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Title page

Current practise used to identify and manage Binge Eating Disorder and Bulimia Nervosa in primary care in the UK: a national survey

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Abstract

Background

Our previous review highlighted that limited knowledge and understanding of Binge Eating Disorder (BED) and Bulimia Nervosa (BN) amongst primary care professionals may negatively impact their identification and management. Whilst UK guidelines provide some guidance on identification and management, it is currently unknown what, if anything, is actively implemented in practice.

Aim

To map current practices used in primary care in the UK to identify and manage BED/BN.

Design and Setting

An online mixed-method survey focused on primary care settings.

Methods

A combination of convenience and purposive sampling was used for recruitment. The sample comprised healthcare professionals (HCPs) working in primary care and individuals with lived experience (LE) of BED/BN aged 16+ years. Data was analysed using descriptive statistics and thematic analysis.

Results

Of 598 respondents, 347 (58%) were HCPs, 251 (42%) were individuals with LE. Up to 74.3% of HCPs reported not actively screening for BED/BN. SCOFF questionnaire was reported to be the most used standardised tool for identifying potential BED/BN. HCPs reported referral as the main way of managing BED/BN, while LE participants reported using self-help as the main way of managing BED and referral for BN.

Differences in practices between BED/BN are reported among HCPs and LE, such as identification practices, as are differences in HCP and LE perspectives, such as ways to manage BED.

Conclusion

There are considerable variations in primary care practice for identifying and managing BED/BN. Providing clear guidelines for both HCPs and patients should be prioritised to ensure consistent care delivery.

Keywords

binge eating disorder, bulimia nervosa, primary health care, general practice, identification, management, survey, current practice

How this fits in

This research is highly relevant to general practice, where identification and management of BED/BN happen. Given the increasing prevalence of BED/BN, with primary care as the main hub of the care pathway, understanding current practices is essential for future interventions, clinician support and guidelines.

Introduction

Binge-type eating disorders (EDs), such as Binge Eating Disorder (BED) and Bulimia Nervosa (BN), are the most common EDs, with increasing prevalence (1). BED/BN are characterised by regular binge eating episodes, during which individuals consume large amounts of food in a short period and experience a loss of control over their eating behaviour, resulting in an inability to stop (2). In the case of BN, binge eating episodes are followed by compensatory behaviours, e.g. laxative abuse to counteract

overeating and its potential side effects, e.g. weight gain (3). Late identification and management of BED/BN can lead to decreased quality of life (4), worsened health status (2,5), and substantial healthcare costs and strain on health systems (6,7).

Primary care plays a crucial role in identifying and managing BED/BN. However, our recent systematic review found that many healthcare professionals (HCPs) lack confidence in identifying BED/BN, and may be discouraged from doing so due to limited access to treatment and referral pathways, as well as unclear roles and responsibilities, such as who should screen and when (8). Furthermore, UK National Institute for Health and Care Excellence (NICE) guidelines offer a vague description for primary care HCPs of what to take into consideration when identifying or managing BED/BN, but focus more on AN, low-weight BN and secondary care (9). Although the guidelines provide some recommendations regarding management, it remains unknown whether specific areas offer other management options. Due to limited clarity surrounding the specific role of primary care in the identification and management of BED/BN, and their rising prevalence, it is crucial to understand and improve current practice in primary care. While some studies have focused on AN (10,11), to the authors' knowledge, no previous studies have explored routine UK primary care practice in relation to BED/BN.

To address these gaps, we aimed to examine where, how, by whom, and with what tools, if any, BED and BN are identified and managed in UK primary care, and to integrate HCP with complementary lived-experience perceptions.

Method

Design

An online, anonymous, mixed-method survey including quantitative and qualitative responses.

Participants

The target population included (1) primary care HCPs (e.g., general practitioners (GPs), psychological wellbeing practitioners (PWPs), nurse practitioners, dentists, community pharmacists, other allied health professionals), (2) individuals with lived experience (LE) of BED/BN, and (3) service commissioners. For detailed eligibility criteria, see Table 1. We chose to include all primary care HCPs because individuals with BED/BN can present with different mental and physical health symptoms, e.g. depression, dental problems, and weight management across primary care, and with the increasing focus on allied HCPs, we wanted to understand and explore their potential role as well in the BED/BN care-pathway.

106 **Table 1.** Summary of participant exclusion and inclusion criteria

	Inclusion Criteria	Exclusion Criteria
HCPs and Commissioners	Practising in UK primary care with professional training. Have access to the internet via any device.	Practising only in a non-UK primary care setting Practising in secondary or tertiary care No adequate fluency in English
Lived Experience	Adults aged >16 from any background Identifies as someone suffering from the symptoms of BED/BN – this would be assessed in the study via self-reported eligibility questions Experience with the UK primary care system Have access to the internet via any device.	Children and adolescents aged <16 Diagnosis of AN No adequate fluency in English

Recruitment

Participants were recruited through a combination of convenience and purposive sampling over a period of 12 months from February 2024.

Convenience sampling

Links to the survey were shared via the South West Peninsula Clinical Research Network, organisational mailing lists (e.g. BABCP), newsletters (e.g. PACT), websites, and through social media (e.g.,LinkedIn, and Facebook).

Purposive sampling

We applied to the NIHR Bioresource Centre Maudsley, to request the identification and recruitment of participants with LE of BED/BN from the Eating Disorders Genetics Initiative Study UK (EDGI UK). EDGI UK is an online project (IRAS 243566, REC reference 19/LO/1254). Participants consenting to take part in EDGI UK do so via an online portal (https://edgiuk.org/) and provide consent to be contacted about other research studies that they may be eligible for. Participants are informed that their eligibility for these studies will be determined based on information they have provided (i.e., questionnaires). The request was reviewed and approved by a Steering Committee. Any data released by EDGI UK must be used in accordance with the Data Protection Act 2018.

Sample size

Due to the exploratory nature of this study, no sample size was predetermined prior to recruitment.

Patient and public involvement (PPI)

The survey was developed in consultation with a PPI group and a GP advisor. They reviewed the survey and offered guidance on format, question types, content, and recruitment strategy. This helped ensure that the survey questions were clear, concise, and relevant to the focus.

Data collection

Those interested in participating in the survey were invited to click a link or scan a QR code, which directed them to the survey hosted by Qualtrics XM. Participants were first asked to self-categorise into one of our three participant groups (HCPs, LE, commissioner), then they were screened for eligibility. Eligible participants were provided with a Participant Information Sheet and a consent form. From this point, participants were presented with different surveys, using a combination of closed and open-ended questions, based on their participant status, as detailed below (See Supplementary Material 1 for all survey contents).

HCPs

First, data were collected on demographics, profession, and experience with BED/BN. Based on their experience with BED/BN, HCPs were presented with 8-16 questions, depending on their responses, separately for BED/BN. These questions inquired about screening practices, tools used and known, and management practices employed.

LE

Following data on demographics, participants were asked to self-report information about their ED type and clinical diagnosis status. No formal clinical

tools were used to identify the diagnosis status. Participants were then presented with 13-16 questions, depending on their responses, to explore their experience with the process of their ED being identified, the types of any management received/used, perceived appropriateness of this management, and whether it was known to be standard practice.

At the end of the survey, all participants were given the opportunity to enter a raffle for a £50 shopping voucher by providing their email addresses to be contacted. Otherwise, no compensation was provided to participants for their participation.

Data analysis

Descriptive statistics were used to summarise the demographic characteristics and closed-ended responses separately for each type of participant. IBM SPSS (Statistical Package for the Social Sciences) software package was used to analyse the data. A post-hoc logistic regression analysis was conducted on the clinical diagnosis status of ED to examine the differences between these groups. Pearson's $\chi 2$ was tested to compare the difference in identification and management between BED and BN. While confounds, such as profession or gender, may have interacted with the findings, given the study's scope and the absence of a pre-registered analysis to explore them, we have not assessed them. Open-ended questions were thematically coded and analysed. These codes were not converted into counts, but were used to provide context alongside quantitative findings. Quotes are used to illustrate the results. Findings are presented as percentages for specific responses, followed by qualitative results where available to provide further insight into the quantitative data.

Results

Sample

Initially, 1,399 individuals responded to the survey, of whom 915 were eligible to participate. After excluding individuals who did not provide consent or fully complete the survey, 598 participants were included in the analysis (See Figure 1).

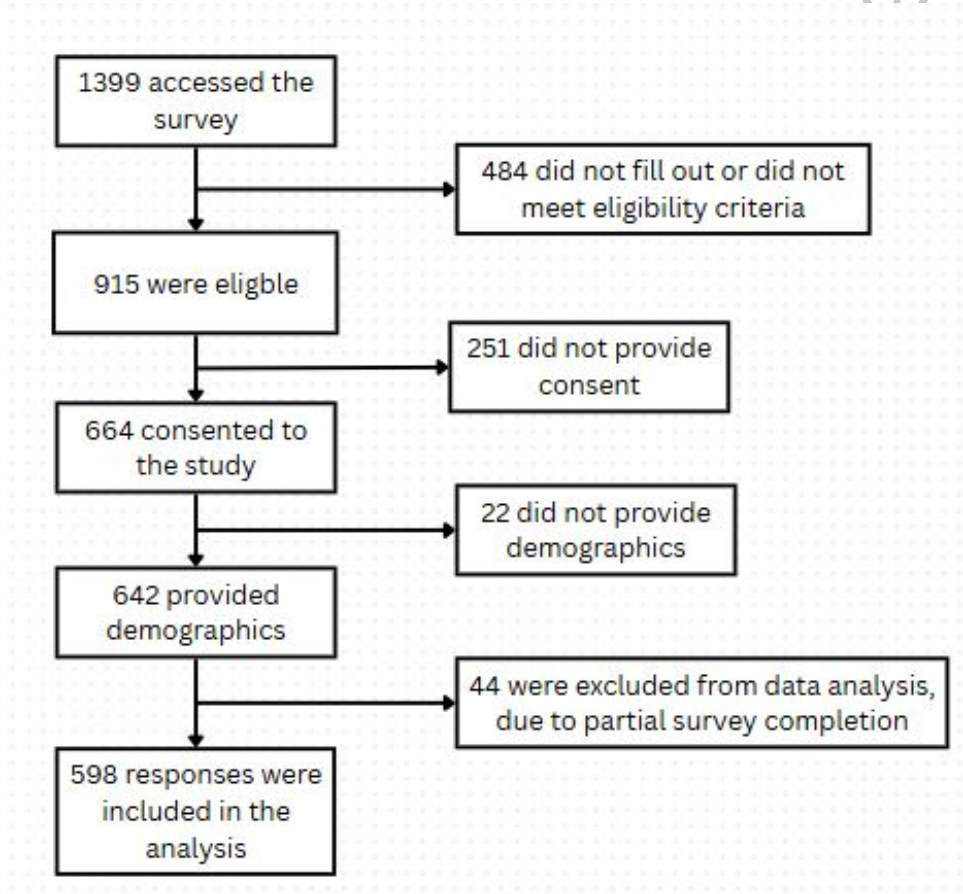

Figure 1. Participant flow

Demographics

347 HCPs (see Table 2) and 251 individuals with LE (see Table 3) were included. Most HCPs reported being white, women, females and GPs. More than two-thirds of HCPs had experience with either BED and/or BN. Most HCPs worked at GP surgeries. HCPs were represented from all seven regions of NHS England. An overwhelming majority of individuals with LE reported being white, women and females, with nearly two-thirds reporting having symptoms of BED. The logistic regression revealed that

people with BN (36.7%) were nearly four times as likely to be clinically diagnosed as people with BED (63.3%) (OR 3.93, 95% CI 2.10 to 7.35).

192 **Table 2.** Demographics of healthcare professionals

		HCPs (N=347)
Age (years)	Mean (SD)	44.33 (9.758) Range: 22-73
Sex	N (%) female	232 (66.9%)
	N (%) male	113 (32.6%)
	N (%) prefer not to say	2 (0.6%)
Gender	N (%) woman	231 (66.6%)
	N (%) man	113 (32.6%)
	N (%) prefer not to say	3 (0.9%)
Ethnicity[1]	N (%) white	269 (77.5%)
	N (%) Mixed/Multiple ethnic groups	7 (2.0%)
	N (%) Black/African/ Caribbean/Black British	12 (3.5%)
	N (%) Asian/Asian British	51 (14.7%)
	N (%) Other ethnic group	4 (1.2%)
	N (%) Prefer not to say	4 (1.2%)
Role	N (%) GP	223 (64.3%)
	N (%) Nurse practitioner	36 (10.4%)
	N (%) Dentist	13 (3.7%)
	N (%) Psychological wellbeing practitioner	8 (2.3%)
	N (%) Other HCPs[2]	67 (19.3%)
Length in role (years)	Mean (SD)	M=12.58 (9.235) Range: 0.4-39 years
Experience with BED	N (%) Yes	230 (66.3%)
Experience with BN	N (%) Yes	235 (67.7%)

Overview of BED & BN experience	N (%) Both	216 (62.3%)
	N (%) Neither	98 (28.2%)
	N (%) BED only	14 (4.0%)
	N (%) BN only	19 (5.5%)

[NB: [1]See full elaboration on ethnicity: white (English/Welsh/Scottish/Northern Irish/British, Irish, Gypsy or Irish Traveller, Any other White background), mixed/Multiple ethnic groups (White and Black Caribbean, White and Black African, White and Asian, Any other Mixed/Multiple ethnic background), Black/ African/Caribbean/Black British (African, Caribbean, Any other Black/African/Caribbean background), Asian/Asian British (Indian, Pakistani, Bangladeshi, Chinese, Any other Asian background), Other ethnic group (Arab, Any other ethnic group) [2]See full elaboration on other HCPs: Nursing Roles, Allied Health Professionals, Pharmacy Roles, Medical Doctors (Locums and Trainees), Mental Health & Psychology, Health Coaching & Coordination]

Table 3. Demographics of individuals with lived experience

		BED (N=159)	BN (N=92)	Overall (N=251)
Age (SD)	Mean (SD)	43.00 (12.995) Range: 16-74	33.54 (11.053) Range: 20-67	40.00 (13.246) Range: 16-74
Sex (%)	N (%) female	151 (95.0%)	91 (98.9%)	242 (96.4%)
	N (%) male	5 (3.1%)	1 (1.1%)	6 (2.4%)
	N (%) prefer not to say	3 (1.9%)	-	3 (1.2%)
Gender (%)	N (%) woman	144 (90.6%)	90 (97.8%)	234 (93.2%)
	N (%) man	7 (4.4%)	1 (1.1%)	8 (3.2%)
	N (%) non-binary	5 (3.1%)	-	5 (2.0%)
	N (%) transgender	1 (0.6%)	-	1 (0.4%)

	N (%) prefer not to say	1 (0.6%)	-	1 (0.4%)
	N (%) no specifications given	1 (0.6%)	1 (1.1%)	2 (0.8%)
Ethnicity (%)[1]	N (%) White	152 (95.6%)	80 (87.0%)	232 (92.4%)
	N (%) Mixed/Multiple ethnic groups	3 (1.9%)	7 (7.6%)	10 (4.0%)
	N (%) Black/African/ Caribbean/Black British	1 (0.6%)	2 (2.2%)	3 (1.2%)
	N (%) Asian/Asian British	-	-	-
	N (%) Other ethnic group	-	2 (2.2%)	2 (0.8%)
	N (%) Prefer not to say	2 (1.3%)	1 (1.1%)	3 (1.2%)
		1 (0.6%)		1 (0.4%)
Education (%)	N (%) Secondary school up to 16 years	11 (6.9%)	2 (2.2%)	13 (5.2%)
	N (%) Higher or secondary or further education	36 (22.6%)	23 (25.0%)	59 (23.5%)
	N (%) College or university degree	75(47.2%)	35 (38.0%)	110 (43.8%)
	N (%) Postgraduate degree	33 (20.8%)	25 (27.2%)	58 (23.1%)
	N (%) Doctorate	2 (1.3%)	6 (6.5%)	8 (3.2%)
	N (%) Prefer not to say	2 (1.3%)	1 (1.1%)	3 (1.2%)
Employment (%)	N (%) Full-time	68 (42.8%)	54 (58.7%)	122 (48.6%)
	N (%) Part-time	27 (17.0%)	11 (12.0%)	38 (15.1%)
	N (%) Unemployed	17 (10.7%)	7 (7.6%)	24 (9.6%)
	N (%) Student	12 (7.5%)	11 (12.0%)	23 (9.2%)
	N (%) Other[2]	31 (19.5%)	8 (8.7%)	39 (15.5%)
	N (%) Prefer not to say	4 (2.5%)	1 (1.1%)	5 (2.0%)
Clinical diagnosis (%)	N (%) Yes	77 (48.4%)	72 (78.3%)	149 (59.4%)

[NB: [1]See full elaboration on ethnicity: white (English/Welsh/Scottish/Northern Irish/British, Irish, Gypsy or Irish Traveller, Any other White background), mixed/Multiple ethnic groups (White and Black Caribbean, White and Black African, White and Asian, Any other Mixed/Multiple ethnic background), Black/ African/Caribbean/Black British (African, Caribbean, Any other Black/African/Caribbean background), Asian/Asian British (Indian, Pakistani, Bangladeshi, Chinese, Any other Asian background), Other ethnic group (Arab, Any other ethnic group) [2]See full elaboration on other type of employment: retired, disabled, carer, homemaker, self-employed, part-time student and working]

HCP perspective

Identification practices

Most HCPs reported not actively screening for BED/BN. Where provided, responses indicating reasons for this included time constraints and workload (leading HCPs to request information only if warranted by symptoms); lack of knowledge, training and awareness of screening tools; perception of a low prevalence of BED/BN in population, limited financial and systemic support, such as limited treatment available for patients and screening for BED/BN being out of remit for some HCP roles. However, it must be acknowledged that the terminology “screening” in the context of mental health conditions like BED/BN might be used differently by clinicians.

The most used standardised screening tool for BED/BN was reported to be SCOFF questionnaire (see Table 4). No significant differences were observed between BED/BN.

Only 2.61% (N=6) and 3.83% (N=9) of HCPs reported knowing about other tools for BED/BN, respectively (apart from those in Table 4). These included the Binge Eating Scale, Meed, Arden’s ED template, intraoral scans, and Eating Attitude Test. HCPs reported awareness from various educational opportunities and prior work experience on ED wards. HCPs reported not using these tools due to time constraints.

224 **Table 4.** Percentage of HCPs actively screening and using screening, diagnostic or other tools to identify BED and BN.

			BED (N=230)		BN (N=235)		X^2 (df), p-value
				Where provided, responses included		Where provided, responses included	
Screening practice[1]		N (%) Yes	59 (25.7%)	• Clinical relevance and diagnostic importance for not only BED but also other mental and physical health conditions, such as *"depression"* and *"obesity"*; • Having good access to secondary care services • Prior general experience with EDs or further general ED-specific training • duty of providing care	80 (34.0%)	• Clinical relevance and diagnostic importance for not only BN but also other mental and physical health conditions, such as *"depression"* and *"weight management"* • Being part of medical reviews, facilitating access to secondary care services • Perceived prevalence in the population, standard practice within the service • Prior general experience with EDs	3.9 (1), 0.05
Tools used[2]	**SCOFF Questionnaire**	N (%) Yes	63 (34.4%)		86 (47.8%)		3.1 (1), 0.08
	Eating disorder screen for primary care	N (%) Yes	24 (14.6%)		27 (15.0%)		0.0 (1), 0.92
	Structured Clinical Interview for DSM-5 (SCID-5)	N (%) Yes	4 (2.4%)		5 (2.8%)		0.0 (1), 0.84
	The Eating Disorder Assessment for DSM-5 (EDA-5)	N (%) Yes	1 (0.6%)		3 (1.7%)		0.8 (1), 0.36
	Eating Disorders Examination Questionnaire (EDE-Q)	N (%) Yes	3 (1.8%)		4 (2.2%)		0.1 (1), 0.79
	Structured Interview for Anorexic and Bulimic Syndromes Eating Pathology Symptoms Inventory - Clinician Rated Version (EPSI-CRV)	N (%) Yes	0 (0%)		0 (0%)		-

Other non-standardised methods	N (%) Yes	80 (48.8%)	• No tools=56 (72.7%) • Clinical examination, history, direct questioning=16 (20.8%) • Other standardised tools=5 (6.5%)	70 (38.9%)	• No tools=47 (70.1%) • Clinical examination, history, direct questioning=19 (28.4%) • Other standardised tools=1 (1.5%)	3.4 (1), 0.06

[NB: [1]qualitative data is presented in a descending order, [2]N=66 (28.7%) for BED and N=55 (23.4%) for BN HCPs did not provide an answer. Percentages provided in the table are based on response rates.]

Management practices

Most HCPs reported using one method of management for BED/BN. The most used management technique for BED/BN was referral, followed by self-help (see Table 5). While no significant quantitative difference can be seen between BED/BN, qualitative data suggest the use of different approaches. For example, HCPs reported referring BN more often to eating disorder services (EDS) compared to cases with BED. BED was frequently reported to be referred to secondary care, without further specification, which could suggest a lower BED referral to EDS than indicated. Some HCPs highlighted barriers around referrals to EDS, including weight restrictions and refusal to treat BED. Furthermore, qualitative data suggest that within in-house treatment, a more integrated approach was taken to manage physical and mental health in BN, whilst BED was reported to be managed from either a physical or mental health perspective, with a greater focus on physical health. Lastly, an overlap between self-help and referral can be observed in the use of the voluntary sector. However, HCPs more often reported offering online resources and evidence-based literature to individuals with BN than to those with BED.

244 **Table 5.** Summary of the type of management options used by HCPs in primary care for BED and BN[1]

			BED (N=230)		BN (N=235)	X^2 (df), p-value
			Where provided, responses included		Where provided, responses included	
Referral	N (%) Yes	199 (91.7%)	**Primary care-** weight management services, dietitians, NHS Talking therapies, social prescribers, health and wellbeing coaches **Secondary care**- community mental health team, eating disorder service, community eating disorder team, bariatric service **Voluntary sector**- charities, e.g. *"BEAT"*	222 (95.3%)	**Primary care-** referral to GP, dietitians, NHS Talking therapies, mental health worker **Secondary care**- community mental health team, eating disorder service, community eating disorder team **Voluntary sector**- charities, e.g. *"BEAT"*	2.4 (1), 0.12
Self-help	N (%) Yes	77 (35.5%)	**Voluntary sector**- charities, e.g. *"BEAT", "Mind, Mental Health Foundation"* **Self-help materials**- online resources, websites, e.g. *"NHS websites", "Centre for Clinical Interventions run by the Government of Western Australia", "workbooks", "digital apps"* **Psychological support**- encouraging self-referral to NHS talking therapies, support groups	77 (33.0%)	**Voluntary sector**- charities, e.g. *"BEAT", "Mind", "SHOUT", "SEED""* **Self-help materials**- online resources e.g., education, relevant literature, websites, e.g. *"NHS websites", "Centre for Clinical Interventions run by the Government of Western Australia", "digital apps", e.g. "Eating Disorder Support App"* **Psychological support**- self-referral to NHS talking therapies, counselling, support groups, offer general advice and a brief intervention in combination with self-help materials	0.3 (1), 0.59
In-house support	N (%) Yes	52 (24.0%)	**Psychological and social support**- different forms of CBT, motivational interviewing, emotional support, use of mental health practitioners and social prescribers, support groups **Physical support**- weight checks, vital checks (including blood pressure and oxygen levels), ECG, bloods, GP reviews	48 (20.6%)	**Psychological and social support**- different forms of CBT, counselling motivational interviewing, emotional support e.g. listening to the patient and validating concerns, use of primary care network mental health team and local mental health workers for regular reviews, use of social prescriber, support groups **Physical support**- weight checks, vital checks, ECG, bloods to check electrolyte and vitamin abnormalities, diet advice to avoid vitamin deficiencies, dental management on the impacts of acid, regular GP reviews	0.7 (1), 0.39
Pharmacology	N (%) Yes	19 (8.8%)	Antidepressants/SSRIs, e.g. fluoxetine, other medications as suggested by NICE, supplements, medication for symptom control, e.g. nausea, appetite stimulant medication, e.g. *"mirtazapine, sugar-free gum, weight loss medication"*	26 (11.2%)	Antidepressants/SSRIs, e.g. fluoxetine, other medications as suggested by NICE, supplements, medication for symptom control, e.g. nausea, appetite stimulant medication, e.g. mirtazapine, Duraphat 5000/2800	0.7 (1), 0.40

Other	N (%) Yes	4 (1.8%)	Unsure about the management offered or using a tailored approach that can include combinations of all of the above, depending on the patient's needs and presentation	N=4 (1.7%)	Unsure about the management offered, no definite pathways reported for management, hence using a tailored approach that can include combinations of all of the above, depending on the patient's needs and presentation	0.0 (1), 0.92

[NB: [1]N=13 (5.7%) for BED and N=2 (0.9%) for BN HCPs did not provide an answer. Percentages provided in the table are based on response rates.]

LE perspective

From symptoms to diagnosis

As mentioned earlier, 48% of people with BED, while 78% of people with BN, had a formal diagnosis. Table S1 provides an overview of the symptoms and events leading to a suspected or confirmed diagnosis of BED/BN. Overall, most individuals reported being nervous or very nervous about seeking medical advice (see Table S1). Nearly two-thirds of individuals with BED and half with BN reported expecting to receive negative medical advice, such as receiving advice about weight loss from their HCP.

Of the 42.1% of individuals with BED reporting being asked specific questions by HCPs, these included questions about eating behaviour, patterns and emotions; relationship with food; duration of problem and past life events; weight-related questions (current weight or weight loss focus) and probing their needs. While most individuals did not expect further questions, others anticipated being asked about the emotional and psychological impact of BED, its day-to-day effects on them, and comprehensive questions about comorbidities.

Of the 59.8% of individuals with BN reporting being asked specific questions, these included questions about binge-purge behaviour, its frequency and duration; physical health related questions, primarily about weight; and questions about mental health in general and shame-inducing or dismissive questions, such as *“Are you not worried about your daughter discovering what you do?”* or *“Why can’t you just stop, then your symptoms would go away?”*. While most individuals did not expect further questions to be asked, others anticipated being asked about the mental health aspect of BN rather than physical health; mental health history, including ED or presence of ED within the family; and their needs.

Management and its perceived appropriateness

According to those with LE, the most common way of managing BN was referral (34.8%), followed by other management options, such as a combination of them (18.5%) (see Table S2). However, for BED, the most common management approach was self-help (37.1%), followed by referral (30.2%). Significant differences between BED/BN can be seen in the use of self-help, medication and other management methods. Despite the differences in management practices, the most appropriate management option was perceived to be referral.

Discussion

Summary

Our results highlighted limited active identification of BED/BN and differences in the tools used to carry it out. Qualitative and quantitative differences were observed between the management of BED/BN. Overall, variations in practice are observed in the identification and management of BED/BN in primary care in the UK.

Strengths and limitations

Whilst surveys have their limitations (12), e.g., high drop-out rates, or a lack of depth in open-ended questions, they can be very effective in mapping practices and provide a state-of-the-art picture of current issues (13,14). A potential bias in the perspectives of surveyed HCPs and LE may be present in our results due to the omission of dyad-level data. Moreover, the representativeness of our sample cannot be established due to the limited data available on the wider primary care workforce (15). However, our sample captures the voices of allied HCPs, who are increasingly central to primary care (16), thereby providing a novel approach to understanding primary care practice. Moreover, the absence of commissioners could provide an incomplete picture of the state of primary care. Hence, results must be interpreted with caution.

Comparison with existing literature

Our review (8) suggested that barriers exist in accessing EDS for BED/BN, findings further supported by our survey results. However, our findings also suggest existing self-referral practices to EDS in the UK. Self-referral to secondary care has been suggested as a potentially effective way to increase early interventions (17). Furthermore, a recent evaluation of resource allocation to self-admissions to EDS in Sweden reported such practice to be a “win-win situation” (18). However, the

applicability to BED/BN is unclear due to a restrictive ED focus. Despite the economic and conceptual support for self-referral to EDS, it is unclear from our data who the service provider is (private or NHS) and whether this approach is national. Hence, further evidence is needed to map out these services in the UK, explore whether BED/BN are being accepted in those services and evaluate the models from a health economic perspective. This would inform future guidelines on ED care pathways and could reduce pressure on primary care if services are commissioned nationwide.

Implications for research and/or practice

Our findings highlighted that apart from antidepressants, different weight loss medications were used by individuals with LE to manage their symptoms. Currently, NICE guidelines only support the use of antidepressants as a pharmacological approach to managing BED/BN (19). However, recent reviews suggested that some weight-loss medications, such as Mounjaro or Wegovy, could offer a reduction in body weight and in the severity and frequency of binge episodes (20,21). This could lead to symptom reduction and support with comorbidities, such as obesity, resulting in a potential improvement in quality of life and a decrease in economic burden. However, currently, limited evidence is available on the use of these drugs specifically for binge eating management. Hence, further research is needed to explore the effects of these medications in the context of BED/BN and explore their usage with the NICE guideline-suggested psychological treatments to ensure patient safety.

We found that weight was reported to be a considerable factor in the identification and management of BED and BN. Some individuals with LE reported weight being a barrier to help-seeking and diagnosis. Literature on weight stigma concurs with these findings, suggesting that weight stigma is present among HCPs (22–24) and among patients

internally (25). Our findings on BMI and weight-based admission to ED services highlighted limited access to treatment for the most common EDs, leaving these individuals to go “missing in the middle” and putting further pressure on primary care to manage these cases. Although weight seems to be primarily impacting LE negatively, we acknowledge the importance of it in BED/BN management for HCPs, e.g. physical health monitoring (19,26). Hence, discussions among all interest holders must occur to revise the current practice of using weight to access treatment, and to close the gap between primary and secondary care, both of which have been called for by prior studies (27,28).

Conclusion

Our findings provide a basis for exploring potential new interventions and evaluating existing ones for BED/BN in a primary care setting and offer evidence to inform national guidelines on ED pathways.

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Ethical approval

The study was approved by the North West - Greater Manchester East Research Ethics Committee (IRAS: 333157, REC reference: 23/NW/0383).

Data availability

Materials and data used for the conduct of this research are available from the study authors on reasonable request.

Competing interests

The authors declare no competing interests.

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While preparing this manuscript, we utilised Grammarly AI and ChatGPT to enhance readability and language clarity. After using this tool, we reviewed and edited the content as needed and take full responsibility for the content of the publication.

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