BDA The Association of UK Dietitians

Mental Health

Specialist Group

Practice Guidance for Dietitians Working in Eating Disorders

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Lived experience address

What your patients wish you knew

People suffering from an eating disorder (anorexia for example) do not have a certain 'look'. You can be in a room full of 100 people and 10 of them have anorexia, you would not be able to pick out those 10 people just based on how they look. Eating disorders can present so different for each person. Someone with anorexia might wear make up and nice clothes as a way of pretending to others that they are okay but inside they are really not okay. Never comment on the appearance of someone with an eating disorder, most of the time the person really will not like it. Instead maybe give a nice compliment about how hard they might be working or how they are so kind and creative. Anything is nice to hear apart from comments about their physical appearance

"Talking to a dietitian about changes to their diet and increasing food intake, it is one of the hardest things they will ever have to do"

When talking about food and diet, sometimes a gentle and soft approach will really benefit someone with an eating disorder. Food can be the scariest thing in this persons world, it can make things feel even more scary if the dietitian they are working with has a strict or bossy approach. Eating disorders can feel very scary for the person suffering and sometimes they just need some kindness and a gentle caring approach to help them

Eating disorders are never a choice. the person didn't want this to happen to them and they would like to be without their eating disorder. They most of the time have this illness to help them feel safe or certainty in their life. Talking to a dietitian about changes to their diet and increasing food intake is one of the hardest things they will ever have to do. Be patient with them and recognise how anxious they might be feeling going into a dietetic appointment. Maybe thank them for the courage it took them to agree to talk with you.

People with eating disorders are some of the most thoughtful, caring, creative, talented and kind people. Their brains are just so mean to them. They are fighting such a hard battle. They often might come across stressed, short tempered and irritated but that is not really who they are! They are just poorly. Don't be offended or create a judgement on them if they come across irritated. Food and weight can be something very scary for them and they will want to protect themselves.

If the patient does not want to talk about calories and numbers, please listen to them and accommodate to what they feel most comfortable with. Counting calories and numbers, that can become very obsessive for someone with an eating disorder. Some people (like myself) find it helpful to stay away from counting calories. It helps to ask the patient if they are comfortable with seeing calories and numbers written down or would they prefer not to.

"Recovering from an eating disorder is messy; a rollercoaster. Each week is not the same and the feeling of hope can come and go"

It is not always straightforward. Increasing diet and eating different foods, it will most likely be very up and down. Don't expect it to go perfect or in a straight line. Recovering from an eating disorder is messy, a rollercoaster, each week is not the same and the feeling of hope can come and go. It is not an easy journey at all so expect some steps backwards and some forwards

Words by Rachelle Petho

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Introduction

Eating disorders are a psychiatric illness associated with high rates of morbidity and mortality if left untreated (van Hoeken and Hoek, 2020). Symptoms are classified using strict diagnostic criteria as outlined by the Diagnostic and Statistical Manual for Mental Disorders 5 (DSM-5) and International Statistical Classification of Diseases and Related Health Problems (ICD-11) (American Psychiatric Association, 2022; World Health Organisation, 2021). ICD-11 classification includes several eating disorder diagnoses including Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), Avoidant Restrictive Food Intake Disorder (ARFID)vand Other Specific Feeding and Eating Disorders (OSFED). Literature examining UK prevalence rates is lacking, however Beat, a UK eating disorders charity, estimates that around 1.25 million people in the UK have an eating disorder (BEAT, 2022). Effective treatment of an eating disorder must address biopsychosocial and behavioural factors (Treasure, Duarte and Schmidt, 2020). Nutritional counselling plays a crucial role in the care plan, with the dietitian being ideally suited to take the lead in managing the nutritional aspects of treatment (NICE, 2017; Royal College of Psychiatrists, 2022; QED, 2023).

Document aim

The aim of this document is to inform and support dietitians who interact with patients with eating disorders at any level. It seeks to provide guidance that encourages safe, effective, and efficient dietetic practices. Additionally, the document aims to clarify the roles and responsibilities of specialist eating disorder dietitians while offering pathways for non-specialist dietitians to acquire the necessary training, support, and supervision to work safely and competently within their scope of practice.

Objectives

- To guide dietitians at all levels in assessing and managing patients with eating disorders.
- To clarify the differences between the roles of specialist dietitians and those without eating disorder expertise in managing eating disorders.
- To outline the role of dietitians in multidisciplinary teams (MDTs) and family-based interventions.
- To offer recommendations for professional development, clinical supervision, and workload management.
- To highlight the ethical considerations and patient autonomy in dietetic practice related to eating disorders.

- To promote continued learning and the use of outcome measurements and reporting in dietetic care.
- To promote collaborative practices across healthcare systems, supporting holistic and joined up care for individuals with eating disorders.

Role and responsibilities

Specialist Eating Disorder Dietitians

The aetiology of eating disorders (EDs) is still not fully understood and is likely a combination of biological, psychological and environmental factors (Treasure, Schmidt & Kan, 2020). Whilst making dietary change is necessary for recovery, it often exacerbates difficult thoughts and/or feelings, and may increase the likelihood of other presenting difficulties e.g. self-harm, substance abuse etc (Levine, 2020). Suicide is a particular concern, and studies have been fairly consistent in finding an elevated risk of suicide in people with eating disorders (Mandelli et al., 2018). Dietitians should, therefore, avoid lone working and carrying inappropriate responsibility for patients with EDs, particularly individuals with a high physical and/or psychological risk (Royal College of Psychiatrists, 2022).

The role of dietitians in managing eating disorders has been the subject of ongoing discussion in the literature. Research indicates that this role can often be poorly defined, leading to confusion regarding the specific responsibilities of dietitians in treatment teams. Several studies point out that there is no universally accepted framework or set of guidelines outlining the specific duties of dietitians in eating disorder treatment, leading to variations in practice (Malson et al., 2018). The boundaries between the roles of dietitians, psychologists, and other health professionals can be ambiguous, resulting in uncertainty about when and how dietitians should intervene (Hay et al., 2019). Furthermore, research has shown that many dietitians feel underprepared to work with eating disorder patients due to insufficient training in this area, further complicating their role (Rieger et al., 2020).

An integrative review by Heafala and colleagues (2021) aimed to identify, critically appraise and synthesise the current evidence of the dietitian’s role in the treatment of eating disorders. The review identified several key themes regarding the role of dietitians in eating disorder (ED) treatment. Dietitians act as collaborators, educators, and counsellors, providing personalised nutrition care while working in multidisciplinary teams. They also seek a holistic approach to treatment beyond weight restoration, which includes fostering healthy relationships with food. However, many dietitians report

feeling underprepared for the complexities of EDs and express a strong desire for more training, particularly in psychological aspects and counselling. Patients and carers perspectives on dietetic care are mixed, further highlighting the need for more standardised training and clearer role definitions for dietitians in ED care (Heafala et al., 2021).

The dietitian's role in assessment is to: determine nutritional status; estimate requirements for growth (where appropriate) and assess eating patterns and behaviour; knowledge, food rules and beliefs; meal planning, shopping and cooking skills; motivation to change, and how underlying psychopathology impacts on eating behaviours and behaviour change. The dietitian can develop the nutrition section of the treatment plan in consultation with the patient and multidisciplinary team (MDT) , and support the patient and the MDT throughout implementation. This can include intensive one to one or family work, but also group work. The development of a good therapeutic relationship is essential, as is enhanced communication, behaviour change training and care and compassion to support nutritional rehabilitation.

Dietitians need to have a clear understanding of their own limitations and scope of practice, and seek support from the other members of the team when appropriate. As dietary beliefs and behaviours can often become entangled with psychological distress, dietitians may be faced with complex psychological presentations. However, it is important that professional boundaries are kept at all times, and that the dietitian maintains a focus on food-related problems with clear articulation of roles and responsibilities.

Many specialist ED dietitians will be trained to deliver dietetic care which is informed by a psychological therapy, e.g. Cognitive Behavioural Therapy (CBT) informed approach. Less commonly, dietitians may be trained and supervised to provide a psychological intervention. For example, they may deliver Guided Self Help for BED or BN.

Boundaries are exceptionally important; the dietitian may feel pressure to compromise on issues related to nutritional care such as the calorie content, or the type of foods consumed. Recovery from an eating disorder often leads to the emergence of distressing feelings and increased anxiety that the individual would rather avoid. It can be useful to set the boundaries from the start of treatment, including what is negotiable, and what is non-negotiable, explaining a clear rationale for this and ensuring measures are not punitive. The degree of 'negotiation' will generally change depending on the acuity of illness and stage of treatment. All dietetic care should be delivered in a trauma informed and neuro affirming manner, where specialist dietitians are equipped to address unique needs of underserved populations who may experience eating

disorders differently. Dietitians can seek further support and guidance in clinical supervision.

The degree of nutrition related knowledge and confidence will vary between patients. Whilst eating disorders are unlikely to arise as a result of a dietary 'knowledge deficit', dietetic psychoeducation can provide an important role to patients and families where eating disorder cognitions have affected their beliefs. Psychoeducation from a dietitian can provide a trustworthy source of knowledge that supports individuals and families to challenge ED driven food beliefs. The dietetic role in education extends to offering support and education to health professionals, families, carers, non-specialist dietitians, involved with patients with eating disorders, and the public, through various mediums such as group work, presentations, and the media. Thus, the specialist dietitian must have advanced communication skills, as well as have an up-to-date knowledge of the evidence base to support their advice.

Non - Eating Disorder Dietitians

National best practice guidance recommends dietitians providing input into primary care, acute medical wards and eating disorder services (NICE, 2017; Royal College of Psychiatrists, 2022). Individuals with eating disorders are likely to present to and access care across a range of healthcare settings, and due to eating disorders manifesting as persistent and disordered patterns of eating, dietitians may be the first health care professional to come into contact with an undiagnosed eating disorder patient. Therefore, it is important for the dietetic workforce to have some baseline knowledge of the assessment and treatment of eating disorders, regardless of clinical specialism. If the dietitian is not trained in eating disorders, they are to consult a dietitian who is trained (Royal College of Psychiatrists, 2022).

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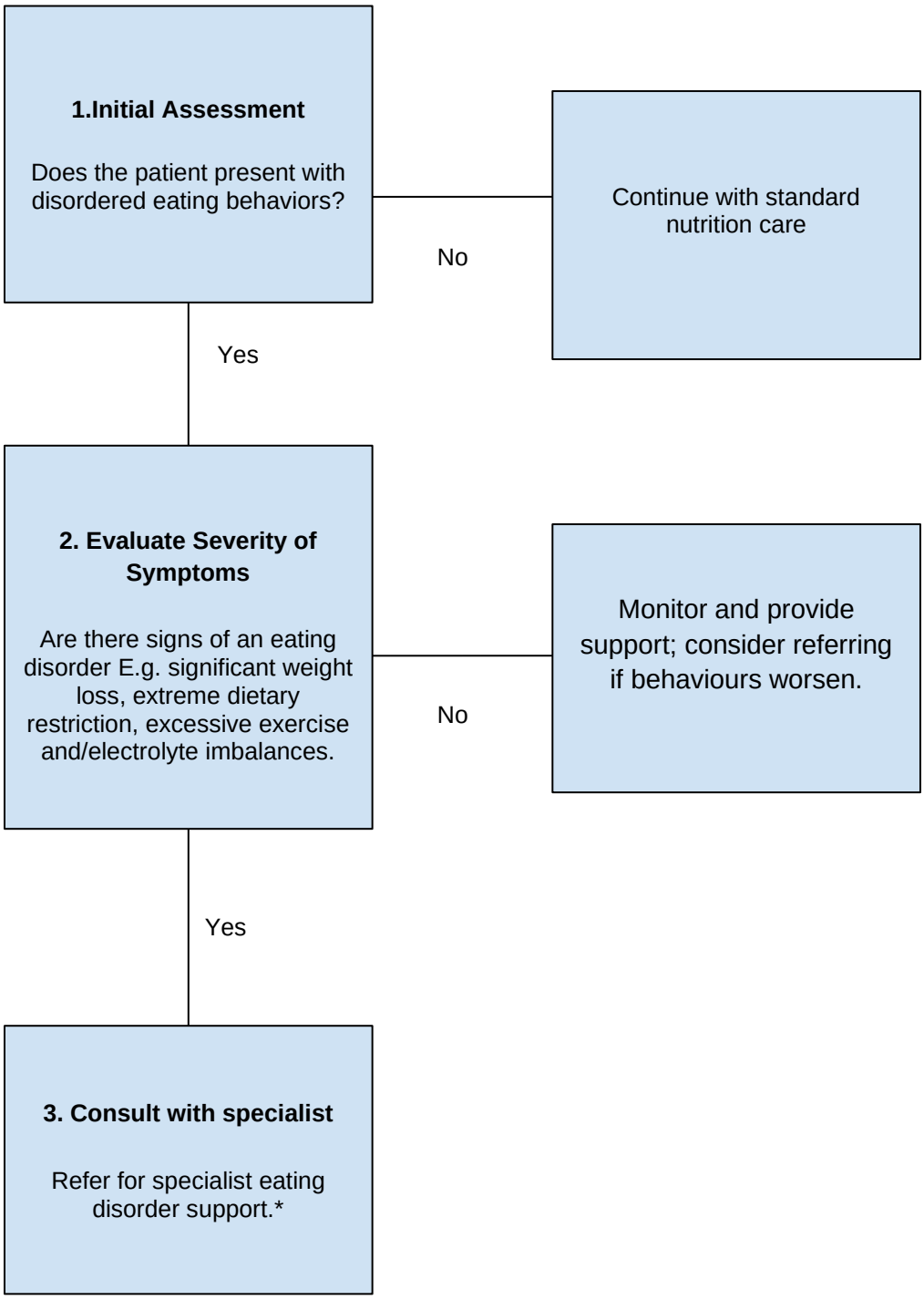
Furthermore, a non- eating disorder dietitian can offer assessment, sign-posting and short-term education for individuals with an eating disorder and their carers, providing they liaise with the other health professionals involved in managing the patient's medical and psychological care. Non–eating disorder dietitians should seek guidance and support from an experienced/specialist eating disorder dietitian for the duration of the short-term work, and recognise their own limitations. Dietitians can also refer to the MEED checklist for Dietitians (Royal College of Psychiatrists, 2022) and NICE guidance (NICE, 2017). Longer-term treatment or treatment of severe or complex patient's needs should be addressed by a specialist service that includes a dietitian with specialist knowledge of eating disorders.

The flowchart below serves as a guideline for non-eating disorder dietitians to assess whether a referral to a specialist eating disorder dietitian is necessary. It is imperative for all dietitians to be equipped in the identification of potential early signs and symptoms of eating disorders. Non-eating disorder dietitians have a vital role in enabling early intervention, potentially reducing the need for more intensive care later.



*As part of the referral process, assess if any of the following risk factors are present and refer to the GP for physical health monitoring:

-Significant weight loss or malnutrition
- Medical complications (e.g., electrolyte imbalances)
- Co-occurring mental health issues (e.g., depression, anxiety)
- Family history of eating disorders

Dietitian Role in the Multidisciplinary Team

The specialist dietitian is an important member of the multidisciplinary team (MDT); with the expert skills needed to address these complex disorders involving food, weight and appetite. As highlighted by the National Institute for Health and Clinical Excellence (NICE, 2017), dietary counselling should be provided as part of a multidisciplinary approach. Managing medical risk is not the sole responsibility of the dietitian, although the nutritional assessment is a key aspect of the medical risk assessment, especially during the process of refeeding and in the management of refeeding syndrome. The dietitian should ensure that other team members also share responsibility for managing physical risk e.g. General Practitioner (GP), or Psychiatrist. Dietary counselling is required to guide an individual back to normalised eating patterns, behaviours and nutritional adequacy, but it is not a substitute for psychotherapy. Another team member is required to treat the underlying psychopathology, e.g. psychologist, or specifically trained therapist. Where dietitians contribute to the shared formulation, and ongoing assessment of the eating problems, it is best practice for patients to have a designated care co-ordinator, or Lead Professional for the dietitian to work alongside to help assess and manage clinical risk. As noted previously, assessment of complex or higher risk patients should be multidisciplinary, ongoing and comprehensive (Royal College of Psychiatrists, 2022).

Dietitians Roles and Responsibilities - Avoidant/Restrictive Food Intake Disorder (ARFID)

Avoidant/Restrictive Food Intake Disorder (ARFID) was first recognised within diagnostic manuals as an eating and feeding disorder in 2013. ARFID is characterised by a pattern of eating that avoids certain foods or food groups entirely and/or eating small amounts due to lack of interest in food, high sensitivity to sensory aspects of food (such as texture, colour, or taste), and/or fear of adverse consequences such as being sick or choking. These restrictive eating patterns can result in significant health problems. It differs from other eating disorders in that people with ARFID do not restrict

their food intake for the specific purpose of losing weight or managing feelings of fear and anxiety around their shape and size.

Whilst the dietetic role within ARFID continues to develop, dietetic care is an essential component of the multidisciplinary approach required within the assessment and management of ARFID. The BDA ARFID Specialist group have produced their own position statement regarding the dietetic role within this practice area. This can be found in the guidelines section for more information.

Dietitians Roles and Responsibilities - Child and Adolescent Care

Nutritional inadequacy and associated secondary effects serve a significant risk to growth and development within children and adolescents. Whilst the majority of the physical effects of starvation, which are well documented within the literature (Hornberger and Lane, 2020), are reversible, nutritional inadequacy during childhood and adolescence can result in a failure to achieve adult growth potential. Low peak bone mineral density as a secondary effect of starvation is a concern as it can irreversibly affect skeletal health in adulthood (Solmi et al., 2016). Further, childhood and adolescence is a crucial time for the development and expression of self. Peer interaction is an important part of life for most. Inability to engage in social activities, either due to a need for intensive eating disorder care or where eating disorder symptomatology disrupts ability to engage with meaningful peer activity must be acknowledged when considering the secondary effects of eating disorders in the child and adolescent population. Despite nutritional rehabilitation being well accepted as a crucial component of child and adolescent eating disorder recovery, research on the dietetic role within this patient group is scarce. Existing studies mainly concentrate on the role of the dietitian in adult eating disorder treatment and highlight dietitians as essential in the management of malnutrition, whilst also needing to work collaboratively and in accordance with psychological and medical aspects of the treatment (Brennan et al., 2024).

Dietitians Roles and Responsibilities Within Family Based Interventions For Eating Disorders

No empirical studies which assess the effect of nutrition counselling on treatment outcomes in family based interventions have been conducted, to date. In the absence of

such studies, the ability to advance our understanding of the role of dietitians in treatment remains limited (Brennan et al., 2024). The most current evidence and guidelines for the dietitian's role are discussed below.

Family therapy for anorexia nervosa (FT-AN) is recommended as a first-line treatment for young people with Anorexia Nervosa (AN) by the National Institute for Health and Care Excellence (NICE, 2017).

A multidisciplinary team (MDT) approach is described as paramount in both the FT-AN manual and the current UK guidance and standards on specialist child and adolescent eating disorder service structure, to ensure that holistic care (including, nutritional, physical monitoring, medication and psychiatric assessment) is offered. Dietitians, alongside other key professions, are described as core members of this MDT (Brennan et al., 2024; Simic and Eisler, 2019). However, the roles and responsibilities of the dietitian are not clear and the dietetic role is often underestimated. For example, some literature suggests that if the primary therapist delivering a family based intervention does not have adequate nutrition knowledge, a dietitian “could be beneficial” (Lian, Forsberg and Fitzpatrick, 2019).

In a study by Brennan and colleagues, the exploration of MDT perspectives on the role of the dietitian within FT-AN supported dietetic involvement in some cases. Dietitians were seen by experienced clinicians as a valuable resource, which should be considered and offered when indicated for selected families. They concluded that further guidance on the role of the dietitian within FT-AN is required to support best practices in this area and ensure consistent evidence-based practice across services delivering this treatment. To further advance our understanding of the topic, high-quality research studies are needed (Brennan et al., 2024).

A 2021 integrative review exploring the dietetic role within eating disorder care identified that most carers felt all those with an eating disorder diagnosis should have access to dietetic referral and a lack of dietetic provision caused carer concern (Heafala et al., 2021).

Overall, we recognise further research is needed to articulate the dietetic role within the treatment of child and adolescent eating disorders. Dietitians practising within the child and adolescent eating disorder MDT should seek further training and supervision to understand principles of family based interventions, including the crucial role of the family in enabling change and how this impacts dietetic practice.

Knowledge Skills and Training

Working with patients with eating disorders requires a comprehensive level of knowledge and skill mix to meet the complex needs and challenges of this patient group.

Specialist dietitians should have a sound knowledge of the development and maintenance of eating disorders in addition to an understanding of the physiological, psychological and medical aspects of a range of eating disorders. This needs to be underpinned by a broad understanding of mental health and psychological interventions and their application e.g. Cognitive Behavioural Therapy-Enhanced (CBT-ED), FT-AN and manualised approaches such as SSCM (Specialist supportive Clinical Management) and MANTRA (Maudsley Anorexia Treatment for Adults).

Enhanced communication, counselling and motivational interviewing skills are vital, especially since not all individuals with an eating disorder are motivated to change their behaviours, and ambivalence is an expected symptom of eating disorders. Mental health comorbidities and neurodivergence are common, and an understanding of adapting dietetic practice for these patient populations is important. Further training in these areas can be beneficial in supporting behaviour change.

Dietitians should therefore address their ongoing training needs via a personal development plan and an annual appraisal to ensure that they are adequately skilled to work in this area. A list of recognised post graduate training and qualifications are given below.

Criteria	**Essential**	**Desirable**
Communication skills	Level 1 and 2 behaviour change training	Level 3 behaviour change training
	Motivational interviewing training	Motivational interviewing masters module
Knowledge about eating disorders e.g.aetiology, neurobiology,	BDA introduction to Mental Health, Eating Disorders and Learning Disabilities	Advancing Dietetics in Eating Disorders (2 Day Course)

physiology, risks, comorbidities, treatments etc		Advanced Eating Disorders (1 Day Course)
	Attendance at regional group meetings where available	Attendance at regional and national meetings.
	Regular Clinical supervision from experienced eating disorders Dietitian	
Psychological approaches training	1-2-day course in core psychological approach delivered by service e.g. CBT-E, FBT, GSH, etc. E.g. an Introduction to this way of Working. E.g. https://www.oxfordcbt.co.uk/	Full training in core psychological approach delivered by service e.g. CBT-E, FBT, SSCM, MANTRA etc by a recognised training provider. E.g. https://www.oxfordcbt.co.uk/
Secondary psychological approaches training		Training in any of the following: Mindfulness, Compassion Focused Therapy, Cognitive Remediation Therapy etc
Training to support Avoidant Restrictive Food Intake Disorder		BDA Advancing Dietetics in Avoidant Restrictive Food Intake Disorder (ARFID)
Safeguarding	Basic training	SOS Approach to Feeding Food Chaining

	Safeguarding supervision	
Miscellaneous	SOS Approach to Feeding Food Chaining	

**This is not an exhaustive list*

Clinical Supervision

Supervision is a process of professional support and learning, undertaken through a range of activities, which enables individuals to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety of care.

Working with patients with eating disorders can be both personally and professionally demanding. Typically, patients may present as distressed, anxious and/or depressed. As previously stated, patients may struggle to disentangle their emotional distress from more practical dietetic matters. Dietitians are therefore regularly confronted with challenging psychological issues. Furthermore, patients may evoke particular emotional responses in the professional, and at times this may influence the therapeutic process.

Access to regular and good quality clinical practice supervision from an experienced eating disorders dietitian and other MDT members is important. This will enable reflection on clinical practice and time to consider emotional and relationship issues, which may arise during consultations. The frequency of supervision should reflect the supervisees experience and competence within the relevant specialism and their work context (such as working part-time, returning from maternity leave, working in isolation or in a team).

The minimum frequency and duration of practice supervision for newly qualified dietitians is 1 hour weekly during the first 3 months, 1 hour monthly thereafter. This should be in addition to preceptorship. This can be reduced to 1 to 1.5 hours every 4 – 6 weeks once when suitable, but individuals should feel able to ask for more or less based on their needs (BDA, 2024).

Restorative supervision aims to support the needs of practitioners working with clinically complex caseloads or in roles which are emotionally demanding and require

difficult decision making. Examples within the dietetic workforce could include working in mental health settings and with terminally ill people. For those working in mental health settings, this is recommended to be a minimum of 1-1.5 hours every 6 weeks.

Practice supervision can be available in a number of different ways, including one to one, group, face-to-face, or on the telephone (BDA MHSG 2024). Some practice supervision may therefore need to be provided from outside the dietetic profession, such as within psychological services. If this is the case, it is essential that the supervisor has a clear understanding of both professional and clinical dietetic issues, as practice supervision can include caseload management and professional management.

Lastly, dietitians should avoid lone working and carrying inappropriate responsibility for patients with eating disorders, particularly individuals of a high physical and/or psychological risk (Royal College of Psychiatrists, 2022). Freelance dietitians are therefore advised not to work with eating disorder patients in isolation and to engage in regular supervision.

More guidance can be found in the BDA Clinical Supervision Guidelines.

Caseload Management

The British Dietetic Association (BDA) has updated its guidance on safe staffing levels, emphasising the importance of safe caseload management for dietitians (BDA, 2024). A safe caseload refers to the number of patients you can manage effectively while ensuring high-quality care and positive outcomes. Several factors contribute to determining what constitutes a safe caseload, such as patient complexity (Table 1.0) and the service model.

Different settings (inpatient, outpatient, community) have varying requirements. For example, outpatient services may suggest a dietitian-to-patient ratio of 1:15 to 1:25, whereas inpatient settings may require a ratio closer to 1:0 to 1:12 due to the intensity of care needed (BDA, 2024).

Patients with more severe eating disorders, co-occurring mental health issues, or medical complications may require more intensive support, which may necessitate lower caseloads for dietitians. Generally in mental health sessions patients have longer appointment times with more frequent follow up, which needs to be taken into consideration.

Inpatient Services

The type of inpatient service (e.g., acute vs. longer-term care) can influence caseload numbers. Acute services may require more intensive involvement from dietitians, suggesting lower caseloads. According to the British Dietetic Association (BDA) Safe Staffing and Safe Workload Guidance (2024), a recommended caseload is no more than 10-12 patients per whole-time equivalent (WTE) dietitian. For part-time dietitians, this recommendation can be adjusted proportionally; for instance, a dietitian working 0.5 WTE would ideally manage a caseload of 4 to 5 patients, while a 0.8 WTE dietitian might handle 6 to 8 patients. This guideline facilitates individualised care, allowing for thorough assessments and personalised meal planning, which are essential for addressing the complex needs of patients with eating disorders (Fitzgerald et al., 2020; BDA, 2024).

The range also reflects the varying role of the dietitian within inpatient services. For example, some services will heavily rely on dietetic input in all areas related to nutrition within the unit, whereas some services may have other health professionals, such as Occupational Therapy (OT) and nursing staff, with a special interest in nutrition and appropriate training, who are able to support the role of the dietitian in these settings.

Furthermore, supporting complex needs patients through behaviour change is time-consuming, requires the development of a good therapeutic relationship, and the need for frequent ongoing support to ensure treatment outcomes are met.

Outpatient Services

In the outpatient setting, there are other factors to consider when determining capacity and safe caseloads, such as travel time, access to physical health clinics and clinic space to see patients.

There are currently no guidelines for caseload management in eating disorders for outpatient services. The BDA Safe Staffing and Safe Workload Guidance (2024) suggests that the recommended caseload is no more than 15 to 20 patients per WTE dietitian. For part-time dietitians, this recommendation can be adjusted accordingly; for example, a dietitian working 0.5 WTE would ideally manage a caseload of 7 to 10 patients, while a 0.8 WTE dietitian might handle 12 to 16 patients. This is to account for the varying complexity of the patient group and the amount of indirect work required in outpatients, such as documentation and communication with MDT members (BDA, 2024) . These activities are essential for ensuring continuity of care and effective collaboration within the MDT.

Furthermore, a Delphi study on consensus-based guidelines for outpatient dietetic treatment of eating disorders found that the majority of panellists anticipated patients would benefit from 16 to 20 sessions of outpatient dietetic treatment. They specifically recommended that patients with AN have weekly sessions with a dietitian (McMaster et al., 2020). This level of treatment intensity must be considered when determining safe caseloads, as it highlights the need for sustained, individualised support, which can impact the number of patients a dietitian can effectively manage at one time.

As there is limited evidence around safe caseloads in eating disorders due to the variability of what inpatient and outpatient services offer, safe caseload numbers should be agreed at a service level and regularly reviewed in clinical supervision. A safe caseload for dietitians is context-dependent and should consider patient complexity, recommended staffing ratios, and the collaborative nature of care. Regular assessment and adjustment of caseloads based on these factors are crucial to ensure quality patient care.

Stress Management

Dietitians can adopt several strategies to mitigate stress and prevent burnout, which is often characterised by high emotional demands and workload pressures. Prioritizing self-care is essential; engaging in regular physical activity, practising mindfulness, and maintaining a balanced diet can help dietitians manage stress effectively (Hoffman et al., 2019). Establishing clear boundaries between work and personal life allows for necessary downtime, which is crucial for mental health (Ruth et al., 2020). Additionally, seeking peer support through professional networks or mentorship can provide emotional resilience and enhance coping mechanisms (Zabinski et al., 2021). Continuous professional development, including training in stress management techniques, can further equip dietitians with the tools to handle workplace challenges and maintain job satisfaction (Pawlak et al., 2019). By integrating these strategies into their routines, dietitians can create a sustainable work environment that promotes well-being and reduces the risk of burnout.

Continuing Professional Development (CPD)

CPD is how professionals maintain and develop throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice (HCPC, 2023).

The Health and Care Professions Council (HCPC), as the regulatory organisation for Allied Health Professionals (AHPs), has set Professional Standards of Continuing

Professional Development (HPC, 2006). Continuing to update and extend knowledge and skills is an essential feature of maintaining the competency of professional practice. All HCPC registrants are required to undertake CPD in order to maintain registration.

In considering the continuing professional development requirements of dietitians working in eating disorders, training courses/conferences and organisations are detailed in appendix 1. This is not an exhaustive list.

Use of Technology in Treatment

In recent years, there has been an increase in use of technology for the treatment of eating disorders, particularly during the COVID-19 pandemic. The NHS long term plan aims to increase the range of digital health tools and services (NHS, 2019) . Dietitians therefore have a responsibility of being aware of the recent research and guidelines on the use of technology in patient care.

The types of virtual treatment in place for eating disorders are varied and include the delivery of therapy remotely in real-time (e.g., videoconferencing), the provision of support between therapy sessions (e.g., email, texting, instant messaging), and self-help and self-monitoring interventions (e.g., internet self-help, internet-based CBT (iCBT), smartphone applications, etc.), each of which can be used alone or in combination (Nils Lindefors et al., 2016; Sadeh-Sharvit, 2019).

So far, the evidence for acceptability and effectiveness of technology in eating disorders is limited. There is also a lack of studies in older patients, men, sexual and ethnic minorities, with the majority of studies being conducted on children and adolescents(Ahmadiankalati et al., 2020).

A 2020 scoping review (Dufour et al., 2022) supported the use of technology for the treatment of eating disorders in children and young people. In particular, internet self-help guides were useful for decreasing eating disorder symptomatology, and the evidence to support this finding was of high quality. Limited evidence was found on the use of mobile phone applications in children and young people. They concluded that more research is needed, particularly regarding videoconferencing and mobile applications (Dufour et al., 2022).

Dietitians should be aware of best practice guidelines and the associated risks when using technology to assess and review patients with eating disorders, particularly in the freelance setting if services offered are fully remote.

Measures should be put into place to ensure the patient's weight and physical health is being monitored appropriately. For example, liaising with the GP. If this is not possible, then the dietitian would be advised to consider if it is safe to continue working with patients who are clinically at risk and require regular physical health monitoring. Accessing supervision in instances such as these may be helpful.

Outcome Measurement and Reporting

The NHS Long Term plan encourages outcome collection as this enables services to identify processes that are effective as well as those that may need adapting; to improve service-user care and ensure a cost-effective service is provided with resources allocated accordingly.

Eating disorders, especially Anorexia Nervosa (AN), are reported to have amongst the highest mortality rates in mental health. With limited evidence for current pharmacological and/or psychological treatments, there is a responsibility within health research to better understand outcomes for people with a lived experience of eating disorders, factors and interventions that may reduce the detrimental impact of illness and to optimise recovery (Miskovic-Wheatley et al., 2023). However, there is a lack of agreement on the definitions for recovery, remission and relapse (Bardone-Cone, Hunt and Watson, 2018),

The NHS guidance for Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care Guidance for commissioners and providers (NHS, 2019), recommends routine outcome measurement should be in place consistently across community eating disorder services and inpatient or intensive day patient services on three levels.

1. **Individual level**: helps to empower the person, inform on progress towards their goals, monitor their symptoms and inform clinical practice.
2. **Service level**: used to assess people’s experience of care to monitor service provision and quality of care.
3. **Population level**: can be used to monitor the uptake of the service in the area, add to local prevalence data and compare to national data.

Examples of Types of Outcomes in Eating Disorders

Dietetic outcomes e.g. knowledge gained, behaviour change and food or nutrient intake changes.

Clinical and health status outcomes e.g. functional assessments such as hand grip dynatometry, laboratory values, weight, blood pressure, risk factor profile changes, signs and symptoms, clinical status, complications (health outcomes).

Patient-reported functional or experiential outcomes e.g. quality of life, satisfaction, self-efficacy, self management, functional ability (dietetic outcomes).

Health care utilisation and cost outcomes e.g. special procedures, planned/unplanned clinic visits, preventable hospitalisation, length of hospitalisation, (health outcomes).

Types of Outcomes Measures

Patient Reported Experience Measures (PREMs)

PREMs collate the patients' objective experience of care. By focusing on specific aspects of the care process, e.g. being seen on time, PREMs seek to remove the subjectivity associated with measures of satisfaction e.g EDE-Q.

Patient Reported Outcome Measures (PROMs)

PROMs are standardised, validated instruments or question sets used to measure patients' perceptions of factors such as their health status (impairment), their functional status (disability), and their health-related quality of life (well-being). They are usually designed as questionnaires that measure the impact of clinical interventions in a strictly clinical sense, i.e. did the intervention improve the patient's physical or mental condition in a meaningful sense, and if so, by how much? Further examples are the Bristol stool chart or a urine colour chart.

Therapy Outcome Measures (TOMs)

Therapy Outcome Measures can be used to monitor changes over time in the following four broad areas based on the international classification of functioning, disability and health (WHO, 2007). These include impairment (the underlying condition), activity (ability to complete daily activities, participation (social participation) and wellbeing (emotional health). See appendix 3 for potential measures and outcomes when working with eating disorders.

Ethical Considerations and Patient Autonomy

Treating patients with eating disorders is associated with an array of ethical concerns, including balancing patients' health and autonomy. A study by Walker and colleagues on practitioners' perspectives on ethical issues within the treatment of eating disorders identified that the main ethical issues were insufficient level of care, lack of evidence-based practice, family involvement, limited access to expertise and patient autonomy (Walker et al., 2020).

Autonomy is the ability to make your own decisions about what to do, rather than being influenced by someone else or told what to do. Anorexia nervosa patients often refuse treatment despite their extremely low nutritional status, which requires immediate treatment. However, informed consent must be obtained from the patient before performing therapeutic actions. Therefore, treatment refusal by patients with anorexia nervosa causes an ethical dilemma for health professionals. Dietitians should seek out mental health legislation training through their trust, and also consider enrolling in the BDA Capacity Assessment training, to increase their knowledge in this area.

The least restrictive option to treatment should always be considered as a first step. However, Nasogastric feeding (NG-feeding) may be required due to food and/or fluid refusal, and at times NG-feeds are carried out with physical restraints against the will of the service-user under appropriate legislation e.g. the Mental Health Act. The decision to Nasogastric Tube (NGT) feed a patient under restraint would never be a stand-alone Dietetic decision. Rather, it should always be a consultant led, multi professional decision in consultation with the patient and their family (Fuller, Tan and Nicholls, 2023). Further guidance around feeding under constraint can be found in the guidelines section.

Dietitians are advised to work within their scope of practice, make decisions in liaison with the MDT and discuss complex issues around ethics and autonomy within clinical supervision. Non-specialist dietitians can seek support and guidance from the specialist eating disorder dietitian and MDT.

Specialist Roles and Extended Practice

Career progression in the field of eating disorders for dietitians is essential to foster professional development and ensure high-quality care.

Examples of an extended role that eating disorder dietitians can undertake is completing a medical prescribing course, which could enable a dietitian to prescribe

refeeding medication, for example. It is important that dietitians continue to be supervised in their advanced practice roles and work within their scope of practice.

More information on Advanced Practice can be found on the BDAs Advanced Practice page

https://www.bda.uk.com/practice-and-education/nutrition-and-dietetic-practice/dietetic-workforce/advanced-practice.html

For further examples of dietitians roles in advanced practice, please refer to the MHSG career case studies which can be found on our website.

Policy, Protocol and Development

BDA Safe Caseload Guidance recommends that across a dietetic department, the average percentage of work time allocated to care contact time should not exceed 75% as this has been shown to be a level at which clinicians are likely to feel safe when practising. For the average band 5 dietitian (who generally would spend less time on service focused activity) a figure of up to 85% is likely to be acceptable. Band 6 dietitians are expected to spend a significant portion of their time (around 70-80%) on direct clinical work, including assessments, consultations, and follow-up care for patients. This is especially true in settings such as inpatient care, outpatient services, and community clinics. For band 7 and 8 staff, up to 65% and 40% respectively is likely to be safe (BDA, 2024).

Eating disorder dietitians have the expertise both at an individual patient and strategic level to identify, assess, care plan, treat, monitor and review individuals to achieve patient-centred outcomes, and train others to treat eating disorders, as part of the MDT.

Dietitians should expand their role beyond clinical duties and be encouraged to actively contribute to the creation of local clinical pathways, the development of policies, urgent treatment protocols, and national guidelines such as the MEED guidelines. This broader involvement helps to shape and improve the overall treatment landscape for eating disorders, ensuring a more integrated and effective approach to patient care.

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Appendices

Appendix 1: Continuing Professional Development

In considering the continuing professional development requirements of dietitians working in eating disorders, training courses/conferences and organisations are detailed below. This is not an exhaustive list.

BDA Mental Health Specialist Group. This is a specialist group of the BDA that has over 700 dietitians working in the field of mental health, eating disorders and learning disabilities. The website has an excellent resource section and membership includes regular e-mail updates in this clinical area.

BDA Mental Health Specialist Group: Introduction to Mental Health course. This includes an introduction to working in mental health and eating disorders; suitable for those beginning to work in this area.Further details from https://www.bda.uk.com/events/calendar.html

BDA Mental Health Specialist Group: Advancing Dietetics in Eating Disorders (2 Day Course.)It is aimed at Dietitians new to eating disorders who need more depth than the BDA Introduction to Mental Health, Learning Disabilities, and Eating Disorders (ED) course or Dietitians wanting to specialise in or have an interest in ED. Further details from https://www.bda.uk.com/events/calendar/advancing-dietetics-in-eating-disorders-2-day-course3.html

BDA Mental Health Specialist Group: Advanced Eating Disorders (1 Day Course). This course is aimed at Advanced Dietitians with a minimum of 4 years of Eating Disorder experience; it is recommend completing the 2-day Eating Disorders course before attending this course. Further details from: https://www.bda.uk.com/events/calendar/advanced-eating-disorders-i-day-course.html

BDA Mental Health Specialist Group: Advancing Dietetics in Avoidant Restrictive Food Intake Disorder (ARFID). This is a new course designed to introduce dietitians to the dietetic assessment and treatment of ARFID in adults and children. It will be useful for dietitians working in community, mental health and acute settings. Further details from https://www.bda.uk.com/events/calendar/may24.html

Beat. This is the official eating disorders registered charity, providing information and help on all aspects of eating disorders for sufferers, carers and professionals. Further details from https://www.beateatingdisorders.org.uk/

International Conference on Eating Disorders London in March. This conference is run biannually and will appeal to those interested in the assessment and treatment of people with eating disorders and who would like to learn more about the very latest developments in this field. Further information can be found at https://www.eatingdisorderconference.com/londoneatingdisorderconference2025/en/page/home

Managed Clinical Network for Eating Disorders North Scotland. Further details from https://www.nhsgrampian.org/service-hub/eating-disorder-mcn/

Appendix 2: Guidelines

Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care Guidance for commissioners and providers (2019). Available at: https://www.england.nhs.uk/wp-content/uploads/2019/08/aed-guidance.pdf The (accessed 4th August 2024).

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Scottish Government Care and treatment of eating disorders: national specification https://www.gov.scot/publications/national-specification-care-treatment-eating-disorders-scotland/pages/1/ (accessed 18 December 2024)

Appendix 3: Potential measures and outcomes when working with eating disorders

Dietetics Domain	**Outcome**	**Outcome Indicator**	**Examples of outcome indicator tools (or potential tool)**
Symptoms	Normalise bowel movements	Bowel frequency and consistency	Bristol stool scale
	Maintain/improve hydration	U&Es	U&Es corrected
Biochemical	Normalise abnormal biochemistry	U&Es, LFTs, FBC, nutritional deficiency	Tool reporting on success of correcting abnormalities
	Improve glycaemic control	Blood glucose levels	Incidence of hypoglycaemic episodes
Physical (nutritional status and physical activity)	Promote nutritional status change as per dietetic goal	Weight change (as kg,BMI or % weight change) Grip strength	Tool tracking how weight/grip strength/moving in desired direction. Presented as line graph
	Improve nutritional adequacy of intake (oral or enteral Nominal)	Assessment of nutritional intake (e.g. diet history; food record charts; enteral feed plan) % of requirements achieved	% case-load meeting Requirements (or various % bands)
	Facilitate transition to oral diet from Enteral feeding	% requirements from oral diet How requirements are being met.	Line graph demonstrating transition from artificial nutrition support to

			oral diet, and timescales. Barriers used to provide context
Psychological	Reduce eating disorder thoughts	Patient reported	The Eating Disorder Examination Questionnaire (EDE-Q)
	Improve body image	Patient reported	Body Shape Questionnaire (BSQ)
Behavioural	Reduce dietary restriction	Compliance with food and drink plan Patient reported experience	The Eating Disorder Examination Questionnaire (EDE-Q)
	Reduce purging	Incidence of purging	Number of purging episodes per day/week

Adapted from the BDA PENG Dietetic Outcomes Toolkit (British Dietetic Association, 2021).

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