommended that health services should ensure that all people with an eating disorder (as well as their families/carers, if appropriate) have equal access to treatment (see recommendation 9, full guideline). Finally, it is expected that users of the guideline are healthcare professionals and as such should be aware of the significance of the wording used in NICE guideline recommendations. It should be noted that NICE produces a version of the guideline ('Information for the public') intended for non-specialists without specialist medical knowledge.

						judgements' document, considering the historic underinvestment of health resources in the treatment of eating disorders.	
340.	SH	BEAT	Short	General	General	The principle of co-production - creating, monitoring and evaluating eating disorders services and treatment in collaboration with people with lived experience of an eating disorder (including patients, carers and people who have recovered from an eating disorder) should be advocated for in this guideline.	Thank you for your comment. Unfortunately no evidence was identified to support a recommendation on co-production.
341.	SH	BEAT	Short	General	General	The importance of culturally-sensitive/informed psychotherapy has not been highlighted. This will be necessary to help deliver recommendation 1.1.2 (bullet point 3) and to ensure that people from minority ethnic backgrounds with eating disorders benefit equally from psychotherapy.	Thank you for your comment. No amendment was made as it would be a point of good practice that culturally-sensitive/informed psychotherapy is delivered by health care professionals.
342.	SH	BEAT	Short	General	General	The guideline fails to adequately acknowledge patients who may be experiencing a relapse. There is little advice on how to recognise and treat eating disorders in these patients, including whether procedures should be carried out differently compared to patients with a first-episode or first-presentation eating disorder.	Thank you for your comment. No RCTs that address relapse were identified for inclusion, only evidence from patients who had severe and enduring eating disorders and evidence on the effectiveness of stepped-care. However, some recommendations do address those who do not respond to first line treatment and those who have relapsed may fall into this group. Research recommendations have also been made to further explore the effectiveness of stepped care and those who are not responding to treatment.
343.	SH	BEAT	Short	General	General	The recommendations do not include any reference to patients who have had an eating disorder for many years and may	Thank you for your comment. Evidence on people with severe and enduring AN was included in this guideline. However,

						feel that their eating disorder has become 'entrenched'. These patients are sometimes described as having 'Severe and enduring eating disorders' (SEED). Did the committee review the evidence concerning the adaptation of clinical practice to the patient's 'stage of illness'?	no specific recommendations were made for this group given the evidence did not show any significance difference between the two therapies investigated - CBT vs. MANTRA and both of these are recommended for any person with AN. The Committee were also concerned about creating cut-offs for different types of treatment.
344.	SH	BEAT	Short	General	General	The guideline should make professionals aware of the inconclusive nature of some physical health monitoring measurements, including the capacity for blood test results to be distorted by dehydration.	Thank you for your comment. The text has been amended.
345.	SH	BEAT	Short	General	General	Recommendation 1.11.10 refers to a care plan, but only in the context of planning for discharge. Patients should have a care plan from the point when they begin treatment.	Thank you for your comment. The recommendations have been revised to be more inclusive regarding care plans and discharge.
346.	SH	BEAT	Short	General	General	Home treatment has not been covered by the guideline, even though this form of treatment has been a beneficial alternative to inpatient admission in some parts of the country. Home treatment is offered by some of the community eating disorders services for children and young people which were highlighted as examples of 'best practice' provision by NHS England.	Thank you for your comment. No evidence was identified on the effectiveness of home treatment as a beneficial alternative to inpatient admission.
347.	SH	British Psychological Society	Short	General	General	The full report is much clearer about the nature of eating disorders than the short report. We feel that the short report reads too much as if anorexia nervosa was the normative eating disorder, when it is actually the least prevalent one. We feel that this detracts attention from the fact that because of the high prevalence of	Thank you for your comment. The Committee decided to not bias the presentation of the eating disorders in the guideline and chose to present it simply in alphabetical order. On-line treatment pathways, where a lot of health care professionals seek out NICE

						obesity in the UK, logically many, perhaps even most, people with a diagnosable eating disorder (even if they have not been diagnosed) are also overweight or obese. Clinical experience is that primary care practitioners often fail to recognise eating disorders except if the person is thin, and that when a person has both an eating disorder and obesity they can be shunted back and forth between eating disorders services and obesity services, or the psychological problems associated with binge eating can be judgementally trivialised as gluttony.	recommendations, it will appear in no obvious order
348.	SH	British Psychological Society	Short	General	General	The full guideline, appropriately, continuously presents an assessment of the quality of evidence, the strength of effects and associated uncertainty. This is too a large extent lost in the short guideline which, being the most accessible, will be frequently accessed in particular by people with eating disorders themselves and their families, reducing the power of the guideline to inform. Some of the major over-simplifications caused by abbreviation include: focus on only two main forms of psychological therapy; focus on body weight as a major outcome, and anorexia nervosa as the canonical eating disorder; vagueness about common co-morbidities, including obesity, trauma and other major psychological issues. We recommend that a clear and appropriate expression of the caution and	Thank you for your comment. The wording of recommendations in the short guideline is required to follow the methods outlined in "Developing NICE guidelines: the manual"

						qualification noted in the full guideline be included in the short guideline, bearing in mind that most people will only read this.	
349.	SH	British Psychological Society	Short	General	General	Although there have been moves towards a more transdiagnostic approach in the field of eating disorders (e.g. Fairburn et al., 2003), the guideline continues to provide separate recommendations for different diagnostic categories. It is interesting to note that there is increasing convergence in the recommendations for psychological interventions across the different diagnostic categories (with a recommendation of Cognitive Behaviour Therapy for adults in all cases). Perhaps in future revisions of the guidance a more transdiagnostic structure might be considered.	Thank you for your comment. Although research in this field may move in this direction, studies are still being published using populations with specifically diagnosed eating disorders, thus the current recommendations are dictated by how the evidence is collated and presented. Please note also that the introduction and guideline are intended to be a practical evidence-based guideline rather than a textbook.
350.	SH	The British Dietetic Association	Short	General	General	The short version does not explain some of the points that are explore in the long version, which may lead to misinterpretation of the guidelines.	Thank you for your comment. The short guideline follows the format required by NICE and is intended to be a quick reference tool for healthcare professionals who treat and care for people with an eating disorder. It is therefore not the appropriate place to provide explanations of how the recommendations were developed. Please note that the recommendations have been substantially revised.
351.	SH	Interpersonal Psychotherapy UK (IPTUK)	Short	general	general	We request that the panel confirms that recent research by Tanofsky-Kraff et al (2014), which found that a preventative IPT intervention was more effective at reducing binge eating and potentially full-syndrome eating disorders than an active	Thank you for your comment. Prevention of eating disorders was outside the scope of the guideline.

						control and at 3 years after the intervention, IPT was more effective at preventing excess weight and fat gain among those with anxiety and social problems.	
352.	SH	Lancashire Care NHS Foundation Trust	Short	General		Manualised working The guidance places emphasis on manuals. Some service users find manualised working impersonalised and controlling and there are few alternatives given other than manualised treatments. Where manuals are referenced we will expect to see them appear on the NICE "resources" page.	Thank you for your comment. The Committee agreed that manuals should be used as they provide a common structured and formalised method of providing therapy. However, as with all therapy, they agreed that clinicians should always use their judgement in delivering a manual-based intervention and are sensitive to the needs of the individual with the eating disorder. Please note that, no particular manual - with the exception of MANTRA for adult anorexia nervosa (since there is only one such manual) - has been explicitly recommended.
353.	SH	Cardiff and Vale University Health Board	Short	General	General	There is no mention in the general principles of care section in the importance of the motivational model and Motivational Enhancement approach for enabling service user engagement with services in a collaborative manner and theus enabling the ability to match the treatment to the desired goals of the service user – which in some cases will be a partial recovery to a less risky relationship with the ED rather than full recovery. This notion and model (including non-negotiables) is likely to be under a "philosophy of care" heading.	Thank you for your comment. Unfortunately no evidence was identified to support a recommendation on Motivational Enhancement Therapy
354.	SH	Cardiff and Vale University Health Board	Short	General	General	No mention of ARFID or recommendations for its treatment found – does this need a mention as recommended research area or some	Thank you for your comment. AFRID was considered out of scope - people with feeding disorders were excluded

						advice around treatment with an " advised capacity " rather than recommended at his point/ Admittedly it has come from the USA diagnostic criteria but the clinical community may value some emerging evidence advice at this point.	
355.	SH	Cardiff and Vale University Health Board	Short	General	General	Previous guidance had ratings of A, B or C for recommendations dependent on number of RCTs (a sufficient amo9unt got an A) to clinical best practice advice (for a C). This would be preferable rating response rather than discounting it seems anything that has not achieved an A rating at this stage.	Thank you for your comment. The previous guideline reflects how NICE used to present their recommendations. However, the wording of recommendations in the new short guideline is required to follow the methods outlined in "Developing NICE guidelines: the manual". "Developing NICE guidelines: the manual"
356.	SH	Cardiff and Vale University Health Board	Short	General	General	Probably in line with some of the comments above, in terms of treatment recommendations, this guidance seems well suited to acute, non-SEED cases, and may guide Health Boards to focus their work in this active treatment area and discount other good practice work that services undertake with the less motivated, or less able to make change. A section on clinical guidance for working with SEED and service user involvement in service design generally, would be of benefit.	Thank you for your comment. Evidence on people with severe and enduring AN was included in this guideline. However, no specific recommendations were made for this group given the evidence did not show any significance difference between the two therapies investigated - CBT vs. MANTRA and both of these are recommended for any person with AN. The Committee were also concerned about creating cut-offs for different types of treatment.
357.	SH	Oxford Health NHS Foundation Trust	Short	General	General	It would be very helpful if the guidelines could cover the full spectrum of eating disorders and we wonder whether the committee could offer guidance on the treatment of eating disorders such as pica, rumination disorder, avoidant/restrictive food intake disorder (DSM-5, ICD-10) or Vomiting associated with other psychological disturbances	Thank you for your comment. Unfortunately the mentioned eating disorders were outside of guideline's scope. Due to limited time and resources, not all eating disorders could be included.

						(ICD-10, F50.5) as these disorders present from time to time in routine clinical practice and requires assessment, treatment and monitoring – unless the committee is of the opinion that these disorders should not be treated on the NHS.	
358.	SH	Oxford Health NHS Foundation Trust	Short	General	General	1.2.19 – 1.2.23 Terminology around family therapy. There needs to be consistency and clarity regarding the term used for family work (family therapy, family-based treatment, anorexia nervosa focussed family therapy).	Thank you for your comment. The text has been amended so that 'family therapy' is used as a generic term for any family-type therapy, including the most common therapies of Lock and Le Grange's Family-Based Treatment and Maudesley-based Family Therapy. No trials that directly compared these two therapies were identified for inclusion and hence the Committee did not recommend one over the other. Moreover, the Committee considered that the therapies were sufficiently similar to allow comparison against other types of intervention.
359.	SH	Oxford Health NHS Foundation Trust	Short	General	General	Since 2004, many adult ED services have invested significantly to recruit and train CAT, IPT, and family therapists to meet the recommendations of the previous NICE guidelines. Having therapists on their establishments (who are trained in treatment models that are no longer recommended by NICE 2017), will pose a significant challenge to adult NHS ED services e.g. in terms of redeployment or re-training of these therapists in the years to come. There will also be a cost in terms of morale, etc.	Thank you for your comment. Although the new guideline will challenge current adult NHS eating disorder services, the recommendations reflect what the evidence shows. Whilst it is recognised that some services may find it difficult to implement the changes required by the guideline, it is hoped that in the long run that this will result in better outcomes for service users and a more cost effective use of resources.
360.	SH	Oxford Health NHS Foundation Trust	Short	General	General	The a, b, c grading of evidence in the previous NICE guidelines was clear and easy to understand. It is more difficult to	Thank you for your comment. The previous guideline reflects how NICE used to present their recommendations.

						tease out the evidence in the draft long guidelines; the text mixes up recommendations based on discussion in the committee from recommendations based on low/high quality evidence.	However, the wording of recommendations in the new short guideline is required to follow the methods outlined in "Developing NICE guidelines: the manual". "Developing NICE guidelines: the manual"
361.	SH	Oxford Health NHS Foundation Trust	Short	General	General	We notice that older adults are not mentioned in the Guidelines and wonder whether the implication is that the guidelines for adults apply to all patients above 65?	Thank you for your comment. Most of the Committee's discussions were centred around the evidence identified and unfortunately no evidence was found on older people. Nevertheless the recommendations are still relevant to older people. "Age" has been added to the general principles section at the beginning of the guideline to emphasise that all people have the right to equal access to treatments.
362.	SH	Oxford Health NHS Foundation Trust	Short	General	General	Compared to the 2004 Version the full guidelines are written in a format that feels less user friendly and it will be more difficult to follow the guidelines.	Thank you for your comment. The previous guideline reflects how NICE used to present their recommendations. However, the wording of recommendations in the new short guideline is required to follow the methods outlined in "Developing NICE guidelines: the manual". "Developing NICE guidelines: the manual"
363.	SH	Oxford Health NHS Foundation Trust	Short	General	General	Omissions. Research showing that weight gain in the first four weeks is linked to better outcome has not been included (Doyle, P., Le Grange, D., Loeb, K., Doyle, A. C., & Crosby, R. D. (2010). Early response to family-based treatment for adolescent anorexia nervosa. International Journal of Eating Disorders, 43(7), 659–662. And Le Grange, D., Accurso, E., Lock, J., Agras, W. S., & Bryson, S. W. (2014). Early weight gain predicts outcome in two treatments for	Thank you for your comment. Predictors of responsiveness to treatment was outside the scope of the guideline.

						adolescent anorexia nervosa. International Journal of Eating Disorders, 47, 124–129.)	
364.	SH	Oxford Health NHS Foundation Trust	Short	General	General	Omissions. There is lack of mention of which treatment approaches should be considered for enduring long term eating disorders in young people.	Thank you for your comment. Evidence on people with severe and enduring AN was included in this guideline. However, no specific recommendations were made for this group given the evidence did not show any significance difference between the two therapies investigated - CBT vs. MANTRA and both of these are recommended for any person with AN. The Committee were also concerned about creating cut-offs for different types of treatment.
365.	SH	Oxford Health NHS Foundation Trust	Short	General	General	Omissions. There is no mention of the use of the potential value of a motivational interviewing approach to facilitate engagement with psychological treatment (Gowers, S. G. and Smyth, B. (2004), The impact of a motivational assessment interview on initial response to treatment in adolescent anorexia nervosa. Eur. Eat. Disorders Rev., 12: 87–93	Thank you for your comment. Unfortunately engagement with treatment was outside the scope of the guideline.
366.	SH	Oxford Health NHS Foundation Trust	Short	General	General	Cost implications - a number of recommendations have cost implications: 1. Training both non-specialists and specialists 2. Appropriate supervision 3. Training for social care and educational professionals 4. Focal Psychodynamic Psychotherapy 5. Bone densitometry after 6 months of amenorrhoea 6. Blood test and ECG monitoring	Thank you for your comment. Thank you for your comment. The NICE implementation team is developing resource impact tools that will focus on the recommendations that have been identified as likely to have the greatest resource impact and will need the most additional resources to implement or potentially generate the biggest savings. Following consultation with the Committee and the wider stakeholder community, the following areas were prioritised for the resource impact

							assessment: offering psychological treatment to adults and young people with binge eating disorders; providing ECG monitoring for people with eating disorders taking medication; offering a bone mineral density scan anorexia nervosa; and not using inpatient care solely for the provision of psychological treatment for eating disorders. Where relevant, the resource impact report and tool will also consider training needs and associated costs. Also, as appropriate, the 'Trade-off between net health benefits and resource use' sections in the full guideline detail the cost implications of recommendations.
367.	SH	Royal College of Nursing	Short	General	General	Most of the comments above can be applied in a general sense to all the sections of the guidance.	Thank you for your comment.
368.	SH	Royal College of Nursing	Short	General	General	The guidance seems to focus a lot on children and young people. It needs to be balanced and needs to have more attention given to adults with eating disorder, and specifically in-patient care of adults, as, by the time they reach adulthood, they do not just HAVE an eating disorder, it is as though they ARE the eating disorder. They have adopted the eating disorder identity which is hard to shake off/ reinvent themselves. Hence treatment of adults needs to include therapy that assists the person to 'reinvent 'themselves.	Thank you for your comment. The recommendations address both adults and young people despite more evidence being available for adults than young people and none being available for children. The recommendations on inpatient care are relevant for people with eating disorders of all ages.
369.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	General	General	• The list of therapies appears too prescriptive based on what is a relatively limited evidence base with often equally limited or poor follow-up outcome data.	Thank you for your comment. Please note that some of the recommendations for psychological therapies have been, in particular regarding the treatment of adult anorexia nervosa and bulimia nervosa in

						• The concern is this could have significant implications for the commissioning of services resulting in limited treatment choice for patients. This could create real problems for those who do not have a good response to the therapies that are recommended / those for whom these therapies are not suitable. • The focus on RCTs means that there is no mention of therapies with emerging evidence bases e.g., RO-DBT. Case studies with good effect sizes receive no mention while recommendations are based on RCTs with limited effect sizes. • The lack of information about approaches such as DBT and CAT which were included in the 2004 guidelines is a concerning omission. Surely for continuity there should be some discussion / exploration around the use of these previously recommended treatments. • It is difficult to comprehend how ED focused focal psychodynamic therapy can be listed as an equivalent treatment when the findings for example show no impact on BMI. • The lack of guidance regarding the treatment of comorbidities is also a concern. We are potentially left with limited approaches we can use for our more complex presentations and in turn this is likely to negatively impact on research / further	young people. Regarding adult anorexia nervosa, the recommendation regarding eating disorder focussed focal psychodynamic therapy (FPT) (whose manual is only currently published in German) has been moved to make it a second-line treatment if CBT-ED, MANTRA and SSCM do not prove effective. This change was made to reflect the fact that there is evidence of no difference between these three therapies, services may find it costly to provide FPT (especially given that there is as yet no English manual). The recommendations for young people with bulimia nervosa have also been amended to consider individual CBT-ED as a second-line alternative to family therapy (rather than guided self-help) due to (i) the reclassification by the committee of the guided self-help arm in Schmidt et al. 2007 as a form of individual CBT-ED and (ii) to allow for the provision of individual psychological treatment. The recommendations for adults with BED have also been amended to add individual CBT-ED as a third-line option after guided self-help and group CBT-ED because the committee recognised that it may be difficult to recruit sufficient numbers of people to form a group and that some form of individual therapy should be recommended. Generally RCTs provide a more robust and reliable evidence base than case studies due to the fact that confounders

						contributions to the evidence base for these patients - The recommendation that EMDR is not recommended as a treatment for eating disorders could be misinterpreted inadvertently excluding ED patients from trauma work / sequenced ED treatment - It is also concerning that therapy recommendations are based on treatment manuals not yet readily available – we would question how this can be helpful at the point of publication	are less likely to be operative in the sample. While a systematic review of the evidence for a particular issue might ideally and arguably include all types of evidence, from RCTs all the way down to case studies, from a pragmatic point of view this is not possible. Although there are new and emerging therapies in the area of eating disorders, given the volume of evidence that the developers might conceivably have to review, and the attendant time constraints dictated by NICE - the Committee decided to narrow their focus on evidence from RCTs. Regarding the recommendations of the 2004 guideline, there has been a considerable amount of research since this time. The purpose of the NICE guidelines is to provide an up to date guide to current best practice rather than to explain The Committee recognised that people with eating disorders often present with a comorbidity. However, only a few studies were identified that were relevant to our review question of whether eating disorder treatments need to be modified in the presence of a comorbidity. The dearth of evidence was acknowledged by the committee and given the importance of the issue, they made a research recommendation in the hope that this would be rectified. Regarding the inclusion of EMDR, this was mistakenly included in the physical interventions rather than the psychological interventions review. As such, it would not have been included in

							the latter review as it did not report any critical outcomes.
370.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	General	General	Specific advice regarding treatment approaches for those with SEEDS who have exhausted all treatment approaches would be very welcome. There may not be enough evidence to make evidence based recommendations but expert recommendations based on best clinical practice could be included.	Thank you for your comment. Evidence on people with severe and enduring AN was included in this guideline. However, no specific recommendations were made for this group given the evidence did not show any significance difference between the two therapies investigated - CBT vs. MANTRA and both of these are recommended for any person with AN. The Committee were also concerned about creating cut-offs for different types of treatment.
371.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	General	General	The guidelines do not include information about use of CTOs in this population.	Thank you for your comment. The Committee discussed whether specific mention should be made of community treatment orders, which are covered by the Mental Health Act. However, as there does not appear to be any evidence that they are effective (at least in relation to eating disorders) and some evidence (in people with psychosis) that they are not effective (see Burns, T., Rugkåsa, J., Molodynski, A., Dawson, J., Yeeles, K., Vazquez-Montes, M., ... & Priebe, S. (2013). Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. The Lancet, 381(9878), 1627-1633.), it was decided that no mention would be made of them.
372.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	General	General	There is little emphasis within the draft guidelines about the concept of staging of illness and matching treatment approaches to take account of this. Inclusion of expert recommendation/ commentary would be helpful especially in circumstances where cessation of	Thank you for your comment. Although this is of concern, no evidence (besides severe and enduring AN) was found regarding how to manage people at different stages of illness and how to match treatments to take account of this.

						active psychological treatment is being proposed.	
373.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	General	General	Some guidance re: psychological treatment approaches in people with eating disorders pre and post bariatric surgery would be helpful	Thank you for your comment. One recommendation addresses this by stating that explanation should be provided for people with binge eating disorder that psychological treatments aimed at treating binge eating have a limited effect on body weight and that weight loss is a post-therapy target. Recommendations in the NICE guideline on obesity identification, assessment and management for guidance on weight loss and bariatric surgery should also be considered.
374.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	General	General	releasing the draft of the guidelines before Xmas has limited the consultation period which is a concern in terms of achieving adequate consultation.	Thank you for your comment. The consultation period was the standard 6 weeks required by the NICE guidelines manual and very few stakeholders expressed any concern with the deadline for comments. NICE and the NGA showed as much flexibility as they could to those that did, and extending the deadline for consultation would have delayed the whole project unduly.
375.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	General	General	The previous guidelines made explicit which recommendations were based on which level of evidence including expert concensus. Something similar here would be very helpful	Thank you for your comment. The previous guideline reflects how NICE used to present their recommendations. However, the wording of recommendations in the new short guideline is required to follow the methods outlined in "Developing NICE guidelines: the manual". "Developing NICE guidelines: the manual"
376.	SH	South West London and St	Short	General	General	We are concerned that the guidelines do not recognise the transdiagnostic nature of eating disorders. We see a lot of	Thank you for your comment. The transdiagnostic nature of people with eating disorders is referenced in the

		George's Mental Health NHS Trust				clients who move from one diagnostic category to another or who fluctuate between a restrictive/binge purge presentation.	introduction. Although research in this field may move in this direction, studies are still being published using people with specifically diagnosed EDs, thus our current recommendations are dictated by how the evidence is collated and presented. Please note also that the introduction and guideline are intended to be a practical evidence-based guideline rather than a textbook.
377.	SH	South West London and St George's Mental Health NHS Trust	Short	General	General	Given that there are no specific recommendations for the psychology therapy approach in inpatient settings, but there is clear recommendation for some psychotherapy, why is there not a research recommendation to better understand the types of therapies that are most helpful in inpatient settings?	Thank you for your comment. The Committee decided that there was research into other areas that could better improve clinical outcomes in the healthcare service, taking into account both their clinical and economic implications and the state of current knowledge.
378.	SH	The Tuke Centre, part of The Retreat, York	Short	General	General	Considering the poor quality of evidence, the short version is extremely prescriptive. Most clinicians / service users will not have the time or energy to plough through the long version which is like a large text book. People will assume that what is presented in the short version is a summary of the long version. At present this is not the case, the short version is a complete disconnect from the facts presented in the long version.	Thank you for your comment. Generally, the wording of recommendations in the short guideline is required to follow the methods outlined in "Developing NICE guidelines: the manual". In particular, the words ‘consider’ and ‘offer’ are intended to indicate the level of certainty afforded by the evidence, where the former indicates a high degree of certainty (e.g. where the benefits clearly outweigh the harms) and the latter indicates a lower degree of certainty (e.g. where there is a balance between benefits and harms to be thought about). Note that the recommendations in the short guideline have been substantially revised (please also see the relevant LETRs in the full guideline) and it is hoped that it better reflects the content of the full guideline.

379.	SH	NHS Greater Glasgow and Clyde	Short	General	General	There was a general team comment that perhaps more of the valuable work from the full document could be included in the short version since this is the one that will be referenced the most. It was thought that the short version could afford to be longer in order to capture more from the full document.	Thank you for your comment. The wording of recommendations in the short guideline is required to follow the methods outlined in "Developing NICE guidelines: the manual".
380.	SH	NHS Greater Glasgow and Clyde	Short	General	General	We think that there is a strong value of including a Dietitian in the multidisciplinary management of all patients with eating disorders even if direct contact is not required for all.	Thank you for your comment. The committee decided against specifying the exact composition of a multidisciplinary team, especially given the wide variation in services across the country. However, a comment relating to this issue has been added in the relevant LETR in the full guideline.
381.	SH	NHS Greater Glasgow and Clyde	Short	General	General	Whilst it was understood why the general term 'dietary counselling' was used to keep this advice vague and the full document describes this more fully. We thought that it may be valuable to state that good practise would indicate the involvement of a Dietitian either directly or indirectly in most cases.	Thank you for your comment. The committee decided against specifying the exact composition of a multidisciplinary team, especially given the wide variation in services across the country. However, a comment relating to this issue has been added in the relevant LETR in the full guideline.
382.	NICE	NICE quality standards	Short	General	General	• Definitions needed for a number of tools, questionnaires and therapies (individual eating-disorder-focused cognitive behavioural therapy and eating-disorder-focused focal psychodynamic therapy) to aid understanding. • General agreement with the guidance overlaps referenced.	Thank you for your comment. Unfortunately, the short guideline does not allow space to provide definitions. These can be found in the full guideline.
383.	NICE	NICE Social care	Short	General	General	There appear to be no references to people with a learning disability (not really a 'co-morbidity'). Should there be?	Thank you for your comment. The second recommendation states the importance of ensuring people with any disability have equal access to care.

							There is also a recommendation that health care professionals should ensure the person understands what is being communicated to them.
384.	NICE	NICE Social care	Short	General	General	Also, there is no mention of Prader-Willi syndrome – or does it come under 'Other specific eating disorders' – but is it specifically linked to people with LD?	Thank you for your comment. Unfortunately, the Prader-Willi syndrome is outside the scope of this guideline.
385.	SH	British Dental Association	Short	General	Section 1.3-1.8	Dental professionals should be included within the multidisciplinary teams treating in-patients, and should be involved in the ongoing care of out-patients with eating disorders.	Thank you for your comment. The committee decided against specifying the exact composition of a multidisciplinary team, especially given the wide variation in services across the country. However, a comment relating to this issue has been added in the relevant LETR in the full guideline.
386.	SH	Mental Health Foundation	Short	General	Section 1.1	The guidance does not make clear whether mentions of the role of family members or carers are in relation to support for adults with eating disorders, or for children.	Thank you for your comment. The language has been checked and clarified where needed.
387.	SH	Diabetes UK	Short	19-20	9-28, 1-10	We are pleased that insulin omission is included in this guideline as it is estimated to affect up to 40% of women with Type 1 diabetes (Pinhas-Hamiel O. and Levy-Shraga Y., 2013). Men with Type 1 diabetes also have a higher drive for thinness than their non-diabetic counterparts (Svenson M. et. al., 2003). It is also associated with higher rates of diabetes complications (Rodin G. et. al (2003), Goebel –Fabbri et. al (2008), Takii M. et al. (2008) The term "diabulimia" should be included and explained as this is the term that	Thank you for your comment. Regarding the use of the term 'diabulimia', the committee considered your suggestion, but as it is not a diagnostic term, declined to use it. A recommendation regarding diabetes and bulimia nervosa has been added.

						98% of people with it use to describe the condition (Allan J. 2015)	
388.	SH	South West London and St George's Mental Health NHS Trust	Short Ref: Long	15-16 415-624	1.3.6-8 General	We are concerned that this recommendation may imply that the evidence base for single-family therapy is conclusively better than that of existing alternatives, in particular, CBT-E. We are concerned that this recommendation may imply that only single-family therapy can be used for adolescent BN, and that individual therapy has no role in the core treatment of adolescent BN This recommendation will be a challenging change in practice because, as per NICE guidelines CG9, our main pathway is for treatment of adolescents with BN with CBT. This recommendation will be a challenging change in practice because in practice single-family therapy for BN is very challenging and does not have a high success rate on its own. This client group is particular heterogeneous with presentations that require different approaches tailored to the young person and family. There is particular concern that having only one specified recommendation will alienate a significant number of young people and families who are unable or unwilling to access family therapy, and this in particular for a client group that are hard to engage. The NICE guidelines CG9 stated that adolescents with BN "may be treated with CBT-BN, adapted as needed to suit their	Thank you for your comment. Since the publication of the last guideline, two studies have been published that show CBT-ED is less effective compared with FT. Because of the evidence to support its recommendation as a first line treatment in adults, the Committee agreed it could be offered as a second line treatment for young people with bulimia nervosa if family therapy is unacceptable, contraindicated or ineffective. In conclusion, the old guideline made recommendations for adolescents extrapolated from adults, however, there is now have evidence for young people that allowed the Committee to make specific recommendations based on the evidence available. Regarding the Dalle Grave 2015 article, this was not a RCT and was therefore not included in the evidence review. The statement on p. 623 to which reference is made is also in the context of a discussion on substance and medication misuse and is not related to the discussion of evidence for the efficacy of CBT nor to that of family therapy.

						age, circumstances and level of development, and including the family as appropriate" (CG9 4.5.1.4, 4.5.5.1). No mention was made of single-family therapy for adolescents with BN at this stage, despite the availability of Le Grange et al 2007 and Schmidt et al 2007. Indeed, the 2011 7-year review concluded that there was no new evidence identified sufficient to warrant formal review of the guidelines at the time. Therefore, the single major study on which the present draft guidance's decision to exclude CBT for adolescent BN is based was Le Grange 2015, which compared follow-up data on FBT-BN with an adaptation of CBT, CBT-A. (Described in Lock J. 2005 Am J Psychother) The written review in the present draft guidelines makes no mention of reported results for CBT-E for adolescent BN in Dalle Grave 2015. In that study, "two-thirds of those who started treatment (67.6%) had minimal residual eating disorder psychopathology by the end, and half of those who had been binge eating and purging had ceased both forms of behaviour (intent-to-treat figures)." Some comparison can be made to the results from Le Grange 2015, which reported an abstinence rate of 39.4% for FBT-BN and 19.7% for CBT-A at end-of-treatment. The fact that Dalle Grave 2015 did not report on follow-up should not necessarily exclude this study	

						from present consideration, as even in Le Grange 2015, remission rates only increased with time at follow-up after end of treatment for both interventions. Although granted this in itself does not provide evidence for the efficacy of CBT-E, these results at least suggest that CBT-E is very different from CBT-A (indeed, the Lock 2005 description of CBT-A is very different from that of CBT-E in Dalle Grave 2015), and therefore does not exclude CBT-E as proven to be inferior to FBT-BN for adolescent BN. Of note, Waller 2016 (in review) recommends CBT-E as a second-line intervention for adolescent BN. The full guidance (p623) states, "the evidence used to generate these recommendations was very low quality. The evidence was observational and in GRADE (the software used to assess the quality) the evidence starts at very low quality and can only be upgraded if large effect sizes are found or if a dose response is identified. Neither was the case for this review." Given the weak evidence all round, the generally poor response to treatment for adolescent BN with any modality, and the high drop-out rates that make engagement paramount in adolescent BN treatment, we are concerned that the new NICE guidance does not at least state CBT-E as a possible second-line treatment for adolescent BN where FT-BN is unacceptable or ineffective.	

389.	SH	Royal College of Nursing	Short	1	Front box	Perhaps we could reconsider this phrase: "*their families and carers. "* We realise that it is standard but many people with an eating disorder (especially anorexia nervosa) do not consider themselves to be *ill* and therefore are not always comfortable with their loved ones being called *'carers'*. Would it be possible to say something like '*families and others who are important in their lives'?* This is more important for adults, rather than adolescents.	Thank you for your comment. A comment has been inserted at the very beginning of the short guideline stating that 'family members' is to be understood to include siblings, children and partners of people with an eating disorder.
390.	SH	Royal College of Nursing	Short	1	Front box	Re: *Healthcare professionals responsible for assessing and treating eating disorders.* Could it say *Healthcare professionals responsible for assessing, monitoring and treating people with eating disorders..?*	Thank you for your comment. The text has been amended.
391.	SH	BEAT	Short	3	7	Inconsistent wording has been used here: 'treatment of' rather than 'treating', which has been used for all the other diagnoses.	Thank you for your comment. The text has been amended.
392.	SH	BEAT	Short	3	11	There is no section titled 'treating any eating disorder' within the document.	Thank you for your comment. The text has been amended.
393.	SH	BEAT	Short	3	6–9 and 11	We suggest the addition of "people with" or "patients with" between the words 'treating' and the type of eating disorder - to emphasise that treatment should be tailored (as much as possible) to the patient (and carer where appropriate).	Thank you for your comment. It is standard NICE editorial policy to avoid the use of this phrase.
394.	NICE	NICE Social care	Short	4	3	'Family' (generally reads as 'parents') and carers are mentioned frequently. However, adults with an ED may have dependents and there may be issues around this. (Child care, safeguarding etc). Should this be touched upon?	Thank you for your comment. A comment has been inserted at the very beginning of the short guideline stating that 'family members' is to be understood to include siblings, children and partners of people with an eating disorder.
395.	SH	Royal College of Nursing	Short	4	5	Could we include another line in this section - Be aware that people with an	Thank you for your comment. Please note that the recommendations have

						eating disorder may *deny that they have a problem.*	been substantially revised. The committee considered your suggestion but decided not to include this particularly sentence as they considered it to be implied by the current wording.
396.	SH	Mental Health Foundation	Short	4	6	We are concerned that the opening line of the guidance states that people with eating disorders 'may avoid contact with healthcare professionals'. Although we recognise there is research to back this statement up and do not dispute the point should be included, we argue that it sets a negative tone for the guidance that suggests the person with an eating disorder will not be compliant and is therefore stigmatising.	Thank you for your comment. The text has been amended.
397.	SH	BEAT	Short	4	7	Professionals should be made aware that people with an eating disorder may be secretive about their condition or deny its existence when asked to discuss it.	Thank you for your comment. The text has been amended to take your comment into account.
398.	SH	Mental Health Foundation	Short	4	9	Socio economic status should also be included in the bullet points.	Thank you for your comment, this has been revised as suggested.
399.	SH	Oxford Health NHS Foundation Trust	Short	4	12	1.1.2 Please add 'age' under equal access. The guidelines need to cover all people with eating disorders: there are an increasing number of older patients, whose needs should not be overlooked. If the recommendations don't specify age, they may imply that age is irrelevant in terms of access to treatment or that older patients don't exist.	Thank you for your comment. The text has been amended.
400.	SH	BEAT	Short	4	17	The word 'other' should be inserted before the word "mental" to highlight that eating disorders are mental illnesses. This will be particularly important if the 'Context' section (see pages 27-28) is not	Thank you for your comment. The text has been amended.

						significantly improved. To implement this, we suggest splitting this bullet point into two - the first bullet point would read 'any other mental health problems' and the second would read 'any physical health problems or disabilities'.	
401.	SH	BEAT	Short	4	17	'Age' should be added to this list.	Thank you for your comment. The text has been amended.
402.	SH	Royal College of Nursing	Short	4	19 onwards	This is a really important section. It cannot be over-emphasised how sensitive the clinical/ practitioner needs to be. The developers are right to make it clear that the clinician should ask the person with an eating disorder what they know already, this is really important as they do tend to be experts on the matter, sometimes knowing more than the staff. They will be scared that they will be made to eat and thus gain weight, so it is important to recognise that, especially during the assessment period, that sensitivity and KINDNESS is displayed.	Thank you for your comment.
403.	SH	The Association for Family Therapy and Systemic Practice in the UK	Short	4	5–17	These recommendations (Improving access to services) are of great importance but perhaps more emphasis could be placed on developing awareness of adults, young people and children (and their families) from black and ethnic minority groups, perhaps particularly young Asian women, who may not have easy access to services or where established treatments may have less fit with the belief systems of either the patient or their wider family. There may be geographical variation about this.	Thank you for your comment. The recommendations state that all people with an eating disorder and their families or carers have equal access to treatments regardless of, among other things, gender, sexual orientation, religion, belief, culture, place of residence, and any physical or mental health problem. Whilst the Committee recognised that there was a lack of research in BAME groups, other topics of research were considered to have priority.

						Given the lack of data particularly in the UK on this important issue it may be that an additional research recommendation could be made to encourage both audit, and evaluation of response to treatment for adults and young people and their families presenting from black and ethnic minority groups. Reference: Sinha, S & Warfa, N (2013) Treatment of eating disorders among ethnic minorities in western settings: a systematic review. Psychiatric Danubina 25 (2) p.295-299	
404.	SH	Mental Health Foundation	Short	4 – 7		Section 1.1 is focused on children and family and therefore does not explore the impact eating disorders have on adults; this is more important than ever with new research demonstrating that middle aged women are developing eating disorders at higher rates. As we are commenting on the executive summary, we cannot say whether this is true of the full guidance, however if practitioners are reading the summary only, the focus needs to be encompassing of groups other than children and families.	Thank you for your comment. Amendments have been made for clarity as not all recommendations in this section are for children and young people.
405.	SH	College of Mental Health Pharmacy	Short	5	22-24	*If appropriate, encourage family members, carers, teachers and peers of young people with eating disorders to support them during their treatment*	Thank you for your comment. The text has been amended.
406.	SH	BEAT	Short	5	5	People with eating disorders and their family members or carers (as appropriate) should be offered	Thank you for your comment. Several recommendations have emphasised the need to provide information and support

						information on the service/s which the person with the eating disorder could be referred to. Patients and carers should be given information to help facilitate their right to be involved in discussions and make informed decisions about their care, as described in the NICE document: 'your care'.	to people with eating disorders and, if relevant, their families and carers.
407.	SH	Royal College of Nursing	Short	5	6	The guidance uses the word 'empathy', but in the main, service users with anorexia nervosa in particular, tend to believe that workers do not understand them at all and cannot empathise with them. However, a clear, but kind approach tends to be valued.	Thank you for your comment. The guidance includes that health care professionals should be sensitive and show empathy as well as compassion and respect.
408.	SH	BEAT	Short	5	9	Professionals should also be sensitive when discussing a person's behaviours, thoughts and feelings.	Thank you for your comment. The guidance includes that health care professionals should be sensitive and show empathy, compassion and respect.
409.	SH	PEDS Charity	Short	5	12	Suggest also including the word 'patience' as it often takes the service user time to open up acknowledge and accept their difficulties.	Thank you for your comment. No amendment was made as this was not intended to be an exhaustive list, given many of these points are considered good practice.
410.	SH	Royal College of Nursing	Short	5	17	It is pleasing to see that the education needs of young people have been recognised here. This is incredibly important.	Thank you for your comment.
411.	NICE	NICE Social care	Short	5	17	There is no reference to collaboration with Children's services (as appropriate) here. Should there be?	Thank you for your comment. The importance of collaboration between services has been addressed in other recommendations, in particular in the general principles section at the beginning of the guideline.
412.	NICE	NICE Social care	Short	5	18	Could social media / internet chat rooms be specifically included as a 'wider social environment'?	Thank you for your comment. The text has been amended.

413.	SH	BEAT	Short	5	23	Question 3: Beat provides several services which could help professionals to implement this recommendation, including moderated online peer support groups and 'Collaborative care skills' workshops for carers. Further information on these services is available here – https://www.b-eat.co.uk/for-professionals/service-providers/how-can-we-work-with-you and on request by contacting contracts@b-eat.co.uk.	Thank you for your comment. NICE guidelines are primarily targeted towards NHS health care professionals but welcome charities contribution to providing additional support where needed.
414.	SH	North Essex Partnership NHS Foundation Trust	short	5	25	Its not clear whether this section ONLY applies to children and young people or all carers	Thank you for your comment. Amendments have been made for clarity as not all recommendations in this section are for children and young people.
415.	SH	Esoteric Practitioners Association	Short	5	17 – 21	We are concerned that the support scope does not focus on exploring the underlying root causes of the individual's behaviour, which is crucial in the recovery phase. This equally applies to young people. Welsh E. & Ghaderi A. (2013), *Girls At Risk*, Part of the series Advancing Responsible Adolescent Development pp 35-56, Chapter 3 - Eating Disorders and Self Esteem: http://link.springer.com/chapter/10.1007/978-1-4614-4130-4_3	Thank you for your comment. Whilst important, addressing risk factors/ root causes was beyond the scope of the guideline.
416.	SH	BEAT	Short	5	17–24	Either recommendations 1.1.7 and 1.1.8 should be reworded to include adult patients or separate new recommendations should be inserted to address this gap, as both recommendations could also be relevant to adults.	Thank you for your comment. This section has been amended for clarity.

417.	SH	College of Mental Health Pharmacy	Short	6	4-6	*If appropriate, provide written information for family members or carers who cannot attend meetings with a person with an eating disorder for assessment or treatment*	Thank you for your comment. The recommendation has been amended in line with the suggestion.
418.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	6	4-6	We would prefer a guideline which states that parents and carers are strongly advised to attend assessment appointments along with this guideline as it seems to imply that parents and carers could only require written information rather than contributing to the assessment and treatment themselves. Their participation from the beginning is crucial, as per the ethos of Family Based Treatments (FBT). Parents and carers often read NICE guidelines so you giving them a firm role is key.	Thank you for your comment. The text has been amended.
419.	SH	BEAT	Short	6	2	This offer should include an assessment of whether they might require access to treatment for a mental health condition themselves.	Thank you for your comment. The text has been amended.
420.	SH	Oxford Health NHS Foundation Trust	Short	6	2	1.1.9 Is there sufficient evidence for the Guidance to suggest that Family and Friends/Carers groups or skills-based workshops for carers and family members should be considered? There have been quite a few studies on the Maudsley Carers Skills Workshops, summarised by Treasure and Nazar (2016) and a recent meta-analysis (Hibbs et al., 2015, IJEDs). We assume the committee doesn't feel the evidence warrant recommending them yet?	Thank you for your comment. The majority of the studies were for carers of people with anorexia nervosa (including the studies contained in the Hibbs et al. 2015 meta-analysis); the quality of the data was generally very low and showed few beneficial effects. The Committee felt that there was insufficient evidence to support a recommendation for any specific carer intervention.
421.	SH	BEAT	Short	6	3	It is not clear whether these 'emergency plans' relate to the person being cared for, the carer themselves or both.	Thank you for your comment. The text has been amended.

422.	SH	PEDS Charity	Short	6	3	Ensure carer assessments are updated as the treatment progresses / changes as needs often change	Thank you for your comment. The text has been amended.
423.	SH	North Essex Partnership NHS Foundation Trust	Short	6	4	See above. I thought this applied to ALL carers but now “child” is referred to	Thank you for your comment. The text has been amended.
424.	SH	Oxford Health NHS Foundation Trust	Short	6	5	1.1.10: Please add partner – otherwise the guidelines imply that only parents are important carers.	Thank you for your comment. Partners are considered to be included under the term 'family member'.
425.	SH	Oxford Health NHS Foundation Trust	Short	6	14	1.1.11: limits of confidentiality include sharing of risks with carer/ nearest relative/ DVLA – for example, if there is a risk to the public by driving when physically unstable or when considering compulsory treatment.	Thank you for your comment. The text has been amended to clarify that other agencies may have access to information about the person with the eating disorder.
426.	SH	Oxford Health NHS Foundation Trust	Short	6	15	1.1.12 Gillick competence. The guidelines state when seeking consent for assessment or treatment for children below the age of 16 Gillick competence should be respected if they do not want their parents/carers involved. This has been concluded through discussion in the committee and does not include mention of the rights and responsibilities of parents under the Children Act. We wonder if it should be made clear that parents have rights and responsibilities under the Children Act and without information they may not be able to exercise their duty as parents and take appropriate care of their children. This has to be balanced against the need to respect the wishes of the GIllick competent child.	Thank you for your comment. If a child or young person is deemed to be Gillick competent, consents to treatment and does not wish the parents to be involved, then this must be respected by medical staff. A recommendation has been added that refers to the recommendations on compulsory treatment, which mentions the Children Act, to cover the situation when the child or young person does not consent to treatment.
427.	SH	BEAT	Short	6	16	The hyperlink on the phrase 'Gillick competence' currently links to a page on the NICE website rather than any instructions about this complex	Thank you for your comment. The link will be updated as appropriate by NICE. It is a requirement in the NHS that all staff be competent and trained in any

						judgement. It would be useful for readers to be signposted to guidance on how to assess Gillick competence. It could also be strengthened by a reference to the importance of supervision and advice from appropriately trained and experienced colleagues when making this judgement.	assessment that they conduct. It would therefore be expected that if staff were not competent to assess Gillick competence that they would not do so and indeed would seek the assistance of a member of staff who was.
428.	SH	Royal College of Nursing	Short	6	18	Training and competence is an issue. Few nursing staff have any additional qualifications in eating disorders, and the pre-registration course has limited eating disorder content and/or opportunities for placement experience due to the paucity of eating disorder services. Perhaps a recommendation encouraging training and development of healthcare professionals so they can gain more knowledge around the subject would be helpful this could also include reading on the topic. Recommended reading should include some autobiographies as well as text books.	Thank you for your comment. Healthcare staff should not be independently providing interventions or care when they are not competent to do so. It is outside the scope of this guideline to set out training programmes.
429.	SH	BEAT	Short	6	12–14	A bullet point could be added to instruct eating disorders services and any other health and social care professionals involved to provide clear guidance for parents on confidentiality, including regarding the sharing of information about treatment (including medication) with them, particularly when the person receiving treatment is over the age of 16 (or younger if they have been assessed as meeting 'Gillick competency').	Thank you for your comment. The second sub-bullet point covers the suggestion made.
430.	SH	Leicestershire Partnership NHS Trust	Short	6	26	It is important to maintain the multi-disciplinary nature of the specialist teams (inclusive of specialist professionals with	Thank you for your comment. Several of the recommendations note the

						extensive training in working with young people and their families such as Child and Adolescent Psychiatrist, Child and Adolescent Psychoanalytic Psychotherapists, Family Therapist, Clinical Psychologists and Specialist Mental Health Nurses). Beyond the direct therapeutic provision to patients and families there needs to be recognition of the importance of maintaining this element in providing high quality mental health services.	importance of working in multi-disciplinary teams.
431.	SH	Oxford Health NHS Foundation Trust	Short	6	26	1.1.14: professionals assessing and treating eating disorders should be trained in eating disorders. This has important implications, as postgraduate training on eating disorders remains limited for most health care professional groups, including doctors, psychologists, nurses and allied healthcare professionals. We are concerned if that this is not specified, some organisations will not ensure that their staff is appropriately trained. Furthermore, there needs to be a change in curriculum of relevant postgraduate training, such as general medicine, general practice, core psychiatry, mental health nursing where eating disorders are often overlooked.	Thank you for your comment. It is a requirement for all practitioners working within the NHS or any healthcare system to be competent in the relevant procedures before undertaking work with a patient and this would be expected to be the case for people with eating disorders.
432.	SH	BEAT	Short	6	27	Professionals providing treatment for adults with an eating disorder should also be trained and skilled in the bullet points listed in recommendation 1.1.13 as well as professionals providing treatment for children and young people.	Thank you for your comment. The recommendation has been amended as suggested.
433.	SH	BEAT	Short	6	22–25	This recommendation should state that these professionals should also receive training about eating disorders. Those	Thank you for your comment. The stem of the recommendation covers this point.

						professionals providing assessment and treatment should be trained and skilled in the assessment and treatment of eating disorders.	
434.	SH	South West London and St George's Mental Health NHS Trust	Short	7	5-7	We are concerned that this recommendation may imply that the state of clinical knowledge of what works is more advanced than it actually is. Alongside the standardised measures, clinicians should be being encouraged to develop innovative qualitative and mixed qualitative/quantitative measures. Many sufferers resent the standardised measures, which often elicit pseudo-compliance and second-guessing of what the researcher/clinician wishes to hear. The guidelines should better reflect the general sense of humility in the field - we don't know as much as we would like to and our adherence to certain rigid practices (like the sufferers) may be part of the problem.	Thank you for your comment. Although there may be concern regarding the limitations of standardised measures, the Committee considered them still to be the most effective current way to inform both clinicians and service users on the effectiveness of interventions. However, any measure should be interpreted and used in the context of an individual's circumstances and needs, and the way that they respond to treatment.
435.	SH	British Psychological Society	Short	7	1-2	There is a strong emphasis on manualised approaches within the current guidance. There are clear and compelling reasons for this in relation to, for example, Cognitive Behaviour Therapy (in terms of the effectiveness of approaches based on relevant manuals, therapist concerns about adhering to such manuals, and the potential negative consequences of 'therapist drift'). Comprehensive, evidence based manuals are invaluable tools to draw upon in the delivery of psychological interventions for eating disorders, and a	Thank you for your comment. Manuals provide a guidance structure to the delivery of an intervention. In all cases the application of a manual requires clinical judgement and this would be expected to be the case for people who are difficult to engage (e.g. those with comorbidities and/or complex conditions). Unfortunately, very few studies were found regarding whether eating disorder treatment should be modified in the presence of a comorbidity. As such the Committee, recognising the importance of this issue, made a research

						number of excellent examples are available. However, we are concerned that the very general (non-modality specific) recommendation to “Base the content, structure and duration of psychological treatments on relevant manuals that focus on eating disorders” may risk constraining the scope and flexibility of therapy. In young people and adults presenting with high levels of complexity and comorbidity (e.g. trauma and attachment difficulties) there may at times be a need to work in a more diverse, integrative, multi-modal and formulation-driven fashion. It may also be useful in some cases to draw upon potentially helpful approaches for which a comprehensive eating disorder focused manual is not currently available (e.g. schema therapy: Waller et al., 2007; Simpson et al., 2010; Simpson, 2012).	recommendation in the hope that this dearth of evidence would be rectified.
436.	SH	South West London and St George's Mental Health NHS Trust	Short	7	1-2	We are concerned that this recommendation may imply that non-manualised treatments are ineffective. The draft guidelines prioritise manualised treatments in a way that seems to be driven more by ideology than by evidence. A well-established literature attests that Eating Disorder (ED) sufferers suffer above all from having been told what to think and what not to think in very formulaic ways. We regret the present draft's unnecessarily narrow reliance on 'sticking to the manual'. There are some patient-therapist fits that	Thank you for your comment. Manuals provide a guidance structure to the delivery of an intervention. In all cases the application of a manual requires clinical judgement and this would be expected to be the case for people who are difficult to engage (e.g. those with comorbidities and/or complex conditions).

						are best suited to both parties being directed by the manual. Our clinical practise has shown that with complex clients and clients with comorbid difficulties, using evidence based models with a degree of flexibility is key to engagement and recovery.	
437.	SH	Royal College of Nursing	Short	7	3	Receiving supervision is very important indeed. Working with this client group can be exhausting and rates of staff burn-out are high. However, we believe that *clinical* rather than *managerial* supervision is required, ideally from somebody independent to their service who has got specialist knowledge in eating disorders. Anecdotes from colleagues including those working within an independent patient service and providing clinical supervision, have found that many staff seem ill-informed but not able to express their lack of knowledge/ skills, hence supervision tends to be quite educational , but also quite supportive/ restorative.	Thank you for your comment. The text has been amended as suggested.
438.	SH	Oxford Health NHS Foundation Trust	Short	7	4	1.1.16: professionals should receive specific training about the physical, psychological and social aspects of eating disorders, and receive appropriate supervision. Supervision alone cannot substitute for training.	Thank you for your comment. This is covered by the recommendation that professionals who assess and treat people with eating disorders should be competent to do so for the age groups for whom that they provide care.
439.	SH	BEAT	Short	7	6	Professionals should be trained in how to use and interpret standardised outcome measures.	Thank you for your comment. This is covered by the recommendation that professionals who assess and treat people with eating disorders should be competent to do so for the age groups for whom that they provide care.

440.	SH	Oxford Health NHS Foundation Trust	Short	7	6	1.1.16 The EDE-Q covers bulimic behaviours, so this is duplication – suggest keep EDE-Q only.	Thank you. This has been amended as suggested.
441.	SH	Esoteric Practitioners Association	Short	7	2 and 5	Is there any potential for input into training material offered to professionals working with eating disorders?	Thank you for your comment. The recommendations to use 'relevant' manuals was based on the fact that the majority of the relevant reviewed studies examined manualised interventions. Whether or not there is potential for input into training materials is outside the scope of this guideline.
442.	SH	BEAT	Short	7	10	Implementation of this recommendation could be improved through examples of how these professionals should monitor treatment adherence in people who use their service.	Thank you for your comment. The issue of how professionals should monitor service user's treatment adherence is outside the scope of the guideline.
443.	SH	Oxford Health NHS Foundation Trust	Short	7	10	1.1.16 Regarding the recommendation that 'professionals who provide treatments for eating disorders should: monitor treatment adherence in people who use their service' it will be helpful to have a clear definition of 'treatment adherence'. It will be helpful to have guidance on how to 'monitor' treatment adherence in people who use the service, given that up to now it has been very challenging to measure this in practice. It would also be helpful to have clarity on what NHS professionals and services should do with patents who are not treatment adherent but who remain symptomatic – e.g. should they be discharged from the service or receive further support and monitoring? This relates to the question what services should do to patients with severe and	Thank you for your comment. The references made to adherence in part refer to issues of uptake and engagement with treatment for people with eating disorders as well as the situation when individuals are engaged in treatment that they have agreed to, which if appropriate may involve the family/carer. These are important issues and in light of this and other stakeholder comments, some new recommendations were made, in particular regarding the joint agreement of a care plan.

						enduring eating disorders or patients who are classified as extreme in DSM-5 but who are not responding to evidence-based recommended psychological treatment manuals?	
444.	SH	Cwm Taf Health Board	Short	7	11	This comment relates to the identification and assessment section generally. We are concerned that there is no mention of motivation or consideration of the clients 'stage of change' during the assessment stage. In clinical practice this is an essential factor in guiding intervention choice. A client with anorexia who is in the 'contemplation' phase, that is, they may recognise that their eating disorder is a difficulty for them, but it also serves a useful function as a coping strategy, are unlikely to engage well with a CBT approach initially. This could result in wasting time and resources, and ultimately lead to disengagement from the client. We am aware that the CBT-ED protocol does include some sessions on enhancing motivation, however, as this is brief, and is part of an 'action' based therapy, it can have limited effectiveness.	Thank you for your comment. Although there may be challenges engaging people in treatment, as acknowledged in the comment, a number of treatments take this into account (e.g. CBT-ED). With regard to the 'stage of change' model, no evidence was identified for inclusion in the review of different treatment modalities to support this framework or engagement in treatment.
445.	SH	BEAT	Short	7	5–7	We suggest rewording this to include the purpose of the use of these outcome measures for example - "monitor treatment progress and success through the use of standardised outcome measures, for example the Eating Disorders Examination Questionnaire (EDE-Q), bulimic behaviours or weight."	Thank you for your comment. No amendment was made as the recommendation wording was considered sufficiently detailed.
446.	SH	Oxford Health NHS Foundation Trust	Short	7 8	12	There is no mention of (assessing) the impact of social media and internet usage in this section on assessment.	Thank you for your comment. Reference to the internet and social media has been included in the recommendations.

447.	SH	The Association for Family Therapy and Systemic Practice in the UK	Short	7	3–10	Training and Competencies We welcome the consideration given to training and supervision, and would like to elaborate on this. Re Professionals who provide treatments for eating disorders – a recommendation should be made that professionals should be trained in the psychological therapy they are providing. Family Therapists in eating disorders services should be pivotal to the use of the (widely used) Lock and Le Grange manual, and other eating disorder focused family based treatment manuals, both inputting into its practice and the supervision.	Thank you for your comment. This is covered by the recommendation that professionals who assess and treat people with eating disorders should be competent to do so for the age groups for whom they provide care.
448.	SH	PEDS Charity	Short	7	13	Concern regarding the current guidelines for children in relation to access and waiting times document and how the access and waiting times are different for adults. Could	Thank you for your comment. It is not clear what the query is.
449.	SH	Royal College of Nursing	Short	7	14	Another frequent place to identify eating disorder is at leisure/ sports facilities. It would be great to educate some of the leisure centre workers/ sports coaches to recognise eating disorder and know what to do to help the person to seek appropriate support.	Thank you for your comment. The list is not intended to be exhaustive. Note that one of the recommendations concerning initial assessment in primary and secondary care recommends that those conducting assessments should consider whether the person engages in activities at high risk of eating disorders.
450.	SH	Oxford Health NHS Foundation Trust	Short	7	15 17	1.2.1 Please add: 'including acute hospitals'. Patients with severe eating disorders often need admission or treatment in A&E or acute hospitals, and the recognition and awareness is poor,	Thank you for your comment. The recommendations have been revised to include mention of acute hospitals and have taken into account the point made

						resulting in delay in appropriate treatment, or premature discharge. The NICE guidelines provide an opportunity to rectify this problem. Without specifying the role of the acute hospitals, there is a risk that the guidance is regarded as irrelevant for them. Please add an additional bullet point about the workplace, and higher education.	regarding people who have a severe eating disorder.
451.	SH	The Association for Family Therapy and Systemic Practice in the UK	Short	7	8–9	The guideline recommends monitoring competence. We are curious why this is specified here. Professionals providing interventions have their competence monitored by relevant professional / registration bodies and by clinical supervision and we fully support the importance of this. Is there particular concern about the delivery of interventions in eating disorder services? Is this a recommendation about adherence to treatment manuals alongside use of professional clinical judgement?	Thank you for your comment. The Committee felt that 'therapist drift', away from standardised 'unevidenced' practice is common (see introduction for some references), leading to a waste of resources and negative outcomes. Hence they felt it important to recommend that professionals have their competence monitored to make it more likely that this would not occur.
452.	SH	Royal College of Nursing	Short	7	18 onwards	We are not sure why over-exercising has not been included	Thank you for your comment. The list is not intended to be exhaustive. Note that one of the recommendations concerning initial assessment in primary and secondary care recommends that those conducting assessments should consider whether the person engages in activities at high risk of eating disorders.
453.	SH	BEAT	Short	7	19	'Social withdrawal or avoidance particularly from situations that may involve food', should be added to this list.	Thank you for your comment. The text has been amended.

454.	SH	BEAT	Short	7	19	Use of diet pills and misuse of diuretics could also be added to this list of potential signs of an eating disorder.	Thank you for your comment. The text has been amended.
455.	SH	Mental Health Foundation	Short	7	20	We question whether a low BMI should be referred to as an 'early identifier' for those with eating disorders. If a low BMI is to be included in this section, it should be done recognising wider psychological identifiers. We argue that psychological identifiers should be highlighted to allow for identification of high risk individuals who have a "healthy" BMI; we believe the focus on BMI isolates the identification of individuals with bulimia, OFSED, or Binge Eating Disorder. Further to this, the guidance does not include any psychological identifiers for early intervention, for example mood disturbances, suicidal thoughts and difficultly coping.	Thank you for your comment. Although identifying such risk factors, as suggested, is important, this issue was outside the scope of the guideline.
456.	SH	BEAT	Short	7	21	'Rapid weight loss' should be added to this list.	Thank you for your comment. The text has been amended.
457.	SH	British Psychological Society	Short	7	23	We would recommend adding two bullet points to this list: "people who engage in extreme exercise practices sometimes indicated by recurrent help-seeking for sports related injuries" and "substance abuse, especially of drugs that reduce appetite including cocaine and amphetamine-like drugs."	Thank you for your comment. The suggestion given regarding engaging in extreme exercise practices is covered by the last bullet point; the suggestion regarding substance abuse is covered by a subsequent recommendation in the same section.
458.	SH	BEAT	Short	7	26	Disproportionate concern about shape should also be listed - this could be achieved by editing this line to read: "a disproportionate concern about their weight and/or shape (for example…)"	Thank you for your comment. The text has been amended.

459.	SH	Oxford Health NHS Foundation Trust	Short	7	18, 19	1.2.2 Regarding 'initial assessments in primary and secondary care' and the recommendation that professionals should 'think about the possibility of an eating disorder in people with', we wondered whether an extra bullet point should be added to the list i.e.: • a persistent disturbance of eating or eating-related behaviour. In this regard, DSM-5 states that in essence: Feeding and eating disorders are characterised *by a persistent disturbance of eating or eating-related behaviour* …' DSM-5, p.329. Using the proposed draft list, without the additional bullet point, means that professionals might overlook eating disorders such as pica, rumination disorder, etc.	Thank you for your comment. Pica and rumination disorder were not included in the scope of the guideline.
460.	SH	BEAT	Short	7	18–28	This list should also include psychological distress and perhaps a wider range of disordered eating behaviours.	Thank you for your comment. Psychological distress is covered by the bullet point 'Other mental health problems'. Please note the list has been amended in response to stakeholder comments.
461.	SH	College of Mental Health Pharmacy	Short	8	23-24	*Do not use screening tools (for example SCOFF) as the sole method to determine whether not a person has an eating disorder*	Thank you for your comment. Not sure what needs addressing.
462.	SH	British Society of Gastroenterology	Short	8	Line 1	Managing chronic illnesses should also include Coeliac Disease	Thank you for your comment. 'Coeliac disease' has been added to the list.
463.	SH	BEAT	Short	8	2	"coeliac disease, or food allergies." should be added on the end of this line.	Thank you for your comment. 'Coeliac disease' has been added to the list.
464.	SH	Mental Health Foundation	Short	8	3	Since the DMS5 (2013) does not include menstrual disturbances, we argue this should also be left out of the guidance.	Thank you for your comment. Although it is true that menstrual disturbances (e.g. Amenorrhea) is no longer a diagnostic

							criteria of anorexia, this list is not intended to reproduce the diagnostic criteria for eating disorders but rather factors that may indicate the presence of an (undefined as yet) eating disorder.
465.	SH	PEDS Charity	Short	8	9	Include use of diet pills /diuretics	Thank you for your comment. The text has been amended.
466.	SH	British Dental Association	Short	8	10	The BDA recommends that “dental erosion” be broadened to “atypical dental wear, often of an erosive nature”. Some patients with eating disorders exhibit various dental parafunctional activities, such as clenching, grinding and sometimes excessive tooth brushing linked to frequent vomiting. These can lead to other forms of tooth wear in addition to erosion.	Thank you for your comment. The text has been amended.
467.	SH	British Dental Association	Short	8	10	Although dental erosion is listed as a potential indication of an eating disorder, there is no suggestion as to how a dental professional might proceed if atypical dental wear is identified in a patient and suspected to be linked to an eating disorder. Dentists have regular contact with otherwise “healthy” patients, who might not present to other healthcare settings seeking advice or treatment, and are well placed to identify possible signs of non-oral diseases.	Thank you for your comment. No relevant RCTs examining dental interventions were identified from searches for the physical complications review. The vast majority of the literature consisted of case studies or narrative reviews on how to treat dental-related eating disorder complications. Note that in the recommendations statement is made that professionals conducting assessments should check for the physical signs of atypical dental wear.
468.	SH	Oxford Health NHS Foundation Trust	Short	8	10	Please also add unexplained electrolyte abnormalities, and hypoglycaemia – as these can be potentially fatal.	Thank you for your comment. The text has been amended to reflect your suggestion.
469.	SH	Oxford Health NHS Foundation Trust	Short	8	15	1.2.3 Please add age.	Thank you for your comment. The text has been amended.
470.	SH	Leicestershire Partnership NHS Trust	Short	8	17	Should there be a statement about engaging hard to reach communities and presence of EDs in BME? Perhaps	Thank you for your comment. No amendment was made as equality issues were considered to be sufficiently

						review of the recommendations around these too, as it is important now more than ever to ensure “equal access” to treatments	addressed in the general principles section at the beginning of the guideline.
471.	SH	Oxford Health NHS Foundation Trust	Short	8	19	1.2.4 Please add pubertal delay.	Thank you for your comment. The text has been amended. Please note that the recommendations have been substantially revised.
472.	SH	Oxford Health NHS Foundation Trust	Short	8	22	1.2.5 Pease add: But can affect all age groups	Thank you for your comment. The recommendation is specific to those at most risk and does not imply that eating disorders cannot affect anyone outside of these age ranges.
473.	SH	Royal College of Nursing	Short	8	23	This is very important. SCOFF questionnaire is over-used and often used solely and can be unhelpful.	Thank you for your comment.
474.	SH	Oxford Health NHS Foundation Trust	Short	8	28	1.2.8 Please also add acute hospitals: they have a role in the assessment of patients with eating disorders – as some patients first present in acute emergencies to acute hospitals.	Thank you for your comment. The recommendations have been revised to include mention of acute hospitals.
475.	SH	BEAT	Short	8	15–16	This recommendation should also refer to the other groups/communities mentioned in recommendation 1.1.2 including age, gender identity (including people who are transgender), sexual orientation, religion, belief, culture or family origin, where people live and who they live with, any other mental health problems, and, any physical health problems or disabilities.	Thank you for your comment. The text has been amended to be more general.
476.	SH	BEAT	Short	8	17–19	Recommendation 1.2.4 should also inform professionals that eating disorders in children are often quite different to how they appear in young people or adults and that the diagnostic criteria/guidelines can be less helpful for these patients. The 'Great Ormond Street Criteria' set out in the paper 'Children into DSM don't	Thank you for your comment. The recommendation has been amended to clarify.

						go: A comparison of classification systems for eating disorders in childhood and early adolescence' by Dr Dasha Nicholls and colleagues (2000 - http://bit.ly/2fNVCl5) could be cited as a useful resource to guide professionals in the diagnosis of children with disordered eating/eating disorders.	
477.	SH	BEAT	Short	8	21 & 22	The phrase 'risk of eating disorders' is ambiguous. It would be clearer if it referred to onset or development of eating disorders. More specifically the age range of 13-17, which is cited here, is more typical of the onset of anorexia nervosa than the other eating disorders. This recommendation should reflect the evidence that age of onset for Bulimia nervosa and Binge eating disorder is often later than 17.	Thank you for your comment. The recommendation has been amended to clarify that an eating disorder can develop at any time during a person's life.
478.	SH	BEAT	Short	8	26–27	This recommendation includes the phrase "whether to offer treatment for an eating disorder". This wording implies that there are some people with an eating disorder, who do not need to be offered treatment. Early intervention is important in all cases. This recommendation should be reworded to condemn the dangerous and short-sighted use of Body Mass Index (BMI) thresholds to determine access to treatment. This is a major barrier preventing or delaying access to treatment for many patients and it is important that service users, carers and campaigners can use the NICE guideline to challenge this. The guideline should also warn professionals about the need to consider musculature, ethnicity, age	Thank you for your comment. The committee felt that the wording of the recommendation does not have the implication you assert as it applies to people who are suspected to have (rather than known to have) an eating disorder. BMI is a widely used measure in the health services and as such this guideline is not the appropriate place to provide advice about how to interpret it. Indeed, it is expected that all NHS staff who need to interpret BMI, generally and as it specifically related to eating disorders, are competent to do so.

						and sex and any other salient factors when interpreting BMI.	
479.	SH	BEAT	Short	9	2	This could also include enquiring about the use of other forms of compensatory behaviour including use of diet pills, misuse of laxatives, misuse of diuretics and over-exercising.	Thank you for your comment. This is covered in a preceding recommendation.
480.	SH	Oxford Health NHS Foundation Trust	Short	9	2	1.2.8 Please replace starvation with malnutrition and refer to the BAPEN website (see above)	Thank you for your comment. The text has been amended. The Committee declined to include reference to the BAPEN MUST tool as the assessment of malnutrition is covered by MARSIPAN.
481.	SH	BEAT	Short	9	3	The word 'other' should be inserted before the word "mental" to highlight that eating disorders are mental illnesses. This will be particularly important if the 'Context' section (see pages 27-28) is not significantly improved.	Thank you for your comment. The text has been amended.
482.	NICE	NICE Social care	Short	9	8	Should this list include living circumstances and relationships?	Thank you for your comment. There is a recommendation in the general principles section that precedes the assessment section that covers these.
483.	SH	BEAT	Short	9	9	Some wording to encourage eating disorders services (or any mental health service providing treatment for people with eating disorders) to accept self-referrals would be welcomed here in light of the difficulty many people with eating disorders can experience in securing a referral (from primary care in particular).	Thank you for your comment. Reference is made to the possibility of self-referrals in the general principles section at the beginning of the short guideline.
484.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	9	10	Clearly, there are going to be HUGE resource implications for secondary care if GPs are being advised to refer anybody suspected of having an eating disorder to specialist eating disorders services for assessment and treatment. We appreciate that the intentions in making this recommendation are to	Thank you for your comment. This recommendation has been significantly revised. Prompt and early access to treatment is an important consideration for people with eating disorder as there is some evidence to suggest that early intervention is associated with positive outcomes. The current recommendation

						improve services accessibility and provide opportunity for earlier intervention. If, as we suspect will happen, Assessment and Waiting times to treatment are applied to adult services, there is a strong likelihood that the focus will be lost on those who are most in need of treatment because of milder/sub-threshold/non-eating disorder cases taking up valuable assessment slots. There is also the possibility that in an effort not to be" in breach" of " time to treatment" targets to deliver NICE concordant treatment we could be trying to deliver CBT-ED in the back of an ambulance!	suggests prompt access to effective services, which may include a range of community-based self-help and formal psychological treatment services.
485.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	9 and general	10	It would be helpful to provide information to GPs within the guidelines regarding which physical observations(weight,BP,TEMP,P) should accompany referral to an eating disorders service and to specify when an ECG is indicated and which blood investigations should be performed in order to support secondary care eating disorders in order to prioritise referrals urgency. It would further be helpful for GPs to be aware that organic conditions that can cause weight loss should have been considered and excluded before making a referral especially in atypical presentations eg. addisons, thyroid dysfunction, cancers etc. It would be helpful to have a chart within the guidelines for clinicians to be able to refer to outlining medical risk assessment to make the guidelines more useful from	Thank you for your comment. In light of stakeholder comments, the recommendations both for referral and inpatient care have been revised to clarify that direct referrals to paediatric and adult mental health wards are possible. The recommendations for the assessment and monitoring of eating disorders have also been revised. Although a checklist has not been included at this time, the suggestion as to whether or not such a checklist would be helpful has been passed to NICE implementation.

						a practical perspective rather than having to refer separately to MARSIPAN guidelines. Advice about frequency of physical monitoring re: blood investigations, ECG based on good practice if not evidence would also be helpful It would be helpful to provide guidance to GPs about referring very medically compromised patients to medical units for urgent admission rather than attempting to navigate referral to outpatients or to a SEDU.	
486.	SH	BEAT	Short	9	13	This recommendation should be edited to ensure that if a "community-based, age-appropriate eating disorders service" is not available in their area, General Practitioners (GPs) (and others) will understand that they should still refer the patient to an appropriate equivalent service such as a local generic Child and adolescent mental health service (CAMHS) or adult mental health service (depending on the patient's age), or to an eating disorders service out of the local area (if appropriate).	Thank you for your comment. This recommendation has been significantly revised. Prompt and early access to treatment is an important consideration for people with eating disorder as there is some evidence to suggest that early intervention is associated with positive outcomes. The current recommendation suggests prompt access to effective services, which may include a range of community-based self-help and formal psychological treatment services.
487.	SH	BEAT	Short	9	16	People with eating disorders and their family members or carers (as appropriate) should be offered information on the service/s which the person with the eating disorder is referred to. Providing this information could help reduce any concerns about attending the assessment at the secondary or tertiary service, increasing the chance that the patient will attend their appointment.	Thank you for your comment. The recommendations on communication and information at the beginning of the guideline emphasize that healthcare professionals should ensure that people with an eating disorder (and their families/carers, if appropriate) should receive sufficient information and support to ensure that they are well informed about their condition and related risks, and understand the available treatments.

488.	SH	BEAT	Short	9	20	Given the risk of many readers not then reading the NICE guideline which has been signposted could some of the key points of this guideline be included here - e.g. a named contact to coordinate the transition; joint meetings; developmentally appropriate care and the abolition of rigid age-based thresholds?	Thank you for your comment. The short guideline is comprised of all the recommendations from the full guideline and there is not the space to provide details of other NICE guidelines. Interested readers can either consult the full versions of any cited NICE guidelines, the short guideline or the *Information for the public* version of the guideline.
489.	SH	South West London and St George's Mental Health NHS Trust	Short	9	20	Moreover, (young) adults with anorexia nervosa are often developmentally (including maturity, cognitive abilities, psychological status, social and personal circumstances, communication needs, etc) younger than their biological ages even when they reach 18 or older. To be coherent with the recommendations found in NG43 (Transition from children's to adults' services for young people using health or social care services), which this draft mentioned (p.9 line 20), it is important to mention family therapy as a treatment of choice for adults with anorexia nervosa especially for those who are in need of adolescent to adult transition support, post high mental health risks, and/or lack developmental appropriateness or readiness to engage only in individual-based treatments. Family therapy in practice can also be complimentary and be provided concurrently with other individual-based treatments.	Thank you for your comment. It is important when developing any transition plan to take into account the need to deliver appropriate treatment plans. This is made clear in the recommendation and the expectation is that current treatments would be taken into account. This will involve some flexibility in the delivery of psychological interventions. A recommendation regarding family therapy might be unhelpful if explicit recommendations for adults were made, especially given the absence of evidence in this area.
490.	SH	BEAT	Short	9	10–11	Question 1: Unnecessary delays can occur if General Practitioners (GPs) (or other professionals making the referrals)	Thank you for your comment. This implementation issue is outside the scope of the guideline, but will be passed

						are not informed about the local service/s available, or if when making the referral they do not provide the full set of information required by the service. This highlights the importance of training for GPs (and other health and social care professionals) and the provision of clear, agreed referral procedures as well as regular liaison/communication between services and primary care. It would also aid implementation if all GPs are provided with both details of the local service/s available and how to make a referral on their practice's Information Technology (IT) system. This IT system should also include reference to NHS Improvement's commissioning guidance concerning patient 'choice of provider' which we referred to in our comment on recommendation 1.2.10.	to the NICE implementation team for their consideration.
491.	NICE	NICE Social care	Short	9	21	Should this include reference to other, non-health services such as those for Children and Families?	Thank you for your comment. The text has been amended as suggested.
492.	SH	Oxford Health NHS Foundation Trust	Short	9	24	1.2.10 It would be helpful to make recommendations regarding commissioning services for university students given the high prevalence of eating disorders in this group and frequent changes of residence. Most university students want to be treated closer to their place of study. However, it's important to take into account the fitness to study guidance, as some students may need to take time out of their study to ensure the best chance of recovery: http://www.heops.org.uk/heops_guidance	Thank you for your comment. Although this is an important issue, it was outside the scope of the guideline.

						_fitness_to_study_with_severe_eating_disorders.pdf	
493.	SH	The Association for Family Therapy and Systemic Practice in the UK	Short	9	9–16	There were queries about whether there is a distinction between inpatient and outpatient treatment, particularly perhaps in respect of psychological treatment, although this is discussed in the full guideline pages 168-175. There could be a useful note here, or alongside each psychological therapy recommendation to specify that the psychological intervention can be used in either inpatient or outpatient settings if this is the case.	Thank you for your comment. The recommendation has been revised to be neutral as to the setting.
494.	SH	BEAT	Short	9	9–16	We are pleased to see the committee seeking to address this topic given the common problem of General Practitioners (GPs) (and others) taking a 'wait and see' approach, in contradiction to the principle of early intervention. We note the explanation given in the full guideline for the decision not to use the word 'immediately', however could the committee consider the option of using more specific wording here, as the interpretation of 'without delay' may differ considerably between professionals? Could the guideline set a maximum time limit, to provide extra clarity to people with eating disorders and their carers? This recommendation could also be strengthened by adding some of the detail included on page 174 of the Full guideline - including the need to refer the patient: whatever the perceived severity	Thank you for your comment. The committee considered your comments and decided that, contrary to their original decision, the word 'immediately' was appropriate and unambiguous, and therefore made a specification of a maximum time limit unnecessary.

						of the eating disorder, whatever the patients weight or Body Mass Index (BMI) and whatever the length of the waiting list at the service being referred to.	
495.	SH	BEAT	Short	9	27	Since this 'safeguarding' section is within the general chapter on identification and assessment and it is not in a section which is focussed on children and young people it should refer to the assessment of people of all ages. Healthcare professionals should be alert throughout assessment and treatment to signs of abuse, whatever the age of their patient.	Thank you for your comment. This section has been moved to the general principles section at the beginning of the guideline and amended to apply to people of all ages.
496.	SH	BEAT	Short	9	19–20	Question 3: NHS England has developed a Commissioning for Quality and Innovation (CQUIN) payment incentive on 'Transitions out of Children and Young People's (CYP) Mental health services' to incentivise good practice - https://www.england.nhs.uk/2016/09/improve-mental-healthcare/. NHS England states that to benefit from this payment, trusts must "ensure patients have a transition plan, know their dedicated key worker and were involved in planning with their parents or carers".	Thank you for your comment.
497.	SH	BEAT	Short	9	19–25	Question 3: NHS England's Children and Young People – Improving Access to Psychological Therapies (CYP-IAPT) programme has produced a 'Mental Health Services Information Passport' (https://www.england.nhs.uk/mentalhealth/2015/10/15/passport-brief-yp-mh/; https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/10/cyp-info-passport-yp-example.pdf) which was	Thank you for your comment and the information provided which has been considered.

						specifically designed to allow children and young people to tell their story while moving between practitioners or services. It is aimed at those already using Child and Adolescent mental health services (CAMHS).	
498.	SH	BEAT	Short	9	24–25	Question 3: NHS Improvement has published some concise statements on the issue of choice of provider for people with a mental health problem. One of these is aimed at patients and carers - 'Choice in mental health: how it can work for you' (https://improvement.nhs.uk/uploads/documents/choice_in_mh_services_service_users.pdf) and the other at commissioners - 'Choice in mental health: advice for commissioners' (which can be downloaded via a link in the first document). These resources could be useful for service-users, providers and commissioners, as they articulate clearly patients' legal rights under the NHS Constitution to choose where they access treatment, after referral, even if this is in another part of England. Importantly the service-user document, also signposts readers to options for making a complaint should their request be rejected at the local level, including the options to complain to NHS Improvement or NHS England.	Thank you for your comment. These documents will support the implementation of the recommendations of this guideline.
499.	SH	Oxford Health NHS Foundation Trust	Short	9	18, 19, 20	1.2.10 Given the recommendation that 'care should be coordinated' when a young person moves from children's to adult services (see the 19 NICE guideline on transition from children's to adults' services) it would be helpful to indicate	Thank you for your comment. It is important when developing any transition plan to take into account the need to deliver appropriate treatment plans. This is made clear in the recommendation and the expectation is that current treatments

						whether family therapy should be offered in adult ED services? In this regard, the NICE guideline 'Transition from children's to adults' services for young people using health or social care services (Published: 24 February 2016, p. 11, 1.2.22) recommends that 'Adults' services should take into account the individual needs and wishes of the young person when involving parents or carers in assessment, planning and support'. If young people, request family therapy should this be offered in adult services – especially because this is recommended for the whole period that they are linked to children and adolescent services?	would be taken into account. This will involve some flexibility in the delivery of psychological interventions. A recommendation regarding family therapy might be unhelpful if explicit recommendations for adults were made, especially given the absence of evidence in this area.
500.	SH	NHS Lothian	Short	10		We have concerns that the summary in the shortened version for treatment for anorexia is potentially misleading regarding the strength in recommendation of CBT and focal psychoanalytic when the full summary provides significant evidence of equivalence between therapeutic approaches especially after 1 year follow up. It is not clear that there is evidence for the detailed description of the approaches e.g. twice a week sessions in first part of treatment rather than once a week or up to 40 sessions over 1 year rather than treatment over 18 months. It would also be helpful to frame the summary in relation to the strength of the evidence base (e.g. low or very low). Nationally services are using a wider range of approaches e.g. interpersonal	Thank you for your comment. The recommendations have been to include CBT-ED, MANTRA and SSCM as first-line interventions, and focal psychodynamic therapy (FPT) as a second line option. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. Regarding longer-term support, including for those who have not benefitted from treatment, please note that the recommendations have been revised to offer the possibility of further sequenced psychological treatment, and continued

						therapy and cognitive analytical therapy. Given the strong equivalence effects and status of the evidence base it would be more helpful to have benchmarking information (including recovery and drop out) so that services could ensure that any models employed could be meaningfully audited. We are particularly concerned that the advice may be misleading for commissioners regarding the length of required therapeutic support for those with the most severe and enduring presentations. It would be extremely challenging in practice if services were not commissioned to be able to offer this group with the highest need extended contracts (e.g. more than 1 year) and our clinical experience would suggest that for more severe presentations that a minimum of 24 mths is required. There is no evidence about the potential gains post 40 sessions and it would be helpful to have this gap highlighted rather than the implication being that there is no role for longer term work. It would also be helpful given the high levels of co-morbidity for this group (especially personality disorder) for there to be a recognition that there is no evidence specifically related to patients with these needs and that this may influence both choice of model and length of required treatment.	support and management of the person with an eating disorder.
501.	SH	South West London and St	Short	10		We are concerned that the guidelines treat those with mild to moderate anorexia in the same way as those with	Thank you for your comment. The Committee recognised that some people may have an eating disorder for a long

		George's Mental Health NHS Trust				Severe and enduring eating disorders (SEED). Clinically we find significant differences in what these clients need and what treatments are effective.	time and that it may be severe, and that furthermore it can be difficult to conduct studies in this difficult to treat group. However, (i) there was little evidence using this group, and the Committee (ii) thought that there was no accepted nor acceptable definition of SEED available in the literature, and (iii) did not wish their recommendations to be driven by this subgroup of patients.
502.	SH	South West London and St George's Mental Health NHS Trust	Short	10		Whilst it is good that the draft specifies "psychological treatment for adults with anorexia nervosa" (p.10) which is absent in the original CG9, it is unclear why SSCM or MANTRA are recommended only as alternative if CBT-ED and focal psychodynamic-ED are ineffective, when the former and the latter address different aspects of the treatment. Also, they are often complimentary and in practice the latter is provided prior to the provision of the former. The latter is generally more readily available and clinically deemed to be appropriate to be provided to most patients in in Adult Eating Disorder Services if not all than the former because of the general lack of resources or contraindications.	Thank you for your comment. The recommendations have been revised to include CBT-ED, MANTRA and SSCM as first-line interventions, and focal psychodynamic therapy as a second line intervention. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision.
503.	SH	South West London and St George's Mental Health NHS Trust	Short	10		Family therapy is missing in the recommendation under "psychological treatment for adults with anorexia nervosa" (p.10). The randomised treatment trials done by Russell et al. (1987) found no differences in eating disorder symptoms in a five-year follow-up between family therapy and individual control treatment. The Dare et al (2001)	Thank you for your comment. Data from Russell et al. (1987), from group 1, was included in the evidence review of psychological therapies for anorexia nervosa in young people since the average age of this group was <18 years-old; data from the other anorexia nervosa group was excluded due to the small sample size. Regarding Dare et al.

						study found family therapy to be one of the three specialist treatments (together with CBT and focal psychoanalytic psychotherapy) in the one-year follow up to be more effective than routine treatment, whereas no significant differences were found between the three treatments. References Dare, C., Eisler, I., Russell, G.F.M., Treasure, J. & Dodge, E. (2001) Psychological therapist for adult patients with anorexia nervosa: A randomised control trial of out-patient treatments. *British Journal of Psychiatry*, 178, 216-221. Russell, G.F.M., Szmukler, G.I., Dare, C. & Eisler, I. (1987) An evaluation of amily therapy in anorexia nervosa and bulimia nervosa. *Archives of General Psychiatry,* 44, 1047-1056.	(2001), there were several other studies included in the evidence review for psychological therapies for adult anorexia nervosa. The Committee decided to amend their recommendations for psychological treatment of adult anorexia nervosa to include CBT-ED, MANTRA and SSCM as first-line treatments, and focal psychodynamic psychotherapy as second-line treatment. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision.
504.	SH	College of Mental Health Pharmacy	Short	10	3-7	Please include other Key Objectives: • *Another important objective is to encourage a more positive, healthy attitude to body image and eating* • *To reduce risk*	Thank you for your comment. The recommendations have been amended.
505.	SH	South West London and St George's Mental Health NHS Trust	Short	10	4-5	We are concerned that this recommendation may imply that widely established practices gathered under the umbrella of the 'recovery approach', which encourage NHS services	Thank you for your comment. Recommendations to support discussion of treatment options and the preferences of the person with the eating disorder have been included at a number of points

						governed by NICE guidelines nonetheless to let the sufferer decide upon her treatment goals, are suddenly off-task and should concentrate upon medical recovery services only. In particular, this clause should not apply to sufferers categorised as severe and enduring, for whom research base strongly suggests that quality of life within the illness is the indicated treatment goal and who would be instantly alienated by any service who insisted on medical recovery only.	in the guideline. The importance of considering a range of outcomes including social, education and occupational outcomes have also been highlighted in a number of recommendations, all of which are important in helping people establish a better quality of life even if any problems directly associated with the eating disorder persist.
506.	SH	NHS Greater Glasgow and Clyde	Short	10	1.2.14	It was appreciated what a huge piece of work this was and it is of great value to have all the evidence collated together and thoughtfully reviewed. We are concerned that the first line of recommended psychological treatment for AN is manualised, despite the relatively little low quality of the evidence. Are we really saying we are not valuing other treatment not offered manually? (CBT, CFT, ACT etc) Whilst we fully appreciate the value of manualised treatment especially for trainees and research, our clinical experience indicates that the first priority is establishing the relationship and motivation to change. Then the scene is set for active therapy. We feel that it is a loss not to include the original therapies CBT, CAT, IPT etc. In our experience a formulation driven psychological treatment is of equal (and at times greater) value to an evidence based manual.	Thank you for your comment. The use of manuals provides a guidance structure to the delivery of an intervention and that, in all cases, their application requires clinical judgement. This would be expected to be the case for people who are difficult to engage (such as those with a long-standing condition). Regarding the therapies mentioned in the comment, please note that the recommendations for anorexia nervosa have been substantially revised; CAT and IPT were not recommended because other interventions (such as CBT-ED) were shown to be more effective. Regarding training, all healthcare professionals working in the NHS must be competent to deliver the relevant interventions in the relevant age group and the Committee have made this clear in their recommendations. Please note that the recommendations about training and competencies have been amended. Regarding the treatment of complex

						Should we be stating who is best trained to offer the therapy or are we saying any health professional could provide this approach? We do not feel that this soundly reflects the reality of interventions offered to complex patients with AN (with low BMI's ie less than 14) within a specialised eating disorder service. It is appreciated that further research is needed on the stepped care model, but is there enough evidence to suggest abandoning this model at the present time. Whilst this is not directly stated by the guideline, the clinical recommendations may imply this. Within Greater Glasgow and Clyde, the eating disorder service sits within a stepped care model and guidelines recommending a more prescribed and uniform approach to treatment for all eating disorder patients at all stages and severities, would require a review of the current service model.	patients (those with BMI<14), the Committee recognised that there were very few studies conducted in this patient group and were consequently wary in making specific recommendations. Furthermore, the Committee were not convinced that the oft-used acronym of SEED was either tenable or particularly useful as a way of guiding treatment. Regarding stepped care, although the clinical experience of your unit may suggest that the stepped care model should be abandoned, the evidence review for the issue of stepped care found very few studies on which to base firm recommendations. Hence the Committee made a research recommendation to rectify the dearth of evidence.
507.	SH	BEAT	Short	10	3	Typographical error - according to the contents page this should denote the beginning of section 1.3. This would then require changes to the numbering of the sections (and recommendations) that follow.	Thank you for your comment, this has been revised.
508.	SH	Cardiff and Vale University Health Board	Short	10	3	While treatment of AN is undoubtedly aimed at weight regain, there are instances where weight regain is not an aim and the service user seeks learning on how to live with an enduring mental illness in a less risky manner – see above point. In this case treatment is	Thank you for your comment. The text has been amended to reflect your remark. Please note that the recommendations for the treatment of anorexia nervosa have been substantially revised.

						more likely to be around enhancing quality of life, coping with difficult emotions, relationships etc and making safe arrangements for some form of healthy longevity. This aspect does need to be understood as valuable treatment and as such part of NICE recommendations as without it many SU will fall into repeated risky phases..	
509.	SH	College of Occupational Therapists	Short	10	4	Please include the red italics to the following line 1.2.12 Be aware that a key goal of treatment for anorexia is to help people reach a health body weight or BMI for their age. *For people with severe and enduring conditions key alternative goals may be to help them reach and maintain a safe weight whilst remaining ill and improve the quality of their life.*	Thank you for your comment. The Committee agreed that the specific category of SEED lacked a convincing evidence base (Wonderlich et al 2014) and no evidence that it impacted outcomes found in our review of the evidence (Caglugi et al. 2013). However, there are people whose eating disorder is severe and long lasting and have suggested elsewhere in the guideline that in some circumstances continuing contact with services to better manage their quality of life should occur.
510.	SH	College of Occupational Therapists	short	10	4	Treating anorexia nervosa Be aware that a key goal for the treatment of anorexia is to help people reach a healthy body weight or BMI for their age for patients and or *for severe and enduing conditions a key goal is maintaining a safe body weight*	Thank you for your comment. The issue of people who have a severe and enduring condition has been addressed elsewhere in the guideline and continuing contact with services to better manage their quality of life has been suggested. However the Committee did not reach consensus on what should be considered a safe weight for people with such a condition and therefore did not take up the suggestion of this as a further goal of treatment. Determining a 'safe' weight for the person with the eating disorder should be the result of a decision

							between the person and the healthcare professional responsible for their care.
511.	SH	Mental Health Foundation	Short	10	4	In addition to the BMI goal, the recommendations should take note of other wider factors, for example, psychological adjustments. While we do not dispute the inclusion of BMI as a factor, on its own it is too straightforward; recovery is an individual process that can be measured in numerous ways. As no other factors are noted, the guidance is overly simplified, therefore not reflective of the available evidence.	Thank you for your comment. The recommendation has been expanded to take it into account.
512.	NICE	NICE Social care	Short	10	4	Is it 'a key goal' or 'the key goal' (('a) suggests there others -if so they should be listed also	Thank you for your comment. The recommendation has been expanded to take it into account.
513.	SH	Oxford Health NHS Foundation Trust	Short	10	5	1.2.12 Please add: this is important both for optimal health as well as addressing one of the main maintaining factors of the psychopathology. It is important that treatment addresses physical, psychological and social factors.	Thank you for your comment. The recommendation has been expanded to take it into account.
514.	SH	College of Occupational Therapists	Short	10	8	Psychological treatments for adults with anorexia nervosa Please include the red italics in the below statements For people with *significant psycho-social impairments or disabilities consider occupation-focussed interventions as an adjunct to CBT-ED including:* o *supported eating* o *supported exposure to feared foods* o *supported public eating*	Thank you for your comment. The Committee decided to only consider RCT evidence for the review of psychological treatments of anorexia nervosa. As no RCT evidence was found specifically examining the efficacy of occupation-focussed interventions, it would not be appropriate to recommend their use as an adjunct to CBT-ED.

						○ *meal preparation training* ○ *independent living skill interventions* ○ *lifestyle restructuring activities* ○ *experiential community-based leisure activities* ○ *Social and recreational activities*	
515.	SH	Hywel dda Health Board	Short	10	8	There is a very narrow range of therapies mentioned and as the evidence base for Anorexia Nervosa is not vast for any therapy we feel that to exclude many of the therapies delivered in clinical practice is limiting. Our service delivers many modalities including Systemic, Cognitive Analytical Therapy, IPT, CRT, PCP as well as referring on for DBT if felt appropriate. We are also currently in the process of accessing training for clinicians for Compassion focussed therapy that will further enhance the knowledge and skills base of our team and therefore enhance what we have available to offer our patients. Whilst we agree that CBT should be offered as a first line treatment and we have clinicians offering this treatment having been trained and supervised by the Oxford team we know that many patients do not respond to this treatment therefore it is important to offer a range of therapies that patients may be able to gain benefit from.	Thank you for your comment. The recommendations have been revised to include CBT-ED, MANTRA and SSCM as recommended first-line therapies, and focal psychodynamic therapy as second-line. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision.
516.	SH	Cwm Taf Health Board	Short	10 14	8 20	This comment relates to the psychological treatment of both AN and BN. We are extremely concerned about the narrow range of therapeutic interventions included in the guideline for	Thank you for your comment. The recommendations have been revised to include CBT-ED, MANTRA and SSCM as recommended first-line therapies, and focal psychodynamic therapy as second-

						both conditions. Clients in our service, and services we have worked with in the past, have benefitted considerably from additional therapies, particularly Cognitive Analytic Therapy and Interpersonal Psychotherapy (it is unclear whether these would be included under the remit of 'eating disorder focussed focal psychodynamic therapy', although these interventions do both draw on a psychodynamic approach). We have also found that Dialectical Behaviour Therapy programmes have been beneficial for clients with eating disorders (across presentations) and emotion regulation difficulties, and we are aware that there is a growing evidence base for this. Schema Therapy is also a helpful model for clients with eating disorders which has not been included. We are also concerned about the lack of evidence included on group-based interventions which have been effective in our service. For example 'Contemplation' based group work can be very helpful as a precursor to more active treatments such as CBT, as it can shift a client's motivation to overcome their eating disorder (as discussed in comment 1). Psycho-educative nutrition groups have also been valuable. The narrow range of therapies included in the guideline would significantly affect how our services are delivered. It would reduce client choice and affect the person-centred approach we aim to promote within our service. Implementing the guideline in this current form would	line. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. Regarding group therapies, there was no RCT evidence identified that examined group psychological interventions for anorexia nervosa. Regarding group psychological interventions for bulimia nervosa, 10 RCTS were identified. The evidence from these studies were presented in the relevant evidence review and included in the NMA analysis. However, whilst the Committee's recommendations were based on the results of the NMA, the Committee decided to exclude from their decision making any comparisons that had less than 125 pooled participants across all studies. Due to the relatively small number of pooled participants in the group intervention comparisons, the Committee excluded them from consideration when making recommendations.

						prevent eating disorder sufferers from accessing interventions we have seen to be meaningful and effective for them.	
517.	NICE	NICE Social care	Short	10	8	No guidance is offered as to when to use which therapeutic approach to use/in what circumstances to use each. Is that right?	Thank you for your comment. The available data does not allow for the identification of a particular group or subgroup within people with an eating disorder who would benefit from a particular treatment. In light of this, the recommendations have been revised to include information on the nature and content of treatment as well as advice to support the person with an eating disorder (and their families/carers).
518.	SH	BEAT	Short	10	4–5	Since weight restoration must be accompanied by changes in cognitions and behaviours if the healthy body weight is to be maintained, this recommendation could be improved by reference to the key goal of remission from psychological and behavioural symptoms.	Thank you for your comment. The Committee took a view that reaching a healthy weight is a key objective of anorexia nervosa treatment. However they accepted that other variables such as cognitions are important and are central to the delivery and monitoring of other treatments (e.g. CBT-ED) as covered in the recommendations. Nevertheless, the Committee were concerned to maintain a clear focus on the central objective of anorexia nervosa treatment.
519.	SH	BEAT	Short	10	9	The use of the word 'consider' for both of these treatments is concerning. This would imply (to a lay reader at least) that access to treatment for these patients is less important, especially given that most readers are unlikely to read (or find) the explanation in the 'Developing NICE guidelines: the manual' about what NICE actually means when it uses the word 'consider'. Even if the typical recovery rates and quality of evidence to date to	Thank you for your comment. However, as noted, the use of the words 'offer' and 'consider' is required by NICE in accordance with its proscribed standards. Interested lay readers who do not have specialist medical knowledge should refer to *Information for the public* available from the NICE website.

						support these treatments is lower than for some of the treatments which NICE will have reviewed for other conditions, it is important that the NICE guideline uses language which reflects the principle that adults with anorexia nervosa should be entitled to access the best treatments we currently have for them.	
520.	SH	Esoteric Practitioners Association	Short	10	4 – 5	Deep consideration needs to be given to the value of the treatment if it is simply to focus on the symptom and not the root cause. We believe that a key goal or focus of treatment is to bring greater understanding to the causes of the eating disorder behaviour, rebalancing the focus for outcomes on weight/BMI with an emphasis on addressing the fundamental beliefs and ideals of the patient that influence their perceptions of themselves and the world, leading to unresolved lack of self-worth and self-esteem issues. It is also important to utilise self-care practises to support the recovery process. Otherwise we are simply treating the symptoms rather than addressing the underlying issues, and consequently setting the individual up for repeat cycles of their behaviour. http://everydaylivingness.com/before-after-universal-medicine-my-bulimia-story-from-self-worth-issues-to-self-love/ Noting here, that the key goal needs to go beyond a questionable marker of healthy body weight or BMI, but rather look towards a full and complete recovery	Thank you for your comment. The choice of BMI or body weight as a critical outcome for anorexia nervosa, for example, should not be taken to imply that this is the only outcome that matters for the amelioration of the person with the eating disorder. However, it was necessary for the Committee to choose certain outcomes (e.g. remission) rather than others to guide their decision making, especially given the profusion of measures used in the literature.

						for the patient, meaning they are left feeling confident in themselves moving forward. http://www.bbc.co.uk/news/health-36956849 http://www.huffingtonpost.com/david-belk/body-mass-index_b_7693450.html)	
521.	SH	Lancashire Care NHS Foundation Trust	Short	10	9	CAT Cognitive Analytic Therapy should be specifically included as a therapy option. It has a good evidence base, is available immediately and widely (certainly more widely than FPT) addresses psychological difficulties associated with the illness and is particularly helpful for people with a personality disorder (a very common comorbidity) that CBT would not work well for.	Thank you for your comment. The evidence considered by the Committee included studies that used CAT as well as numerous other studies published since the 2004 guideline. The Committee concluded that the evidence supported the recommendation of other therapies. No relevant RCT evidence was identified examining the efficacy of CAT in people with an eating disorder with a comorbid personality disorder.
522.	SH	Esoteric Practitioners Association	Short	10	12	CBT – ED programmes should also cover and encourage understanding of the underlying causes of the behaviour, to ensure sustainability of any changes after and beyond the 40-session programme. These suggestions are also relevant to P14 Line 23, P15 Line 6. We recommend for consideration this be done by: 1. Bringing more focus and awareness to the level of self-worth or self-esteem the patient has, and the extent to which ideals and beliefs regarding themselves is influencing the behaviour/illness.	Thank you for your comment. The recommendations for CBT-ED in the treatment of adult anorexia nervosa were based on the relevant studies, which were all manualised and had the features specified. Consideration of the root cause of the eating disorder is not part of CBT-ED treatment.

						https://womeninlivingness.wordpress.com/2014/12/20/the-affects-of-image-in-media-not-so-sexy-for-young-women/#more-2408 2. Including a more directed focus on self-care with patients – this could be a part of the suggested homework. A shift in focus onto self-care can take their mind off the illness, whilst also bringing the patient naturally to greater self empowerment through making more positive choices in their life: ps://blog.hellosundaymorning.org/2017/01/how-to-practice-self-care/ 3. Throughout treatment, supporting the patient to look at the personal triggers which lead to the behaviour. This will help to get to the root cause of the illness which can in turn support a full recovery and less likelihood of a relapse in the future. http://www.unimedliving.com/food/overeating/overeating-a-dysfunctional-relationship-with-food.html	

523.	SH	Leicestershire Partnership NHS Trust	Short	10	12	The research quoted in support of CBT-ED only includes patients with a BMI above 14. In clinical practice, patients with a BMI below 14 will often require in excess of 40 sessions to facilitate restoration of healthy weight – *the* key goal of treatment. In view of this it would be worthy to consider including consideration of extended sessions of either CBT-ED or eating disorder focussed focal psychodynamic therapy – as there is no evidence against this	Thank you for your comment. Please note that the recommendations have been revised to include CBT-ED, MANTRA and SSCM as first-line treatments, and focal psychodynamic therapy as a second-line option. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. Regarding longer-term support, including for those who have not benefitted from treatment, please note that the recommendations have been revised to offer the possibility of further sequenced psychological treatment, and continued support and management to the person with an eating disorder.
524.	SH	BEAT	Short	10	6–7	We suggest editing this recommendation to read: 'When weighing people with anorexia, consider sharing the results with them and (if appropriate) their family members and carers, whilst being mindful of recommendation 1.1.5. Professionals should be aware that some patients will not want to be informed about their weight and for some of these patients doing so, at least in the early phases of treatment, could prove counterproductive'. The wording suggested in the final sentence is based on the deliberations of the committee detailed in page 273 of the draft full guideline.	Thank you for your comment. As you may be aware, the terms 'consider' and 'offer' have a specific function within the NICE guidelines, which is to reflect the quality of evidence. Broadly speaking, 'offer' is used when evidence is stronger, and 'consider' where it is less strong or there is more uncertainty. 'Consider' therefore refers to the strength of evidence that the Committee felt was available when making their recommendations. Note that the expression 'if appropriate' refers to whether or not imparting information would be the right thing to do in light of

							the needs of the person and the relationship with their family or carers.
525.	SH	Royal College of Nursing	Short	10	14	Cognitive behavioural therapy – Eating Disorder (CBT-ED) programme are the ideal, there is no doubt, but therapists trained in this are few and far between.	Thank you for your comment. NICE guidelines are limited to recommendations regarding what is considered best practice and do not address their implementation in this way.
526.	SH	NHS Greater Glasgow and Clyde	Short	10 14 15 17 17 17	14 25 7 3 7 21	When a self-help book or treatment manual is advised could we be specific as all manuals are not of equal quality. I appreciate that the authors need to state where there is a conflict of interest (ie their own manual). But this is relevant for the treatment recommendations for all disorders.	Thank you for your comment. It is not generally possible for NICE to recommend specific manuals. However, please note that effective components of manualised treatment are outlined in the relevant recommendations.
527.	SH	BEAT	Short	10	15	The wording used to denote the appropriate length of treatment should include a safeguard to protect against the risk of patients being offered too few sessions. A concern with the advent of waiting time targets (at least for children and young people so far), given the capacity constraints of many services, is that some services/commissioners may ration the duration of treatment they offer, even if this is not in the patient's interest, in order to help meet these targets.	Thank you for your comment. The word 'typically' has been added to the sentence to allow for some flexibility and the use of clinical judgement.
528.	SH	Oxford Health NHS Foundation Trust	Short	10	15	1.2.15 The recommendation for anorexia nervosa is typically 40 sessions of treatment. We wonder what the committee's recommendations are on what should happen after the allocated number of sessions when patients remain at risk or have shown partial or no-remission in symptoms?	Thank you for your comment. The recommendations have been updated to specify that CBT-ED, MANTRA or SSCM should be offered, relative to the service user's preference, to the adult with anorexia nervosa as first-line interventions, and focal psychodynamic therapy as second-line. The recommendations have also been revised to allow a sequencing of treatments if one of them is thought to be

							inappropriate. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. Moreover, the bullet point concerning the length of treatment has been amended to allow a greater or lesser number of sessions as determined by clinical judgement and informed patient choice.
529.	SH	Hywel dda Health Board	Short	10	8 – 11	I am concerned with the limitations of psychological services suggested are only two. This is because of a number of factors including 1. The message it gives regarding other therapies that arguably have as much evidence base as the two suggested such as CAT; family / systemic therpay; Motivational interviewing not to mention the lack of other forms of research such as Practice based research 2. The fact that the majority of clients with AN that I work with (systemic psychotherapy) have a BMI that is lower (below 15) than the evidence produced for CBTe and focal psychodynamic psychotherapy. 3. It would leave a number of very useful psychological approaches redundant.	Thank you for your comment. The recommendations have been revised to include CBT-ED, MANTRA and SSCM as recommended first-line therapies, and focal psychodynamic therapy as second-line. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. Whilst the Committee recognised that there are people with a severe eating disorder, they did not wish their recommendations to be driven by consideration of the most severe group of people. Equally, for understandable reasons, there were very few studies conducted in this hard to treat population and, on this basis, the Committee refrained from making any specific recommendation for this group.

530.	SH	Esoteric Practitioners Association	Short	10	28	ED-focused focal psychodynamic therapy programmes must also cover and encourage understanding and practising greater responsibility and self-care as outcomes, to ensure sustainability of any changes after and beyond the 40-session programme.	Thank you for your comment. Whether or not focal psychodynamic therapy should or could benefit from including the suggested elements is outside the scope of this guideline.
531.	SH	Lancashire Care NHS Foundation Trust	Short	10	28	FPT There is no training for this specific model in the UK. There is a manual (in German), however one concern is that unless there is country-wide training in this specific then delivering such an approach purely through a manual could even be detrimental, as without the robustness of actual training, clinicians may deliver this specified approach in a hap-hazard style with minimal guidance. For example, how will such clinicians also be supervised if there are no supervisors trained in Focal Psychodynamic Therapy? It appears this is based on one RCT – so it is not clear why this has been included over CAT. If it must be included, the weak evidence should be termed "consider offering" in line with the NICE guidelines development manual. FPT misses how important the relational aspects often are within this client group, especially as many of them have a history of trauma. The current financial climate will be a barrier to embedding this therapy into	Thank you for your comment. The recommendations have been revised to include CBT-ED, MANTRA and SSCM as recommended first-line therapies, and focal psychodynamic therapy as second-line. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision.

						practice, whereas CAT (which has a degree of overlap with FPT) and has been included in other / previous ED NICE guidance, is in use currently and is therefore a more pragmatic option. In addition, FPT would not be available for a long time, given the cost and training required.	
532.	SH	Oxford Health NHS Foundation Trust	Short	10	12–17	1.2.15 The recommendation states that CBT-ED therapists should 'create a personalised treatment plan based on the processes that appear to be maintaining the eating problem. However, the CBT-E treatment manual (Cognitive Behavior Therapy and Eating Disorders, Fairburn, 2009): recommends Interpersonal therapy if interpersonal factors are maintaining the eating disorder. In this regard, we are aware that IPT has been omitted from these guidelines as a treatment option. Similarly, in the absence of a recommendation for family therapy for adults, there is no recommended model to address interpersonal maintaining factors either through an individual-focussed model or family/systems-based approaches for adults with eating disorders.	Thank you for your comment. The evidence for a range of interventions was reviewed. Please note that the Committee reconsidered the evidence and decided to revise their recommendations to consider MANTRA and SSCM in addition to CBT-ED as first line interventions, with focal psychodynamic therapy as a second-line option. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. In this guideline the available evidence for IPT was not sufficiently strong to support its recommendation. In implementing the recommendations, it is expected that all psychological interventions for anorexia nervosa take maintaining interpersonal factors into consideration. Hence, no suggested revisions were made to the recommendations.

533.	SH	Esoteric Practitioners Association	Short	10	16 – 17	True healing or 'recovery' may look different from one person to the next, so to define it in such a limited and results-driven manner does not feel supportive to the person, but rather defines them as a problem simply to be fixed. This promotes identification with the person as having something intrinsically wrong with them, which runs the risk of confirming their negative view of themselves as a primary cause of their behaviour. We recognise the need to be more specific in our outcomes, going beyond an aim to reduce the risk to physical health and any other symptoms of the eating disorder, but to look deeper towards what a full and complete recovery for patients actually means. We understand this requires a sound understanding first and foremost of the underlying root cause and triggers for individuals in treatment. By supporting the patient to identify fundamental misperceptions about themselves and key aspects of their lives, we can encourage them to responsibly re-define the way they choose to perceive their relationship with self and others, which allows the patient to fully resolve and heal the earlier psychological tensions that led to the eating disorder behaviour.	Thank you for your comment.
534.	SH	BEAT	Short	10	21–22	This should emphasise the importance of re-visiting the treatment-plan/formulation during therapy.	Thank you for your comment. Please note that the recommendations for all the recommended psychological treatments have been substantially revised. Some general recommendations applying to

							any person with an eating disorder regarding care planning have also been inserted. Although psychological formulation is an important issue to be considered when developing a treatment plan, this has not been specified as the guideline covers key functions as part of standard care for people with eating disorders in the NHS.
535.	SH	South West London and St George's Mental Health NHS Trust	Short	10-11	10/28-11/20	The inclusion of psychodynamic psychotherapy is welcome but the limited emphasis on manualised psychodynamic psychotherapy appears to be an unwarranted ideological position and leaves the guidelines at risk of appearing divorced from reality on the ground. See also comment 1 above.	Thank you for your comment. Please note that the recommendations have been revised to include CBT-ED, MANTRA and SSCM as first-line therapies and focal psychodynamic therapy if they do not prove effective. It was agreed that manuals provide a guidance structure to the delivery of an intervention. In all cases the application of a manual requires clinical judgement and this would be expected to be the case for people who prove resistant to manualised therapy.
536.	SH	British Psychological Society	Short	10 – 18		The range of recommended psychological therapies is more restricted than that specified in previous NICE guidance on eating disorders. Recommendations for Cognitive Analytic Therapy / CAT, Interpersonal Psychotherapy / IPT, and Dialectical Behaviour Therapy / DBT have been removed, and there is an emphasis on two main manualised therapies (Cognitive Behaviour Therapy and focal psychodynamic therapy) for adults, and on family therapy for young people. These recommendations will have implications for service provision, as	Thank you for your comment. The Committee has revised their recommendations for the treatment of adult anorexia nervosa to include CBT-ED, MANTRA and SSCM as first-line treatments, and focal psychodynamic therapy as second-line treatment. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. Although implementing the recommendations may require some

						some eating disorder therapists may work primarily within the therapeutic modalities which are no longer recommended. In addition, it is likely that only a minority of eating disorder practitioners will be currently trained in the provision of focal psychodynamic therapy. It may therefore be initially challenging to implement this recommendation, until sufficient staff are trained in the approach. There is of course a need to focus use of limited resources on training staff in therapeutic approaches with the strongest evidence base. At the same time, there is acknowledgement (p272, full version) that the quality of evidence in the area is low, that there are few studies focusing on individuals diagnosed with anorexia nervosa, and that there are significant difficulties recruiting and retaining research participants. Potentially, alternative approaches may be helpful in some cases, but this may not be reflected in the limited research literature. It would therefore be helpful for the supervision arrangements within eating disorder services to include access to clinicians whose training encompasses a range of therapeutic modalities, including not only Cognitive Behaviour Therapy but also other potentially useful approaches. This would facilitate a flexible and integrative approach to working with more complex cases if needed.	retraining of staff and development of supervision but this issue is expected to be a matter for local determination and implementation, to be managed over a period of time.

537.	SH	South West London and St George's Mental Health NHS Trust	Short	11/15/18		We are concerned that the short version of the guidelines sounds very prescriptive, whilst the full guidelines are less so. The exclusion of treatments such as MBT, IPT, CAT, CFT, DBT, DBT-RO, and DBT-BN/BED groups in the short guidelines is concerning as this could lead to a lack of training and provision in these therapies and a lack of ongoing research to improve the evidence base. These are mentioned in the full guidelines as having limited evidence, yet have similar outcomes to CBT/ focal psychodynamic psychotherapy. It would be useful to have them included in the short-guidelines as an option when the recommended treatments are not acceptable/available or sufficient.	Thank you for your comment. Please note that the recommendations for the use of psychological interventions in the treatment of eating disorders have been substantially revised. In particular, the recommended interventions for adult anorexia nervosa have been expanded to include MANTRA and SSCM as first-line options, and eating disorder focussed focal psychodynamic therapy as a second line option. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. Regarding the specific therapies you mention: no RCT trials were found that examined the efficacy of mentalisation-based therapy (MBT) or compassion-focused therapy (CFT). Overall, the remaining therapies were not recommended mainly due to the small sample sizes, uncertainty in the outcomes, or lack of convincing evidence that they were effective or cost-effective compared with the recommended interventions on the critical and important outcomes. For example, only two RCT studies were found that examined DBT or DBT-RO, one for bulimia nervosa and one for BED; only 2 RCT studies were found that examined CAT or ICAT, one for anorexia nervosa and one for bulimia nervosa; 2 studies were found on IPT for anorexia nervosa were found, 3 for

							bulimia nervosa and two for BED (one group, one individual).
538.	SH	PEDS Charity	Short	11	Section either School or Education	Advice for schools re devising a risk management care plan for someone having community treatment. In practice we have had issues where we've had to go into school with managing anxieties as the school view has been if the person is having input for anorexia in the community they shouldn't be attending until they are weight restored (this wasn't helpful for the student who is doing well and isn't medically unstable but seem to be a reaction to anxiety around the management of EDs)	Thank you for your comment. Unfortunately providing general education and information about eating disorders in schools and an education context was outside the scope of the guideline.
539.	SH	South West London and St George's Mental Health NHS Trust	Short	11	21-24	We would welcome adding Mentalisation Based Therapy for Eating Disorders (MBT-ED) to the list of treatments to be considered, especially when there is diagnosed co-morbidity with personality disorders.	Thank you for your comment. No evidence was identified that met inclusion criteria for the evidence review.
540.	SH	South West London and St George's Mental Health NHS Trust	Short	11	1.2.18	"Consider anorexia-nervosa-focused family therapy for young people with anorexia nervosa, *delivered as* single- *or* multi-family therapy" We are concerned that this recommendation may imply that multi-family therapy is a straight alternative to single-family therapy. Anecdotally, we are aware of examples where this has been tried, and the results have been poor. Multifamily therapy for Adolescent AN has only been trialled with concurrent single-family therapy. There is no evidence that multifamily therapy for	Thank you for your comment. The recommendation has been revised to make clear that multifamily therapy should be offered in addition to single family therapy.

						Adolescent AN is an effective treatment on its own. Eisler et al 2010 in The Treatment of Eating Disorders: A Clinical Handbook describes multifamily therapy entirely as an addition, "The overall MFG program is offered for 1 year and combines work with the MFG (typically six families) and single-family FBT-AN treatment with the intent to enhance and boost the effectiveness of the single-family approach." There has no doubt been some development in practice in this respect by the time of publishing the results from the RCT, although the core issue remains. Eisler et al 2016 BMC Psychiatry states, "Families randomised to the MFT-AN group were all initially engaged in treatment individually until 5–7 families had been recruited to create a new group (a new group thereby starting approximately every six weeks)." "Individual family meetings are scheduled in the intervals between group meetings as needed with the overall length of treatment for each family being 12 months." "Families were seen in between group meetings, the frequency and overall number of such meetings determined by clinical need although the expectation was that these sessions would be less frequent than in the FT-AN group."	

						It therefore remains clear that concurrent single-family therapy is an integral part of multi-family therapy for adolescent AN. The guidance should explicitly state that multi-family therapy is an addition to single-family therapy, not a straight alternative to the latter.	
541.	SH	BEAT	Short	11	2	The wording used to denote the appropriate length of treatment should include a safeguard to protect against the risk of patients being offered too few sessions. A concern with the advent of waiting time targets (at least for children and young people so far), given the capacity constraints of many services, is that some services/commissioners may ration the duration of treatment they offer, even if this is not in the patient's interest, in order to help meet these targets.	Thank you for your comment. The text has been amended to allow for the use of clinical judgement in deciding what the number of sessions for an individual with an eating disorder should be.
542.	SH	BEAT	Short	11	21	This could be strengthened by adding some guidance on when either therapy may be judged to have proven 'ineffective', perhaps referring to recent evidence about the importance of early change on prognosis in CBT-ED.	Thank you for your comment. The approach that the Committee took to monitoring change during an individual's course of treatment was to recommend routine sessional monitoring and that this be used to guide both the delivery of therapy and decisions whether or not continue, cease, or switch to an alternative, treatment. This would be a matter for the individual clinician's judgement in combination with an informed discussion with the person with an eating disorder. Note the revision of recommendations regarding treatment options in anorexia nervosa, which will entail the routine monitoring just described.

543.	SH	Oxford Health NHS Foundation Trust	Short	11	21	1.2.17 It would be helpful if the Guidelines could define 'ineffective' when it suggests that when individual CBT-ED or focal psychodynamic-ED is 'ineffective' alternative models should be considered. The term 'ineffective' is potentially vague and might be interpreted differently by patients, carers and professionals. It is not very clear at which point the recommended first choice of psychological intervention for AN should be reviewed and considered as ineffective or inappropriate. It would be helpful to have a sense of when different approaches should be considered and after how many sessions. Whilst there is a clearer stepped approach for BN and BED, there is still much less clarity in AN.	Thank you for your comment. The approach that the Committee took to monitoring change during an individual's course of treatment was to recommend routine sessional monitoring and that this be used to guide both the delivery of therapy and decisions whether or not continue, cease, or switch to an alternative, treatment. Individual clinicians should use their judgement in consultation with an informed discussion with the person with an eating disorder (and if appropriate their family or carers). Note the revision of recommendations regarding treatment options in anorexia nervosa, which will entail the routine monitoring just described.
544.	SH	Oxford Health NHS Foundation Trust	Short	11 & 16	21 26	It would be helpful to note that none of the currently available and NICE recommended psychological treatments have 100% success rate. Furthermore, the length of illness can be many years, much longer than 20-40 sessions in trials. It would be helpful to comment on what should be offered on the NHS to those patients who typically did not respond to treatment in research trials. Similarly, what should be offered by services to severe and enduring eating disorders (SEED)?	Thank you for your comment. Regarding longer-term support, including for those who have not benefitted from treatment or those who have a severe and enduring condition, the recommendations have been revised to offer the possibility of further sequenced psychological treatment, and continued support and management to the person with an eating disorder.
545.	SH	College of Occupational Therapists	Short	11	25	Psychological treatment for young people with anorexia nervosa For *young* people with *significant psycho-social impairments or disabilities consider occupation-focussed interventions such as*	Thank you for your comment. The recommendations are based on the detailed consideration and discussion of published studies by the Committee according to NICE process, as detailed in document PMG20 Developing NICE guidelines: the manual available for

						○ *supported eating* ○ *supported exposure to feared foods* ○ *supported public eating* ○ *age appropriate meal preparation training* ○ *supported parental meal preparation and family eating* ○ *independent living skill interventions* ○ *lifestyle restructuring activities* ○ *experiential community-based leisure activities* ○ *social and recreational activities for inpatients in out of school time*	download from the NICE website. As such, it would not be appropriate to include the points made at this stage of guideline development, in lieu of published high quality evidence (in this case, RCTs).
546.	SH	Esoteric Practitioners Association	Short	11	5 – 20	In the patient-centred approach described in 1.2.16, there is reference made to the process of identifying pro-anorexic patterns of behaviour and how they influence the life of the person. We would like to see more enquiry into the 'why', the cause of the symptoms, so that the person is not encouraged to identify with and merely learn to manage the symptoms but rather HEAL them, so that they have the opportunity to feel resolved with true health and wellbeing. http://www.unimedliving.com/before-and-after/weight-loss/before-and-after-kylie-jackson.html	Thank you for your comment. Whether or not focal psychodynamic therapy should or could benefit from including the suggested elements is outside the scope of this guideline.

547.	SH	Lancashire Care NHS Foundation Trust	Short	11	25	FBT The guidance suggests family therapy but then goes on to specify FBT using a manual. It would be helpful to have some clarity as to whether there is also room to deliver standard family therapy, enabling the therapist to use their own clinical judgement rather than rely on a manual.	Thank you for your comment. The use of a manual provides a guidance structure to the delivery of an intervention. It is expected that the delivery of manual-based interventions would always be subject to the use of clinical judgement and sensitive to the individual needs of the person with the eating disorder.
548.	SH	BEAT	Short	11	26	The word 'consider' should be replaced with "offer" given the relatively strong evidence-base for this treatment and the decision to use the word "offer" for bulimia-nervosa focussed family therapy for young people with bulimia nervosa in recommendation 1.3.6.	Thank you for your comment. In developing the recommendations, the committee considered the strength of the evidence (for example, the number of trials and participants), the outcomes of treatment and their attendant reliability (e.g. risk of bias). In this particular case, the use of 'consider' in this recommendation reflects the fact that in terms of remission, the evidence suggests that the treatment for anorexia nervosa is less effective than for bulimia nervosa.
549.	SH	Oxford Health NHS Foundation Trust	Short	11	11–24	Where there is a lack of a clear evidence base in young people, the committee has made recommendations for young people drawing on the evidence base for adults. Similarly, we wonder whether the Guidelines can make recommendations for younger adults (17+) living at home, based on the evidence base for young people. This is particularly relevant to anorexia nervosa, as it is associated with significant delay in psychosocial development. Consequently, we wonder whether the committee would consider a general recommendation for young people under the age of 25 where clinical judgement is used in considering whether	Thank you for your comment. Extrapolating a recommendation from evidence regarding one age range (e.g. adults) to another age range (e.g. young people), it would be better if there was relative certainty about the age range the recommendations are based on. Hence the Committee decided that no specific recommendation should be made with regard to this given the overall low quality of available evidence.

						to offer interventions recommended for patients under 17 years, depending on the presentation of the patient? E.g. offer anorexia-nervosa-focused family therapy to someone who is still living at home.	
550.	SH	Oxford Health NHS Foundation Trust	Short	11	11–24	1.2.17 We notice that cognitive analytic therapy (CAT); interpersonal psychotherapy (IPT) and family interventions as treatment models for Anorexia Nervosa have been omitted – this is a significant change from the 2004 Guidelines.	Thank you for your comment. As you may understand, there has been a wealth of studies conducted since 2004. Note that the Committee has revised their recommendations for the treatment of adult anorexia nervosa to include CBT-ED, MANTRA and SSCM as first-line treatments, and focal psychodynamic therapy as second-line treatment. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision.
551.	SH	BEAT	Short	11	21–22	We question the use of the words "not available" here as this could be interpreted as implying that it will be acceptable for services to disregard the recommendations in 1.2.14-1.2.16.	Thank you for your comment. The text has been amended to remove this implication.
552.	SH	Esoteric Practitioners Association	Short	11	21 – 24	We would like to recommend Universal Medicine Therapies, to complement or support the treatment modalities already provided by the NHS. http://www.universalmedicine.net/what-doctors-say.html http://www.unimedliving.com/healing/everyday-healing/how-do-universal-medicine-therapies-work.html	Thank you for your comment. Unfortunately no evidence for these therapies was identified that met our inclusion criteria

553.	SH	Hywel dda Health Board	Short	11	21 – 24	Again the scope of possibilities is reduced; there would be other approaches that locally have proven to be effective which would be without NICE guideline / support. I think that it would be useful to highlight the lack of substantive evidence and make reference to utilising local knowledge and practice based evidence that may not be available / fitting with the Cochrane library.	Thank you for your comment. The Committee has revised their recommendations for the treatment of adult anorexia nervosa to include CBT-ED, MANTRA and SSCM as first-line treatments, and focal psychodynamic therapy as second-line treatment. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. A discussion of the evidence regarding, for example, its quality and limitations, can be found in the relevant LETRs of the full guideline.
554.	SH	Oxford Health NHS Foundation Trust	Short	11	21–24	1.2.17 In the context of long waiting lists, it will be helpful if the committee could give guidance on how many consecutive manualised treatments and sessions patients should receive? For example, if 40 sessions of CBT-ED are ineffective for a patient, should this be followed up by 40 sessions of Focal Psychodynamic Psychotherapy, followed by SSCM and MANTRA (while other patients wait). And what should services offer if the patient still doesn't respond, continues to have a severe/extreme eating disorder (as defined by DSM-5) and if the patient, family, GP, other professionals opposes discharge? We feel that there is a real opportunity for the Committee to address these clinical dilemmas in the NHS.	Thank you for your comment. The recommendations have been revised to include CBT-ED, MANTRA, and SSCM as first-line interventions, and focal psychodynamic therapy as second-line; the recommendations have also been amended to offer the possibility of further sequenced psychological treatment, and continued support and management to the person with an eating disorder. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision.
555.	SH	Oxford Health NHS Foundation Trust	Short	11	21–24	1.2.17 Given the efficacy of the recommended manualised interventions is low, would the committee advise that	Thank you for your comment. New recommendations have been inserted to address the person with anorexia

						professionals use other individual psychotherapies (e.g. individualised formulation-based approaches or clinical judgement to consider alternative psychological interventions) if none of the recommended manualised interventions are effective? We are concerned that a recommendation for manualised approaches only, ignores the evidence and clinical reality that manualised approaches don't treat 100% patients effectively. It is essential that the Guidelines offer suggestions on how to treat patients with eating disorders who remain symptomatic and do not respond to manualised treatments.	nervosa who has not benefited from any of the recommended interventions for anorexia nervosa. The use of manuals provides a guidance structure for the delivery of an intervention but that, in all cases, their application requires the use of clinical judgement that is sensitive to the individual needs of the person.
556.	SH	BEAT	Short	11	29–31	The wording of this recommendation is confusing. Presumably it is intended to accommodate the practice of conducting some sessions with the young person on an individual basis, as part of the family therapy, although if this is the case it seems to overlap with recommendation 1.2.21. In its current wording, it may be misinterpreted as saying that it is possible to receive evidence-based family therapy without the family ever being present alongside the young person. This connects to the issue identified in the full guideline of 'therapist drift' or poor adherence to evidence-based treatment approaches. A study of therapists in the USA found that many claimed to be providing family therapy for eating disorders, whilst actually appearing to deliver it purely on an individual therapy basis (Kosmerly, Waller and Robinson, 2015 -	Thank you for your comment. The Committee recognised that although the majority of evidence was on family therapies that involved both the person with the eating disorder and their family/carers, one study (Eisler 2000) suggested that separate family therapy may be more effective that conjoint family therapy (in particular when there were high levels of maternal criticism). They therefore decided to recommend either type of family therapy to be determined by the clinical judgement of the therapist.

						http://onlinelibrary.wiley.com/doi/10.1002/eat.22276/abstract).	
557.	SH	The Association for Family Therapy and Systemic Practice in the UK	Short Full Also see page 7	11–12 278-281 lines 1-2	26 (page 11) to 3 (page 12)	For young people with anorexia the guideline recommends anorexia-nervosa-focused family therapy delivered as either single- or multi-family therapy (page 11 lines 26-28), then goes on to recommend the use of a family-based treatment manual for eating disorders (page 12 line 3). In the full guideline there is a helpful discussion about the evidence for family therapy. We have two comments. Firstly, 'family based treatment', outside of specialist eating disorder services, is sometimes used to mean multimodal treatment (including individual, family and wider systems work with a central focus on the family). Therefore it might in this guideline be helpful to use the term anorexia-nervosa *(or eating disorder)* focused family based treatment manual so that this avoids any risk of misunderstanding. Hence, For young people with anorexia the guideline recommends anorexia-nervosa-focused family therapy delivered as either single- or multi-family therapy Then specify (page 12 line 3) * use an anorexia-nervosa *(or eating disorder)* focused family based treatment manual	Thank you for your comment. The Committee felt that the two most common therapies of Lock and Le Grange's Family-Based Treatment and Maudesley-based Family Therapy therapies were sufficiently similar to allow comparison against other types of intervention and the LETR in the relevant section has been updated to reflect this. No trials that directly compared these two therapies were identified and the Committee decided that they should not recommend one over the other. Regarding the use of terminology, the text has been amended to use 'family therapy' as a generic term and to make clear that the Committee is not recommending a particular form of family therapy (in particular those mentioned in the comment).

						Secondly the recommendations recommend the use of a (/an eating disorder focused) family-based treatment manual, but do not specify which particular manuals have been recommended by NICE, and it was thought some clarity here would be helpful. Hence this could be read as including any of the below for example: This could imply use of Lock and le Grange (2013); Lock et al (2001) rather than one of 3 treatment manuals, the first 2 widely available in the UK where many eating disorders clinicians have attended relevant workshops Lock, J. & Le Grange, D. (2013) Treatment manual for anorexia nervosa: a family based approach. 2nd edn. New York: Guilford Press Lock, J., Le Grange, D., Agras, W.S. & Dare, C. (2001) Treatment manual for anorexia nervosa: a family based approach. New York: Guilford Publications, Inc. Eisler, I., Simic, M., Blessit Eisler, I., Simic, M., Blessitt, E., & Dodge, L. & Team. (2016). Maudsley service manual for child and adolescent eating disorders (Revised). London: Child and Adolescent Eating Disorders Service, South London	

						and Maudsley NHS Foundation Trust. Available at: http://www.national.slam.nhs.uk/services/camhs/camhs-eatingdisorders/resources/ The third is an unpublished treatment manual used in trials led by Arthur Robin in the US Robin, A., Siegal, P., Koepke, T., Moye, A., & Tice, S. (1994). Family therapy versus individual therapy for adolescent females with anorexia nervosa. *Journal of Developmental & Behavioral Pediatrics*, 15, 111-116. Robin, A., Siegal, P., Moye, A., Gilroy, M., Dennis, A., & Sikand, A. (1999). A controlled comparison of family versus individual therapy for adolescents with anorexia nervosa. *Journal of the American Academy of Child and Adolescent*	
558.	SH	Leicestershire Partnership NHS Trust	Short	11&15	26	In the sections on Psychological Treatment for Young People with Anorexia Nervosa (p11 of short version and p277 of full version) and Psychological Treatment of Young People with Bulimia Nervosa (p15 of short version and p533 of fell version) a number of terms are used including: • Family therapy – ED • Family-based therapy • ED-focused FT • Anorexia-nervosa-focused family therapy	Thank you for your comment. The text has been amended to clarify that the Committee is not recommending a particular form of family therapy. Regarding the recommendations for psychological interventions for anorexia nervosa in young people, although there were relatively few RCT studies conducted in this age group and clinical practice may suggest that other therapies are efficacious, it was not within the scope of the evidence review to include other kinds of evidence (such as observational studies or case studies).

						• Bulimia-nervosa-focused family therapy • Family based treatment • CBT-ED (which we assume refers to CBT-E, we prefer the latter terminology). The variation of terms is confusing. In addition, the Association for Family Therapy and Systemic Practice states in its Code of Ethics and Practice (June 2016), Introduction (Paragraph F): The terms Family and Systemic Psychotherapist, Systemic Psychotherapist and Family Therapist refer to a person who has completed accredited qualifying-level training, and is registered with UKCP within the College of Couple, Family and Systemic Therapy. Most family based treatments or interventions offered within CAMHS Eating Disorders Services are not offered by Family Therapists but by a range of CAMHS clinicians (including family therapists). Therefore when referring to the Maudsley Approach or Family Based Treatment (Locke) it will be more accurate to use a more generic term e.g. Anorexia or bulimia focused Family-Based Treatments to avoid young people and their families being given the impression that they are receiving Family Therapy when their clinician is not suitably qualified to provide this. The new guideline restricts the options available for the treatment of young people with ED. The guideline leaves	Regarding focal psychodynamic therapy, please note that the recommendations for adult anorexia nervosa have been revised and that it is now a second-line option if CBT-ED, MANTRA and SSCM do not prove effective or are unacceptable or contraindicated. Finally, the evidence review did not identify any relevant studies for psychodynamic therapy or IPT in young people with anorexia nervosa. The Committee therefore did not recommend them for use in this group.

						little room for patient choice (effectively only two available options for Children and Young people with AN). As per draft guidelines (p4 of 33), people "have the right to be involved in discussions and make informed decisions about their care". It is important to be able to recommend alternative treatment options (such as Psychodynamic Psychotherapy and IPT) to families who cannot engage with FBT and young people who have been offered CBT in the past with limited success. For example, practice base evidence shows us that there is added value in offering additional treatment options (such as Psychodynamic Psychotherapy and IPT). This is even more relevant as Focal Psychodynamic Psychotherapy is recommended as a treatment option for adults – and therefore its efficacy is recognised. Including these treatment options in the guidance, allows clinicians the option to explore these both as second line treatment or additional treatment options.	
559.	SH	Oxford Health NHS Foundation Trust	Short	11	21–24 & 26–27	1.2.17 We hope that the Guidelines would continue to allow the option to consider anorexia-focussed family therapy for people older than 17. An omission or recommendation not to offer family therapy for people over 17 will create multiple dilemmas in practice, for example: • Should family therapy terminate whenever a young person turns 18, despite anorexia-focussed family therapy being the main	Thank you for your comment. It is important when developing any transition plan to take into account the need to deliver appropriate treatment plans. This is made clear in the recommendation and the expectation is that current treatments would be taken into account. This will involve some flexibility in the delivery of psychological interventions. A recommendation regarding family therapy might be unhelpful if explicit recommendations for adults were made,

						NICE recommendation until the patient is 17 years and 364 days old? It makes no clinical sense to terminate the main recommended treatment for young people overnight when patients turn 18. • Transitions between CAMHS and adult ED services will become problematic as family therapy will no longer be on offer – even if the young person has not completed a full course of treatment in CAMHS. • Occasionally, family therapy is needed in adult ED services to help the parents/carers and young adult to make the transition from CAMHS where a family approach was followed to the adult service where individual treatment models are typically offered. • Adult services will no longer be able to meet patient and carer choice and preferences for family therapy, nor will adult ED services be able to offer family therapy if the formulation is clear that the family is either maintaining the problem or an essential part of treatment.	especially given the absence of evidence in this area.

						• Without the option for family therapy it will become impossible to address the interpersonal maintaining factors for some young adults who are still living at home. • Family interventions are not included in the 2017 guidelines for adults whereas it was included in the 2004 guidelines meaning there will be no option to offer more intensive treatments if individual manualised approaches are ineffective. In this regard, the 2004 Guidelines stated: o *4.4.2.6 For patients with anorexia nervosa, if during outpatient psychological treatment there is significant deterioration, or the completion of an adequate course of outpatient psychological treatment does not lead to any significant improvement, more intensive forms of treatment (for example, a move from individual therapy to combined individual and family*	

						work or day care, or inpatient care) should be considered. (NICE, 2004, p. 66) • In summary, many patients, family members, carers, professionals, service providers would find it unacceptable if the Guidelines suggest that no family work should be offered to patients (17+) for the next 10-15 years in the UK.	
560.	SH	The Association for Family Therapy and Systemic Practice in the UK	Short	12	4–7	The recommendations for anorexia-nervosa focused family therapy for young people with anorexia recommend 18-20 sessions over at most one year, and recommend a review of the needs of the young person 4 weeks after treatment begins then every 3 months, to establish how regular sessions should be and how long treatment would last. Does this mean that all treatment or just family therapy should be over in one year? There seems a place for additional flexibility e.g. those who need further interventions which may include additional family therapy, a separated intervention or individual treatment. Whilst many young people may be sufficiently recovered to be discharged within 9 – 12 months of commencing treatment it would be unfortunate to build	Thank you for your comment. The recommendation has been revised to make clear that this is the number of sessions and duration of therapy that typically should occur, whilst leaving it at the clinician's discretion in conjunction with informed patient choice whether in a particular case therapy should have more or less sessions or should occur over a shorter or longer period of time.

						in an expectation that treatment must be finished in a year for the small group that need significantly longer and possibly will need a range of treatments. This would be recognising that some people, due to clinical need, may benefit from more intensive or longer term treatment. Remaining in treatment too long appears to be safeguarded by the recommendation for regular 3 monthly reviews addressed in point 63 above. Whilst there does not appear to be clear evidence for anorexia nervosa focused family therapy which extends over 12 months, we suggest a more helpful recommendation might be "consist of 18-20 sessions usually over at most one year", so that if there are good clinical reasons, e.g. identified in the review, to continue this is deemed possible.	
561.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	12	5 & 6	Review at 4 weeks is clinically too soon to know whether the patient is recovering or starting to recover. Having a rigid number of weeks for review does not help as there are many things that interfere with being able to stick to this (including individual patient factors) so having a broader time range for initial review may help to adjust review timings for individual patients. A guideline stating that initial review between weeks 4-7 may give a better opportunity to get to know the patient and individualise care.	Thank you for your comment. The primary purpose of the recommendation is to assess progress in treatment and not, as is implied, to assess whether the individual should continue or not with treatment (though this might be the result of the review). The recommendation clearly states that there is need for further review and consideration and no amendment was made.

562.	SH	BEAT	Short	12	5–7	Could this recommendation also stipulate that these 'reviews' should consider whether or not anorexia-nervosa-focused family therapy may be the most appropriate form of treatment for the patient? This decision could perhaps be informed by the evidence which has emerged about the potential for early-change to predict outcome from family therapy for eating disorders.	Thank you for your comment. There is a recommendation in this section to emphasize that other interventions such as CBT-ED or adolescent-focused individual therapy should be considered if family therapy is unacceptable, contraindicated or ineffective. Regarding early change, although there is some evidence that early change predicts efficacy of treatment, examining this issue was beyond the scope of the guideline.
563.	SH	BEAT	Short	12	19	The use of the wording 'final phase' here implies that the previous bullet point should be seen as the second or middle phase, however this is not stated in line 16.	Thank you for your comment. The text has been amended.
564.	SH	BEAT	Short	12	25	Recommendation 1.2.19 should include a stipulation that the young person and their family should be offered follow-up appointments to help monitor and consolidate recovery.	Thank you for your comment. Further coordination and management of care may be required and a new recommendation, which would address the comment, has been made at the beginning of the section on anorexia nervosa.
565.	SH	BEAT	Short	12	26	The word "consider" should be replaced with "offer" given a) the evidence of the severe distress commonly experienced by carers, b) the fact that their current levels of distress may be creating a barrier to their involvement in the family therapy and c) the evidence regarding the importance of carer well-being on the well-being of the patient. Also, this recommendation contradicts with the principle of recommendation 1.1.9 which instructs that professionals "Should offer them [all family members or carers] an assessment of their own needs...".	Thank you for your comment. The words 'consider' and 'offer' have a specific use in the NICE guidelines depending on the strength (level of certainty) of the evidence, in line with *Developing NICE guidelines: the manual*. Please note the recommendations regarding family therapy for young people with anorexia nervosa have been revised. This recommendation does not contradict recommendation 1.1.9 as this is about the assessment of needs, rather than being about providing support. In any case, the evidence for the efficacy of

							carer interventions (regardless of whether they are also involved in family therapy) was not strong with minimal benefits demonstrated by the identified studies/interventions (e.g. self-help vs treatment as usual). As such, the Committee recognised the distress that can be experienced by someone caring for an individual with an eating disorder and hence - consistent with the lack of convincing evidence for the superiority of one intervention versus another - recommended that support be considered.
566.	SH	Esoteric Practitioners Association	Short	12	20 – 22	What methods are envisaged to support the young person to establish a level of truly sustainable independence? We know it is critical at this juncture to introduce self-enquiry and self-care as a responsible way to establish and facilitate independent management of underlying and potentially ongoing mental health issues. https://www.liveinnermost.com/3-tips-to-deal-with-overeating/	Thank you for your comment. Whilst the Committee recognised the importance of supporting people with eating disorders at long term follow up after treatment, this was outside the scope of the guideline.
567.	SH	BEAT	Short	12	29–30	This appears to duplicate part of recommendation 1.2.18 (specifically page 11, lines 29-31).	Thank you for your comment. The text has been amended.
568.	NICE	NICE Social care	Short	13	22-25	Low bone mineral density sounds like a condition that might have a variety of effects on a person and possible complications for them alter in life. If so, is it right to say that the primary aim of treating it is to achieve and maintain a healthy BMI? Or, should it say 'at this point'?	Thank you for your comment. The text has been amended.

569.	SH	BEAT	Short	13	1	This could be of greater value to professionals if it stated some elements which would contraindicate the use of family therapy for these patients.	Thank you for your comment. The Committee decided that specifying when family therapy is contraindicated would be too prescriptive and that it should be a matter of clinical judgment combined with informed patient choice.
570.	SH	BEAT	Short	13	1	If possible this could be strengthened by adding some guidance on when this therapy may be judged to have proven 'ineffective', perhaps referring to recent evidence about the importance of early change to prognosis in family therapy for eating disorders.	Thank you for your comment. The Committee did not specify the conditions under which a family therapy should be deemed ineffective because they did not want to be overly prescriptive and believed that it should be a matter of clinical judgement in conjunction with an informed choice by the person with the eating disorder. Although early change appears to be a good predictor of effective therapy, this issue was not reviewed as it was beyond the scope of the guideline.
571.	SH	Lancashire Care NHS Foundation Trust	Short	13	1	Range of therapeutic options The guidance does not place enough emphasis on service user choice of therapies available It would be useful to have more detailed options for those young people who have already tried and dislike CBT-E. CFT-E is a gap in the therapies that could be offered, given its good research findings	Thank you for your comment. The right of the person with an eating disorder to have choice in the therapies they receive is supported. Indeed, recommendations are given for family therapy and adolescent-focused individual therapy as alternative interventions. However, it is not possible to recommend every extant therapy purely on the basis of patient preference, especially if there is a lack of evidence for its efficacy. Regarding compassion-focussed therapy, although there is some evidence for its efficacy, the Committee decided to focus their attention on randomised control trials of psychological and other interventions and unfortunately, no such trials were identified in the literature search.

572.	SH	Lancashire Care NHS Foundation Trust	Short	13	7	Dietetics support There is little mention of the support / input dietetics give, despite how highly valued they are to staff and service users.	Thank you for your comment. The recommendation for dietary advice has been amended to specify that only a dietitian should provide it.
573.	SH	PEDS Charity	Short	13	7	Concern that issues around the management of exercise (including any guidelines) is not addressed ie LEAP model is implemented with success in many services around the country but has not been explored	Thank you for your comment. No RCT evidence regarding the management of exercise for people with an eating disorder was identified for inclusion to the review.
574.	SH	PEDS Charity	Short	13	To follow 7 'Section on Driving'	Driving and can we give any advice re factors which should be taken into consideration if someone is to continue /be advised against driving (DVLA has nothing concrete) and BMI /percentile alone isn't reliable. Lots areas are devising their own protocols which are varying.	Thank you for your comment. Issues regarding the DVLA and any responsibilities that health practitioners may have - for example regarding a person's fitness to drive - are outside the scope of guideline.
575.	SH	BEAT	Short	13	4–6	This appears to partly duplicate recommendation 1.1.9.	Thank you for your comment. This recommendation is specific to the case of whether family members or carers need family therapy support if family therapy with the young person is conducted without them; recommendation 1.1.9 is a more general recommendation that family members or carers should be offered an assessment of their needs, regardless of the particular kind of therapy if any the young person is receiving.
576.	SH	Mental Health Foundation	Short	13	23	The guidance only refers to low bone density in women; there is no recognition of this issue among men with eating disorders. While there is a higher percentage of women who live with	Thank you for your comment. The relevant recommendations have been amended.

						anorexia, services will see men within treatment for anorexia (10%) therefore guidance is required around how practitioners should handle this physical complication/symptom in men.	
577.	SH	BEAT	Short	13	22–23	This section should not only refer to women as low bone mineral density can affect males too.	Thank you for your comment. The relevant recommendations have been amended.
578.	SH	College of Mental Health Pharmacy	Short	14	4-15	I don't believe the evidence for the use of oestrogens and bisphosphonates in young women with anorexia nervosa is strong enough or robust enough to form the basis of a recommendation. In any case the fact that it is an unlicensed indication should be identified. The use of bisphosphonates in anorexia nervosa is not supported or recommended by the osteoporosis society.	Thank you for your comment. The Committee agreed that the most convincing evidence for treatment of adult women was for bisphosphonates, although recognised in their recommendation that there was some uncertainty. Moreover, since the aim of first-line treatment for anorexia nervosa should be to restore and maintain a healthy body weight, the Committee thought that bisphosphonates could be used in those women who have long-term low body weight and low bone mineral density. They felt confident in recommending that practitioners consider the use of bisphosphonates in this group given that NICE has recommended alendronate or risedronate for people without eating disorders but at high risk of osteoporotic failure (see NICE technology appraisal guidance TA160/TA161). Please see the relevant LETR in the full guideline for further discussion.
579.	SH	Oxford Health NHS Foundation Trust	Short	14	4–11	1.2.32 As there are potential risks on growth in the use of oestrogens in young people, the Guidelines need to be clearer regarding the level of long term low body weight and low bone mineral density	Thank you for your comment. The Committee have recommended that oestrogen use should not be routine and that specialist advice from a paediatrician

						which would trigger consideration of the use of oestrogen, to prevent unnecessary use.	or endocrinologist should be sought before commencing it.
580.	SH	BEAT	Short	14	19	Inconsistent wording has been used here - 'treatment of' rather than 'treating' which has been used for all the other diagnoses.	Thank you for your comment. The text has been amended.
581.	SH	Leicestershire Partnership NHS Trust	Short	14	20	IPT BN has been used for the treatment of bulimia nervosa(BN) , binge eating disorder (BED)and unspecified eating disorders (UED) for over 20 years. There is a wealth of information supporting the use of IPT BN in this patient group through use of outcome data, follow up studies and anecdotal evidence including patient feedback and therapist review. IPT BN consists of 12-20 sessions of individual therapy in 3 stages of treatment, assessment, treatment and ending. The assessment covers: engagement, comprehensive history of eating disorder, interpersonal inventory, diagnosis of disorder, sick role, psychoeducation, keeping an eating record, introduction of regular eating and support, advice or encouragement to make behavioural changes. Following agreement of a relevant interpersonal focus, the patient moves to the treatment stage and works on addressing the links between their interpersonal problems and eating disorder symptoms. Symptoms are monitored each week and the patient is encouraged to use bingeing or purging as markers of interpersonal distress. This helps them to focus on developing interpersonal solutions to their eating	Thank you for your comment. As you may understand, a great deal of research has occurred in the time since the publication of the last guideline in 2004. The committee considered the evidence for the efficacy of IPT and a range of other interventions. After considering the quality of the data, direct pairwise comparisons and the results of the network meta-analysis (both of which showed that IPT was not effective), the committee were confident only in recommending guided self-help and individual CBT-ED (please see the relevant appendices for further details). Whilst the committee recognised that not every individual with an eating disorder will benefit from the recommended interventions, they were not able to recommend treatments for which there was evidence of no or little effect. The committee recognised that it is very common for the person with an eating disorder to have a significant physical or mental health comorbidity and that the presence of one may have a substantial impact on the delivery of treatments. The committee also recognised the dearth of evidence for how comorbidities may affect the efficacy of particular treatments and therefore developed a specific

						disorder and to develop a sense of mastery over their lives, whilst continuing to be supported to use a regular eating pattern and to reduce bingeing/purging. Through involving the patients interpersonal network in their treatment, they are also starting to work on developing their own independence and skills at managing their eating disorder, which is strengthened by the support of others. This aids in the termination stage, where the patient works on managing their eating symptoms without therapy and on identifying their own relapse prevention plan with the support of their family or friends. IPT BN is manualised (Whight et al 2011). All of these points meet the criteria suggested in the draft guidelines for CBT ED – IPT BN focuses on interpersonal difficulties and emotions and their link to eating disorder symptoms whereas CBT ED focuses on challenging the thoughts and behaviour affecting the symptoms. There is a vast amount of overlap between the two treatments. The NHS Constitution identifies that patients should have a choice in the treatments that they receive. Only having one individual therapy in the NICE guidelines for BN, BED or UED limits the patients' choice to one therapy. CBT is not the treatment of choice for all patients and is not effective for all patients. IPT BN remains a viable alternative treatment for BN, BED or UED. Eating disorder (ED) services in the UK recognise this	research recommendation calling for studies to examine precisely this point.

						and offer a variety of therapeutic approaches for treatments, to enhance compliance, reduce dropout rates and to offer choice. The draft NICE guidelines suggest that a patient with BN, BED or UED with a comorbid mental health problem should receive the most appropriate treatment first . Most patients with BN or BED have a low mood or emotional dysregulation aspect to their disorder. IPT is in the NICE Guidelines for the treatment of depression and IPT BN addresses both depression and eating disorder in the model. It has proved very effective at reducing symptomatology of both disorders and outcome measures for both are routinely used in clinical practice (HamD, BDI). Patients with BED are commonly above a normal range for healthy BMI, often falling into the obese category. Bingeing for these patients is often not driven by hunger and they frequently have issues around attachment or trauma. The emotion regulation or interpersonal elements to their disorder are well addressed through IPT, helping the patient to identify other ways of getting their needs met by developing interpersonal skills and increasing confidence at self mastery. Most of the evidence used to support the use of CBT ED for treatment of bulimia nervosa and binge eating disorder has	

						been assessed using GRADE as very low or low, as was the data supporting IPT. There is no long term data to support the use of CBT ED over IPT for the treatment of bulimia nervosa , binge eating disorder or unspecified eating disorders . Cost effectiveness analysis highlights that CBT ED is the most expensive treatment option, whereas IPT BN is relatively cheap. Whilst there has not been the volume of studies looking at IPT with eating disorders compared to those looking at CBT, there is evidence that IPT is as effective as CBT for the treatment of these patients. This evidence was used to recommend the use of IPT as an alternative treatment for bulimia and binge eating disorders in the previous NICE guidelines (2004) and that evidence has not changed or been refuted in any way. Fairburn compared IPT BN to CBT BN (1991,1993,2015) and recognised that IPT and CBT achieved similar outcomes in terms of remission at the end of therapy. At follow up patients who had received IPT continued to demonstrate improvements. Whilst this evidence may be small numbers, it was sufficiently compelling for IPT to be included in the 2004 Guidelines. These findings have not been refuted, there is no evidence that IPT is no longer an effective treatment, ergo it should remain in the NICE Guidelines as an alternative to CBT ED.	

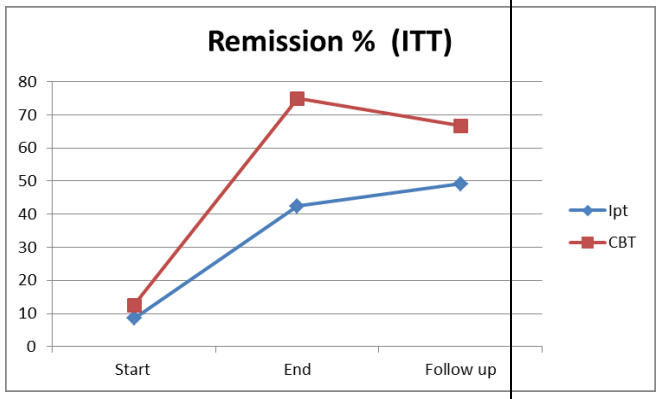
						Lastly, clinical practice dictates that we often work with patients who have significant co morbidity resulting from a history of trauma and neglect. These are patients who have key issues in their relationship, hence they have difficulties trusting and engaging with professionals. These are patients who have problems negotiating their needs in relationship. They seem to understand the rational of IPT which has helped them make sense of their symptoms, enabling them to make changes, and to maintain these changes post therapy. It is rare for a patient not to make any change. IPT outcomes in Leicestershire Adult Eating Disorder Service 2013-2015 Data from the EDEQ for patients completing IPT and CBT in the Leicestershire Adult Eating Disorder Service between Jan 2013 and Dec 2015 has been pooled. Outcomes measures (EDEQ) wwwere issued at start of therapy, end of therapy and 4 months post end of therapy. Remission is defined as having an EDEQ global score of less than 2.77 (this community norm for EDEQ plus 1 standard deviation). The percentage of patients reporting OBE's of 1 or more in the preceding 28 days and the median number of OBE's has also been reported. This is in line with the outcomes detailed by Fairburn et al in his 2015 paper comparing CBT and IPT. This is also in	

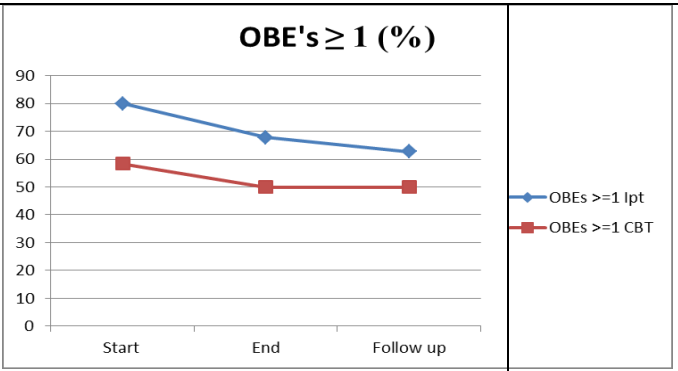
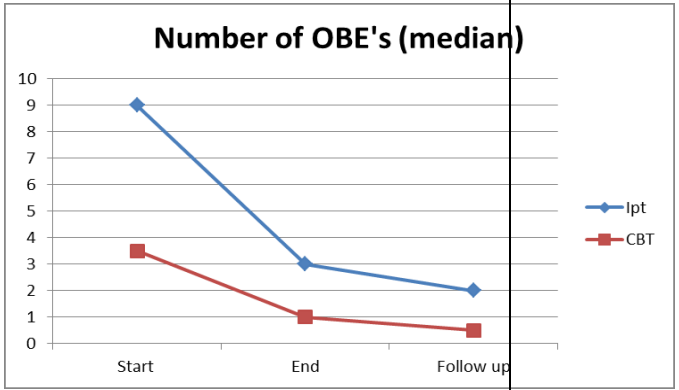
line with the outcomes used by the Eating Disorders NICE committee.

	Start				End				Fo
	IPT (n=59)		CBT (n=24)		IPT (n=59)		CBT (n=24)		IP (n
	n	%	n	%	n	%	n	%	n
Remission	5	8.5	3	12.5	25	42.4	18	75	29
OBE's ≥1	47	80	14	58.3	40	67.8	12	50	37
	Median	(IQR)	Median	(IQR)	Median	(IQR)	Median	(IQR)	Median

CBE's (n)	9	(2, 20)	3.5	(0, 14)	3	(0, 8)	1	(0,2)	2			

Intention to treat analysis was used whereby if the data was missing from a time point the data from the previous time point was carried forward.
There was start data from 59 IPT patients and 24 CBT patients. Results are detailed below.



						  Interestingly the final remission rates for both IPT and CBT are almost identical to those published by Fairburn in 2015.	
582.	SH	BEAT	Short	14	21	The use of the word 'consider' for both of the treatments recommended for adults with bulimia nervosa (guided self-help and CBT-ED) is concerning. This would imply (to a lay reader at least) that access to treatment for these patients is less important, especially given that most	Thank you for your comment. The wording of recommendations contained in both the full and short guidelines is required to follow the methods outlined in "Developing NICE guidelines: the manual". Furthermore, the short guideline is not intended for 'lay readers'

						readers are unlikely to read (or find) the explanation in the 'Developing NICE guidelines: the manual' about what NICE actually means when it uses the word 'consider'. Even if the typical recovery rates and quality of evidence to date to support these treatments is lower than for some of the treatments which NICE will have reviewed for other conditions, it is important that the NICE guideline uses language which reflects the principle that adults with bulimia nervosa should be entitled to access the best treatments we currently have.	but rather for health and social care professionals. A separate 'Information for the public' version of the guideline is produced by NICE for people without specialist medical knowledge and can be downloaded from their website. Comments about the NICE requirements for clinical guidelines should be directly addressed to NICE.
583.	SH	BEAT	Short	14–15	21–28; 1–22	There is an inequity when comparing the recommendations for adults with anorexia nervosa and adults with bulimia nervosa concerning access to individual/face to face psychotherapy. For patients with bulimia nervosa, the recommendations prioritise the provision of guided self-help. Whilst guided self-help is effective for and preferred by some patients, others may prefer to choose individual/face-to-face therapy. We are concerned that some health professionals may interpret this section in such a way as to only 'consider' individual therapy if guided self-help has been tried first and proven unsuccessful. If patients are compelled to go through guided self-help against their preferences and this treatment proves unsuccessful, this may squander the chance that was available to the health professionals when the patient first sought help. This could be interpreted by the patient as them having 'failed' or as evidence that	Thank you for your comment. The recommendation has been revised to clarify that individual CBT-ED should be considered if guided self-help is unacceptable, contraindicated or ineffective.

						they cannot recover - thereby leading to disengagement from some of these patients. This would be likely to prove harmful and thus contradict the principles set out on page 18 of the full guideline.	
584.	SH	Cardiff and Vale University Health Board	Short	15		Surprised not to see IPT mentioned as has a very good evidence base for both BN and BED and, we have found, as a bolt on for Anorexia. Perhaps insufficient RCTs? The feeling is from our service that it would still be good as an advised at minimum? I think IPT-UK may be making a good response separately but here we add our own concern about this omission, as clinicians getting good outcomes for this group and thinking it is valuable to have choice between CBT-ED and another therapy. I think it may be listed under the "psycho-dynamic" therapies but so not think that those who practice it would necessarily badge it as such.	Thank you for your comment. Regarding psychological treatments for bulimia nervosa, low quality evidence from three RCTs (n=425) showed IPT is less effective on remission compared with any other intervention. Also, low quality evidence from two RCTs (n=350) showed IPT is less effective on remission compared with any other intervention in those who had bulimia for more than 5 years but there was some uncertainty. For binge eating disorder, low quality evidence from 1 RCT (n=205) showed there to be no difference on remission, BMI or binge eating between IPT and any other intervention.
585.	SH	BEAT	Short	15	4	Whilst this recommendation does refer to the provision of CBT-ED if guided self-help is found to be "not acceptable", no clarity is provided on how this 'acceptability' should be determined. The use of the word 'consider' here implies (at least to a lay reader) that it could be deemed acceptable for a service to deny access to individual psychotherapy for patients with bulimia nervosa, who have turned down guided self-help, in ignorance of patient choice and disregard for their self-esteem and well-being.	Thank you for your comment. The text has been amended to make it clear that clinicians should use their clinical judgement in determining whether guided self-help is acceptable or not. NICE clinical guidelines are intended to describe best practice based on a systematic review of the current evidence, with the phrases 'consider' and 'offer' reflecting the strength of the evidence used to make the recommendation (See Developing NICE guidelines: the manual for further information).
586.	SH	BEAT	Short	15	4	Given the relatively strong outcomes from Randomized Controlled Trials of	Thank you for your comment. 'Consider' is used instead of 'offer' to reflect the

						CBT-ED for adults with bulimia nervosa, why has the word 'consider' been used instead of 'offer' for this form of treatment?	strength of the evidence in accordance with methods outlined in "Developing NICE guidelines: the manual".
587.	SH	Interpersonal Psychotherapy UK (IPTUK)	Short	15	3 – 5	Following consultation with specialist eating disorder services across the UK and internationally, we are very concerned that the current draft of the guideline limits treatment suggested for bulimia nervosa in adults to one model of psychological therapy if self help proves ineffective. This removes Interpersonal Psychotherapy (IPT), previously included as a second line treatment consideration. This revision of the guideline is at odds with current and long standing practice based evidence of good outcomes using IPT for bulimia nervosa across several specialist eating disorder services. We are not aware of new research that discredits the original evidence for IPT (Fairburn et al, 1993, Fairburn et al 1995, Agras et al, 2000) and we would ask that the panel confirm Prof Fariburn's earlier studies have been included in the analysis, as they do not appear in Appendix N. The broad based IPT practitioner community represented in this submission can find no reason to bypass this evidence in the current guideline. Clinicians, have expressed dismay that an effective and commonly used treatment intervention will become more difficult to access and training opportunities will be limited or removed if IPT is removed from the treatment guideline.	Thank you for your comment. The cited papers have been included in our analysis. Low quality evidence from three RCTs (n=425) showed IPT is less effective on remission compared with any other intervention (predominantly CBT-ED) for bulimia nervosa. Also, low quality evidence from two RCTs (n=350) showed IPT may be less effective on remission compared with any other intervention (CBT-ED) in those who had bulimia for more than 5 years. Moreover, the economic analysis showed that IPT was not a cost effective intervention. The references have now been included in Appendix N.

588.	SH	Interpersonal Psychotherapy UK (IPTUK)	Short	15	3 – 5	Question 1: The revised recommendation will be challenging and problematic to implement because it does not offer evidence based patient choice. Neither does it inform flexible and responsive thinking by clinicians in making informed and tailored decisions about the preferred treatment approach for adults with bulimia nervosa. Creating a monopoly with a single modality recommendation is at odds with the available evidence and with good practice models, which aim to provide evidence based choice for patients. Furthermore, this fails to offer guidance for patient for whom CBT-ED is unhelpful or unsuitable. Interpersonal difficulties are a core difficulty for many patients with bulimia nervosa and offering evidence based treatment that is designed to address maladaptive interpersonal patterns is essential in affording some patients the opportunity to meaningfully formulating the context and consequence of their disorder. IPT is also a recommended treatment for depression, a frequently co-occurring disorder with bulimia nervosa, and the IAPT Annual Report for 2015-2016 demonstrated that IPT has among the highest recovery rates of the recommended individual interventions for depression.	Thank you for your comment. Compared with other interventions, IPT was less effective on a variety of critical and important outcomes; moreover the health economic analysis also showed that it was not cost effective. Hence, the Committee did not recommend it as a treatment for bulimia nervosa in young people.
589.	SH	Esoteric Practitioners Association	Short	15	10	We are concerned that at this first phase of treatment, addressing the root cause is missing and should be a foundational aspect of the treatment, to be introduced at this stage so as to be reviewed and	Thank you for your comment. The recommendations for CBT-ED in the treatment of adult bulimia nervosa were based on the relevant studies, which were all manualised and had the features specified. Consideration of the root cause

						discussed throughout the treatment package. See all references above.	of the eating disorder is not part of CBT-ED treatment.
590.	SH	BEAT	Short	15	16	The word 'eat' should be inserted after 'binge'.	Thank you for your comment. The text has been amended.
591.	SH	BEAT	Short	15	23	In the same way that SSCM and MANTRA have been included as secondary recommendations for patients with anorexia nervosa why haven't secondary recommendations been included for patients with bulimia nervosa, for whom CBT-ED have proven ineffective (for example IPT and/or I-CAT)?	Thank you for your comment. The Committee has revised its recommendations to recommend CBT-ED if family therapy proves ineffective. However, it did not have a strong view regarding which interventions should be used if family therapy and CBT-ED are found to be ineffective. In the case of adult anorexia nervosa, there was evidence of no difference between several interventions (e.g. CBT-ED, MANTRA, SSCM and FPT). (Please note that the recommendations for adult anorexia nervosa have been revised.) This is not the case for bulimia nervosa since the evidence showed that other interventions such as IPT were less effective than family therapy and CBT-ED.
592.	SH	Leicestershire Partnership NHS Trust	Short	15	26	We have concerns about patients who present without parents due to the ego - dystonic nature of BN. If first line is manualised family based treatment doesn't work in the cohort who present independently of adult parent/carers they end up only with the option of self-help. We have used IPT and even CBT ED in these instances and that outcome measures and binge/purge reduction are all significantly improved. Patient feedback is also positive. We have then added FT in to the treatment offer when young people have felt confident/stable enough to share their illness with the	Thank you for your comment. The recommendations have been revised to recommend CBT-ED as second-line treatment if family therapy is ineffective/not acceptable. This recommendation was amended due to (i) the reclassification by the committee of the guided self-help arm in Schmidt et al. 2007 as a form of individual CBT-ED and (ii) to allow for the provision of individual psychological treatment.

						adults around them. We are not sure self-help would have produced the results we have had with IPT.	
593.	SH	BEAT	Short	15	15–17	This section should also refer to purging and other compensatory behaviours.	Thank you for your comment. The text has been amended.
594.	SH	BEAT	Short	15	26–27	There is no mention of this form of treatment being offered in a multi-family format, despite the reference to this for anorexia nervosa-focused family therapy in recommendation 1.2.18.	Thank you for your comment. Multifamily therapy for anorexia nervosa in young people was recommended on the basis of evidence from an RCT (Eisler et al. 2016); there has as yet been no equivalent studies for multifamily therapy aimed at the treatment of bulimia nervosa.
595.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	16	27-28	There is no acknowledgement of or reason given for fluoxetine being taken out of the guideline as a treatment for BED/Bulimia Nervosa. A clearer statement around this would be helpful as many GPs start patients on Fluoxetine prior to referral. It remains included in RANZCP clinical practice ED guidelines as evidence based treatment which is only a few years old. Lisdexamphetamine is noted to be effective in BED and licensed for use in the USA. Like other medications such a topiramate in the UK, it could be used off label here yet the committee hasn't felt able to make this recommendation because it is only licensed for this use in the USA. ED focused psychodynamic psychotherapy has been used mostly in Germany yet the committee has overwhelmingly endorsed this treatment approach within the UK despite very few professionals having experience in it and no manual being available.	Thank you for your comment. Fluoxetine, and more generally pharmacological interventions, were not recommended for the treatment of either bulimia nervosa or BED because the included studies were generally of a low or very low quality and appeared to confer little benefit versus placebo, and little additional benefit when combined with psychotherapy. Furthermore, only a few of the studies reported the critical outcome of remission; regarding BED, few of the pharmacological agents were effective on remission and binge frequency at end of treatment and follow up, the studies for each comparison were generally of a small sample size and follow up data was not always reported. Regarding lisdexamfetamine in particular, although it showed positive results on remission compared with placebo, the Committee could not recommend it because there was no evidence for its long-term effectiveness and it is not licensed for use in the treatment of eating disorders in

							the UK. Regarding the recommendations for psychological interventions for adult anorexia nervosa, please note that they have been revised to include CBT-ED, MANTRA and SSCM as first-line options (to recognise the fact that there is evidence of no difference between these therapies), and eating-disorder focussed focal psychodynamic therapy - recognising that the manual is yet to be published in English and that it may have cost implications for services - as a second-line option.
596.	SH	BEAT	Short	16	2	The wording for this bullet point should be changed to avoid 6 months being interpreted as the maximum duration which will ever be needed for this treatment.	Thank you for your comment. The recommendation has been amended to allow clinician's flexibility in determining, in conjunction with the individual with an eating disorder, how long treatment should last.
597.	SH	Royal College of Nursing	Short	16	9	This is crucial and should be right at the top of the list, not buried in the lower ranks: *establish a good therapeutic relationship with the young person and their family members or carers*	Thank you for your comment. The text has been amended.
598.	SH	BEAT	Short	16	13	This could be made clearer through the addition of examples of types of compensatory behaviour.	Thank you for your comment. Examples of compensatory behaviours are provided in the recommendations for identification and assessment.
599.	SH	BEAT	Short	16	7–8	The words "attempting to control" should be inserted in place of the word "controlling" to avoid implication that self-induced vomiting or laxative abuse are effective means of "controlling weight". In addition to vomiting and laxative misuse, other forms of so-called compensatory behaviours should also be included -	Thank you for your comment. The text has been amended.

						fasting, over-exercise, diuretic misuse and perhaps also the use of diet pills.	
600.	SH	BEAT	Short	16	24	If recommendation 1.2.20 is to be included for young people with anorexia nervosa, then an equivalent should be included here for young people with bulimia nervosa. Carers of young people with bulimia nervosa can experience equally severe levels of distress as carers of young people with anorexia nervosa.	Thank you for your comment. A recommendation to this effect has been added as suggested.
601.	SH	BEAT	Short	16	24	If possible this could be strengthened by adding some guidance on when this therapy may be judged to have proven 'ineffective', perhaps referring to recent evidence about the importance of early change to prognosis in family therapy for eating disorders.	Thank you for your comment. The Committee recommended routine sessional monitoring as a way to guide both the delivery of therapy and decisions whether or not continue, cease, or switch to an alternative, treatment. Individual clinician's should use their judgement in consultation with an informed discussion with the person with an eating disorder (and if appropriate their family or carers).
602.	SH	BEAT	Short	16	24	Whilst the equivalent recommendation for anorexia nervosa-focused family therapy (1.2.22) referred to occasions when this therapy may be contraindicated, this issue has not been mentioned here for bulimia nervosa-focused family therapy.	Thank you for your comment. The recommendation has been amended as suggested.
603.	SH	BEAT	Short	16	24	Whilst this recommendation does refer to the provision of 'bulimia nervosa-focused guided self help' if bulimia nervosa-focused family therapy is found to be "not acceptable", no clarity is provided on how this 'acceptability' should be determined. The use of the word 'consider' here implies (at least to a lay reader) that it could be deemed acceptable for a service to deny access to alternative	Thank you for your comment. The recommendations at several points emphasise that treatment decisions should be made together with the person with an eating disorder, providing - as a matter of course - full information about the various treatment choices and any related support that may be needed. Regarding the use of the word 'consider': NICE clinical guidelines are intended to

						treatment for young people with bulimia nervosa, who have turned down family therapy, in ignorance of patient choice and disregard for their self-esteem and well-being.	describe best practice based on a systematic review of the current evidence, with the phrases 'consider' and 'offer' reflecting the strength of the evidence used to make the recommendation (See Developing NICE guidelines: the manual for further information).
604.	NICE	NICE Social care	Short	16	28	The only recommendation made with regard to medical treatment for bulimia nervosa is not to offer medication as a sole treatment. It is not clear why there are no recs with regard to what medication to use, when.	Thank you for your comment. The Committee did not recommend any pharmacological intervention for bulimia nervosa because the evidence was generally of very low or low quality, few of the studies reported the critical outcome of remission, and there were few benefits apparent in the reviewed studies that would justify recommending its use.
605.	SH	BEAT	Short	16	24–26	As with adults there is an inequity when comparing the recommendations for young people with anorexia nervosa and young people with bulimia nervosa concerning access to individual/face to face psychotherapy. Whilst individual/face-to-face therapy is cited in recommendation 1.2.22 (for anorexia nervosa), it is not even mentioned in recommendation 1.3.8 (for bulimia nervosa). Whilst guided self-help is preferable and effective for some patients, others may prefer to choose individual/face-to-face therapy. We are concerned that recommendation 1.3.8 could restrict access to individual therapy for young people with bulimia nervosa for whom family therapy has proven unsuccessful or was not acceptable. If these patients are compelled to go	Thank you for your comment. The recommendations for psychological interventions to treat bulimia nervosa in young people have been substantially revised. In particular individual CBT-ED is recommended as a second-line option to family therapy rather than guided self-help. Amendments have also been made to clarify that individual CBT-ED should be considered if family therapy is unacceptable, contraindicated or ineffective.

						through guided self-help against their preferences and this treatment proves unsuccessful this may squander the chance that was available to the health professionals when the patient first sought help. This outcome could be interpreted by the patient as them having 'failed' or as evidence that they cannot recover - thereby leading to disengagement from some of these patients. This would be likely to prove harmful and thus contradict the principles set out in the full guideline on page 18.	
606.	SH	BEAT	Short	17	3	We are concerned that the use of the stronger term 'offer' here may in practice mean that the first-line treatment for almost all patients with binge eating disorder, whatever their severity or preferences, becomes guided self-help.	Thank you for your comment. The majority of evidence for psychological treatments for people with BED was for guided self-help compared with either wait list control or another intervention. The Committee recommended it as a first-line intervention because it was more effective on remission for both these comparisons at both end of treatment and follow up, and the health economic analysis found that it was the most cost effective. No evidence of differential effect by severity was found within the available evidence. Regarding the use of 'offer', the phrases 'consider' and 'offer' used in the recommendations are intended to reflect the strength of the evidence used to make the recommendation in line with NICE policy (See Developing NICE guidelines: the manual for further information).
607.	SH	BEAT	Short	17	3; 5	This should be termed 'binge-eating-disorder-focused' rather than 'binge-eating-focused', so that the wording matches with the diagnostic label.	Thank you for your comment. The text has been amended.

608.	SH	BEAT	Short	17	16	This could be strengthened by adding some guidance on when this therapy may be judged to have proven 'ineffective'.	Thank you for your comment. The Committee recommended routine sessional monitoring as a way of monitoring change. This can be used to guide both the delivery of therapy and decisions whether or not continue, cease, or switch to an alternative, treatment. Individual clinician's should use their judgement in consultation with an informed discussion with the person with an eating disorder (and if appropriate their family or carers).
609.	SH	BEAT	Short	17	17	Since the weaker term 'consider' was used in recommendation 1.3.3 for bulimia nervosa, why was the word 'offer' used for this recommendation?	Thank you for your comment. 'Consider' is used instead of 'offer' to reflect the strength of the evidence in accordance with methods outlined in "Developing NICE guidelines: the manual".
610.	SH	BEAT	Short	17	17	This should also include a reference to occasions when guided self-help may be contraindicated. Contraindication was mentioned in recommendation 1.2.22 for anorexia nervosa-focused family therapy.	Thank you for your comment. Contraindication is now mentioned as appropriate in the relevant interventions for the various types of eating disorder. However, the Committee decided against explicitly specifying the conditions under which the relevant intervention would be ineffective or contraindicated.
611.	SH	Esoteric Practitioners Association	Short	17	19	CBT – ED programmes must also cover and encourage understanding and practising self-responsibility and self-care as outcomes, to ensure sustainability of any changes after and beyond the 16-week programme.	Thank you for your comment. The recommendations for CBT-ED in the treatment of adult anorexia nervosa were based on relevant studies, which were all manualised and had the features specified. Consideration of the root cause of the eating disorder is not part of CBT-ED treatment.
612.	SH	BEAT	Short	17	22	The wording of this bullet point should be changed to reduce the risk of 16 sessions over 4 months being interpreted as the maximum duration which will ever be needed for this treatment.	Thank you for your comment. The sentence has been amended to permit the clinician flexibility in determining, along with the individual with an eating disorder, how long treatment should be.

613.	SH	BEAT	Short	17	16–18	Whilst guided self-help is effective for and preferred by some patients, others may prefer to choose either group-based or individual/face-to-face psychotherapy. Whilst this recommendation does refer to the provision of 'group eating-disorder-focused cognitive behavioural therapy (CBT-ED)' if 'binge-eating-focused guided self-help' is found to be "not acceptable", no clarity is provided on how this 'acceptability' should be determined. We are also concerned that some health professionals could interpret this guidance as meaning that adults with binge eating disorder should only be offered either guided-self-help or group-based CBT. The omission of any reference to individual/face-to-face therapy implies that it could be acceptable for a service to deny access to this form of treatment for patients with binge eating disorder, in ignorance of patient choice and disregard for their self-esteem and well-being. Even if the evidence is unclear for the comparative clinical and cost-effectiveness of individual and group-based CBT-ED for patients with binge eating disorder, this should not prevent patients who are uncomfortable attending group-based therapy from being able to access individual CBT-ED.	Thank you for your comment. The acceptability of a psychological intervention is a matter for clinical judgement in conjunction with an informed discussion with the individual with an eating disorder of the treatment options. In terms of developing the recommendations, the Committee was guided by the health economic model, which supported the clinical and cost effectiveness of guided self-help and group CBT. Therefore, the Committee did not feel able to recommend individual form of CBT-ED for the treatment of binge eating disorder.
614.	SH	BEAT	Short	17	16–18	If patients who had wanted to receive individual/face to face psychotherapy are compelled to go through guided self-help and/or group-based CBT this may be received as a message that they 'do not deserve' their preferred treatment. If they	Thank you for your comment. The clinical evidence and health economic review showed that guided self-help and CBT-ED were the most cost-effective interventions. There were also very few studies found for other psychological

						engage in these less intensive forms of treatment and they prove unsuccessful, this risks squandering the chance that was available to the health professionals when these patients first sought help. This outcome could be interpreted by some patients as them having 'failed' or as evidence that they cannot recover - thereby leading to disengagement. This would be likely to prove harmful and thus contradict the principles set out in the full guideline on page 18.	interventions, which made it difficult for the Committee to make any further recommendations.
615.	SH	BEAT	Short	17	16–18	Why has group-Interpersonal Psychotherapy (IPT) not been included in this recommendation? Was Hilbert et al. (2012 - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3290797/) included in the evidence review? Hilbert et al. (2012) provides longer term follow up on Wilfley et al (2002).	Thank you for your comment. Hilbert et al 2012 was not included in the evidence review because 12-month follow up data from the original study had already been included (Wilfley 2002) and only the first 90 participants were selected to be included in the long-term follow up study. The Committee did not recommend group IPT because the health economic analysis showed that guided self-help was the most cost effective intervention and that group IPT, though clinically effective, was not cost effective.
616.	SH	Interpersonal Psychotherapy UK (IPTUK)	Short	17	16 – 18	We experience the same concern that the treatment recommendations for Bingle Eating Disorder have been reduced to self help or group CBT-ED, again removing consideration of IPT, which has consistently shown comparable longer term outcomes to CBT (Wilfley et al, 1993, 2002; Wilson et al 2010). Given the limited evidence base and range of recommendations we would strongly urge the panel to reinstate a consideration of IPT in both the BN and BED sections. The options open to	Thank you for your comment. Regarding Wilfley 1993 for group CBT-ED vs group IPT in bulimia nervosa, only outcomes for depression were extractable for use in the meta-analysis. Overall, IPT for BN was less effective on remission than other interventions, whilst on binge frequency it favoured other interventions (though there was uncertainty). Regarding Wilfley 2002, this was included in the evidence review from group psychological therapies in BED. Overall, although there was evidence of

						clinicians are significantly reduced if alternative and evidence based treatments are not even offered for consideration in the guidelines.	no difference between group CBT-ED and group IPT on both remission and other outcomes, it was not recommended because the health economic analysis showed that it was not cost effective.
617.	SH	Esoteric Practitioners Association	Short	17	23 – 25	We consider that at this stage and in support of the wider treatment being offered, an enquiry is needed to nominate fundamental beliefs and ideals in relation to the patient and the world they live in, which foster a fundamental lack of acceptance and validation of themselves. This will provide the individual with a context for responsibly approaching their behavioural self-monitoring, encourage accountability for behavioural choices and support exiting any victimhood. See references above.	Thank you for your comment.
618.	SH	BEAT	Short	18	24-27	We are concerned about the implication of this recommendation for those patients who need to learn to manage exercise and challenge unhealthy exercise-related behaviours through gradual exposure.	Thank you for your comment. Unfortunately, no relevant trials that addressed the management of exercise and the reduction of unhealthy exercise-related behaviours were identified for inclusion to the review.
619.	SH	BEAT	Short	18	14-15	In the full guideline, the phrase 'Atypical eating disorders' is used, but it is not used here. This may create further confusion and a consistent approach should be adopted.	Thank you for your comment. The change in the definitions of eating disorders in the DSM, which is the most frequently used diagnostic system in this area, in its most recent edition (DSM-V) from EDNOS to OSFED makes it difficult to refer to eating disorders that do not conform to the three main categories of anorexia nervosa, bulimia nervosa and binge eating disorder. Thus the phrase 'atypical eating disorders' is intended to capture the disorders typically included in the categories if EDNOS (with the exception of BED) and OSFED.

620.	SH	BEAT	Short	18	21-22	The opportunity should be taken in section 1.6 to emphasise the importance of intervening early with children to reduce the risk of symptoms escalating and their eating disorder becoming more firmly rooted.	Thank you for your comment. Unfortunately the issue of early intervention was outside the scope of the guideline.
621.	SH	BEAT	Short	18	4	'Binge eating' should be replaced with 'binge eating disorder' as these are not interchangeable terms.	Thank you for your comment. The sentence is correct as it is.
622.	SH	BEAT	Short	18	5	The phrase "weight loss is a post-therapy target" should be reworded, perhaps to "weight loss is not a target of therapy for binge eating disorder" - this is because the guideline should not imply that all patients who have recovered from binge eating disorder should try to lose weight after therapy, especially given the well-documented risk of progression from obesity to a restrictive eating disorder.	Thank you for your comment. The text has been amended.
623.	SH	NHS Greater Glasgow and Clyde	Short	18	14	Treating other specified feeding and eating disorders (OSFED). We would suggest clarification and consistency regarding whether DSM5 or ICD 10 diagnostic criteria apply throughout this guidance.	Thank you for your comment. The committee decided that the use of 'OSFED' was appropriate given the wide use of the DSM categories.
624.	SH	BEAT	Short	18	17	The opportunity should be taken in section 1.5 to emphasise the severity of Other Specified Feeding and Eating Disorders (OSFED) and the importance of early intervention for this group of patients. This message is reflected in the full guideline but not here, and it is generally accepted that most readers will only look at the recommendations themselves. It is common for these patients to be denied access to treatment and these new guidelines should do	Thank you for your comment. Although early intervention is important, this issue is beyond the scope of the guideline. Regarding the treatment of OSFED, it is clear in the guideline that all people have the right to equal access to treatment. Although some people with OSFED may be denied treatment, this an implementation issue and therefore outside the scope of the guideline.

						everything possible to help address this inequity.	
625.	SH	BEAT	Short	18	17	The inclusion of the word 'consider' is inappropriate as it implies (at least to a lay reader) that it could be acceptable for a service to deny treatment to patients with Other Specified Feeding and Eating Disorders (OSFED). It is already common for these patients to be denied access to treatment and these new guidelines should do everything possible to help address this inequity. Another way to emphasise this point could be to spell out the guidance by stating: "If the patient with Other Specified Feeding and Eating Disorders (OSFED) has a set of symptoms which most closely resembles anorexia nervosa, then offer the treatments outlined in the recommendations in section 1.2. If the patient with Other Specified Feeding and Eating Disorders (OSFED) has a set of symptoms which most closely resembles bulimia nervosa, then offer the treatments outlined in section 1.3...".	Thank you for your comment. At several points the recommendations emphasise that treatment decisions should be made with the person with an eating disorder and that this should be performed with full information about the various treatment choices and any related support that may be needed provided as a matter of course.
626.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	18	9 & 10	We appreciate there is a lack of evidence base for treating Binge Eating Disorders (BED), but self-help and groups may not be feasible at younger ages. Low numbers of patients presenting at various points in the year will mean group treatments for BED as a whole are not feasible. Self-help and CBT are treatments that require considerable motivation on the part of the child/young person. If there is little motivation, FBT may be the only option but there is nothing else if this is not possible.	Thank you for your comment. Only one study was found that examined the efficacy of family therapy (in adults; Gorin et al. 2003). This study had a relatively small sample size (n=63) and showed no difference with another intervention. The Committee therefore decided not to recommend family therapy for the treatment of binge eating disorder in young people.

627.	SH	BEAT	Short	18	21	The inclusion of the word 'consider' is inappropriate as it implies (at least to a lay reader) that it could be acceptable for a service to deny treatment to children with eating disorders.	Thank you for your comment. The short and full guidelines are not intended for lay members without specialist medical knowledge. The guidelines follow NICE's preferred way of writing recommendations with 'consider' and 'offer' being used to indicate the increasing strength of evidence associated with the relevant recommendation. Please refer to *Developing NICE guidelines: the manual* available from the NICE website for more information. A version of the guideline 'Information for the public' intended for lay members without specialist medical knowledge is published by NICE and is also available from their website.
628.	SH	NHS Greater Glasgow and Clyde	Short	18	24	We felt that there may be a role for yoga as an adjunct to treatment (not treatment per say) as we have found it a valuable alternative to other forms of exercise and it helps build a healthier body image.	Thank you for your comment. Only one RCT was found that examined the effect of adjunctive yoga to treatment as usual compared with treatment as usual only in an eating disordered sample. However, no difference was found on any of the reported outcomes with the exception of a small improvement in EDE-restraint scores at 3-weeks follow up. The Committee thus felt that the evidence was not sufficient to make a recommendation to offer or consider yoga as such.
629.	SH	The Association for Family Therapy and Systemic Practice in the UK	Short	18	25	EMDR is classified as a physical therapy rather than a psychological therapy. This appears to be an error.	Thank you for your comment. The inclusion of the one study on EMDR in the physical interventions, rather than the psychological interventions, review was an error. However, as such, it would not have been included in the psychological interventions review as it only reported outcomes for body image memories.

630.	SH	Esoteric Practitioners Association	Short	18	25	We would like to enquire why physical therapies are not offered as part of treatment for eating disorders, as we have found body-focused modalities essential in supporting individuals to come into a deeper relationship with themselves and their bodies as part of the healing process. http://www.universalmedicine.net/chakra-puncture.html http://www.esotericyoga.com/esoteric-yoga.html	Thank you for your comment. The evidence review on physical interventions for eating disorders generally showed that they were not effective on the relevant critical and important outcomes and would therefore not be cost effective to offer.
631.	SH	Diabetes UK	Short	19	16-18	Diabetes clinicians must take responsibility for monitoring the physical health of people with diabulimia as poor diabetes management can lead to hyper- or hypoglycaemia, both of which can have serious medical consequences.	Thank you for your comment. Please note that the Committee has made a number of revisions on the management of diabetes for people with eating disorders, including a strong emphasis on the importance of collaboration between teams and some clarity regarding the division of labour between them.
632.	SH	South West London and St George's Mental Health NHS Trust	Short	19	Section 1.8 considered in general	Personality Disorders and Post Traumatic Stress Disorders are omitted from the list of relevant co-morbidities and yet are widespread and problematic co-morbidities when working with people with eating disorders. The guidelines in general appear to favour a narrow definition of a 'pure' Eating Disorder and a manualised treatment for same, when the presenting reality at service level is much more complex.	Thank you for your comment. The recommendation does not pick out any particular psychiatric comorbidity, mainly due to the fact that there was very little evidence on whether eating disorder treatments should be modified in the presence of such a morbidity.
633.	SH	BEAT	Short	19	2	This implies that eating disorders treatment is always delivered by 'specialists', which is inaccurate.	Thank you for your comment. The text has been amended.

634.	SH	NHS Greater Glasgow and Clyde	Short	19	5	Would it be possible to recommend which outcome measures are advisable for use to improve standardisation across the UK?	Thank you for your comment. Whilst the Committee acknowledged the profusion of outcome measures in the literature (in particular, the definition of remission), recommending particular outcome measures (to the exclusion of other measures) is beyond the scope of this guideline. That said, recommendation 1.1.16 recommends using standardised outcome measures such as the EDE-Q.
635.	SH	Mental Health Foundation	Short	19	10	We warmly welcome both the inclusion of diabetes in the guidance and the recommendation that eating disorder teams should be working in collaboration with diabetes teams. Although dia-bulimia is not in the DSM, it is a condition that has serious medical complications that require attention and understanding therefore it is important to have this integrated into the guidance.	Thank you for your comment. The committee have substantially revised a number of the recommendations about the management diabetes and have made specific reference to people with eating disorders and bulimia nervosa. The committee considered whether to use to the term 'diabullimia' but declined to do so on the grounds that it is not a recognised diagnostic category.
636.	SH	Oxford Health NHS Foundation Trust	Short	19	12	1.8.1 Physical and psychological comorbidity is very high amongst patients with eating disorders. It is important that care is not fragmented and that common comorbidities, such as depression, anxiety or physical complications are managed by the same team. Similar example would be managing comorbidities and complications in diabetes. In our experience general adult mental health service lack expertise managing comorbidities in eating disorders.	Thank you for your comment. Some recommendations are made concerning the coordination of care in the relevant sections/chapters in the short and full guideline.
637.	SH	BEAT	Short	19	26-18; 19	Physical health monitoring can often involve the General Practitioner (GP) however GPs are not mentioned in these two recommendations.	Thank you for your comment. The recommendation has been amended to be more inclusive.

638.	SH	British Psychological Society	Short	20	11 - 20	Only very limited recommendations are made around the issue of managing eating disorders when comorbid mental health problems are present. We appreciate that this is mainly due to a lack of available evidence, and indeed a research recommendation has been made around this issue. Nonetheless, it would be useful to highlight the key role of psychological formulation in guiding treatment plans for cases with significant comorbidity in the absence of a clear evidence base. Formulation has been defined as “a hypothesis about a person’s difficulties, which links theory with practice and guides the intervention… it summarises and integrates a broad range of biopsychosocial causal factors” (British Psychological Society, 2011). While there is an acknowledgement elsewhere in the guideline of the need to develop personalised treatment plans based on maintaining factors (p10, short version), it would be helpful to provide a more explicit acknowledgment of formulation as a key skill that should be promoted within eating disorder teams.	Thank you for your comment. Although psychological formulation - including the factors you have identified - and diagnosis are important elements to be considered when developing a treatment plan, this has not been specified as the guideline covers key functions as part of standard care for people with eating disorders in the NHS.
639.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	20	11-18	We feel this guideline is too vague and does not promote joint working between appropriate services. The need for regular joint meetings, a flexible approach and joint working protocols needs to be emphasised otherwise services abrogate responsibility or are uncoordinated.	Thank you for your comment. It is highly important for services to work together to ensure the highest quality care for people with an eating disorder. The need for collaboration between services has been emphasised at several points in the guideline, in particular regarding inpatient care, comorbidities, and care and discharge planning.

640.	SH	BEAT	Short	20	15-18	Perhaps a bullet point could be added to the effect of 'any interaction/influence between the comorbidity and the eating disorder' - An important issue to consider in this decision making could be to attempt to determine whether any co-morbidity pre-existed the eating disorder, is helping to maintain it or has been exacerbated by the eating disorder and whether or not the comorbid illness is likely to be alleviated through successful treatment for the eating disorder.	Thank you for your comment. The Committee recognised the dearth of evidence regarding a primary diagnosis of an eating disorder and a comorbidity and made a research recommendation in the hope that this would be rectified. The treatment of a primary diagnosis of another physical or mental health problem with an eating disorder comorbidity was outside the scope of the guideline.
641.	SH	British Psychological Society	Short	20	15-18	We would suggest an additional point: “the existence and severity of any history of PTSD or trauma” because some people with eating disorders have very severe histories of trauma that greatly hinder treatment. In some cases therapy for trauma may be required before eating problems can be addressed.	Thank you for your comment. Although there is a high level of comorbidity (such as PTSD) in people with eating disorders that can impact on their treatment and some people with eating disorders have a history of severe trauma, not all people with eating disorders have such histories. Hence the Committee refrained from making a specific recommendation regarding PTSD and trauma, instead making general recommendations to refer to the relevant NICE mental health guidelines and calling for more research to be done on the important topic of whether interventions for eating disorders should be modified in the presence of a comorbidity.
642.	SH	Diabetes UK	Short	20	5	We support the inclusion of education courses such as DAFNE but it must be made clear that they are not useful in the treatment stages of diabulimia, but can be helpful as a way of giving someone in the recovery phase the skills and confidence to manage their insulin dose appropriately.	Thank you for your comment. The recommendations for diabetes have been substantially revised and reference to DAFNE in the short guideline have been removed.

643.	SH	Diabetes UK	Short	20	6	Education about the consequences of diabulimia is not helpful as a way of changing behaviour and it can lead to increased fear and guilt and so may lead to disengagement with healthcare services.	Thank you for your comment. The text has been amended.
644.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	20	12	Given the over representation of personality disorder associated with eating disorder presentation within the day hospital and inpatient setting with associated high resource use, in addition to the outpatient population, it is disappointing that the guidelines do not provide specific recommendations or provide more detailed information about current best practice regarding treatment approaches in this population group. The use of DBT approach within multi impulsive bulimia for example? In our experience CBT-ED has higher dropout rates in this subpopulation and there is increased risk of behaviour substitution such as replacing binge purging behaviours with self harm and/or harmful substance/alcohol use.	Thank you for your comment. The evidence review on whether treatments for eating disorders should be modified in the presence of a comorbidity unfortunately did not yield sufficient studies on which to base a recommendation. It was noted that the majority of studies identified in the literature search for this review compared the efficacy of a 2 or more treatments in an eating disorder with a comorbidity group rather than the same treatment in an eating disorder with a corbidity group vs an eating disorder only group. However, the Committee recognised the importance of this issue and hence made a research recommendation to explore this issue further.
645.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	20	12	The same point as above re: associated ASD. It would be helpful to specifically have a committee view on how to adapt treatment approaches in those with autistic spectrum disorders.	Thank you for your comment. The evidence review did not find any studies that examined this issue. The Committee recognised that there was a dearth of evidence on whether eating disorder treatments need to be modified in the presence of a comorbidity and therefore made a research recommendation to this effect.
646.	SH	BEAT	Short	20	21	The 2004 guideline warned professionals about the risk of some drugs prolonging the QTc interval on the ECG and it also stated that "All patients with a diagnosis	Thank you for your comment. The Committee considered the relative risks associated with the use of psychotropic medication in people with an eating

						of anorexia nervosa should have an alert placed in their prescribing record concerning the risk of side effects". Why have these recommendations not been retained in this draft?	disorder, including anorexia nervosa, and in light of this and other comments, the recommendations have been revised.
647.	SH	Mental Health Foundation	Short	20	26	We welcome that the guidance considers how medication might impact an individual in relation to weight and how this might impact their appearance.	Thank you for your comment.
648.	SH	College of Mental Health Pharmacy	Short	21	4-7	Add: *Offer ECG monitoring for people with an eating disorder who are shown to have hypokalaemia*	Thank you for your comment. The text has been amended to mention hypokalemia.
649.	SH	Oxford Health NHS Foundation Trust	Short Full	21 974	4 36	In 'Medical Risk Management' – recommendation 35 is to offer ECG to those taking medication that compromise their cardiac function. It would be helpful to specify whether this should be undertaken by a specialist ED team or primary care (i.e. GP).	Thank you for your comment. The Committee wished to remain neutral as to who should be doing this and viewed it as a matter for local determination.
650.	SH	BEAT	Short	21	14	Why was the term 'consider' used here in place of 'offer'? For example, if this patient is referred to a substance misuse service initially, a multidisciplinary approach may prove decisive in ensuring that the patient is then able to access treatment for their eating disorder without delay following discharge from the substance misuse service.	Thank you for your comment. The recommendations follow NICE's preferred way of stating them, see *Developing NICE guidelines: the manual* for further information, which is available from the NICE website.. In particular, 'offer' and 'consider' are used to indicate the level of certainty, where the former indicates a high degree of certainty (e.g. where the benefits clearly outweigh the harms) and the latter indicates a lower degree of certainty (e.g. where there is a balance between benefits and harms to be thought about). As the evidence for this recommendation was not of good quality the term consider was used,

651.	SH	Oxford Health NHS Foundation Trust	Short	21	19	1.8.18 Monitoring weight and height should be mandatory for all children with eating disorders. Otherwise developmental delay won't be recognised.	Thank you for your comment. The recommendations concerned with treatment or management, weight gain, and the monitoring of weight and eating, are all essential parts of the therapeutic interventions that have been recommended in this guideline. The importance of measuring and monitoring height is captured by other recommendations (see initial assessments in primary and secondary care, assessment and monitoring of physical health in anorexia nervosa).
652.	SH	Oxford Health NHS Foundation Trust	Short	21	21	The *Antenatal and postnatal mental health: clinical management and service guidance* (NICE, 2014, p.35) recommends the following psychological interventions: 1.8.11 For a woman with an eating disorder in pregnancy or the postnatal period: offer a psychological intervention in line with the guideline on eating disorders (NICE guideline CG9) It is therefore important that these new guidelines clarify whether psychological treatment should be offered in pregnancy or the postnatal period.	Thank you for your comment. The recommendations for the treatment of eating disorders pregnant women have been substantially revised.
653.	SH	BEAT	Short	21	27	In this bullet point the word "bingeing" should be replaced with "binge eating"	Thank you. This has been amended
654.	SH	BEAT	Short	21	28	This could also include diuretic misuse, fasting and perhaps also the use of diet pills.	Thank you for your comment. The list is not intended to be exhaustive.
655.	SH	BEAT	Short	22	15-17	General Practitioners (GPs) should assess fluid and electrolyte balance, regardless of whether or not the patient has informed them that they have been engaging in compensatory behaviours.	Thank you for your comment. The text has been amended.

						The patient may not have disclosed their use of compensatory behaviours to the GP (or any other health professional). The fluid and electrolyte results may suggest the presence of these behaviours and help the GP to identify them through subsequent communication with the patient about the results.	
656.	SH	BEAT	Short	22	6	We welcome this recommendation, however argue that this section should also instruct professionals to be aware of the risk of relapse or deterioration of the patient's health post-pregnancy, considering concern they may feel about changes to weight and shape which have resulted from the pregnancy, as well as post-pregnancy changes in hormone levels.	Thank you for your comment. The Committee has developed new recommendations that set out how a mother's health should be monitored during pregnancy and the perinatal period.
657.	SH	British Society of Gastroenterology	Short	22	Line 3–6	Offer ECG monitoring for people with an eating disorder who are taking medication that can compromise cardiac function for example bradycardia 50 beats per minute or prolonged QT interval. This needs to be clearer. What type of ECG monitoring is meant? Does this refer to holter monitoring or ambulatory monitoring or is it referring to static ECG monitoring which can only be carried out in an inpatient setting. The current paragraph lacks clarity.	Thank you for your comment. It is expected that healthcare professionals using this guideline will be competent to decide which type of ECG monitoring is appropriate.
658.	SH	BEAT	Short	22	13	Recommendations 1.10.2 - 1.10.7 refer to several different health professionals as having responsibility for these elements of health monitoring, using the word 'or' and with no instruction on whether a specific individual should be	Thank you for your comment. The recommendations have been amended to remove reference to who should be conducting the assessment. The importance of collaboration between services and working within multi-

						named to oversee this monitoring. None of these recommendations refer to the importance that these professionals work collaboratively to coordinate the implementation of these recommendations. Perhaps the word 'and' could be used in place of 'or', so that for example recommendation 1.10.2 would become "GPs, paediatricians and psychiatrists should think about the need for acute medical care (including emergency admission) for people with...". Perhaps a reference could be included to the Care Programme Approach (CPA) in this section of the recommendations.	disciplinary teams has been emphasised in several of the recommendations in this guideline. Unfortunately, the application of the CPA, which supports coordination of care in specialist mental health services, is outside the scope of this guideline.
659.	SH	Oxford Health NHS Foundation Trust	Short	22	15	1.10.1 Please add: level of malnutrition using the MUST tool http://www.bapen.org.uk/pdfs/must/must_full.pdf	Thank you for your comment. The Committee declined to include reference to the BAPEN MUST tool as the assessment of malnutrition is covered by MARSIPAN.
660.	SH	Oxford Health NHS Foundation Trust	Short	22	18	1.10.2 Please add acute hospital and extreme malnutrition (BMI<15) as explained above.	Thank you for your comment. A reference to extreme malnutrition has been added to the text.
661.	SH	Oxford Health NHS Foundation Trust	Short	22	22	1.10.3. Please add acute hospitals.	Thank you for your comment. The text has been amended to be less specific about who should be conducting the assessment.
662.	SH	NHS Greater Glasgow and Clyde	Short	22	26	Dietitians would not (in our area) usually be prescribing supplements this would be via the patients GP.	Thank you for your comment. The text has been amended.
663.	SH	NHS Greater Glasgow and Clyde	Short	22	27	We agree that supplements to restore electrolyte balance should be offered orally unless the person has problems with gastrointestinal absorption, but also suggest also the severity of the electrolyte disturbance also should be taken into account as this can also	Thank you for your comment. The text has been amended.

						indicate alternative routes including intravenous to be the route of choice.	
664.	SH	BEAT	Short	23	1-14	Definitions should be provided for these terms to help avoid misunderstanding and assist General Practitioners (GPs) and other non-specialists.	Thank you for your comment. NICE does not typically provide a glossary of terms for the short guideline. Moreover, the committee did not wish to be too prescriptive, wanted to allow room for clinical judgement, and it is expected, in any case, that the healthcare professionals listed in the recommendations will know the terms. Please note that there is a glossary in the full guideline.
665.	SH	Oxford Health NHS Foundation Trust	Short	23	1	1.10.5 Please add: acute medicine and gastroenterologists.	Thank you for your comment. The recommendation has been revised to be less specific about who should be conducting the assessment.
666.	SH	BEAT	Short	23	7	This bullet point could perhaps also include the use of diet pills.	Thank you for your comment. No amendment was made because the bullet point as it is - "prescribed or non-prescribed medications" - includes this.
667.	SH	College of Mental Health Pharmacy	Short	23	11	• *Prescribed or non- prescribed medicines especially those known to prolong the QTc interval*	Thank you for your comment. This is covered in the section on inpatient and day patient treatment.
668.	SH	College of Mental Health Pharmacy	Short	23	13	• *Electrolyte imbalance especially hypokalaemia*	Thank you for your comment. This is covered in the section on medication risk management.
669.	SH	Mental Health Foundation	Short	23	15	We welcome the inclusion of advice around teeth brushing; this has been a notable gap in guidance up until this point.	Thank you for your comment.
670.	SH	Mental Health Foundation	Short	23	25	We would like to see more detail around how and when to decrease the use of	Thank you for your comment. Apart from if reported in the identified studies for the relevant evidence reviews, a detailed

						laxatives included in the short version of the guidance.	consideration of this issue was outside the scope of this guideline
671.	SH	BEAT	Short	23	26	In parallel to recommendations 1.10.6 and 1.10.7 for vomiting and laxative misuse, there should also be recommendations concerning diuretic misuse, over-exercise and perhaps also for the use of diet pills, given the importance of these forms of 'compensatory behaviour' for many patients.	Thank you for your comment. The Committee acknowledged your point and consequently have revised the recommendation about laxative misuse to include reference to diuretics; a recommendation has also been inserted regarding over-exercising. These recommendations were based on the informal consensus of the Committee, using their knowledge and experience. Regarding the use of diet pills, these are illegal in the UK and their use is outside the scope of the guideline.
672.	SH	NHS Greater Glasgow and Clyde	Short	23	1,15,21	Should we not be stating 'All health professionals' instead of listing a few so that the importance of this is emphasised and someone does not do it because they aren't included in the list ?	Thank you for your comment. The text has been amended to obviate this issue.
673.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	24	18-29	Interpreting Bone Density scans in young people is difficult and many adult scanning units interpret adolescent results comparing to adult data, so it is inaccurate. Paediatricians who have expertise in interpreting Bone Density Scans should be involved with all patients with abnormal scan results. There needs to be specific guidance about bone density scans in boys and young men as these patients are often forgotten. Guidance is also needed about when to do Bone Density scans in young girls who have not yet started their periods (primary amenorrhea).	Thank you for your comment. The recommendations regarding bone density have been substantially revised.
674.	SH	BEAT	Short	24	18-24	The guideline should not tie decisions of when to carry out bone mineral density	Thank you for your comment. The Committee agreed to focus on longevity

						scans with amenorrhea, as a woman can still be menstruating and experience bone mineral density loss. Also, duration of amenorrhea is an unreliable indicator of bone mineral density. It is unclear what justification there is for the difference in monitoring suggested between 17 and 18 year olds, this appears to ignore developmental differences between patients. Lastly, this wording implies that these scans should be ceased as soon as bone mineral density appears to be within a healthy range, however it would be good practice to carry out further scans at a later date as part of follow up to monitor the stability of recovery.	of underweight, differentiated by children/young people and adults, rather than amenorrhea. They were also more conservative in their recommendations for repeat measurements. They felt that it is not appropriate to use an investigation that uses radiation, given that any intervention for bone mineral density would be based on establishing a healthy weight.
675.	SH	British Psychological Society	Short Full	24 22 354 355	2-5 15 onwards	Within point 1.10.1 Health Monitoring, and specifically 1.10.9, the guideline says, “GP’s should offer a physical and mental health review at least annually to people with anorexia nervosa who are not receiving on-going treatment….” Experience in our services suggests that GP’s could take this as a maximum or a standard approach, whereas for safety it is crucial that they exercise their clinical judgment given all the facts of the case and follow individualised care plans. This would also undermine the capacity for primary care to offer the services that are described in the Full Guidelines under section 6.8 Management of Long and Short term Complications. We recommend that this be clarified in the guideline.	Thank you for your comment. The recommendations have been revised to remove reference to who should be conducting the assessment and monitoring, thus obviating your concerns.

676.	SH	Surrey & Borders Partnership NHA Foundation Trust	Short	24	2-3	Annual GP review is not often enough for these patients who are often at high physical risk. Anorexia has the highest mortality of all mental health disorders and the mortality is for both suicide and due to physical concerns so they need to be monitored very closely. Quarterly is more appropriate.	Thank you for your comment. The recommendation specifies that a physical and mental health review should occur *at least* once a year. Although there are some people who will need a review more frequently than this, depending on severity of illness, it is expected that GPs will use their judgement in conjunction with the person's informed choice to determine how frequently such reviews are needed.
677.	SH	BEAT	Short	24	2	This recommendation should also stipulate that General Practitioners (GPs) should offer these patients information about their condition and sources of support, including pro-recovery peer support (which is moderated if online) and is facilitated by an appropriately trained and supervised individual/s.	Thank you for your comment. The Committee have explicitly recognised, in the general principles section at the beginning of the short guideline, the need that people with an eating disorder, and their families or carers (if appropriate), should receive information and support as a matter of course. Regarding the remark about the individual providing this information and support, it is a requirement in the NHS that any person providing care is competent to do so.
678.	SH	Mental Health Foundation	Short	24	2	We would like to see the section on anorexia recognise other forms of purging, for example, including excessive exercising.	Thank you for your comment. No amendment was made as the reference to purging behaviours without specification of any particular form of purging was considered sufficient.
679.	SH	Mental Health Foundation	Short	24	2	We would like to see suicidal thoughts included in this section. The use of the word ‘mood’ is too broad therefore argue it should be removed.	Thank you for your comment. No amendment was made as the bullet point 'assessment of risk (related to both physical and mental health)' is sufficient to cover the point raised.
680.	SH	BEAT	Short	24	3	These reviews should be offered to the patient more regularly (certainly more frequently than annually), given the capacity for rapid and severe	Thank you for your comment. The recommendation states that the minimum frequency for a physical and mental health review of anyone with an eating

						deterioration in symptoms and the likelihood that some of these patients will be ambivalent about attending such a review. To quote one of our supporters: "As someone who has had an ED for over 30 years...An offer of an annual physical review wouldn't pick up the changes in a person's physical state…Physical changes may indeed occur with rapid deterioration and if offered annually would be akin to allowing high risk to a person's life. An invitation needs to be followed up if possible via the patient's care co-ordinator. There are too many places in which a person in the community will slip through the net."	disorder is one year. Although there are some people who will need a review more frequently than this, depending on severity of illness, it is expected that GPs will use their judgement in conjunction with the person's informed choice to determine how frequently such reviews are needed. Please note that it is emphasised in the recommendations in the general principles section of the guideline that particular care should be taken to ensure that services work together.
681.	SH	Mental Health Foundation	Short	24	3	We are very concerned that the guidance suggests annual physical and mental health review to those not receiving ongoing treatment for their eating disorder. We would like to see guidance stipulate that contact with a health practitioner is necessary once a week.	Thank you for your comment. The recommendation specifies that a physical and mental health review should occur *at least* once a year. However, the suggestion made that every person with an eating disorder should see a health professional once a week would impose a substantial practical and financial burden on such professionals regardless of the severity of illness or the needs of the person with the eating disorder. It is expected that health care practitioners will use their judgement in conjunction with the person's informed choice to determine how frequently such reviews are needed.
682.	SH	Oxford Health NHS Foundation Trust	Short	24	6	1.10.9 For young people it needs to include height and BMI centiles	Thank you for your comment. The text has been amended.
683.	SH	BEAT	Short	24	9	This should go beyond 'mood' to a consideration of common co-morbid	Thank you for your comment. The text has been amended.

						mental health problems including (but not limited to) anxiety, depression, Obsessive Compulsive Disorder (OCD), low self-esteem.	
684.	SH	NHS Greater Glasgow and Clyde	Short	24	15	We agree that monitoring physical and mental health is essential but suggest, in addition, regular risk assessment (with reference to MARSIPAN and appendix of physical risk assessment format) and review of the patient's management, by all health professionals involved in the patient's care, for patients having psychological interventions for anorexia nervosa.	Thank you for your comment. Risk assessment and review of a person with an eating disorder receiving inpatient care (in particular MARSIPAN) is addressed in the recommendations on inpatient and day patient treatment.
685.	SH	BEAT	Short	24	16	This recommendation could be more useful for General Practitioners (GPs) if it specified some of the indicators of increased risk or included a link to information about this. This recommendation should also remind the GP of the need to be alert to the risk of suicide.	Thank you for your comment. This information appears in other sections of the guideline (e.g. assessment and monitoring), which can be consulted as needed.
686.	SH	NHS Greater Glasgow and Clyde	Short	24	18	This is different for patients in Greater Glasgow and Clyde where Endocrinologists working within Bone Mineral Metabolism clinics are no longer suggesting routine and repeat Dexa Bone Scans for younger adult patients with anorexia nervosa and amenorrhoea (with no other risk factors) at risk of low bone mineral density. This is because there it is considered there is no indication for active treatment at this stage aside from nutrition and weight restoration.	Thank you for your comment. The text has been amended to read "consider". However, the measurement of bone mineral density in underweight patients with eating disorders is considered by many to be useful for supporting a better understanding - by patients and families, and those treating them - of what the risks are associated with their low weight. Moreover, as considered in the guideline, there is now some evidence that oestrogen therapy is effective in young females with long standing low bone mineral density on some BMD outcomes and weight change.

687.	SH	BEAT	Short	24	19; 21	This recommendation and others on bone health or osteoporosis should not only refer to women, as low bone mineral density can affect males too.	Thank you for your comment. The text has been amended to focus on underweight people and have made all recommendations to apply to both sexes (except for oestrogen therapy which only applies to women.).
688.	SH	BEAT	Short	24	20; 22	The phrase "…even if the person gains weight" is vague. This could instead read "…even if the person's weight is restored" to emphasise that there is not a reliable correlation between weight restoration and bone mineral density.	Thank you for your comment. The text has been amended. See also the section on interventions for bone mineral density.
689.	SH	BEAT	Short	25	2-5	The word 'consider' should be replaced with "offer" in this recommendation. If a patient with an eating disorder was medically unstable and it was deemed impossible to achieve medical stability and refeeding through outpatient care ("if these cannot be done in an outpatient setting") then it would be dangerous not to 'offer' inpatient or day patient care.	Thank you for your comment. The wording of recommendations is required to follow methods outlined in "Developing NICE guidelines: the manual".
690.	SH	BEAT	Short	25	6-9	This is an important recommendation; however, it could be significantly strengthened in respect of location of the treatment. The current wording of "as near to their home as possible" is meaningless, given that in practice this can mean hundreds of miles from home. This has been illustrated recently by several cases documented in the national press, including a young patient from the South of England who received inpatient care in Scotland (as this was the nearest available to her home). Recommendation 1.2.5.4 in the 2004 Guideline was much more specific and stronger (although for some reason it referred exclusively to patients with anorexia nervosa) which	Thank you for your comment. Please note that the recommendation has been amended. Whilst your concerns are acknowledged, NICE guidelines are intended to specify best practice. Whilst it is clear that the provision of services across the country can vary widely, the availability of services is an implementation issue and therefore outside the scope of the guideline.

						read: "Where inpatient management is required for people with anorexia nervosa, this should be provided within reasonable travelling distance to enable the involvement of relatives and carers in treatment, to maintain social and occupational links and to avoid difficulty in transition between primary and secondary care services. This is particularly important in the treatment of children and adolescents".	
691.	SH	BEAT	Short	25	6-9	Admission to age-appropriate inpatient treatment or day patient care, within reasonable travelling distance should also be available to adults with eating disorders. Section 1.11 only confers this right upon children and adolescents.	Thank you for your comment. The text has been amended.
692.	SH	BEAT	Short	25	12-13	When deciding whether to use day patient or inpatient care, professionals should also take into account whether removal from the home environment is likely to help or hinder recovery. In some instances, support and continued contact with friends and family can be the biggest driver of recovery. For some patients, if this is taken away they may lose sight of the aim of recovery.	Thank you for your comment. Day patient or inpatient care is only recommended for medical stabilisation or for refeeding if it cannot be performed in an outpatient setting.
693.	SH	BEAT	Short	25	16-17	The line: "…be aware that there is no absolute weight or Body Mass Index (BMI) threshold for admission" should be changed to: "be aware that there should not be an absolute weight or BMI threshold for admission" as unfortunately, in practice such thresholds are commonly applied.	Thank you for your comment. The wording has been amended.
694.	SH	BEAT	Short	25	29-30	Shouldn't this recommendation also apply to services which provide day patient care?	Thank you for your comment. Both inpatient and day patient care are included.

695.	SH	South West London and St George's Mental Health NHS Trust	Short	25	Section 1.11 considered in general	We are concerned that this recommendation may imply that the psychological therapies mentioned under 1.2 are the only ones that may be applied in inpatient settings. The guidelines fail to refer to the need for a range of psychological therapies on inpatient wards to improve engagement and access and choice; there being very scarce evidence in support of any one model, partly because of the complexities of researching impact in isolation from other milieu interventions	Thank you for your comment. The evidence that compared the success of inpatient psychological treatment with outpatient psychological treatment was reviewed and generally found either no difference in the outcomes or that outpatient treatment was favoured. The interventions included family therapy, group therapy, interpersonal therapy and CBT-ED. All the types of therapy were reviewed in other sections of the guideline. Please note that the recommendations for inpatient psychological treatment have been updated to make clearer when and for what reasons an individual should be admitted for and discharged from inpatient treatment; further recommendations have also been made regarding care plans for those receiving inpatient care.
696.	SH	NHS Greater Glasgow and Clyde	Short	25	3	For people with an eating disorder and compromised physical health, consider inpatient treatment or appropriate day patient care but would suggest that the addition “dependent on resources”.	Thank you for your comment. Although this may be an issue, the recommendations reflect what is to be considered current best practice.
697.	SH	Oxford Health NHS Foundation Trust	Short	25 & 10	1–5 & 8	It is not clear in which setting psychological intervention should be offered for AN. There appears to be an emphasis on shorter admissions and perhaps a sense that psychological intervention should not be primarily delivered in an inpatient setting. It would be good to have more clarification on how to integrate psychological input in different settings depending on stages of the illness.	Thank you for your comment. The recommendations have been revised to make clear that although inpatient treatment should be avoided if possible, psychological treatment could - in line with NHS policy - be continued or started in an inpatient context depending on the circumstances.

698.	SH	Oxford Health NHS Foundation Trust	Short	25	6	1.11.2 The short draft is not sufficiently clear that medical stabilisation for anorexia nervosa with short duration and without co-morbidity is the treatment of choice (this is clearer in the long version). The potential disadvantages of inpatient treatment for adolescents are not sufficiently clear. It is also not sufficiently clear when a young person should be admitted to a paediatric or a psychiatric setting.	Thank you for your comment. The recommendations have been revised to make them clearer. In particular, more detail has been provided regarding care planning, and the criteria for admission to and discharge from inpatient or day patient care.
699.	SH	Royal College of Nursing	Short	25	6	What about adults with eating disorder requiring hospitalisation? In-patient care for adults often means that they are separated from their children and this can have a profound effect on the mother: child relationship. It should be recommended that a separate area be made available for children's visits, away from the ward.	Thank you for your comment. You have raised an important issue but this matter is for local services to determine how children with eating disorders should be managed.
700.	SH	Oxford Health NHS Foundation Trust	Short	25	10	In our experience acute psychiatric services struggle to manage patients with eating disorders. This is related to lack of relevant training both for nursing and medical staff.	Thank you for your comment. The Committee has in several places stressed the importance that staff working with people with eating disorders must be competent to deliver the relevant interventions, work within multidisciplinary teams and ensure that services are well coordinated. Although staff in acute psychiatric services can struggle to manage people with eating disorders, it is expected that all staff working within the NHS are trained and competent to deliver any interventions/advice that they are expected to deliver and that implementing training is a matter of local service determination.

701.	SH	BEAT	Short	25	11	The use of the word 'consider' here is concerning. This recommendation should clearly state that these patients must be offered treatment and to do otherwise would be negligent.	Thank you for your comment. 'Consider' is used instead of 'offer' to reflect the strength of the evidence in accordance with methods outlined in "Developing NICE guidelines: the manual".
702.	SH	BEAT	Short	25	12	This recommendation should also include the following factors to consider: the patient's motivation levels/self-efficacy and psychological risk.	Thank you for your comment. The recommendations have been substantially revised.
703.	SH	BEAT	Short	25	15	The guideline must be clear that a patient's Body Mass Index (BMI) or weight should not have to be BOTH below the safe range and rapidly dropping for them to be able to access inpatient or day patient care.	Thank you for your comment. The text has been revised to make this clearer.
704.	SH	Oxford Health NHS Foundation Trust	Short	25	26	1.11.5 Psychological treatment is part of inpatient treatment in specialist eating disorder units. It would be difficult to deliver psychological therapies in acute hospital settings when the patient is very unwell. This recommendation may raise unrealistic expectations. As it was pointed out earlier, there have been no RCTs involving patients who have extreme severity.	Thank you for your comment. The guideline is intended to characterise current best practice. The Committee recognised that there is wide variation across the country in the types of services available to individuals and that not all trusts may be able to provide psychological therapy in an inpatient context as a matter of course.
705.	SH	Royal College of Nursing	Short	25	26	Section 1.11.15 *"If a person is admitted for physical health problems caused by an ED then start or continue psychological therapy if appropriate"* What does this mean, as all patients admitted to hospital with severe anorexia nervosa have physical health problems – admission these days is only for very severely ill cases, (particularly for adults as the threshold for Child and Adolescent Mental Health Service (CAMHS) is different).	Thank you for your comment. Although this recommendation follows on from previous recommendations that describe which type of patient is admitted for inpatient care, it also needs to stand alone to ensure that only patients admitted with physical health problems receive inpatient psychological treatments. The "if appropriate" wording should take into account those who unable to engage in formal psychological therapy

						People in hospital at low weights on one hand lack capacity and the ability to engage in formal psychological therapy, but on the other do need skilled psycho-social and motivational interventions (mostly delivered by nurses) to be able to restore their weight.	
706.	SH	Oxford Health NHS Foundation Trust	Short	25	29	1.11.16 This statement would require some elaboration. It is unclear why the Committee felt that this is necessary: to our knowledge, there are no inpatient units in the UK only providing psychological treatment for patients for anorexia nervosa. However, psychological treatment is essential part of inpatient treatment – and continuity before and after admission is crucially important. Inpatient CBT-E for example is a more intensive form of outpatient CBT-E (see Dalle Grave, *2012. Intensive cognitive behaviour therapy for eating disorders)*	Thank you for your comment. Having considered the evidence, the Committee did not believe that it was appropriate for inpatient care to be used solely for the provision of psychological or other interventions to treat the eating disorder in the absence of significant risk to the individual's physical health (e.g. urgent need for medical stabilisation). Although a number of recommendations directly address the issue of medical stabilisation the Committee nevertheless agreed that, in order to support the best use of healthcare resources, it should be made clear that the provision of psychological and related interventions should not be sole reason for admission to inpatient care. Regarding the study of Dalle Grave 2012/2013, whilst this was examined in the evidence review, the Committee did not believe they could recommend inpatient psychological treatment in an inpatient setting (for people with BMI<16.5) in lieu of more evidence.
707.	SH	Oxford Health NHS Foundation Trust	Short	25	12–25	1.11.4 We feel there is no clear indication on when Day patient settings should be considered as opposed to Inpatient settings. The listed criteria are generic to define a patient at increased risk and therefore the need to consider more	Thank you for your comment. The recommendations have been substantially revised. Given the current wide variation in eating disorder services in the country, the Committee decided to not provide further detail.

						intensive input but there is no distinction between suitability/indication specifically for day patient care.	
708.	SH	BEAT	Short	26	1-3	This recommendation should specify that in the case of children and young people, inpatient services should ensure that parents and carers (where appropriate) can access guidance and support regarding post-discharge meal times. Feeding at home after the patient leaves [inpatient] treatment is often anxiety provoking for families and they are often given little guidance and support.	Thank you for your comment. The Committee recommends in the section on working with family members and carers that family/carers are offered assessments of their own needs including the impact of the disorder and any support they may need.
709.	SH	BEAT	Short	26	1	This recommendation should also apply to services which provide day patient care. Either this recommendation or 1.11.10 (page 26, lines 14-15) should also be reworded to provide patients with a stronger case to access community-based treatment after they have been discharged from inpatient care. The 2004 guideline is stronger in this area asserting in recommendation 1.2.2.11 that "Following inpatient weight restoration, people with anorexia nervosa should be offered outpatient psychological treatment...".	Thank you for your comment. The text has been amended as suggested.
710.	SH	British Association for Parenteral and Enteral Nutrition (BAPEN)	Short	26	4	In the section on re-feeding there is mention of the MARSIPAN guidance and also I would recommend that the NICE guidance on nutrition support in adults (Quality standard [QS24]) is also referred to as this is also relevant and the MARSIPAN guidance comes originally from this NICE guidance. This also applies to the full version document.	Thank you for your comment. The committee considered your suggestion but decided that the reference to MARSIPAN is sufficient.

711.	SH	NHS Greater Glasgow and Clyde	Short	26 25	4 22	Dietitians are not mentioned in the Refeeding section which we believe is an omission. We feel that since the document regularly refers to the MARSIPAN guidelines that this could be included in the appendices or even that the boxes referred to from MARSIPAN could be included.	Thank you for your comment. The recommendation made is in line with MARSIPAN, which recommends that staff (which may include dietitians) are appropriately trained. Indeed, reference is made to MARSIPAN and Junior MARSIPAN in the recommendations on refeeding and provide an electronic link to them in the document.
712.	SH	BEAT	Short	26	5	This recommendation should also apply to services which provide day patient care.	Thank you for your comment. The text has been amended as suggested.
713.	SH	Oxford Health NHS Foundation Trust	Short	26	5	1.11.8 This should also apply to acute hospitals, which often have nutritional teams. Please refer to the relevant NICE guidelines https://www.nice.org.uk/guidance/QS24/chapter/Introduction-and-overview	Thank you for your comment. The text has been amended as suggested.
714.	SH	BEAT	Short	26	10	We would prefer a stronger endorsement of the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) and Junior MARSIPAN guidelines as they were specifically developed to address these risks and were endorsed by the Royal College of Psychiatrists, Royal College of Physicians and the Royal College of Pathologists. We suggest replacing the words 'for example' with 'including'. This recommendation could also refer to liaison with the local MARSIPAN group (if available) and use of local MARSIPAN implementation plans (if available).	Thank you for your comment. The text has been amended.
715.	NICE	NICE Social care	Short	26	13	Should there be reference to NICE guidance on hospital discharge/MH Hospital discharge?	Thank you for your comment. The committee was of the view that there are specific and particular problems that relate to the management of people with

							eating disorders, not covered by the NICE guideline NG53 on hospital discharge to community or care home settings. Therefore the Committee made specific recommendations (which have been substantially revised to make them clearer) for care planning and discharge from inpatient care.
716.	SH	BEAT	Short	26	14	The guideline should make recommendations for the core components required in a post-discharge care plan. Did the committee consider endorsing the use of the Care Programme Approach (CPA)?	Thank you for your comment. New recommendations have been introduced regarding discharge planning and overall care planning and support. Unfortunately, the application of the CPA, which supports coordination of care in specialist mental health services, is outside the scope of this guideline.
717.	SH	Oxford Health NHS Foundation Trust	Short	26	14	1.11.10 Please add setting: this applies for acute hospitals as well as specialist eating disorder services.	Thank you for your comment. The text has been amended as suggested.
718.	SH	Oxford Health NHS Foundation Trust	Short	26	27	1.11.13 Discharge planning should always include risk indicators, patient preferences and aftercare services available.	Thank you for your comment. The text has been amended as suggested.
719.	SH	BEAT	Short	27	22-29	We object in the strongest possible terms to this description of eating disorders. If adopted in its present form (and particularly if included in the lay 'Information for the public' version) it will reinforce misunderstanding and stigmatising attitudes. There are a wide range of biological, psychological and environmental/social factors which can contribute to the cause and maintenance of an eating disorder. Eating disorders are serious and complex mental illnesses. This description reduces them to people choosing to adopt behaviours like restriction in order to 'look like	Thank you for your comment. The text has been amended.

						models'. It then says that "emotional consequences" are experienced as a result of the beliefs and behaviours, without explaining that commonly emotional distress precedes the development of the eating disorder. To quote one of our volunteers, who has had an eating disorder herself: "The belief that it is important to have a particular body type is generally secondary or even tertiary to more embedded belief systems that the sufferer is not good enough/lacks value/is a failure etc. Seeking a particular body type is merely the consequence of the primary belief system that is driving the disordered eating behaviour."	
720.	NICE	NICE Social care	Short	27	1-7	This paragraph seems problematic in that it seems to assume that the person has a mental health problem or lacks capacity if they refuse treatment. Neither of these things may be true and the presumption under the Mental Capacity Act is that people do have capacity unless proven otherwise, and may make 'unwise decisions'. This needs to be looked at carefully.	Thank you for your comment. The mere presence of a mental disorder does not entail that the person lacks capacity and indeed this is not the point of the recommendation. It is made clear that the Mental Health Act should be applied in situations where the individual lacks capacity and that the determination of this issue should be made within the appropriate legal framework. This would require considering the issue capacity as specified in the Mental Capacity Act. As such, providing advice on the use of the Mental Capacity Act is beyond the scope of this guideline.
721.	SH	BEAT	Short	27	13-14	Could the committee add any detail to this recommendation on how competency in feeding people without their consent should be defined, assessed and monitored?	Thank you for your comment. It is a requirement of the NHS that staff are trained appropriately to deliver any interventions that they in fact deliver and it would be expected that staff delivering treatment to people with eating disorders would be similarly trained.

722.	SH	BEAT	Short	27	1	Did the committee consider referring to Community Treatment Orders (CTO)? Some patients may actually request to be given a CTO on discharge, out of concerns about being able to rapidly access readmission if their condition was to deteriorate again in future. It may be useful to refer to recommendations 1.6.10-1.6.12 in Nice Guideline 53 concerning CTOs.	Thank you for your comment. The Committee discussed whether specific mention should be made of community treatment orders, which are covered by the Mental Health Act (please see the relevant LETR). However, there does not appear to be any evidence that they are effective (at least in the context of eating disorders) and some evidence (in people with psychosis) that they are not effective (see Burns, T., Rugkåsa, J., Molodynski, A., Dawson, J., Yeeles, K., Vazquez-Montes, M., ... & Priebe, S. (2013). Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. The Lancet, 381(9878), 1627-1633.). The Committee therefore decided not to make mention of CTOs. The Committee agreed that there were aspects relating to discharge planning that were specific to people with eating disorders not covered by NICE guideline NG53 and therefore decided to develop the specific recommendations presented in the guidelines.
723.	SH	BEAT	Short	27	1	This section could be strengthened through the inclusion of a recommendation for non-specialist clinicians to seek advice from experienced specialists when making decisions about compulsory treatment and application of the Mental health act. Recommendation 1.2.5.6 in the 2004 NICE Guideline (although for some reason it referred exclusively to patients with anorexia nervosa) stated: "Healthcare professionals without specialist experience of eating disorders,	Thank you for your comment. The Committee considered your suggestion but decided to stay with the original recommendation as the relevant legal framework provides ample opportunity for second opinions and other considerations to play a role in the decision of whether to detain someone for treatment against their will.

						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." Recommendation 1.2.6.6 from the 2004 Guideline is also relevant to this point.	
724.	SH	Mental Health Foundation	Short	27	15	We would like to highlight that no definition is provided for the term adult, while definitions are provided for both children and young people.	Thank you for your comment. The text has been amended.
725.	SH	Mental Health Foundation	Short	27	22	We contest the notion that people with eating disorders are striving to achieve a particular body type – eating disorders are psychological illnesses and should not be interpreted as a means through which to lose weight/diet, which the guidance can be seen to suggest. This section also only allows us to consider anorexia. Most people with an eating disorder are a normal weight and this is not reflected in this part of the guidance.	Thank you for your comment. The text has been amended.
726.	SH	Oxford Health NHS Foundation Trust	Short	27	28	Please replace starvation with malnutrition. http://www.bapen.org.uk/how-good-is-your-nutritional-care	Thank you for your comment. The text has been amended. The Committee declined to include reference to the BAPEN MUST tool as the assessment of malnutrition is covered by MARSIPAN.
727.	SH	Anorexia and Bulimia Care	Short	27	22–23	You have stated in the 'context' section that people with eating disorders believe it is important to have a 'particular body type'. We are concerned with this statement as it seems very categorical. We have found that many of our service users do not believe this, for instance	Thank you for your comment. The text has been amended.

						wanting to feel empty or have control over their lives, and do not wish to achieve a certain body type at all.	
728.	SH	BEAT	Short	28	6-8	A source should be included to support this statement: "About 15% of people with an eating disorder have anorexia nervosa, which is more common in younger people."	Thank you for your comment. References are not included for text located in this location within the Short guideline.
729.	SH	BEAT	Short	28	3-4	The word 'reported' should be replaced with 'estimated' and the words 'approximately' should be replaced with 'more than'. This would match the language used in page 32: lines 20-21.	Thank you for your comment. The text has been amended as suggested.
730.	SH	BEAT	Short	28	4-5	This source did not estimate that 10% of all cases were male. Whilst males often comprise around 10% of clinical samples, this ratio is not supported by community-based epidemiological studies. Most notably 25% of the people with lifetime experience of Anorexia nervosa or Bulimia nervosa identified by a nationwide US study (Hudson et al (2007)) were male. Also, a review of community-based epidemiological studies by Sweeting et al (2015) suggests that the prevalence of eating disorders in males may be as high as 25%.	Thank you for your comment. The text has been amended to make both these points clear.
731.	SH	College of Occupational Therapists	Short	28	10-11	Amend the line to include the section in red italics as follows ' Eating disorders is associated with poor quality of life, social isolation, *impaired participation in adaptive self-care, productivity, leisure and rest activities* and a substantial burden for family members and carers	Thank you for your comment. The description is not intended to be an exhaustive list of all the factors associated with having an eating disorder.
732.	SH	BEAT	Short	28	2	'This should refer to the impact of these comorbidities on wellbeing and recovery	Thank you for your comment. The text has been amended as suggested.

						and not just to the impact on the cost of treatment. The 'cost of treatment' for people with eating disorders and comorbid conditions, should not be presented as the primary consideration, particularly since effective evidence-based treatment is far more cost-effective in the long run to the alternative of denying these patients access to treatment.	
733.	SH	Mental Health Foundation	Short	28	3	Need to be clear whether prevalence numbers are people in treatment or people with diagnosable conditions. Also, the gender dynamic is not defined enough in this sentence – an issue that is consistent across the short guidance.	Thank you for your comment. The text has been amended to make it clearer.
734.	SH	Mental Health Foundation	Short	28	11	It is unacceptable for people with eating disorders to be referred to as 'substantial burden' in any context as it is highly stigmatising. This sentence urgently needs to be reworded.	Thank you for your comment. The sentence has been amended.
735.	SH	BEAT	Short	28	15	If the exclusion of Avoidant Restrictive Food Intake Disorder (ARFID) is to be detailed here, then it would make sense to also specify the fact that this guideline does not cover the conditions of pica or rumination disorder either.	Thank you for your comment. The text has been amended as suggested.
736.	SH	Oxford Health NHS Foundation Trust	Short	28	15	Rumination disorder has been omitted from the document. Given that it is in the DSM-5, it should be mentioned here.	Thank you for your comment. The text has been amended as suggested.
737.	SH	BEAT	Short	28	24	It is not clear why only 5 of the total 7 research recommendations mentioned in the full guideline, have been listed in this document. What is the reason for this? Is this because the two excluded research	Thank you for your comment. NICE requires that the Committee pick 5 research recommendations that they consider to be of highest national priority for inclusion in the short guideline. The

						recommendations are deemed to be of a lower priority, as that is the implication? As a result, this has also made it impossible to comment in the same level of detail for these recommendations.	remaining recommendations appear in the full guideline.
738.	SH	College of Occupational Therapists	Short	28	24	We recommend the below recommendations for research are included 1. Clinical and cost effectiveness of psychoeducational and experiential occupation-focussed interventions designed to improve: a) eating and meal preparation skills b) adaptive lifestyle skills (i.e. participation in adaptive self-care, work/study leisure and rest activities for adults and young people with anorexia within inpatient and day patient settings) c) Independent living skills 2. Clinical and cost effectiveness of social and recreational activities within inpatient and day patient settings for adults and young people designed to improve engagement in and experience of treatment plus development of therapeutic alliance 3. Why this is important Expert experience asserts that without facilitated social, creative and	Thank you for your comment. The Committee reviewed the suggested research recommendation however declined to include it in the guideline as they considered other areas of research to be of greater national importance.

						recreational activities engagement in and experience of treatment and therapeutic alliance is impaired	
739.	SH	BEAT	Short	29	1-2	It is not clear what is meant by the phrase 'complex binge eating disorder'. Also, this detail is not included in the equivalent part of Appendix G.	Thank you for your comment. The text has been amended.
740.	SH	BEAT	Short	29	14-15	Inconsistent wording has been used between this section and the equivalent section of Appendix G (concerning the lack of evidence on children).	Thank you for your comment. This has been revised for consistency.
741.	SH	Oxford Health NHS Foundation Trust	Short	29	27	We agree with the committee that 'studies that have been published have not always provided adequate definitions of remission' and it would therefore be helpful if the NICE guidelines could provide a clear definition of 'remission'. The lack of consensus regarding remission makes it very difficult to compare studies in a meaningful way, and it can be misleading (such as in the ANTOP trial, where remission was defined as a BMI of 17. One previous study showed that remission rates varied from 3% to 96% depending on the method used. *Couturier J[1], Lock J. What is remission in adolescent anorexia nervosa? A review of various conceptualizations and quantitative analysis. Int J Eat Disord. 2006 Apr;39(3):175-83.*	Thank you for your comment. It is not within the scope of the guideline to provide a definition of remission.

742.	SH	BEAT	Short	29	28	The bullet point: "bingeing and other compensatory behaviours" incorrectly implies that bingeing is classified as a compensatory behaviour.	Thank you for your comment. The text has been amended.
743.	SH	BEAT	Short	29	30	The word "could" should be replaced with 'should' here, given the importance of qualitative data (including on service-users and parent/carers experiences of treatment) to supplement evidence from future Randomized Controlled Trials (RCTs).	Thank you for your comment. The Committee did not wish to dictate to researchers whether they should or should not collect qualitative data.
744.	SH	BEAT	Short	30	1-4	Is this referring to mediating and moderating factors? If so perhaps it would be useful to use this language as it is more specific.	Thank you for your comment. The text has been amended as suggested.
745.	SH	BEAT	Short	30	22-24	Is this referring to mediating and moderating factors? If so perhaps it would be useful to use this language as it is more specific.	Thank you for your comment. The text has been amended as suggested.
746.	SH	BEAT	Short	30	20	The bullet point: "bingeing and other compensatory behaviours" incorrectly implies that bingeing is classified as a compensatory behaviour.	Thank you for your comment. The text has been amended.
747.	SH	BEAT	Short	30	21	We suggest adding '(for anorexia nervosa)' after "weight or BMI".	Thank you for your comment. The text has been amended as suggested.
748.	SH	BEAT	Short	30	22	As with the first research recommendation (page 29, line 29) guidance on minimum post-treatment follow up would strengthen this recommendation.	Thank you for your comment. The Committee has specified a minimum of a one-year follow up post-treatment.
749.	SH	BEAT	Short	30	22	Qualitative data should be collected on the acceptability of shorter vs. longer duration of treatment and whether shorter duration of treatment may suit certain patients more than others, given the importance of qualitative data (including on service-users and parent/carers experiences of treatment) being	Thank you for your comment. Qualitative data, in particular on the experience of how interventions are delivered and on issues of access and acceptability, are important aspects of any research study. It would be expected that this important area would be developed by the appropriate funding bodies but that

						generated to supplement evidence from future Randomized Controlled Trials (RCTs).	specifying this level of detail is not required.
750.	SH	BEAT	Short	31	2-5	Inconsistent wording has been used between this section and the equivalent section of Appendix G.	Thank you for your comment. This has been revised for consistency.
751.	SH	BEAT	Short	31	16-18	Is this referring to mediating and moderating factors? If so perhaps it would be useful to use this language as it is more specific.	Thank you for your comment. The text has been amended as suggested.
752.	SH	BEAT	Short	31	14	The bullet point: "bingeing and other compensatory behaviours" incorrectly implies that bingeing is classified as a compensatory behaviour.	Thank you for your comment. The text has been amended.
753.	SH	BEAT	Short	31	15	We suggest adding '(for anorexia nervosa)' after "weight or BMI".	Thank you for your comment. The text has been amended as suggested.
754.	SH	BEAT	Short	31	16	As with the first research recommendation (page 29, line 29) guidance on minimum post-treatment follow up would strengthen this recommendation.	Thank you for your comment. The Committee has specified a minimum of a one-year follow up post-treatment.
755.	SH	BEAT	Short	31	16	Qualitative data should be collected on the acceptability of different stepped care approaches to psychological therapies, given the importance of qualitative data (including on service-users and parent/carers experiences of treatment) being generated to supplement evidence from future Randomized Controlled Trials (RCTs).	Thank you for your comment. Qualitative data, in particular on the experience of how interventions are delivered and on issues of access and acceptability, are important aspects of any research study. It would be expected that this important area would be developed by the appropriate funding bodies but that specifying this level of detail is not required.
756.	SH	BEAT	Short	32	11-13	Is this referring to mediating and moderating factors? If so perhaps it would be useful to use this language as it is more specific.	Thank you for your comment. The text has been amended as suggested.
757.	SH	BEAT	Short	32	21-22	Please remove the following: "Beat estimates that around 10% of these people are male." Beat does not	Thank you for your comment. The text has been amended to make both these points clear.

						advocate such an estimate. Whilst males often comprise around 10% of clinical samples, community-based epidemiological studies suggest that the true prevalence of eating disorders amongst males is much higher than this and may be as high as 25%. Most notably 25% of the people with lifetime experience of Anorexia nervosa or Bulimia nervosa identified by a nationwide US study (Hudson et al (2007)) were male. Also, a review of community-based epidemiological studies by Sweeting et al (2015) suggests that the prevalence of eating disorders in males may be as high as 25%.	
758.	SH	BEAT	Short	32	21-22	Inconsistent wording has been used between this section and the equivalent section of Appendix G. NICE is cited in this part of Appendix G.	Thank you for your comment. This has been revised for consistency.
759.	SH	BEAT	Short	32	8	The bullet point: "bingeing and other compensatory behaviours" incorrectly implies that bingeing is classified as a compensatory behaviour.	Thank you for your comment. The text has been amended.
760.	SH	BEAT	Short	32	9	We suggest adding '(for anorexia nervosa)' after "weight or BMI".	Thank you for your comment. The text has been amended as suggested.
761.	SH	BEAT	Short	32	11	As with the first research recommendation (page 29, line 29) guidance on minimum post-treatment follow up would strengthen this recommendation.	Thank you for your comment. The Committee declined to specify minimum post-treatment follow up.
762.	SH	BEAT	Short	32	11	Qualitative data should be collected on the acceptability of different approaches to treating an eating disorder in people with a co-morbidity, given the importance of qualitative data (including on service-users and parent/carers experiences of	Thank you for your comment. Qualitative data, in particular on the experience of how interventions are delivered and on issues of access and acceptability, are important aspects of any research study. It would be expected that this important

						treatment) being generated to supplement evidence from future Randomized Controlled Trials (RCTs).	area would be developed by the appropriate funding bodies but that specifying this level of detail is not required.
763.	SH	Lancashire Care NHS Foundation Trust	Short	32	14	Research / evidence One area of particularly poor coverage is the service offered to men, those with very low BMIs (e.g. 14 and below), older adults (e.g. 25 years or older), black and minority ethnic (BAME) groups. This is a particular issue when translating the service offer to those in the north west of England. Owing to the small numbers of individuals affected, it is unlikely that an RCT will be possible and so further raises the importance that other types of evidence are used in making recommendations. We would appreciate further clarity in the guidelines about how the transition from the poor quality evidence available was made to recommendations. This is of particular importance if the options for psychological therapy recommended remain so narrow. It is possible that the guideline will be discredited / ignored without this.	Thank you for your comment. The Committee acknowledged that there is little research in BAME groups and explicitly recommend that treatment should be offered regardless of ethnicity and culture. However, the Committee thought that the areas of research recommended were of particular priority.
764.	SH	BEAT	Short	32	16	Why does this recommendation only focus on males who are over 18 years old as opposed to males of any age?	Thank you for your comment. The Committee restricted the research recommendation to males over 18 years of age due to the fact that whilst there is a substantial body of research in male and female children and young people under 18, there is a noticeable dearth of research in the former group.

765.	SH	BEAT	Short	32	29	The bullet point: "bingeing and other compensatory behaviours" incorrectly implies that bingeing is classified as a compensatory behaviour.	Thank you for your comment. The text has been amended.
766.	SH	BEAT	Short	33	2-4	Is this referring to mediating and moderating factors? If so perhaps it would be useful to use this language as it is more specific.	Thank you for your comment. The text has been amended as suggested.
767.	SH	BEAT	Short	33	1	We suggest adding '(for anorexia nervosa)' after "weight or BMI".	Thank you for your comment. The text has been amended as suggested.
768.	SH	BEAT	Short	33	2	As with the first research recommendation (page 29, line 29) guidance on minimum post-treatment follow up would strengthen this recommendation.	Thank you for your comment. The Committee has specified a minimum of a one-year follow up post-treatment.
769.	SH	BEAT	Short	33	2	Qualitative data should be collected on the acceptability of different approaches to treatment for men with eating disorders, given the importance of qualitative data (including on service-users and parent/carers experiences of treatment) being generated to supplement evidence from future Randomized Controlled Trials (RCTs).	Thank you for your comment. Qualitative data, in particular on the experience of how interventions are delivered and on issues of access and acceptability, are important aspects of any research study. It would be expected that this important area would be developed by the appropriate funding bodies but that specifying this level of detail is not required.
770.	SH	Royal College of Nursing	Short	45	25	This suggestion of self-help is great, but it needs to be tied into monitoring at primary care level. Suggesting that a practitioner trained in self-help is the ideal, but it would not always be available. GP practice nurses could be of assistance.	Thank you for your comment. The suggestions made raise important issues but at a level of detail that is beyond what can be included in the guideline or the recommendations contained therein. Furthermore, it would be expected that issues such as setting of treatment and care and who provides treatment would be addressed by the appropriate funding bodies.
771.	SH	BEAT	Appendix	General	General	The title of the Appendices A-G document includes the word	Thank you for your comment. This has been revised for consistency.

						'management' which is not consistent with the title of the guideline itself.	
772.	SH	BEAT	Appendix A	10	11-13	Doesn't including both the terminology from Diagnostic and Statistical Manual of Mental Disorders (DSM) IV and DSM5 here risk only adding to the confusion?	Thank you for the comment. The use of both terms is necessary so as to capture the fact that studies using either EDNOS or OSFED were eligible for inclusion in the evidence reviews depending on whether they met the other inclusion criteria.
773.	SH	BEAT	Appendix A	10	4-5	No sources are provided for these prevalence estimates. Do they represent estimates of lifetime prevalence rather than point or period prevalence?	Thank you for your comment. This is the scoping document and not intended as a reference document for practitioners.
774.	SH	BEAT	Appendix A	10	6-7	No source is provided for this estimate of the incidence of anorexia nervosa in primary care.	Thank you for your comment. This is the scoping document and not intended as a reference document for practitioners.
775.	SH	BEAT	Appendix A	10	7-8	No source is provided for this prevalence estimate. Is it an estimates of lifetime prevalence rather than point or period prevalence?	Thank you for your comment. This is the scoping document and not intended as a reference document for practitioners.
776.	SH	BEAT	Appendix A	10	9-10	No sources are provided for these prevalence estimates. Is the 2.2% figure cited an estimate of lifetime prevalence rather than point or period prevalence? No source is cited for the male: female ratio.	Thank you for your comment. This is the scoping document and not intended as a reference document for practitioners.
777.	SH	BEAT	Appendix A	10	15-16	No source has been cited for this statement.	Thank you for your comment. This is the scoping document and not intended as a reference document for practitioners.
778.	SH	BEAT	Appendix D	22	31	'Beat' should now be re-entered into this list.	Thank you for your comment. The list has been amended.
779.	SH	BEAT	Appendix G	68	3	It is not clear why only 5 of the total 7 research recommendations have been listed in Appendix G. What is the reason for this? Is this because the two excluded research recommendations are deemed to be of a lower priority, as that is the implication? As a result, this has also	Thank you for your comment. Please note that the research recommendations have been amended and revised. The 5 research recommendations that appear in the short guideline, some of which are now different to those that appeared in the first draft, are those that the

						made it impossible to comment in the same level of detail for these recommendations as we have for the others.	Committee consider to be the most important national priorities in terms of the effect well conducted studies in these areas can have on patient outcomes. Although the remaining research recommendations may lack the detail of the five that appear in the short guideline and that this may make it difficult to comment on in detail, the research recommendations serve to highlight areas that the Committee feel are in need of research, rather than to completely dictate the design and protocol of any studies conducted in response to them.
780.	SH	BEAT	Appendix G	68	29	The bullet point: "weight or BMI" should be deleted as weight reduction is not a primary goal of psychotherapy for Binge Eating Disorder (BED) as explained elsewhere in the guideline.	Thank you for your comment. The research recommendations have been amended as suggested.
781.	SH	Lancashire Care NHS Foundation Trust	Question 1			Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. The inclusion of FPT – a manual based, little known therapy, included on the strength of one RCT will require the training of many staff as very few people have heard of this therapy, and fewer still are trained in it. Conversely, there are many Cognitive Analytic Therapists / people trained in CAT, which in the past has been included in the NICE guidelines on the basis of positive research outcomes, and which appears to have overlaps with FPT (in terms of the relational focus and efficacy of use with	Thank you for your comment. The Committee have revised their recommendations to include CBT-ED, MANTRA, and SSCM as first-line interventions (in recognition of the fact that there is evidence of no difference between these therapies), and - recognising that the manual is not yet available in English and the recommendations could have significant cost implications for some services and that it will take some time to put them into practice - FPT as a second-line option. A substantial amount of research has been conducted since the 2004 guideline and services should change to reflect the currently available evidence. However, this is ultimately an implementation issue and a matter for local service

						clients for whom other treatments have not been successful). It is not pragmatic in the current financial climate to train individuals on the strength of one RCT and buy a manual related for a little known therapy when there is a similar therapy which works very well, and people are already trained in it – some directly as a result of CAT being included in past NICE guidelines.	determination. It should be noted that the study on which the recommendation for FPT was based was a relatively large trial (n=242, Zipfel 2014) for this area of research; although there was no difference between FPT and other interventions (CBT-ED and optimised treatment as usual) on remission at end of treatment, it was more effective on remission, BMI and eating disorder psychopathology at follow up. The committee considered CAT to be sufficiently similar to focal psychoanalytic psychotherapy to be classified under the category of 'general psychodynamic therapy'. As such, only 2 studies were identified that examined general psychodynamic therapy (Dare 2001, Treasure 1995) versus another intervention; no differences were found on remission and all-cause mortality at end of treatment, nor on remission, BMI and other outcomes at follow up.
782.	SH	Lancashire Care NHS Foundation Trust	Question 2			Would implementation of any of the draft recommendations have significant cost implications? Yes – the training of therapists, and also the potential that CAT therapists currently working in eating disorders will no longer be able to use the approach, and so there may also be the cost of recruitment, should these people choose to leave the service	Thank you for your comment. The committee has revised their recommendations for the treatment of adult anorexia nervosa to include CBT-ED, MANTRA and SSCM as first-line options and FPT as a second-line option. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. However this is an implementation issue and ultimately one for local

							determination. That said, as some stakeholders have noted, focal psychodynamic therapy is not so different from CAT and all services are encouraged to put the recommendations into practice.
783.	SH	Lancashire Care NHS Foundation Trust	Question 3			What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) For the efficacy of CAT to be recognised and included in these guidelines as it has been in previous NICE guidelines. For NICE to include any Manuals as a resource in the “resources” page of the guideline	Thank you for your comment. Please note that the recommendations for adult anorexia nervosa have been revised to include CBT-ED, MANTRA and SSCM as first-line options and focal psychodynamic therapy as a second line option. The Committee considered CAT to be sufficiently similar to focal psychoanalytic psychotherapy to be classified under the category of 'general psychodynamic therapy'. As such, only 2 small studies were identified that examined general psychodynamic therapy (Dare 2001, Treasure 1995) versus another intervention; no differences were found on remission and all-cause mortality at end of treatment, nor on remission, BMI and other outcomes at follow up. By contrast, the evidence for the recommended therapies was considered to be stronger, with higher sample sizes, less uncertainty and more reported outcomes on which to base their recommendations. Hence, the committee did not recommend CAT for the treatment of adult anorexia nervosa. Regarding manuals, although manualised interventions are recommended, no particular manual (with the exception of MANTRA) is specifically recommended. As such, the manual used to deliver the recommended

							interventions is left to the discretion of local services. In addition, the relevant manuals are under copyright and therefore cannot be included as part of the guidelines.
784.	SH	National Clinical Reference Group for Specialised Mental Health Services, NHS England	Full	General		The period allowed for consultation on this guideline was inadequate and it is very disappointing that requests for an extension of the deadline were declined. A consultation period of six weeks, falling over the Christmas and New Year holiday period, is clearly insufficient for a document of nearly 1,000 pages. It has been impossible in the time available for stakeholders, many of whom are busy clinicians, to read and comment adequately on the document. Some may have decided not to comment at all. The failure to consult adequately will call into question the validity of the guideline. As described below, many of the recommendations are based on inadequate evidence but stakeholders have not been given sufficient time to critique the document properly. The guideline is likely to be regarded in many quarters as the definitive statement of good clinical practice; this could lead to serious distortions of clinical priorities as commissioning and operational decisions will be based on its recommendations and clinicians are likely to be put under pressure to adopt them. The guideline relies excessively on the personal opinions and experience of the small number of clinicians who make up	Thank you for your comment. The consultation period was the standard 6 weeks required by the NICE guidelines manual and very few stakeholders expressed any concern with the deadline for comments. NICE and the NGA showed as much flexibility as they could to those that did, and extending the deadline for consultation would have delayed the whole project unduly. Regarding the recommendations for the treatment of anorexia nervosa, the Committee has substantially revised them to include CBT-ED, MANTRA and SSCM as first line treatments and focal psychodynamic therapy as second line. The Committee revised these recommendations to reflect the facts that (i) there was evidence of no difference in effect between CBT-ED, MANTRA and SSCM, and (ii) the manual is not yet published in English and some services may incur significant costs in providing eating-disorder-focused focal psychodynamic therapy Regarding the use of informal consensus to guide the writing of recommendations, this is permitted by NICE when there is a lack of evidence. Although the concerns regarding the 'small' number of people on the Committee are acknowledged, the 19-strong Committee members included several psychiatrists and psychologists, a

						the guideline development committee. This potentially raises the risk of bias and further diminishes the validity of the guideline. There are certainly areas of practice – most notably the treatment of anorexia nervosa - where there is a dearth of published evidence. However, we feel that this should have resulted in a more cautious approach to making recommendations. Where there is a lack of evidence, this should have been acknowledged and the guideline development committee should have refrained from making recommendations rather than basing them on the opinions of committee members. The opinions of individuals or a small group are not a sufficiently robust basis for a guideline which purports to be based on a rigorous analysis of the evidence. One example is the recommendation to offer SSCM and MANTRA as alternatives to CBT-ED and focal psychodynamic therapy. The evidence reviewed showed no significant benefit from either SSCM or MANTRA compared with any other treatment, but these interventions are nevertheless recommended on the basis that "The committee agreed that it was important to consider SSCM and MANTRA as alternatives to CBT-ED and focal psychodynamic therapy because many healthcare professionals currently deliver these therapies to adults with anorexia nervosa and both are considered effective". Further examples are given below.	dietitian, a mental health nurse, a paediatrician, a GP and two lay members. Although not every profession and not every voice can - as a matter of practicality and time constraints - be represented on a NICE Committee, consultation is an opportunity for stakeholders to raise any concerns they may have. This opportunity has certainly been taken up by stakeholders, despite the consultation period falling over Christmas and the New Year and it is hoped that the revisions made in response to stakeholder comments have improved the guideline.

785.	SH		Full	General		Studies quoted in the discussion sections are not referenced, which makes it difficult to identify which papers are being referred to.	Thank you for your comment. Particular studies, unless they were of particular interest to the Committee, are not normally referenced in the LETR discussion section of each evidence review.
786.	SH	National Clinical Reference Group for Specialised Mental Health Services, NHS England	Full	410; 838		The recommendation to offer a low carbohydrate diet (which is not defined) to people with eating disorders and diabetes is premature and appears to be based solely on the experience of one committee member. We are in the early stages of establishing what are effective interventions for these patients and there is no published evidence to support this recommendation. While this approach might be appropriate for some individuals, it is not justified as a general recommendation for all patients. At the outset of treatment, intensive glucose management is not an appropriate goal and a “permissive” approach (Brown and Mehler, 2014) is warranted. However, the recommendation for a low carbohydrate diet seems to be based on the principle that it allows the patient to achieve normoglycaemia with inadequate does of insulin. It could be argued that matching carbohydrate intake to the amount of insulin the patient will accept enables maximum energy release while maintaining normoglycaemia. Clinical experience indicates, however, that patients rarely have a sufficiently consistent insulin dose - or carbohydrate intake - to make this possible.	Thank you for your comments. In response to stakeholder comments, the diabetes recommendations have been substantially revised. In particular the recommendations regarding a low carbohydrate diet and the use of DAFNE have been removed. The discussion in the LETR has also been substantially reviewed.

						This approach therefore risks weight loss unless additional energy is supplied from other sources (protein and fat). However, both of these carry risks and patients are unlikely to accept an increase in fat intake. There is also a risk of hypoglycaemia and neuroglycopenia which can impair cognitive function and the therapeutic process. More importantly, a low carbohydrate diet risks reinforcing the patient's avoidance of carbohydrate and insulin, which may be further legitimised in the patient's mind by improved glycaemic control. The recommendation to offer all patients with diabetes who are misusing insulin carbohydrate counting and an intervention such as DAFNE does not take account of the fact that many patients are not ready for these when they first present and need time spent on more basic diabetes education first. These firm recommendations appear to be based on nothing more than a "suggestion" (p842) from the committee. The statement (p841) that "family members may also need to care for someone if they hyper or phyo" is gibberish.	
787.	SH	National Clinical Reference Group for Specialised Mental Health Services, NHS England	Full	273		The recommendation that focal psychodynamic therapy should be based on a manual is problematic for two reasons. The first is that there is no empirically tested and validated manual available in English. The second is that psychodynamic therapy is, by its very	Thank you for your concern. The recommendations have been revised to include CBT-ED, MANTRA and SSCM as first-line options and FPT as a second-line option. The Committee was aware that while some therapists are trained to deliver focal psychodynamic therapy, the

				275 274-275		nature, exploratory and individualised rather than prescriptive. Although general principles can be outlined, it cannot therefore be manualised in the same way as therapies such as CBT. We do not agree that “few people in the NHS are trained in focal psychodynamic therapy”. There are in fact a large number of professionals in the NHS who have been trained in focal psychodynamic therapy, which is used for a variety of problems. While few, if any, eating disorders professionals have been trained in the specific model adopted by the German group, there are a significant number of psychodynamically trained staff working in eating disorders units and many will have been trained in focal therapy as part of their psychotherapy training. We are concerned that the recommendation of a maximum of 40 sessions of focal psychodynamic therapy is not based on any evidence. Given the lack of evidence, we do not think that it is justified to specify a number of sessions. There is no research on which to base the duration of any therapy model for AN and there have been no comparative studies of different durations of psychodynamic therapy. Indeed, we feel it is an omission that the guideline does not even discuss the potential benefits of longer-term psychodynamic therapy. Although longer-term therapy has not been formally evaluated, clinicians	wide variation in services offered in the NHS across the country meant that it might have significant financial and organisational consequences for many treatment providers (in particular for those who do not have staff trained to deliver FPT for eating disorders). Indeed, several stakeholders have noted that offering FPT will be difficult for them to implement. The Committee also noted the dearth of research on the optimum length of therapy and therefore made a research recommendation in the hope that high quality RCT studies would be conducted on precisely this issue. The recommendation to consider offering a maximum of 40 sessions of focal psychodynamic therapy was based on the Zipfel et al 2014 study in which the participants averaged approximately 40 sessions of therapy (regardless of which group - CBT-E, FPT or TAU - they were assigned to). This recommendation has been amended to make clear that this is the typical number of sessions that may be needed, thus allowing that more or less sessions may be required according to individual needs. A manual provides a common structure around which a therapist can base their practice however, in all cases, clinical judgement must be exercised in collaboration with the informed decision of the individual with the eating disorder in the delivery of the relevant intervention.

						working psychodynamically with AN patients have often seen good results with this approach. There is also a substantial clinical literature describing the effects of longer-term therapy (see, for example, the recent special issue of the Journal of Infant, Child and Adolescent Psychotherapy http://www.tandfonline.com/toc/hicp20/current). The decision to recommend a maximum of 40 sessions seems to have been made on the basis that "Generally, in most clinical studies psychodynamic therapy is intensive and consists of 40 sessions over 40 weeks. Also, the number of sessions and duration of treatment is in line with the recommended dose of cognitive behavioural therapy for people with anorexia nervosa." It is well known that research studies are often based, for practical and non-clinical reasons, on relatively short durations of treatment and we do not feel it is justifiable to base a recommended duration in clinical practice on what has been used in research studies. The argument that the duration of treatment should be based on that recommended for CBT rests on the highly questionable assumption that a suitable duration for one therapy is necessarily suitable for an entirely different therapy. Eating disorders services across the country use a variety of therapeutic	

						models, including a variety of psychodynamic and CBT models. We regard this diversity as a strength and would be concerned about it being curtailed by an overly restrictive recommendation which specifies only two models. Most services already work to a strategy of delivering one or two models well. The rigidity of the recommendations in this guideline will result in many services being forced to train staff in new models, in which they will be less skilled, when there is no evidence that existing therapy models are ineffective. Given the paucity of effective interventions for anorexia nervosa, we are also concerned that these recommendations will inhibit the development of new therapeutic approaches. We would favour a more broad statement that focal psychodynamic therapy and CBT have the best evidence base but other approaches may also be considered.	
788.	SH	National Clinical Reference Group for Specialised Mental Health Services, NHS England	Full	196		The recommendation to review inpatient treatment after four weeks is based exclusively on “an informal method of consensus” within the guideline development committee and no rationale is given for choosing four weeks. We agree on the importance of monitoring progress closely and ensuring that admissions are not prolonged unnecessarily. We also agree that the need for continued inpatient treatment should be reviewed frequently but a requirement to hold a formal review meeting within four weeks of admission in all cases is unduly prescriptive. For	Thank you for your comment. Please note that the relevant recommendations have been revised in response to this and other stakeholder comments. It has been emphasised that at admission, a care plan should be created that specifies, among other things, clear objectives and outcomes for the admission and moreover, how they will be discharged. Furthermore, although a review should occur within 1 month of admission, this is to assess whether inpatient care should be continued, stepped down or stopped. As part of the review, it has been specified that a

						some patients, four weeks may be too short a period to carry out a comprehensive assessment, which can form the basis for a reliable assessment of progress and a decision about whether or not to continue inpatient treatment. The need to limit calorie intake in the early stages of refeeding means that patients may not have reached a steady state in terms of weight gain and there is sometimes an initial "honeymoon period" when the patient shows little distress at the limited weight gain achieved during this period. We propose instead a recommendation that a formal review meeting, within the framework of the Care Programme Approach, should be held early in the admission and should include community services. The precise timing of this meeting will depend on what other review processes are in place in the unit but a period of six weeks from admission is suggested. During this time, a comprehensive assessment should be carried out, which includes physical and nutritional status, a comprehensive psychological formulation, assessment of the patient's suitability for psychological therapy and an assessment of needs after discharge. The review meeting should then be used to agree a treatment plan with the patent, community service and family if appropriate. Further meetings should be held during the admission, and close liaison with	schedule for further reviews (if appropriate) should be agreed. Regarding support, the need for support throughout treatment and care for both the person with the eating disorder and (if appropriate) the family/carer has been emphasised at several points in the guideline.

						community services maintained throughout. The patient's needs after discharge should be considered carefully from the beginning of inpatient treatment and plans put in place as early as possible for appropriate support after discharge. Seeking a second opinion routinely after four weeks would be extremely expensive, both financially and in terms of the time of the limited number of people who have the expertise to provide these opinions. We feel that second opinions should be reserved for those patients who present serious management challenges or have proved resistant to treatment over a prolonged period.	
789.	SH	National Clinical Reference Group for Specialised Mental Health Services, NHS England	Full	398		The recommendations in relation to the use of transdermal 17-β-oestradiol with cyclic progesterone are premature. They are based on a single study (actually published in 2011 not 2013) which produced only modest gains in BMD. At 18 months, lumbar spine bone mineral apparent density had increased by only 1.9% in treated patients, as opposed to 0.2% in untreated patients. The results of this study are at odds with those of previous studies of oral oestrogen replacement and the putative explanation (reduced suppression of IGF-1) is unproven.	Thank you for your comment. The Committee felt that the study referred to provided evidence from an RCT of better increase in BMD. They were clear in the guideline that first-line prevention and treatment should be weight restoration. However for a number of women who have had long standing underweight and progressively decreasing BMD z-scores, incremental oral or patch oestrogen represents an intervention. The guideline is clear that this should only be considered in these groups. The Committee separated it from use of higher dose oral oestrogen as there is no evidence for that. They also agreed that the explanation regarding suppression of IGF-1 is hypothesised in the paper mentioned, and have removed

							commentary on this particular aspect in the full guideline.
790.	SH		Full	187-9		We were disturbed to see that the recommendation that "When electrolyte imbalance is detected, it is usually sufficient to focus on eliminating the behaviour responsible", has been carried over unmodified from the previous guideline. No evidence is adduced to support this statement, which flies in the face of what is known about the increased risk of ventricular arrhythmias and sudden death in patients with electrolyte disturbance. Eliminating the responsible behaviour may take a considerable length of time and patients will be at risk in the interim. The previous sentence even acknowledges that electrolyte imbalance (particularly hypokalaemia) is one of the causes of death in anorexia nervosa. Treatment with oral electrolyte supplements (with or without the use of a PPI in resistant cases of electrolyte disturbance secondary to vomiting) should be instituted before the patient develops evidence of incipient organ failure and requires emergency admission. There are a number of errors in the discussion of acid-base and electrolyte disturbances: 1. There are references to both ECT and EEG, when presumably ECG is intended.	Thank you for your comment. The relevant LETR has been amended to take the remarks made into account.

						2. In laxative abuse, loss of bicarbonate from the bowel leads to metabolic acidosis not alkalosis. 3. The statement that "The concern of fluid and electrolyte imbalance is that it may lead to metabolic alkalosis and is generally accompanied by hypochloraemia and hypokalaemia" is misleading. Hypokalaemia in patients who vomit is largely secondary to metabolic alkalosis, which leads to compensatory renal excretion of bicarbonate and potassium. 4. Salt loading is not a common cause of fluid and electrolyte imbalance in bulimia nervosa. 5. Fluid and electrolyte imbalance is not necessarily detected with routine screening and significant intracellular electrolyte depletion can occur with normal plasma values. 6. "Constipation" is often due to inadequate food intake.	
791.	SH	National Clinical Reference Group for Specialised Mental Health Services, NHS England	Full	184		The section on medication risk management makes no mention of the need to give reduced doses of paracetamol to underweight patients, due to the risk of hepatotoxicity.	Thank you for your comment. There are a range of issues regarding the management of people with eating disorders that were outside scope of guideline and therefore could not be dealt with.
792.	SH	National Clinical Reference Group for Specialised Mental Health Services, NHS England	Full	190-197		A major flaw in the guideline is the lack of acknowledgement of the role of planned inpatient treatment for patients who have failed to respond to outpatient intervention. We agree that inpatient treatment is an expensive resource, which has the potential to divert resources from outpatient treatment. It is therefore essential that it is reserved for	The Committee carefully considered the use of inpatient care and agreed that it was best reserved for individuals who were medically compromised, which is broadly compatible with the first criteria you provide. However based on the reviewed evidence, the Committee considered that day and other forms of care can be just as effective, if not more

						those who cannot be treated in any other way and that it is not prolonged unnecessarily. In order to make effective use of inpatient treatment, the decision to admit should be considered carefully, the aims of admission should be clearly specified and the patient's discharge should not be delayed by a lack of coordination with community services or a failure to plan for discharge at the earliest opportunity. However, we feel that the discussion of planned inpatient treatment is inadequate and does not warrant the recommendation that that its only role is in medical stabilisation of patients who are physically compromised. As recognised in the national service specification for inpatient eating disorders units, there are three principal indications for admission in anorexia nervosa and each requires a different programme of treatment: 1. Indication: rapid weight loss with evidence of system or organ failure, which is potentially life threatening. Intervention: short-term medical stabilisation and initiation of refeeding followed by review of ongoing treatment needs. 2. Indication: outpatient psychological treatment has not been sufficient to effect a change or improvement.	so, when providing care for individuals who require planned refeeding or more intensive psychosocial interventions. Indeed, the evidence – consisting of both RCT and comparative observational studies – and the substantive experience of the committee members, suggested that there was no difference in outcomes between inpatient care and other community-based settings and that inpatient care can have some harmful effects. Concerning the lack of evidence, whilst of course absence of evidence is not evidence of no effect, the committee felt that it would not be right to recommend something for which there is no evidence. The Committee also considered the papers you cite in your comment (and in addition, Steinhausen 2008 [Steinhausen, H. C., Grigoroiu-Serbanescu, M., Boyadjieva, S., Neumärker, K. J., & Winkler Metzke, C. (2008). Course and predictors of rehospitalisation in adolescent anorexia nervosa in a multisite study. International Journal of Eating Disorders, 41(1), 29-36]), all of which are studies on the factors that predict admission/readmission. Three of these studies are in adolescents, whilst one of them is in adults. Although the studies provide useful information on these predictors, they do not offer any data comparing inpatient care with other forms of care and, as such, they do not directly address the issue of which setting is better.

						Intervention: planned admission for refeeding and intensive psychosocial interventions aimed at psychological change. 3. Indication: those at low weight (usually chronically unwell), who are not able to manage in daily life, who require help with weight stabilisation or modest weight restoration, often in the context of medical instability. Intervention: brief period of inpatient treatment to optimise nutritional status. It is worrying that the guideline recognises only the first of these three types of admission. The third type is not discussed at all, although it can form a valuable part of a comprehensive care plan for patients with severe and ensuring anorexia nervosa. The second type, which may or may not be accompanied by restoration to normal weight, is long established in clinical practice and many clinicians know that it can produce good outcomes when all other approaches have failed. We acknowledge that, for largely technical reasons, this approach has not been adequately evaluated in the research literature. However, the lack of research evidence should not lead to a potentially spurious conclusion that this form of treatment is not valid. It is important that lack of evidence of effectiveness is not confused with evidence of lack of effectiveness and we are concerned that	Regarding Gowers 2007, this study had some weaknesses of which the Committee were aware (see the relevant LETRs in the full guideline) when generating the recommendations. Nevertheless it was agreed that these limitations did not detract from the fact that the evidence did not show any advantage for inpatient care over other forms of care. Regarding weight restoration, it was accepted that this can make people with eating disorders more amenable to treatment. Moreover, for people who are severely compromised or in those with very low weight, hospital admission has been recommended as well as close collaboration between healthcare professionals and services providing psychological and other treatments. Regarding early intervention, although it is important, as may be surmised, the Committee did not believe that the evidence supported the view that such treatment should be provided in an inpatient setting nor that early intervention will lead to sustained weight gain.

						this recommendation will deprive patients of an important form of treatment. Although direct evidence of effectiveness is lacking, there is evidence that shorter periods of inpatient treatment are associated with a poorer outcome and that the major predictor of re-admission is the duration of maintenance of a normal weight (Lay et al, 2002). It has been shown that discharge when severely underweight leads to a poorer outcome and a higher rate of re-admission (Baran et al, 1995) and one study of patients discharged after complete weight recovery found that only 25% required re-admission (Castro et al, 2004). Generalising from the trend towards shorter admissions in the USA (p33, line13) is highly questionable, as this trend is driven by financial constraints rather than clinical considerations and its effect on long-term outcomes is unknown. The recommendation that "the only time inpatient care is a viable option for people with an eating disorder is if their physical health is compromised and inpatient treatment is needed for medical stabilisation and the initiation of refeeding" is based on evidence which is rated as very low quality. The guideline quotes one study which compared treatment for a mean of 22 days with treatment for a mean of 38 days. It is misleading to describe this as comparing short-term medical stabilisation with	

						longer-term weight restoration as very few patients will have achieved weight restoration after only 38 days. The results of this study do not justify the conclusion that similar outcomes can be achieved if the person is admitted for short-term medical stabilisation compared with longer-term weight restoration. The TOUCAN study (Gowers et al, 2007) is often quoted in support of the contention that inpatient treatment is no more effective than outpatient. However, this study has a number of methodological weaknesses: 1. It was carried out in an adolescent population, in whom the negative effects of admission (such as separation from family and peers and disruption of education) may be more significant than in adults. 2. The study was obviously not blind. 3. Treatment adherence was significantly poorer for the inpatient arm. 4. Treatment was provided within generic inpatient units rather than specialist eating disorders units. 5. Inpatient treatment lasted only 6 weeks in the first instance, although it could be extended if clinically indicated. 6. 50% of those allocated to outpatient treatment were admitted within the first 2 years of the study. 7. The mean BMI on admission was relatively high at 15.3 kg/m2.	

						Perhaps the major weakness of this study is due to its randomised design. As a result, inpatient treatment was offered as a first-line intervention without reference to severity. This is highly unrepresentative of clinical practice, in which a stepped care approach to treatment is usual. More importantly, randomisation means that there was no matching of intervention to patient need. Consequently, a large number of patients may have received more intensive treatment than they need, with significant negative effects, while others may have received inadequate treatment for their needs. When these results are aggregated, the potential effects of patient x treatment interactions are obscured and there is a regression to the mean, with all treatments appearing to be equally effective. Given these considerations, we feel that the study data do not necessarily support the conclusion that there is no advantage for inpatient over outpatient management. Moreover, caution should be exercised in extrapolating from adolescent to adult populations. Planned inpatient admission provides an opportunity to achieve weight change in parallel with intensive psychotherapeutic interventions and the combination may prove synergistic. It is well documented that weight restoration itself improves anorexic cognitions and may make the patient more available to psychological interventions. It is arguable that	

						restoration to a normal weight requires the patient to confront a central component of anorexic psychopathology in a way which shorter admissions cannot. Waiting until a patient is at medical risk is counterproductive as admissions are far longer for patients who are admitted at extremely low weight and with high medical risk. Moreover, there is clear evidence that patients have a greater chance of recovery in the early years of their illness than they do later in its course, when it has become entrenched. Prolonged outpatient treatment which fails to achieve weight restoration is likely to increase the risk of both chronicity and physical complications; some of these, such as osteoporosis and CNS changes in adolescents, may be irreversible. The recommendation that inpatient treatment should be used only as a short-term, emergency measure is also inconsistent with the statement elsewhere in the guideline that “there is evidence that early weight restoration has an impact on outcome, justifying an aggressive approach to refeeding in the early stages of the illness” (p31). This kind of early intervention is clearly incompatible with waiting until the patient is severely physically compromised. Similarly, using admission only for medical stabilisation and the initiation of refeeding is incompatible with the statement that ““an admission can	

						provide time, space and motivation for psychological change to begin" (p32).	
793.	SH	National Clinical Reference Group for Specialised Mental Health Services, NHS England	Full	527 30	 35	CBT-ED is the only treatment recommended for bulimia nervosa. However, the evidence shows that at most only 50% of patients will respond. Moreover, clinical experience indicates that patients with major co-morbid personality disturbance often fail to respond to manualised CBT and other approaches, such as DBT or psychodynamic therapy, should be considered in these cases. In relation to inpatient treatment, the statement (p30) that "the effect of treatment is often transient" is unsupported by any evidence.	Thank you for your comment. CBT-ED clearly showed that it was superior to other interventions on various outcomes including remission both at end of treatment and follow up. The network meta-analysis also showed that CBT-ED had the highest probability of remission. The Committee felt that the strength of evidence for efficacy of other interventions was poor (e.g. with high uncertainty, small sample sizes etc.), with little evidence of benefits on remission and other outcomes at end of treatment and follow up. They therefore decided not to recommend the use of these treatments. The Committee recognised that high quality studies on whether treatment for an eating disorder needs to be modified in the presence of a psychiatric comorbidity is needed and made a general research recommendation to that effect. Please also note that there is a recommendation that asks clinicians to refer to the relevant NICE guidelines for advice on how to treat the person with the eating disorder with a psychiatric comorbidity. Regarding the statement on p. 30 the relevant sentence has been removed.
794.	SH	National Clinical Reference Group for Specialised Mental Health Services, NHS England	Full	General		In relation to inpatient treatment, there are frequent references to "weight restoration" as a goal of treatment (eg p197) but the approach to inpatient treatment that is recommended clearly precludes restoration to anything approaching a normal weight.	Thank you for your comment. The discussion you refer to on p. 197 is about one of the studies that contributed to the evidence review, rather than a recommendation or endorsement by the Committee. The only use of the term 'weight restoration' regarding the

							Committee's recommendations or deliberations is in the 'Other considerations' section for Refeeding, where it is noted that energy requirements for restoration/growth or maintenance of body weight is highly variable amongst individuals.
795.	SH	National Clinical Reference Group for Specialised Mental Health Services, NHS England	Full	General		Line numbers only appear alongside some of the text, making it impossible to complete this form as requested.	Thank you for your comment. Unfortunately line numbers do not apply to table due to the document template and we are unable to change this.
796.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	General		We are concerned that delayed release of the draft guideline has resulted in inadequate consultation. Planned schedules for stakeholders to prepare responses were missed, and the short 6 week period fell over the Christmas period when many people were on holiday and have significant family commitments. The guideline is an extremely large and complex document that requires considerable time to appraise. We are particularly concerned that service users and carers have not had adequate opportunity to respond. Poor consultation undermines the validity of the guidance. Further consultation is required after revision of the draft.	Thank you for your comment. The consultation period was the standard 6 weeks required by the NICE guidelines manual and very few stakeholders expressed any concern with the deadline for comments. NICE and the NGA showed as much flexibility as they could to those that did, and extending the deadline for consultation would have delayed the whole project unduly.
797.	SH	QED –quality network for Eating Disorders – hosted by Royal College of	Short	Genersl		We are concerned that although the full guideline acknowledges the severe limitations of the evidence base and caution with which recommendations are made, this is not acknowledged in the	Thank you for your comment. The wording of recommendations is required to follow methods outlined in "Developing NICE guidelines: the manual".

		Psychiatrists CCQI				short guidance. The subtlety of 'consider offering' and 'offer' is lost in this context. Given the length and complexity of the full guideline, many stakeholders, particularly service users, carers and non-specialist professionals, will rely upon the short guidance. This is misleading, and is a missed opportunity to provide informed guidance. We have already seen the short guidance misinterpreted as rigid recommendations by some professional colleagues.	
798.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	General		We are concerned that bias has been introduced to the selection of evidence considered, due to biased selection of outcome measures considered acceptable by the small group of experts producing the guideline.	Thank you for your comment. The Committee recognised the dearth of evidence regarding the types of treatments that are efficacious for eating disorders. Given the profusion of outcomes in the literature, the Committee chose outcomes for which firstly, there would be at least some comparable data available and secondly, would be useful in deciding between competing interventions. Moreover, due to time constraints in guideline development, it would not have been feasible to report and consider every outcome reported in the literature.
799.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	General		We are concerned that throughout the guideline, recommendations are made that overstate the evidence. The appraisal of selected evidence is thorough, reasonable and well documented in the full guideline. However, given that the number of studies is small (and in many areas extremely small), the quality of data is frequently rated low or very low quality,	Thank you for your comment. The ratings of evidence as 'low' or 'very low' are specific to the use of GRADE and have a technical meaning. These ratings take into account the sample size, but also such factors as risk of bias, uncertainty in the effect estimate and publication bias. Reflecting the quality of evidence as rated in GRADE, the majority of recommendations ask practitioners to

						and very significant limitations and uncertainty are acknowledged, the recommendations made frequently extend way beyond the quality and certainty of the evidence.	'consider' the relevant intervention or action reflecting that there is some uncertainty, whilst only a few recommendations use the stronger 'offer' where there is 'convincing' evidence that an intervention or action is efficacious or needed (e.g. by dint of physical health risk or legal requirement).
800.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	General		We are concerned that many of the recommendations are underpinned by the consensus opinion of the very small group of experts forming the NICE guideline group. The majority of the group members have expertise in a narrow aspect of the field of eating disorders. Thus for many recommendations there are only 1 or 2 members with expert experience in that domain. For example, only 3 members have any experience of inpatient treatment, and of these, none has expertise in adolescent inpatient care. Of these 3 members with inpatient expertise, only one appears to have experience of providing a catchment area service across the full care pathway for anorexia nervosa. People with severe and enduring anorexia nervosa often need repeated periods of treatment in outpatient and inpatient settings and the evidence base must be understood in this context to make informed expert recommendations for cost effective care. The membership also lacked full multidisciplinary representation, with occupational therapy omitted.	Thank you for your comment. The composition of the Committee was determined by the scope of the guideline. This scope was subject to consultation. In determining the composition of the group, the selection process was carefully conducted to ensure that the group was (i) broadly representative consisting of both professionals and non-professionals, and (ii) of a size that would enable effective group discussions. Both these aims were met in our selection of 20 individuals. Extending the membership further would have likely made the discussion and consideration of evidence considerably more difficult. In any case, as you are aware, the guideline and the recommendations contained therein are open and subject to stakeholder comments and it would be expected that concerned individuals/groups would bring their experience to bear in commenting on them. Such stakeholder comments are an essential and invaluable part of crafting NICE guidelines and have a significant impact on their final form.
801.	SH	QED –quality network for	Full	General		We are concerned that in the appraisal of selected evidence, lack of independent	Thank you for your comment. Due to the relatively small number of studies, many

		Eating Disorders – hosted by Royal College of Psychiatrists CCQI				replication of findings is not acknowledged when present as a limitation of the evidence base.	of the findings of studies have not been replicated. However, this is not specific to the study of eating disorders and indeed is a general issue in the health and related- sciences. The reasons for this are beyond the scope of the guideline. Note that in the recommendations, the use of 'consider' and 'offer' have technical meanings as advised by NICE (See Developing NICE guidelines: the manual) to indicate the level of certainty, where the former indicates a high degree of certainty (e.g. where the benefits clearly outweigh the harms) and the latter indicates a lower degree of certainty (e.g. where there is a balance between benefits and harms to be thought about). As such, recommendations that are based on only one study are likely to use 'consider' unless there is convincing evidence (e.g. large sample size, low risk of bias, large effect size).
802.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	General		Americanised spelling should be corrected. Eg dietician.	Thank you your comment. The text has been amended throughout the guideline.
803.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	General		We are concerned that there are inconsistencies between the introduction (chapter 2) and the subsequent body of the guideline and recommendations. For example, on page 32 the tube feeding section cites studies suggesting NG feeding does not have negative impact on outcome and may be superior to oral feeding for those with binge purge	Thank you for your comment. Some revisions have been made to the relevant paragraph in chapter 2.

						subtype of AN. However, in section 6.8 on page 404, the guideline concludes that the evidence is insufficient for recommendations about NG feeding to be made. The rationale for highlighting this evidence in the introduction is therefore unclear. There are many other examples throughout the introduction.	
804.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	General		We are concerned that there is no comment or recommendation in the guideline about what *care* is appropriate for those with long duration of eating disorder. The section on coordination of care is a welcome addition to the guideline and makes some useful recommendations. Page 174 coordinated care, contains a statement that 'many people with eating disorder will require treatment for a long period of time, often a number of years.' (Indeed, a subgroup of patients may require care for many years.) However, the section on treatment of anorexia nervosa recommends a very limited range of therapies that can be considered for duration of 40 sessions – a year at most. There is therefore no guidance about what care or treatment should be delivered for these 'long periods of time'. It is helpful to distinguish between *care* and *treatment* for eating disorders. Treatment can be conceptualised as intervention aimed at improvement in core symptoms of disorder, and thus also function and quality of life. Care can be conceptualised as a supportive biopsychosocial approach aimed at maintaining stability, optimising quality of	Thank you for your comment. Some recommendations have been added to address the issue of long-term care and management of people with eating disorders who do not wish to access treatment, or who have not benefited from treatment, and who still have significant issues.

						life and monitoring to provide a safety net. Delivery of care is appropriate and cost effective when there is severe and enduring disorder that has not improved with best available treatments. Judicious provision of care can prevent, or minimise, deterioration into medical or psychiatric crisis that may necessitate admission. Services vary significantly in their allocation of resources to care and treatment. Some services provide only treatment, some provide only care, many try to strike a balance between the two. For other serious mental illnesses (SMIs) the need for provision of care is taken for granted by commissioners and providers alike. This is not the case with eating disorders. Since no need for provision of care is stated in the guideline, there is high risk that commissioners and providers will take the view that it should not be funded. Lack of care for those with high medical and psychiatric risk associated with severe and enduring eating disorder, particularly those who are difficult to engage with care, will result in greater mortality and is likely to result in increased need for admission in medical or psychiatric crisis. The current commissioning arrangements in the UK increase the risk associated with this omission. There is no financial incentive for CCGs to fund care that is necessary to reduce admissions and costs to NHSE funded inpatient care. There may be little consensus about what constitutes appropriate care, and	

						thus highly specified recommendations may be inappropriate. It is nonetheless necessary to state that ongoing care is necessary for those with severe and enduring eating disorder when there is clinical instability, and/or when a person is unable to seek help when needed.	
805.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	full	Treatment of anorexia nervosa		We are concerned that the restriction of the range of treatments recommended for the treatment of anorexia nervosa is not supported by the evidence appraisal, and will be unacceptable to many patients. There are very few studies, rated poor quality, with small effect sizes, great uncertainty and there is little independent replication of findings. Yet on the basis of this extremely poor evidence base, previously recommended, widely used therapies are now excluded. Lack of evidence must be distinguished from evidence of a lack, particularly as the evidence for the 'best' therapies shows them to be ineffective for the majority of patients. Generalisability is limited because the majority of studies providing evidence in this domain recruit from an unrepresentative sample of people with anorexia nervosa - rarely do studies include people with BMI <14, whilst in clinical practice presentations at BMI <14 are commonplace amongst adults (particularly amongst the population of patients using inpatient treatment, for whom prevention of admission is an important treatment outcome).	Thank you for your comment. The recommendations regarding treatments for anorexia nervosa have been revised to include MANTRA and SSCM as first-line treatments in addition to CBT-ED, and focal psychodynamic therapy as second-line. The Committee recognised the difficulties of implementing focal psychodynamic therapy given current practice and that there was no evidence of substantive difference between CBT-ED, MANTRA and SSCM. The Committee also recognised the dearth of evidence for psychological interventions in severely ill people with anorexia nervosa. Note however that there are some studies in this important subgroup, which is evaluated and discussed in the evidence reviews for refeeding and compulsory treatment. Although you are correct in pointing out that a number of the available and reviewed treatments have modest outcomes, NICE guidelines should recommend those interventions that are most likely to provide benefit to the relevant individuals and as such it is our position to recommend interventions where there is evidence of effectiveness (preferably evidence from well-conducted RCTs) and hence . The Committee therefore did not consider it appropriate

						It is extraordinary that the guideline group state that although there is no convincing evidence for MANTRA it is included because it is widely used and thought effective, whilst other therapies widely used and thought effective are not included in the list of options. In these studies, almost universally, the treatment with the (marginally) better outcome is that developed by the research team. This is in keeping with the finding of the Sheffield psychotherapy study that therapists delivering 2 different therapies have the best outcome in their preferred therapy. Ie the therapy developed by the team conducting the research is their preferred therapy, understood most fully and delivered with the greatest passion and skill. It is therefore the most effective (marginally). The guideline acknowledges that the specific model of focal psychodynamic therapy employed by the German group is not widely available. Alternative similar models are widely used in the UK, for example, cognitive analytic therapy. Premature restriction to a narrow range of therapies carries high risk of limiting vital evidence generation in the treatment of a disorder for which there are no treatments that can be considered good, nor even moderately well evidenced. This section should therefore be revised. Rather than embark on a long period of retraining of a large number of therapists to deliver their non-preferred (and thus less effective) therapy, an alternative approach would be to continue to include	to recommend interventions for which there is limited or no evidence in the form of RCTs.

						a broader range of therapies, graded appropriately according to the current evidence base. With guidance that patients should be offered an informed choice, having been provided with information about the evidence base for each, and the clinical judgement of the assessor, based on clinical formulation and treatment history. Recommendations should be made for further research in this domain.	
806.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	Treatment of anorexia nervosa		We are concerned that the inconsistency between the evidence appraisal and the recommendations for treatment of anorexia nervosa indicate a degree of bias within the guideline development group toward therapies developed by members of the group.	Thank you for your comment. The recommendations for psychological interventions for adult anorexia nervosa have been revised to include CBT-ED, MANTRA and SSCM as first line treatments and focal psychodynamic therapy as second line. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision. Please note that when work was discussed that involved one of the Committee members, they were only asked for points of clarification and did not play a role in decision making (please see declarations of interest in Appendix B, and Section 3.3 in the full guideline).
807.	SH	QED –quality network for Eating Disorders – hosted by	Full	Treatment of anorexia nervosa		We are concerned that the strong recommendation that clinicians should use manuals for treatments represents a	Thank you for your comment. The actions set out in Appendix B (declarations of interest) at consultation were not fully accurate and the NGA

		Royal College of Psychiatrists CCQI				conflict of interest for a number of the guideline group.	apologises for this error. Where studies or manuals were discussed that involved one of the committee members, they did not participate in decision making and only answered questions on points of clarification. They did not play a role in the committee's decision making. The appendix has now been updated accordingly. It should be noted that the revised recommendations do not identify any particular manual with the exception of MANTRA (since there is only one such manual).
808.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	Inpatient treatment		The QED steering group recognises the need to reduce ineffective and harmful use of inpatient treatment. In addition to reducing long term harm to patients, doing so could facilitate diversion of valuable resources to much needed universal access to high quality outpatient/community treatment for people with eating disorders. We recognise that there is currently a significant prevalence of prolonged admissions with very poor outcome. It is likely that potential for harm from admission is not considered adequately in clinical decision making about initiating admission, and importantly, about ending admission. We therefore welcome the focus the guideline gives to potential harm. We are concerned that the recommendation that 'the only time inpatient care is a viable option for people with an eating disorder is if their	Thank you for your comment. Please note that the recommendations have been substantially revised to clarify criteria for admission to hospital. Although the evidence was generally of low and very low quality (as rated using the GRADE system of evaluation, the reviewed studies consistently showed that inpatient treatment does not provide benefits over and above the same treatment delivered in other settings. The Committee agreed that early intervention can make substantial difference, as discussed in the relevant LETRs, and have made specific recommendations addressing individuals with a severe form of an eating disorder and who may have lived with this condition for a substantial period of time.

						physical health is compromised and inpatient treatment is needed for medical stabilisation and the initiation of refeeding' is too vague and provides insufficient guidance to optimise the cost effective use of inpatient treatment. It can readily be argued that the vast majority of people with anorexia nervosa have compromised physical health. On the other hand, the draft guideline has already been widely interpreted as indicating that only patients at acute high medical risk should be offered admission. Such an approach would lead to admissions only in extremis, resulting in greater morbidity, chronicity and mortality. It risks greater use of inpatient resources as experience suggests that those at extremely low weight and with more enduring illness tend to need longer admissions to restore sustainable stability. In addition, chronicity is associated with poor outcome. And finally, such an approach also risks conveying a message that 'you are not ill enough to need admission' and thus the risk that people will lose weight in order to access admission. The evidence related to inpatient care is particularly poor in quantity, quality and relevance. This is only partially recognised by the evidence appraisal. For example, the study comparing long and short admissions compares admissions of 22 and 38 days. The average duration of admission in the UK is around 3-5 months and long	

						admissions last for a year and sometimes more. In the absence of evidence to answer any of the key questions, the guideline must by necessity be based on expert opinion. We suggest that further guidance on indications for admission is necessary. Such guidance should differentiate between those early in the course of illness with no previous admissions, and those with enduring illness and repeat admissions. The former have no treatment history to indicate likely response to inpatient care, and experience suggests that carefully planned admission can be a useful adjunct to ongoing outpatient treatment. The latter group, particularly where there have been repeat admissions, have a treatment history that can be used to guide optimal, individualised indications for admission to minimise inpatient use and minimise disconnection from life.	
809.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	Inpatient treatment		It is excellent that review is recommended at 4 weeks of admission, with thought given to non-adherence (recommendations 54 and 55), but we are concerned that this is insufficient to prevent prolonged ineffective admissions. Stronger guidance is needed to prevent these. For example, a patient admitted at extremely low weight might gain weight very effectively for the first 4-6 weeks of admission, but then become very stuck as the emotional distress associated with weight restoration intensifies. How long is	Thank you for your comment. Preventing ineffective admissions is vitally important and a number of recommendations have been made regarding care planning and discharge from inpatient care to discourage these. The Committee agreed that inpatient admission should only be for medical stabilisation on the basis of evidence that there is either no difference in the short- and long-term outcomes of people with an eating disorder who are treated in an inpatient setting compared with other settings, or that it is less

						reasonable to persist without further weight gain? How long is it reasonable to persist if there is clear evidence of psychological change and shift in the family's approach but no further weight gain yet? Should a person be discharged even if they remain at high medical risk? It would be helpful if regular 4-6 week reviews were recommended so that adherence and other treatment options could continue to be thought about. The guideline seems to suggest discharge is appropriate when medical stability has been restored. We suggest that a more appropriate goal is that the person is well enough to continue effective treatment toward appropriately individualised goals at a lower intensity of care. This is a missed opportunity not to develop some guidance about when and how to review risk/benefit of ongoing admission. Without evidence, the guidance cannot be rigidly proscriptive or prescriptive, but could helpfully suggest some guiding principles to support better planned and more cost effective use of inpatient treatment.	effective. The Committee agreed that determining explicit criteria for the decision to continue treatment or not would not be helpful though noted that in many cases early change predicted whether an intervention would be effective. Regarding review of treatment and care, the relevant recommendations have been amended to specify that as part of the review, a schedule for further review on - at a minimum - a monthly basis should be agreed.
810.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	190 & 196		We are concerned that some parts seem contradictory as recommendation 49 recommends inpatient treatment for medical stabilisation and initiation of refeeding (suggestive of short admissions) but weight restoration is a goal for admission in recommendation 56 and other parts of the guidance.	Thank you for your comment. Note that the recommendations for inpatient and day care treatment, as well as those on discharge planning, have been substantially revised. The recommendation regarding medical stabilisation/refeeding specifies the issues that should be thought about

							when considering whether to admit the person with an eating disorder to inpatient or day patient care. The subsequent recommendation makes clear that reaching a healthy weight should not be the sole criteria for discharge.
811.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	General		We are concerned that the guideline development group have perhaps focused excessively on research interests and outpatient treatments developed and championed by group members, to the detriment of developing guidance in domains such as inpatient treatment, where evidence is poor, but broad principles could be developed by drawing upon a broader base of expert opinion (both professional and service user/ carer).	Thank you for your comment. There are many issues that the Committee would have liked to address but due to time constraints they had to choose their review questions according to what they considered to be the most important issues.
812.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	317		Other considerations section states that there was nutritionist on the committee – this is incorrect, it was a dietitian. It is important the difference between a dietitian and nutritionist is not confused. Later in the same section there is reference to the health professional giving dietary advice being likely to be a nutritionist – this should be a dietitian.	Thank you for your comment. The text has been amended.
813.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	410; 618; 838; 904		Recommendations 101,121, 143, 158 for diabetes recommend a low carbohydrate diet. This is not evidence based and not what is done in practice. At this stage avoiding carbohydrate risks underfeeding. Routine feeding should be followed with insulin doses adjusted accordingly. A recommendation should be included to measure ketone levels if a person with diabetes feels unwell, has an	Thank you for your comment. The reference to a low carbohydrate diet has been removed and the recommendations regarding diabetes have been substantially revised.

						infection or has repeated high blood glucose levels to check for ketoacidosis,	
814.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	General		We are concerned that these guidelines will form the basis for commissioning for EDs. As they stand, they are confusing and contradictory, and unhelpfully over prescriptive and restrictive	Thank you for your comment. The recommendations have been revised for clarity in light of stakeholder comments.
815.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	General		Occupational therapy interventions are almost without mention in this guideline. This is likely to be unacceptable to patients who value these interventions, and the broader focus on life that is brought by the OT perspective.	Thank you for your comment. No RCT studies were identified that examined the efficacy of occupational interventions in the treatment of eating disorders.
816.	SH	QED –quality network for Eating Disorders – hosted by Royal College of Psychiatrists CCQI	Full	Inpatient		The inpatient section would benefit from recommendations about basic components of inpatient care such as OT intervention, psychosocial nursing intervention, access to psychological therapy and family based interventions.	Thank you for your comment. The recommendations regarding inpatient care have been substantially revised. However the Committee did not specifically recommend any inpatient interventions as they were of the opinion that inpatient treatment should be avoided if possible unless an individual is admitted for medical stabilisation of physical complications and/or refeeding. Furthermore, very few studies were found that examined the use of the listed interventions in an inpatient context. Note that a new section titled 'Care planning and discharge from inpatient care' has been inserted.
817.	SH	QED –quality network for Eating Disorders – hosted by Royal College of	Full	398		We are concerned that there is no recommendation about testosterone treatment for male patients. Consideration of the specific needs of men with eating disorders is an important equality and diversity issue in ED.	Thank you for your comment. No evidence was identified that addressed this issue. The Committee recognised that there is a dearth of evidence specifically concerning eating disorders in men and made a research

		Psychiatrists CCQI					recommendation in the hope that this would be rectified.
818.	SH	Royal College of Psychiatrists	Full and short			We are concerned that the consultation timescale (6 weeks covering the Christmas holidays for a hugely important, more than 1000 pages document) has been insufficient, For this reason, we have mainly concentrated on the short guidance in detail, and would suggest that the consultation time is extended to allow proper scrutiny of the full document, particularly the interpretation of the evidence – which cannot be fully covered in this document.	Thank you for your comment. The consultation period was the standard 6 weeks required by the NICE guidelines manual and very few stakeholders expressed any concern with the deadline for comments. NICE and the NGA showed as much flexibility as they could to those that did, and extending the deadline for consultation would have delayed the whole project unduly.
819.	SH	Royal College of Psychiatrists	Full and short			The Guidance should include all age groups, including older adults. Whilst the evidence base is limited, these patients exist, and there are important implications for service delivery and training. Older patients should not be discriminated against under the Equality Act. Please find some recent references: Lapid MI[1], Prom MC, Burton MC, McAlpine DE, Sutor B, Rummans TA Eating disorders in the elderly. Int Psychogeriatr. 2010 Jun;22(4):523-36. Schaeffer,J: Elder Eating Disorders: Surprising New Challenge *Eating Disorders Review* November/December 2004 Volume 15, Number 6	Thank you for your comment. The Committee recognised that there was little or no evidence on the treatment of eating disorders in older adults and therefore did not offer any recommendations for this age group. The relevant text in both the full and short guideline has been updated to ensure that age is explicitly mentioned regarding equal access to services. Regarding the references you provide: Lapid et al. (2010) has been included in the introduction to the guideline. Schaeffer (2004) is a narrative review and has not been included as Lapid et al. (2010) provides a more recent update of research on eating disorders in the elderly.
820.	SH	Royal College of Psychiatrists	Full and short			We are concerned that there is no reference to the DSM-5 Feeding and Eating Disorders Categories. Whilst this is a US diagnostic system, it will	Thank you for your comment. The recent change of eating disorder categories in DSM-V to include OSFED and ARFID is mentioned and briefly discussed in the

						influence research and evidence base in the next decade, when the new NICE guidance will be operational in the UK. The DSM-5 introduced a number of important changes, such clarifying severity ratings (in the case of anorexia nervosa these are now in line with the WHO categories of malnutrition). It also introduced new eating disorder categories such as Rumination Disorder, ARFID. It would be helpful to acknowledge the existence of these changes, particularly that the revision of the ICD is likely to include them in the next version. For example, in case of anorexia nervosa, the DSM-5 helps with standardising the concept of remission of BMI (normal between 18.5-25 depending on age and ethnic group, rather than 17.5 which is malnourished).	introduction and in the chapter on the treatment of atypical eating disorders. It should be noted that the treatment of feeding disorders such as rumination or pica disorder was not within the scope of this guideline.
821.	SH	Royal College of Psychiatrists	Full and short			We are concerned that the research is interpreted mechanically without an attempt to standardise basic concepts, such as ‘remission’ or ‘medical stabilisation’. There is a wide variation how these concepts are used, both in research and in clinical practice. This is particularly important when significant changes of practice are recommended based on limited evidence. We strongly recommend that guidance includes an attempt of definition of both of these important concepts. Furthermore, there are a number of errors in interpreting the evidence. The detailed analysis of these would require more time.	Thank you for your comment. When making their recommendations, the Committee discussed differences in the way that researchers have defined these concepts and took these into account in deciding whether to include or exclude data from a particular study. For example, when analysing family therapy for anorexia nervosa in young people, data for 'full' and 'partial' remission were combined in order to allow the meta-analysis of three studies (Lock 2010, Robin 1999, Russell 1987). Regarding errors in interpreting the evidence, we are unable to respond to this point in lieu of more detail.

822.	SH	Royal College of Psychiatrists	Full and short			We are concerned about the lack of inclusion of aspects of treatment in a general hospital setting. The document is said to apply to all NHS settings but lack of details of treatment/care planning whilst people with severe eating disorders require admission to a general hospital for treatment of medical complications or for medical stabilisation, risks perpetuating poor aspects of care in this setting. There are recommendations made in the RCPsych documents 'Marsipan 2nd ed. Guidelines' (referenced) and College Report 183 (2013) 'Liaison psychiatry for every acute hospital: integrated physical and mental health care' page 65-66 but no NICE guidelines addressing requirements in this setting despite the Marsipan guidelines arising from the result of adverse incidents, including deaths, related to lack of expertise in this setting. We are aware of patients requiring prolonged periods in a general hospital whilst waiting for an eating disorder bed despite the general hospital not having access to specialist eating disorder psychological therapy or a psychological therapeutic environment.	Thank you for your comment. Both MARSIPAN and Junior MARSIPAN are referred to in the recommendations about inpatient and day care treatment and in the subsection on refeeding for the treatment of malnutrition. Note also that the recommendations have been substantially revised regarding care planning and discharge from inpatient care. The Committee declined to include reference to CR183 in the guideline.
823.	SH	Royal College of Psychiatrists	Full and short			We suggest using the term 'malnutrition' rather than 'starvation' throughout the documents (both the short and full guidelines). By using the word starvation, there is a risk that the term implies a patient choice rather than the result of an illness. Furthermore, eating disorders result in varying levels of malnutrition (from underweight to overweight, and	Thank you for your comment. The text has been amended. The Committee declined to include reference to the BAPEN MUST tool as the assessment of malnutrition is covered by MARSIPAN.

						severe vitamin deficiencies). This would help to direct non-specialists to existing evidence based tools to assess the severity of malnutrition. The BAPEN MUST tool is easily available on their website and it is widely used by the NHS: http://www.bapen.org.uk/screening-and-must/must-calculator; http://www.bapen.org.uk/pdfs/must/must_full.pdf. This would be particularly helpful for GPs and acute hospitals, but also for self-screening for patients. It would also improve patient safety, as the level of malnutrition is one of the most important risk indicators. This is recognised by the DSM-5: the level of malnutrition is a severity indicator for anorexia nervosa (mild >BMI 17, moderate: BMI 16-16.99, severe BMI 15-15.99, extreme BMI <15). Raising awareness of this would be very helpful. Furthermore, there are NICE guidelines managing malnutrition in hospital settings https://www.nice.org.uk/guidance/cg32 but no guidance on managing 'starvation'. It is important to refer to existing NICE guidance: malnutrition can kill and has a huge cost to the NHS regardless whether the cause is physical or psychological.	
824.	SH	Royal College of Psychiatrists	Full and short			It would also be helpful to make it explicit that there are no RCTs of outpatient psychological treatment of anorexia nervosa with extreme malnutrition (BMI<15). Furthermore, a significant proportion of participants require hospitalisation during the intervention in all such studies.	Thank you for your comment. Although the Dalle Grave 2013 study was included in the evidence review for psychological treatments for adult anorexia nervosa, it was not meta-analysed with the other studies (which were all conducted in predominantly outpatient settings) but looked at on its own as comparing two

						Therefore, we advise caution re generalisability of evidence based treatment for anorexia nervosa – as all clinical trials of outpatients included patients above this BMI. In adult services, patients often present with life threatening malnutrition (BMI 8-12). The only evidence for this patient group is an RCT of an inpatient CBT-E by Dalle Grave (2013). This was a pioneering study, redesigning inpatient treatment using the transdiagnostic principles of CBT-E, producing much better outcomes than traditional inpatient models, during a shorter timescale; potentially offering significant saving to the NHS. We feel that this study was wrongly included in the analysis of individual therapy for anorexia nervosa – as it is a comprehensive inpatient treatment, offering a coherent theoretical framework and addressing both physical and psychological factors. It would be helpful to highlight this study when making recommendation about the treatment of the most severe patients, who require hospitalisation. At the very least, it would be important to encourage further research into inpatient treatment. Given the high cost and poor outcomes, we feel that this is urgently needed.	types of CBT-E inpatient treatments. The study showed no difference between the two versions of CBT-E on BMI, EDE-subscale scores nor general psychiatric features at end of treatment and follow up. As detailed in the relevant LETR, the Committee acknowledged that none of the studies conducted in an outpatient setting included only participants with a BMI <15. However, they felt that - in lieu of more evidence regarding the inpatient treatment of people with a BMI<16.5 and especially given the high costs to the healthcare system - treatment of this subgroup should be the same as those who have a less severe illness. Regarding future research, the committee felt that there were other issues that were of greater national priority and that merited an explicit research recommendation.
825.	SH	Royal College of Psychiatrists	Full and short			The a, b, c grading of evidence in the previous NICE guidelines was clear and easy to understand. It is more difficult to tease out the evidence in the draft long guidelines; the text mixes up recommendations based on discussion in	Thank you for your comment. The previous guideline reflects how NICE used to present their recommendations. However, the wording of recommendations in the new short guideline is required to follow the

						the committee from recommendations based on low/high quality evidence. The text is not user friendly.	methods outlined in "Developing NICE guidelines: the manual". "Developing NICE guidelines: the manual"
826.	SH	Royal College of Psychiatrists	Full and short			It would be helpful to note that none of the currently available and NICE recommended psychological treatments have a 100% success rate. Furthermore, the length of illness can be many years, much longer than 20-40 sessions in trials. It would be helpful to comment on what should be offered on the NHS to those patients who typically did not respond to treatment in research and comment no what services should do with patients with eating disorders for whom treatment manuals don't work – should they be discharged to primary care? Some of these patients remain ill for several decades and require repeated hospitalisation to prevent death.	Thank you for your comment. The recommendations have been revised to be clearer about care planning and discharge from inpatient care.
827.	SH	Royal College of Psychiatrists	Short	4	12	1.1.2 please add 'age' under equal access. The guidelines need to cover all people with eating disorders: there are an increasing number of older patients, whose needs should not be overlooked. If the recommendations don't specify age, they may imply that age is irrelevant in terms of access to treatment or that older patients don't exist.	Thank you for your comment. The text has been amended.
828.	SH	Royal College of Psychiatrists	Short	6	14	1.1.11: limits of confidentiality include sharing of risks with carer/ nearest relative/ DVLA – for example, if there is a risk to the public by driving when physically unstable or when considering compulsory treatment.	Thank you for your comment.
829.	SH	Royal College of Psychiatrists	Short	6	15	1.1.12 Gillick competence. The guidelines state when seeking consent	Thank you for your comment. If a child or young person is deemed to be Gillick

						for assessment or treatment for children below the age of 16 Gillick competence should be respected if they do not want their parents/carers involved. This has been concluded through discussion in the committee and does not include mention of the rights and responsibilities of parents under the Children Act. We wonder if it should be made clear that parents have rights and responsibilities under the Children Act and without information they may not be able to exercise their duty as parents and take appropriate care of their children. This has to be balanced against the need to respect the wishes of the GIllick competent child.	competent, consents to treatment and does not wish the parents to be involved, then medical staff must respect this. A recommendation has been added referring to the recommendations on compulsory treatment, which mentions the Children Act, to cover the situation when the child or young person does not consent to treatment.
830.	SH	Royal College of Psychiatrists	Short	6	26	1.1.14: professionals assessing and treating eating disorders should be trained in eating disorders. Please state this explicitly. This has important implications, as postgraduate training on eating disorders remains limited for most health care professional groups, including doctors, psychologists, nurses and allied healthcare professionals. We are concerned if that this is not specified, some organisations will not ensure that their staff is appropriately trained. Furthermore, there needs to be a change in curriculum of relevant postgraduate training, such as general medicine, general practice, core psychiatry, mental health nursing where eating disorders often overlooked.	Thank you for your comment. The NHS or any healthcare system requires that practitioners working within its systems be competent in the relevant procedures before undertaking work with people. This would be expected to be the case for people with eating disorders.
831.	SH	Royal College of Psychiatrists	Short	7	4	1.1.16: professionals should receive specific training about the physical, psychological and social aspects of	Thank you for your comment. It is a requirement of the NHS, or indeed any healthcare system, that practitioners

						eating disorders, and receive appropriate supervision. Supervision alone cannot substitute for training.	working within its system be competent in the relevant procedures before undertaking work with people using the relevant services. This would be expected to be the case for people with eating disorders.
832.	SH	Royal College of Psychiatrists	Short	7	6	1.1.16 The EDE-Q covers bulimic behaviours, so this is duplication – keep EDE-Q only.	Thank you for your comment. The text has been amended.
833.	SH	Royal College of Psychiatrists	Short	7	10	1.1.16 Regarding the recommendation that 'professionals who provide treatments for eating disorders should: monitor treatment adherence in people who use their service' it will be helpful to have a clear definition of 'treatment adherence'. It will be helpful to have guidance on how to 'monitor' treatment adherence in people who use the service, given that up to now it has been very challenging to measure this in practice. It would be helpful to have clarity on what NHS professionals and services should do with patents who are not treatment adherent – e.g. should they be discharged from the service or receive further support and monitoring? This relates to the question what services should do to patients with severe and enduring eating disorders or patients who are classified as extreme in DSM-5 but who are not responding to evidence-based recommended psychological treatment manuals	Thank you for your comment. The references made to adherence in part refer to issues of uptake and engagement with treatment for people with eating disorders as well as the situation when individuals are engaged in treatment that they have agreed to, which if appropriate may involve the family/carer. These are important issues and in light of this and other stakeholder comments, some new recommendations were made, in particular regarding the joint agreement of a care plan.

834.	SH	Royal College of Psychiatrists	Short	7	15	1.2.1 Please add: 'including acute hospitals'. Patients with severe eating disorders often need admission or treatment in A&E or acute hospitals, and the recognition and awareness is poor, resulting in delay in appropriate treatment, or premature discharge. The NICE guidelines provide an opportunity to rectify this problem. Without specifying the role of the acute hospitals, there is a risk that the guidance is regarded as irrelevant for them. Please add an additional bullet point about the workplace, and higher education.	Thank you for your comment. The text has been amended as suggested.
835.	SH	Royal College of Psychiatrists	Short	8	2	We suggest adding a bullet point 'abdominal pain leading to dietary restriction or vomiting which is not fully explained by physical pathology'	Thank you for your comment. The text has been amended as suggested.
836.	SH	Royal College of Psychiatrists	Short	8	10	Please also add unexplained electrolyte abnormalities, and hypoglycaemia – as these can be potentially fatal.	Thank you for your comment. The text has been amended to reflect your suggestion.
837.	SH	Royal College of Psychiatrists	Short	8	15	1.2.3 Please add age.	Thank you for your comment. The text has been amended.
838.	SH	Royal College of Psychiatrists	Short	8	19	1.2.4 Please add pubertal delay as this a severe complication of chronic malnutrition in children and young people.	Thank you for your comment. The text has been amended. Please note that the recommendations have been substantially revised.
839.	SH	Royal College of Psychiatrists	Short	8	22	1.2.5 Pease add: But can affect all age groups	Thank you for your comment. The text has been amended to emphasise that people of any age can develop an eating disorder.
840.	SH	Royal College of Psychiatrists	Short	8	28	1.2.8 Please also add acute hospitals: they have a role in the assessment of patients with eating disorders – as some patients first present in acute emergencies to acute hospitals.	Thank you for your comment. The text has been amended to include reference to acute hospitals

841.	SH	Royal College of Psychiatrists	Short	9	2	1.2.8 Please replace starvation with malnutrition and refer to the BAPEN website (see above)	Thank you for your comment. The text has been amended. The Committee declined to include reference to the BAPEN MUST tool as the assessment of malnutrition is covered by MARSIPAN (see Recommendation 1.12.4 and 1.12.9).
842.	SH	Royal College of Psychiatrists	Short	7 8	12	There is no mention of (assessing) the impact of social media and internet usage in this section on assessment.	Thank you for your comment. Assessing the role of the internet and social media usage in a person's eating disorder is addressed in another recommendation.
843.	SH	Royal College of Psychiatrists	Short	9	18, 19, 20	1.2.10 Given the recommendation that 'care should be coordinated' when a young person moves from children's to adult services (see the 19 NICE guideline on transition from children's to adults' services) it would be helpful to indicate whether family therapy should be offered in adult ED services? In this regard, the NICE guideline 'Transition from children's to adults' services for young people using health or social care services (Published: 24 February 2016, p. 11, 1.2.22) recommends that 'Adults' services should take into account the individual needs and wishes of the young person when involving parents or carers in assessment, planning and support'. If young people, request family therapy should this be offered in adult services – especially because this is recommended for the whole period that they are linked to children and adolescent services? Family interventions are not included in the 2017 guidelines for adults whereas it was included in the 2004 guidelines.	Thank you for your comment. It is important when developing any transition plan to take into account the need to deliver appropriate treatment plans. This is made clear in the recommendation and the expectation is that current treatments would be taken into account. This will involve some flexibility in the delivery of psychological interventions. A recommendation regarding family therapy might be unhelpful if explicit recommendations for adults were made, especially given the absence of evidence in this area.

844.	SH	Royal College of Psychiatrists	Short	9	24	1.2.10 It would be helpful to make recommendations regarding commissioning services for university students given the high prevalence of eating disorders in this group and frequent changes of residence. Most university students want to be treated closer to their place of study. However, it's important to take into account the fitness to study guidance, as some students may need to take time out of their study to ensure the best chance of recovery: http://www.heops.org.uk/heops_guidance_fitness_to_study_with_severe_eating_disorders.pdf It would be very helpful to comment on fitness to study, as not infrequently students and universities are reluctant to take a break from studying even when there is a significant risk to life or long term health. The fitness to study guidance guarantees that the patient can resume her studies when they are well.	Thank you for your comment. It has been made clear in the general principles at the beginning of the short guideline, in line with the Equality Act, that all people have the right to equal access to treatment.
845.	SH	Royal College of Psychiatrists	Short	9	25	We are concerned that this recommendation does not highlight the difficulty in co-ordinating both mental and physical care related to an eating disorder in general hospital settings. We suggest adding a bullet 'in general hospitals when there is admission for treatment of physical complications of an eating disorder'	Thank you for your comment. A number of suggestions have been made for increased coordination between services including the recommendation that community eating disorders teams should maintain contact with the person with an eating disorder.
846.	SH	Royal College of Psychiatrists	Short	10	5	1.2.12 please add: this is important both for optimal health as well as addressing one of the main maintaining factors of the	Thank you for your comment. The recommendation have been revised in

						psychopathology. It is important that treatment addresses physical, psychological and social factors.	light of this and other stakeholder comments.
847.	SH	Royal College of Psychiatrists	Short and full	10	11	1.2.14 It would be helpful to note that that there are no RCTs for the outpatient psychological treatment of extremely malnourished patients (BMI <15) with anorexia nervosa, or patients with severe psychiatric comorbidities, so any advice for the most severe patients needs to be tentative. The evidence for eating disorder specific focal psychodynamic therapy is based on one German trial with significant methodological problems (as fundamental as defining remission). This psychotherapy was specifically designed for that trial and it is very different from current UK practice of psychodynamic therapy. Before it is recommended as first line treatment, replication studies in the UK would be needed. Regarding the recommendation that 'Eating-disorder-focused focal psychodynamic therapy programmes for adults with anorexia nervosa should: 'use a focal psychodynamic manual specific to eating disorders' the committee noted that an English manual will be available in 2017 and as far we know there are no English training programmes available yet. In practice it might take several years to train a sufficient number of therapists to deliver FBT across the UK. It is also unclear what the minimum training requirements and minimum accreditation	Thank you for your comment. The Committee felt that the evidence for focal psychodynamic therapy was sufficiently strong to recommend that treatment providers should consider offering focal psychodynamic therapy as a treatment for adult anorexia nervosa. However, , they decided to relegate this to a second-line treatment option, and recommend that MANTRA and SSCM in addition to CBT-ED should be offered as first-line options. This was due to the reasons adduced in your comment and the recognition that there is evidence of no difference between the recommended treatments. It is appreciated that implementing the recommendations will likely require some retraining of staff and development of supervision but it is expected that this issue, a matter for local determination and implementation, can be managed over a period of time.

						levels of FBT therapists in the UK would need to be in future. If FBT therapists for example need to be accredited psychodynamic psychotherapists (with additional FBT training) then it would require recruitment of new staff or training of existing staff members in psychodynamic psychotherapy (which is a lengthy and expensive training course). We are therefore concerned that this recommendation in the short version without a caveat will set unrealistic expectations for patients, carers and commissioners that FBT should be immediately available on the NHS. We wonder therefore whether the committee would consider a rephrase of the recommendations and that FPT should be offered when the training manual and relevant training programmes have been made available in English and when UK psychological therapists have been adequately trained. We believe that further research is needed to replicate the findings.	
848.	SH	Royal College of Psychiatrists	Short	10	12-17	1.2.15 The recommendation states that CBT-ED therapists should 'create a personalised treatment plan based on the processes that appear to be maintaining the eating problem. However, the CBT-E treatment manual recommends Interpersonal therapy if interpersonal factors are maintaining the eating disorder. In this regard, we are aware that IPT has been omitted from these guidelines as a treatment option.	Thank you for your comment. It is important when developing any transition plan to take into account the need to deliver appropriate treatment plans. This is made clear in the recommendation and the expectation is that current treatments would be taken into account. This will involve some flexibility in the delivery of psychological interventions. A recommendation regarding family therapy might be unhelpful if explicit

						Similarly, in the absence of a recommendation for family therapy for adults, there is no recommended model to address interpersonal maintaining factors either through an individual focussed model or family/systems based approaches for adults with eating disorders. If this recommendation stands it will have significant impact on practice as many adult services have employed family therapists over recent years and based on the new guidelines these services would gradually have to get rid of all family therapists and no longer offer any couple or family work to patients over 18 years. This would not accommodate the choices or preferences of a small proportion of adults with eating disorders and their carers/family members. A recommendation to exclude all family work for adults with eating disorders would therefore be unacceptable for many patients, family members, professionals and services/organisations. There is a gap in the evidence for family work in adults, but if the guidelines recommend that no family work should be considered for adults then it is likely that all family therapists will lose their jobs and that no further research will happen in adult settings for many years.	recommendations for adults were made, especially given the absence of evidence in this area. Regarding the point made about IPT, in implementing the recommendations, it is expected that all psychological interventions for anorexia nervosa take maintaining interpersonal factors into consideration, hence no revisions were made to the recommendations.
849.	SH	Royal College of Psychiatrists	Short	10	15	1.2.15 The recommendation for anorexia nervosa is typically 40 sessions of treatment. We wonder what the committee's recommendations are on what should happen after the allocated number of sessions when patients	Thank you for your comment. Regarding longer-term support, including for those who have not benefitted from treatment, the recommendations have been revised to offer the possibility of further sequenced psychological treatment, and

						remain at risk or have shown partial or no-remission in symptoms?	continued support and management to the person with an eating disorder.
850.	SH	Royal College of Psychiatrists	Short and full	10	28	1.2.16 The recommendation of using manualised psychodynamic therapy for AN is based on one German study, with significant methodological shortcomings. The manual was specifically developed for the study to mirror CB-TE in terms of frequency and structure to help with double blinding, but at the expense of treatment fidelity. Furthermore, the way the authors defined remission was unusual: BMI 17 is malnourished state and would meet DSM-5 criteria for anorexia nervosa, making the main findings of this study questionable. There is a real concern that this treatment does not address weight and malnutrition.	Thank you for your comment. The remission definition was a PSR score (psychiatric status rating scale) of 1 or 2 and a BMI greater than 17·5 kg/m2. The Committee also noted your concerns but concluded on balance that it should be recommended. However, they decided to revise their recommendations for the treatment of adult anorexia nervosa to also include MANTRA and SSCM as recommended therapies. These recommendations were amended to reflect the facts that (i) there is evidence of no difference between CBT-ED, MANTRA and SSCM, and (ii) there is as yet no English manual for FPT and some services may incur significant costs when implementing its provision.
851.	SH	Royal College of Psychiatrists	Short and full	11	3	1.2.16 Psychoeducation is part of CBT-E but not part of focal psychodynamic therapy (not described in the ANTOP trial) so presumably this is an error here.	Thank you for your comment. This has been amended in the text.
852.	SH	Royal College of Psychiatrists	Short	11	21	1.2.17 It would be helpful if the Guidelines could define ‘ineffective’ when it suggests that when individual CBT-ED or focal psychodynamic-ED is ‘ineffective’ alternative models should be considered. The term ‘ineffective’ is potentially vague and might be interpreted differently by patients, carers and professionals. It is not very clear at which point the recommended first choice of psychological intervention for AN should be reviewed and considered as	Thank you for your comment. The approach that the Committee took to monitoring change during an individual's course of treatment was to recommend routine sessional monitoring and that this be used to guide both the delivery of therapy and decisions whether or not continue, cease, or switch to an alternative, treatment. Individual clinician’s should use their judgement in consultation with an informed discussion with the person with an eating disorder (and if appropriate their family or carers).

						ineffective or inappropriate. It would be helpful to have a sense of when different approaches should be considered and after how many sessions. Whilst there is a clearer stepped approach for BN and BED, there is still much less clarity in AN.	Note that revisions have been made to the recommendations regarding treatment options in anorexia nervosa, which will entail the routine monitoring just described.
853.	SH	Royal College of Psychiatrists	Short	11	21-24	In the context of long waiting lists, it will be helpful if the committee could give guidance on how many consecutive manualised treatments and sessions patients should receive? For example, if 40 sessions of CBT-ED are ineffective for a patient, should this be followed up by 40 sessions of Focal Psychodynamic Psychotherapy, followed by SSCM and MANTRA (while other patients wait). And what should services offer if the patient still doesn't respond, continues to have a severe/extreme eating disorder (as defined by DSM-5) and if the patient, family, GP, other professionals opposes discharge? We feel that there is a real opportunity for the Committee to address these clinical realities in the NHS.	Thank you for your comment. The recommendations have been amended to include CBT-ED, MANTRA and SSCM as first-line options, with focal psychodynamic therapy as a second-line option. Regarding longer-term support, including for those who have not benefitted from treatment or those who have a severe and enduring condition, the recommendations have been revised to offer the possibility of further sequenced psychological treatment, and continued support and management to the person with an eating disorder.
854.	SH	Royal College of Psychiatrists	Short	11	21-24	Given the efficacy of the recommended manualised interventions is low, would the committee advise that professionals use other individual psychotherapies (e.g. formulation-based approaches or clinical judgement to consider alternative psychological interventions) if none of the recommended manualised interventions are effective? We are concerned that a recommendation for manualised approaches only, ignores the evidence and clinical reality that manualised approaches don't treat all patients effectively. It is essential that the	Thank you for your comment. The Committee based their recommendation to use manual-based approaches on the fact that the vast majority of studies examining the efficacy of the relevant interventions were indeed manual based. Manuals provide a guidance structure to the delivery of an intervention. In all cases the application of a manual requires clinical judgement and this would be expected to be the case for people who are difficult to engage with.

						Guidelines offer suggestions on how to treat patients with eating disorders who do not respond to manualised treatments.	
855.	SH	Royal College of Psychiatrists	Short	11	11-24	Would the committee consider a general recommendation for young people under the age of 25 where clinical judgement is used in considering whether to offer interventions recommended for patients under 17 years, depending on the presentation of the patient? E.g. offer family based CBT-ED to someone who is 18/19 years old and still living at home.	Thank you for your comment. When extrapolating a recommendation from evidence regarding one age range (e.g. adults) to another (e.g. young people), it would be better if there was relative certainty about the age range one is basing the recommendations on. Hence the Committee decided to make no specific recommendation with regard to this given the overall low quality of available evidence.
856.	SH	Royal College of Psychiatrists	Short and full	11 (short)	26,27	1.2.18 The recommendation for AN-focussed family therapy to be delivered either as single OR multi-family therapy is misleading and does not follow from the results of the main paper quoted for this recommendation (Eisler et al., 2016). In this paper SFT is compared with SFT plus MFT (the number of single family therapy sessions was not significantly different between the two groups 18.5 vs 19 outpatient sessions) and showed that the combination could be more effective than single family therapy for AN. The recommendation in the NICE Guidelines needs to accurately reflect this result.	Thank you for your comment. The text has been amended.
857.	SH	Royal College of Psychiatrists	Short	14	4-11	1.2.32 As there are potential risks on growth in the use of oestrogens in young people, the Guidelines need to be clearer regarding the level of long term low body weight and low bone mineral density which would trigger consideration of the use of oestrogen, to prevent unnecessary use.	Thank you for your comment. The Committee have recommended that oestrogen use should not be routine and that specialist advice from a paediatrician or endocrinologist should be sought before commencing it.

858.	SH	Royal College of Psychiatrists	Short and full	14	18+	There is nothing about the management of patients with anorexia nervosa is acute hospitals. We regard this as a major omission. Whilst there are no RCTs on this, patients with anorexia nervosa often first present to A&E and frequently inappropriately discharged without any treatment for their extreme malnutrition with potentially life threatening consequences. The full guidance makes reference to the MARSIPAN guidance – but it would be essential t include this into the short guidance too. This would help acute hospitals to raise awareness and improve training. A reference for the NICE Nutrition support guidelines would be extremely helpful. https://www.nice.org.uk/guidance/cg32/resources/nutrition-support-for-adults-oral-nutrition-support-enteral-tube-feeding-and-parenteral-nutrition-975383198917	Thank you for your comment. Reference has been made to MARSIPAN in both the short and full guidelines regarding the treatment of malnutrition by refeeding.
859.	SH	Royal College of Psychiatrists	Short and full	16 (short)	24	We find it surprising that CBT–ED is not recommended at least as a second line treatment for bulimia nervosa. This is inconsistent with other topics in the guidelines where the recommendations for young people have drawn on the evidence for adults where there is a lack of a clear evidence base in young people. There is overwhelming evidence for the use of CBT- ED in adults with bulimia nervosa. Most BN patients are over 16 and therefore have been included in adult trials. The full guidelines state (p535) that CBT-ED is not being recommended due to lack of data in adolescents and the high costings noted in adults. However, there is no mention	Thank you for your comment. The recommendations for the treatment of bulimia nervosa in young people have been revised to recommend family-based therapy for eating disorders as first-line option and CBT-ED as a second-line option. The Committee recognised that providing young people with an individual therapy was important. Please note that after some discussion, one study that was originally classified as guided self-help, was reclassified as a form of CBT-ED (Schmidt 2007). Although there was no difference between family-based therapy and CBT-ED on remission at end of treatment and follow up (2 studies, Le grange & lock 2015, Schmidt 2007), the

						of the clinical effectiveness data in adults which is substantial. Moreover, the failure to recommend CBT- ED is based on a single study (le Grange et al 2015) with 53 adolescent patients undertaking this intervention (US sample). In this study (which compared a family-based approach with CBT-ED) there was no significant difference between the two groups at 12-month follow-up and the authors themselves suggest CBT-ED is a viable alternative to FBT for families who would prefer a largely individual treatment or where families are not available. Furthermore, it is in contradiction with the guidance that young people have a right to exclude their parents from their treatment if they are Gillick competent. CBT-ED focuses on the individual, and in our experience young people well engage in it.	results favoured family -based therapy. Combined with the high cost of CBT-ED in adults, they thus decided only to recommend it as a second-line option.
860.	SH	Royal College of Psychiatrists	Short	11 & 16	26	It would be helpful to note that none of the currently available and NICE recommended psychological treatments have 100% success rate. Furthermore, the length of illness can be many years, much longer than 20-40 sessions in trials. It would be helpful to comment on what should be offered on the NHS to those patients who typically did not respond to treatment in research trials. Similarly, what should be offered to severe and enduring eating disorders (SEED)?	Thank you for your comment. Regarding longer-term support, including for those who have not benefitted from treatment or those who have a severe and enduring condition, the recommendations have been revised to offer the possibility of further sequenced psychological treatment, and continued support and management to the person with an eating disorder.

861.	SH	Royal College of Psychiatrists	Short and full	18	18	There is no mention of Rumination disorder, which is included amongst eating disorders in the DSM-5.	Thank you for your comment. The treatment of rumination disorder, which was not classified as an atypical eating disorder in DSM-IV - but rather as a feeding and eating disorder of infancy or early childhood - was not within the scope of this guideline.
862.	SH	Royal College of Psychiatrists	Short	19	3	We are concerned that this section (1.8) does not highlight the need for collaboration when treating severe physical complications in a general hospital setting. We suggest the sentence is modified to '…teams should collaborate when caring for people with *physical complications or physical or mental health comorbidities'*	Thank you for your comment. The reference to physical complications would not be appropriate here as this section concerns comorbidities.
863.	SH	Royal College of Psychiatrists	Short	19	2	1.8.1 Physical and psychological comorbidity is very high amongst patients with eating disorders. It is important that care is not fragmented and that common comorbidities, such as depression, anxiety or physical complications are managed by the same team. Similar example would be managing comorbidities and complications in diabetes. In our experience general adult mental health service lack expertise managing comorbidities in eating disorders. We are concerned that this section (1.8) does not highlight the need for collaboration when treating severe physical complications in a general hospital setting. We suggest the sentence is modified to '…teams should collaborate when caring for people with	Thank you for your comment. The reference to physical complications would not be appropriate here as this section concerns comorbidities.

						physical complications or physical or mental health comorbidities'	
864.	SH	Royal College of Psychiatrists	Short	19	10	1.8.3 We are concerned that the section on diabetes does not mention the high risk periods of hospital admission or recognition/diagnosis of atypical presentations of eating disorder sin diabetes. We suggest adding two bullet points 'Hospital based Liaison Psychiatry services or Eating disorder services should collaborate closely with physical healthcare teams when people are admitted to a general hospital for physical treatment related to comorbidity diabetes and eating disorder (see MARSIPAN) to ensure both physical and mental health related risks in the hospital setting are appropriately managed and the patient receives some expert psychological management as well as physical treatment. 'Liaison Psychiatry Services and/or Eating Disorder services should be commissioned to provide assessments, and treatment if required, of patients with poor diabetic control related to psychological difficulties linked to weight and body image'	Thank you for your comment. The recommendations have been substantially revised. Note that there is a recommendation in the general principles section of the guideline 'Coordination of care' that specifies that services should collaborate closely to ensure continuity of treatment and care, and a specific recommendation regarding cooperation between healthcare teams when caring for people with an eating disorder and a physical/mental health comorbidity. Furthermore the section on health monitoring has also been substantially amended.
865.	SH	Royal College of Psychiatrists	Short	21	19	1.8.18 Monitoring weight and height should be mandatory for all children with eating disorders. Otherwise developmental delay won't be recognised.	Thank you for your comment. Weight gain, and the monitoring of weight and eating, are all essential parts of the therapeutic interventions that have been recommended in this guideline. Therefore a separate recommendation as suggested is not required.
866.	SH	Royal College of Psychiatrists	Short	22	15	1.10.1 Please add: level of malnutrition using the MUST tool t http://www.bapen.org.uk/pdfs/must/must_full.pdf	Thank you for your comment. The text has been amended. The Committee declined to include reference to the

							BAPEN MUST tool as the assessment of malnutrition is covered by MARSIPAN.
867.	SH	Royal College of Psychiatrists	Short	22	18	1.10.2 Please add acute hospital and extreme malnutrition (BMI<15) as explained above.	Thank you for your comment. A reference to extreme malnutrition has been added to the text.
868.	SH	Royal College of Psychiatrists	Short	22	22	1.10.3. Please add acute hospitals.	Thank you for your comment. The text has been amended to be less specific about who should be conducting the assessment.
869.	SH	Royal College of Psychiatrists	Short	23	1	1.10.5 Please add acute medicine and gastroenterologists.	Thank you for your comment. The recommendation has been revised to be less specific about who should be conducting the assessment.
870.	SH	Royal College of Psychiatrists	Short	24	6	1.10.9 For young people it needs to include height and BMI centiles	Thank you for your comment. The text has been amended to specify that these measurements should be appropriate to the age of the person.
871.	SH	Royal College of Psychiatrists	Short and full	25	3	1.11.1 Medical stabilisation needs to be carefully defined as it is open to widely different interpretations (one Australian study used a discharge BMI of 17.5, whilst in many acute NHS hospitals it only means iv replacement of electrolytes). Furthermore, without careful explanation and aftercare, many patients are falsely reassured by the term: a patient who is discharged from hospital with a BMI of 15 is still extremely malnourished and will continue deteriorating without ongoing weight restoration as part of outpatient treatment.	Thank you for your comment. It would not be appropriate to provide a definition in this guideline.
872.	SH	Royal College of Psychiatrists	Short	25	all	Although section 1.11 describes in-patient treatment it is not appropriate to in-patient treatment requiring a general hospital setting. The statement on line 26 about starting/continuing psychological treatments is, in our experience, too	Thank you for your comment. A reference to the suggested document would not be appropriate. Please note that the recommendations in this section have been revised.

						broad to facilitate high quality eating disorder care. We suggest either adding to this section (see comment 7,8 & 9) or inserting a specific section for treatment in general hospitals (as is in pp65-655 of the RCPsych College Report 183)	
873.	SH	Royal College of Psychiatrists	Short	25	10	In our experience acute psychiatric services struggle to manage patients with eating disorders. This is related to lack of relevant training both for nursing and medical staff. There is significant training implication for staff in general setting to manage these patients well.	Thank you for your comment. The Committee recommended in the section on training and competencies that all staff working with people with eating disorders should be competent to do so and it is an expectation in the NHS that any such staff should be appropriately trained.
874.	SH	Royal College of Psychiatrists	Short	25	26	1.11.5 Psychological treatment is part of inpatient treatment in specialist eating disorder units. It would be difficult to deliver psychological therapies in acute hospital setting when the patient is very unwell. This recommendation may raise unrealistic expectations. As it was pointed out earlier, there have been no RCTs involving patients who are extreme severity.	Thank you for your comment. Although it may be difficult to provide psychological treatment to severely unwell people in an acute setting, this is recognised in the recommendation by the statement that such treatment should be started or continued (if already receiving treatment) 'if appropriate'.
875.	SH	Royal College of Psychiatrists	Short	25	29	1.11.16 this statement would require some elaboration. It is unclear why the Committee felt that this is necessary: to our knowledge, there are no units in the UK only providing psychological treatment for patients for anorexia nervosa. However, psychological treatment is essential part of inpatient treatment – and continuity before and after admission is essential.	Thank you for your comment. Having considered the evidence, the Committee did not think that it was appropriate for inpatient care to be used solely for the provision of psychological or other interventions to treat the eating disorder in the absence of significant risk to the individual's physical health (e.g. urgent need for medical stabilisation). Although a number of recommendations directly address the issue of medical stabilisation the committee nevertheless felt that, in order to support the best use of healthcare resources, it should be made

							clear that the provision of psychological and related interventions should not be sole reason for admission to inpatient care. Regarding the study of Dalle Grave 2012/2013, whilst this was examined in the evidence review, the committee did not feel they could recommend inpatient psychological treatment in an inpatient setting (for people with BMI<16.5) in lieu of more evidence.
876.	SH	Royal College of Psychiatrists	Short	26	5	1.11.8 This should also apply to acute hospitals, who often have nutritional teams. Please refer to the relevant NICE guidelines https://www.nice.org.uk/guidance/QS24/chapter/Introduction-and-overview	Thank you for your comment. The text has been amended as suggested.
877.	SH	Royal College of Psychiatrists	Short	26	14-15	1.11.10 Please add setting: this applies for acute hospitals as well as specialist eating disorder services. We suggest adding a bullet point General hospitals should not discharge someone following treatment for physical complications of an eating disorder without agreeing a follow up care plan for the eating disorder with a mental health professional. This is really important for patient safety.	Thank you for your comment. A new recommendation has been inserted and existing ones revised regarding care planning and discharge from inpatient care plans in response to this and other stakeholder comments.
878.	SH	Royal College of Psychiatrists	Short	26	27	1.11.13 Discharge planning should always include risk indicators, patient preferences and aftercare services available.	Thank you for your comment. The text has been amended as suggested.
879.	SH	Royal College of Psychiatrists	Short	27	28	Please replace starvation with malnutrition. http://www.bapen.org.uk/how-good-is-your-nutritional-care	Thank you for your comment. The text has been amended. The Committee declined to include reference to the BAPEN MUST tool as the assessment of malnutrition is covered by MARSIPAN (see Recommendation 1.12.4 and 1.12.9).

880.	SH	Royal College of Psychiatrists	Short	28	15	Rumination disorder has been omitted from the document. Given that it is in the DSM-5, it should be mentioned here.	Thank you for your comment. The text has been amended as suggested.
881.	SH	Royal College of Psychiatrists	Short	29	27	We agree with the committee that 'studies that have been published have not always provided adequate definitions of remission' and it would therefore be helpful if the NICE guidelines could provide a clear definition of 'remission'. The lack of consensus regarding remission makes it very difficult to compare studies in a meaningful way, and it can be misleading (such as in the ANTOP trial, where remission was defined with a BMI of 17. One previous study showed that remission rates varied from 3% to 96% depending on the method used. Couturier J[1], Lock J. What is remission in adolescent anorexia nervosa? A review of various conceptualizations and quantitative analysis. Int J Eat Disord. 2006 Apr;39(3):175-83.	Thank you for your comment. Remission should be consistently defined but it is not within the scope of the guideline to provide a definition of remission.
882.	SH	Royal College of Psychiatrists	Full	18	32	We suggest that this new guideline also provides an opportunity to address the increased risk of poor care, incidents, including death, by treatment of physical complications of eating disorders in general hospitals that led to MARSIPAN guidance and guidance in RCPsych CR183, both of which have been	Thank you for your comment. MARSIPAN and Junior MARISPAN are referred to in the recommendations about inpatient and day care treatment. The Committee declined to refer to CR183 in their recommendations.

						produced since the previous version of the guidelines was published.	
883.	SH	Royal College of Psychiatrists	Full	29	28	We are concerned these statements imply the guidance may not apply to general hospital settings. We suggest adding a sentence along the lines of 'Professionals in secondary physical healthcare settings, where patients with eating disorders may present or require admission for treatment of physical complications of their eating disorder, may not have sufficient expertise or access to appropriate specialist mental health expertise to manage eating disorders	Thank you for your comment. It is not clear what part of the guideline this comment refers to. Please note that the recommendations have been substantially revised.
884.	SH	Royal College of Psychiatrists	Full	30	36	We are concerned that this does not include the period that may be required in a general hospital prior to a move to an eating disorder in-patient unit.	Thank you for your comment. It is not clear what part of the guideline this comment refers to. Please note that the recommendations have been substantially revised.
885.	SH	Royal College of Psychiatrists	Full	33	1	The reference is to the old version of the Marsipan guidelines, whereas the references accurately link to MARSIPAN guidelines form 2014. We suggest also referring to guidance for management in RCPsych Council Report 183 'Liaison Psychiatry for every acute hospital: integrated physical and mental health care'.	Thank you for your comment. Both MARSIPAN and Junior MARSIPAN are referred to in the recommendations about inpatient and day care treatment and in the subsection on refeeding for the treatment of malnutrition. The example medical risk parameters have been updated to the 2014 versions of these documents. Note also that the recommendations have been substantially revised regarding care planning and discharge from inpatient care. The Committee declined to include reference to CR183 in the guideline.
886.	SH	Royal College of Psychiatrists	Full	33	1	We are aware of patients waiting considerable periods in general hospitals for a specialist bed. We therefore suggest adding (see comment 7) 'If	Thank you for your comment. It is not clear what part of the guideline this comment refers to. Please note that the

						admission to a general hospital is required, before specialist admission, for initial treatment of physical complications of an eating disorder, this should be kept to the minimum period required for safe transfer to a specialist eating disorder unit'	recommendations have been substantially revised.
887.	SH	Royal College of Psychiatrists	Full	104	20	We suggest adding 'general hospitals' to sites where an eating disorder may present. Although paediatricians are mentioned, adults also present in general hospital settings.	Thank you for your comment. The list is not intended to be exhaustive.
888.	SH	Royal College of Psychiatrists	Full	160 and 162	17, 28 and 23/24	These statements refer to 'general outpatient (CAMHS) for adults' which is confusing as adults don't receive treatment in CAMHS. Can the committee make it clearer that they mean 'general adult mental health services'?	Thank you for your comment. The text has been amended.
889.	SH	Royal College of Psychiatrists	Full	186	Rec 38 & 39	In Health Monitoring of all Eating Disorders' delete 'eating disorder specialist' as it is not appropriate for a psychological therapist to assess the cause of unexplained electrolyte imbalance or to offer supplements for this.	Thank you for your comment. Reference to who should be assessing electrolyte imbalances has been removed as it is a requirement for all people working in the NHS that they are adequately trained and competent in delivering the interventions (or conducting the assessments) they in fact deliver.
890.	SH	Royal College of Psychiatrists	Full	355	1	We are concerned that the section 'Clinical Evidence for: What interventions are effective at managing or reducing 1 short and long-term physical complications of eating disorders?' understandably is unable to source evidence of emergency treatment requiring general hospitals and therefore clinical lessons learnt from experts, incident reviews and coroners are largely omitted by the guidance. This leads to our suggestions to include specific	Thank you for your comment. It is not clear of the relevance that this evidence would have to the evidence review in question. The effect of the setting in which a treatment is delivered is addressed in the evidence review on the coordination of care (Chapter 5) and compulsory treatment (Chapter 10).

						statements relating to general hospital admission and to research	
891.	SH	Royal College of Psychiatrists	Full	398	Rec 82	Regarding the suggestion to consider treatment with biphosphonates for osteoporosis in long term low weight patients over 18, we suggest specifying the need to liaise with an ED specialist before prescribing as some GPs tends to prescribe even in patients without necessarily a long-term history of ED. Also, often they do not offer enough information for the patient to be able to make an informed decision on this.	Thank you for your comment. The recommendation is clear that prescribing bisphosphonates to women with anorexia nervosa should only be considered in those who have long-term body weight and low bone mineral density. A new recommendation has been inserted at the beginning of this section to emphasize that bone mineral density results should be interpreted by a trained professional.
892.	SH	Royal College of Psychiatrists	Full	988	22	We suggest other research topics could relate to management of eating disorders requiring a general hospital admission, maybe looking at whether outcomes are altered by either • longer duration of general hospital admission (eg. Whilst waiting a longer time for a specialist bed) or • involvement of on-site mental health services that include a Consultant Psychiatrist (Liaison psychiatry or eating Disorder teams) compared to where no on-site mental health team is present	Thank you for your comment. The Committee considered your suggestion but decided that there were other areas of research that were more important. Please note that the research recommendations have been revised.
893.	SH	Royal College of Psychiatrists	Full	971	12	We suggest including the bullet in comment 2 (point 'abdominal pain leading to dietary restriction or vomiting which is not fully explained by physical pathology')	Thank you for your comment. The text has been amended as suggested.
894.	SH	Royal College of Psychiatrists	Full	972	12	'We suggest including the bullet in comment 3 ('in general hospitals when there is admission for treatment of	Thank you for your comment. The list is not intended to be exhaustive. Please note that the recommendations have been substantially revised.

						physical complications of an eating disorder')	
895.	SH	Royal College of Psychiatrists	Full	976	7	We suggest including the bullet in comment 7 ('If admission to a general hospital is required, before specialist admission, for initial treatment of physical complications of an eating disorder, this should be kept to the minimum period required for safe transfer to a specialist eating disorder unit')	Thank you for your comment. It is not clear which recommendation your remark is intended to refer to. Please note that the recommendations have been substantially revised.
896.	SH	Royal College of Psychiatrists	Full	976	7	We suggest including the bullet in comment 8 ('If admission to a general hospital is required for treatment of physical complications of an eating disorder a Consultant in Eating Disorders and/or Liaison Psychiatry should be involved in setting treatment goals with the Consultant Physician and visits to the ward by members of a Liaison Psychiatry and/or Eating Disorder team should be provided to support both the ward staff and patient as well as advising on discharge planning.)	Thank you for your comment. The section on care planning has been revised (now called ' Care planning and discharge from inpatient care) and some recommendations have been added to clarify that a care plan should be developed in collaboration with the person with an eating disorder (and their family/carers if appropriate) and identify clear objectives and outcomes for admission, set out the discharge process, and involve a review when medically stabilised or within one month of admission.
897.	SH	Royal College of Psychiatrists	Full	976	52	We suggest including the bullet in comment 9 (General hospitals should not discharge someone following treatment for physical complications of an eating disorder without agreeing a follow up care plan for the eating disorder with a mental health professional)	Thank you for your comment. The section on care planning has been revised (now called ' Care planning and discharge from inpatient care) and some recommendations have been added to clarify that a care plan should be developed in collaboration with the person with an eating disorder (and their family/carers if appropriate) and identify clear objectives and outcomes for admission, set out the discharge process, and involve a review when medically stabilised or within one month of admission.

898.	SH	Royal College of Psychiatrists	Full	21 974	4 36	In 'Medical Risk Management' – recommendation 35 is to offer ECG to those taking medication that compromise their cardiac function. It would be helpful to specify whether this should be undertaken by a specialist ED team or primary care (i.e. GP). Many eating disorders have limited medical input due to historical commissioning arrangements.	Thank you for your comment. Reference as to who should be conducting ECG monitoring has been removed.
899.	SH	Royal College of Psychiatrists	Full	189 and 976	1 and 1-3	Recommendation 45 recommends monitoring of physical and mental health for patients with 'AN receiving psychological interventions'. In the notes below the committee justify not specifying whom does this as they believe it should be an agreed plan between primary care and specialists, with clarity on who takes responsibility. We suggest rephrasing the recommendation to state this 'A *clear plan and specified responsibility needs to be agreed between primary care and specialist ED teams to monitor the physical and mental health of people with AN receiving psychological interventions'.*	Thank you for your comment. The recommendations regarding monitoring of physical and mental health of anorexia nervosa have been substantially revised and are now included in a section on physical health management, monitoring and management of eating disorders. Whilst the Committee did not wish to specify who should take responsibility, a recommendation has been made for all eating disorders in the general principles section at the beginning of the short guideline that services should ensure that they are well coordinated.
900.	SH	Royal College of Psychiatrists	Short and full	General		1.2.19 – 1.2.23 Terminology around family therapy. There needs to be consistency and clarity regarding the term used for family work (family therapy, family-based treatment, anorexia focussed family therapy).	Thank you for your comment. The terminology in the guideline has been simplified to make this clearer by the use of the expression 'family therapy' when referring to the general type of therapy.
901.	SH	Royal College of Psychiatrists	Short	General		Cost implications - a number of recommendations have cost implications: 7. Most specialised services struggle with demand and have limited capacity to deliver evidence based treatments.	Thank you for your comment. The demands on specialist services are recognised but the delivery of effective treatments, through promoting better outcomes, is one way in which an increase in efficiency of the services can be achieved. The Committee have

						Delivering evidence based treatment as promptly as possible would improve patient outcomes, but has cost implications in terms of staffing levels – as the majority of adult eating disorder services struggle with long waiting lists currently. 8. Over recent years many adult ED services have invested significantly to recruit and train CAT, IPT, and family therapists to meet the previous NICE guidelines (2004). Having these therapists on their establishments will pose a significant challenge to adult NHS ED services e.g. in terms of redeployment or re-training in the years to come. Their will also be a cost in terms of morale, etc. 9. Training both non-specialists and specialists. 10. Appropriate supervision 11. Training for social care and educational professionals, and staff in acute hospitals 12. The management of comorbidity ideally should be managed by the same team. This requires an expansion of eating disorder psychiatrists, not just for young people, but also for adults. 13. Physical monitoring: Bone densitometry after 6 months of amenorrhoea, blood test and ECG monitoring. GPs are reluctant to do this, due to	recommended those treatments that are established as being clinically or cost-effective. The emergence of new evidence as described in this guideline has led to a different range of family and psychological treatments being recommended. This may require some retraining and development of supervision but it is expected that this issue, a matter for local determination and implementation, can (as you say) be managed over a period of time. With regard to the impact of eating disorders on the wider healthcare system, recommendations have been included for increased awareness of eating disorders as well as for information for families and carers to support wider uptake and engagement with treatment. Recommendations have also been made regarding the need for better management of individuals in acute healthcare settings. This along with your recommendation for better training are matters that should be dealt with through local implementation. Thank you for your comment regarding bone density, which was considered by the Committee, including a primary care practitioner. The view was that this was feasible for GPs to be doing this. In particular they felt that this was important because a number of people with eating disorders who require this monitoring do not engage with specialist secondary services. The comment regarding university

						resource issues (both time and cost) and expect specialist services to perform these. However, if these tasks are picked up by specialist services, there needs to be an expansion of medical staff which requires funding 14. Special funding arrangements should be developed to support treatment for university students.	students is outside the scope of the guideline.

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*