

Perceived confidence, competence and training in evidence-based treatments for eating disorders: a survey of clinicians in an Australian regional health service

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Abstract

Objectives: Eating disorders (EDs) are challenging to treat and contribute to considerable morbidity and mortality. This study sought to identify the educational preparedness, competence and confidence of clinicians to work with people with EDs; and to identify how services might be improved.

Methods: Clinicians who worked in the emergency department, medical, paediatric wards and mental health services were invited to complete an online survey.

Results: From the 136 surveys returned, 73% of respondents reported little or no confidence working with EDs. There was a strong linear correlation between perceived confidence and competence and hours of education. Those with 70 or more hours of self-reported training were 2.7 times more likely to rate themselves as both confident and competent. Improving services for people with eating disorders included the provision of appropriate training, improving access to services including psychotherapy, and facilitating consistency in and continuity of care.

Conclusions: To increase the confidence and competence of the workforce, regular training around EDs should be undertaken. The establishment of a specialist team to provide services across the continuum of care for people with severe or complex EDs appears warranted in a regional health service.

Keywords: eating disorder, anorexia nervosa, confidence, training

Eating disorders (EDs) are considered challenging to treat and contribute considerably to morbidity and mortality. The highest rates of death occur in those with anorexia nervosa where one in five deaths are by suicide.¹ Despite people with EDs presenting to primary care for treatment of health problems, EDs are poorly recognised in primary care with only a minority of people with a diagnosable ED estimated to receive appropriate EDs specific treatment.^{2–4} The majority of people with EDs are not treated by mental health services but those that are tend to present as complex and challenging.^{5,6} Successful treatment requires a coordinated multidisciplinary response across primary care (general practice), emergency department, hospital and outpatient treatment settings.⁷ However, health professionals have been found to hold stigmatising attitudes towards people with EDs, and people with EDs have been found

to engender reactions such as frustration, hopelessness and perceptions of incompetence and worry.^{8,9}

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) clinical practice guidelines for the treatment of EDs provide explicit physiological parameters to guide decisions about hospital admission, re-feeding and the provision of evidence-based psychological treatments.⁷ Many people do not receive all elements of treatment, may not receive empirically supported thera-

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pies or receive treatment of sufficient intensity or duration to be effective.¹⁰

Local context

The Cairns and Hinterland Hospital and Health Service (CHHHS) has the responsibility of providing public hospital and health services to a population of approximately 250,000. A snapshot of current service users of the CHHHS mental health service on the 13 October 2017 revealed that, from a total of 1824 people receiving care, there were 17 individuals with a primary or secondary ICD-10 diagnosis of F50*. In 2016, 33 people with a primary diagnosis of an ED and 23 individuals with a secondary diagnosis received mental health services. In the same year there were 36 hospital separations for EDs. Four individuals had lengths of stay over 100 days accounting for 1090 bed days. The average length of stay for the remainder was 16 days (SD=16).

An interdisciplinary ED interest group was established in Cairns and developed a survey to explore factors that might contribute to competence and confidence working with people with EDs, elicit perceptions on how services could be improved and inform a training agenda.

Methodology

The survey was developed and deployed using Qualtrics survey software. It sought information about respondents' area of practice, experience, estimates of the amount of training specifically relating to EDs, general confidence and competence working with EDs. Knowledge and competence in domains of knowledge and practice derived from the RANZCP guidelines on the treatment of EDs was elicited.⁷ The Likert scale structure was derived from a survey of competence and confidence of clinicians working in the UK.¹¹

The project received approval from the Far North Queensland Human Research Ethics Committee (HREC/17/QCH/88-1161). An invitation to complete the survey was sent via email to clinicians of the CHHHS. The dataset comprising completed surveys was imported into Excel (Office365v1711+real-statistics). Responses were examined for normality using the Shapiro Wilk test and Spearman's r ($p < 0.05$) was the metric selected to report correlations. Qualitative data derived from the open-ended questions was imported into NVivo and a thematic content analysis was undertaken by the first author using the method proposed by Corbin and Straus.¹² Only a brief summary is provided here.

Results

Surveys were partially completed with demographic and work place data by 134 respondents. As illustrated in Figure 1, respondents were from a range of disciplines. Sixty-one (46%) reported working in mental health and

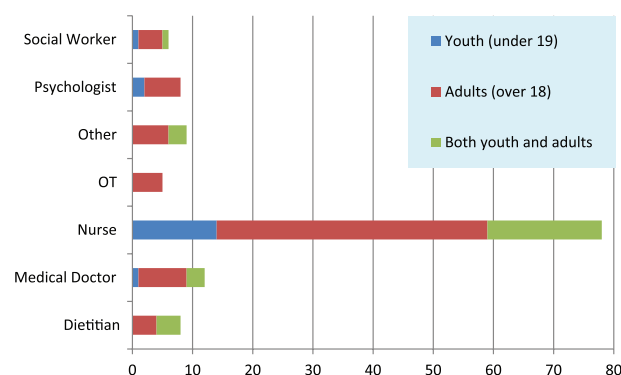


Figure 1. Numbers of respondents by professional identification and youth or adult focus.

their stated experience ranged from 0.2 to 32 years (mean=12.6, median=10, SD=9.4). Five respondents worked as therapists. Of the medical doctors who completed the survey ($n=13$), 8 worked in mental health, 2 in emergency medicine and 3 in other specialties. Respondents were asked to specify how often they worked with people with EDs on a Likert scale from "never" to "almost every day". The most common response was "rarely" ($n=61$). Few respondents reported working with people often ($n=10$) or almost every day ($n=2$) and they all reported being confident and competent in their work.

Self-reported general confidence and competence working with EDs was elicited via five-point Likert scales (see Table 1) and completed by 111 respondents. Forty-one (37%) reported feeling confident and 40 (36%) reported being competent in their work with EDs. There was a strong positive linear correlation between confidence and competence ($r=0.79$).

Respondents were asked to estimate the number of hours of training they had received relating to EDs and 100 surveys were included where the respondents had entered a number in at least one training area. As illustrated in Table 2 there was considerable variability in the hours of training reported. Hours of training ranged from 0 ($n=4$) to 1320 hours (median=70 hours). The highest mean hours of reported education was for self-education and the related item, reading and referring to guidelines (mean=33). Reading guidelines had the strongest relationship to confidence ($r=0.63$) followed by hours of clinical supervision ($r=0.62$). Hours of workshop attendance had the strongest correlation with self-reported confidence ($r=0.65$) followed by hours of reading guidelines ($r=0.63$). Undergraduate education and postgraduate study appeared to have no relationship to self-reported confidence or competence. Those on or below the median total hours for education (70 hours) rated themselves on average as not confident (mean=1.8) and not competent (mean=2.5). Those above the median rated themselves as confident (mean=3) and competent (mean=3.7). Those who reported 70 or more hours of training were 2.7 times

Table 1. Self-rated general competence and confidence working with eating disorders

Competence		Confidence	
Not Competent at all	6 (5%)	Not confident at all	20(18%)
Aware but have no specific skill	33 (30%)	A little confident	50 (45%)
Some knowledge / little experience	32 (29%)	Confident	24 (22%)
Knowledge and skill to apply	33 (30%)	Very confident	13 (12%)
Highly competent and able to train others	7 (6%)	Extremely confident	4 (3%)

Table 2. Estimates of hours of training regarding eating disorders (n=100)

Type of training / education	Hours of education on eating disorders				Correlation with			
	0 h	< 20 h	20–40 h	> 40 h	Mean	SD	Confidence	Competence
<i>Undergraduate / pre-registration training</i>	37	42	8	13	21	38	0.05	0.03
Post graduate studies	68	19	2	11	13	34	0.39	0.39
Attendance at in-house in-service education	45	38	10	7	15	27	0.55	0.56
Attendance at workshops facilitated by experts on eating disorders	53	30	7	10	16	32	0.55	0.65
Clinical supervision specifically addressing patients with eating disorders	68	18	2	12	17	41	0.62	0.55
Mentorship by an experienced or expert peer	69	19	3	9	14	37	0.51	0.55
Self-education – online courses or reading	29	35	16	20	32	46	0.54	0.54
Reading and reference to guidelines on the treatment of eating disorders	26	37	16	21	33	47	0.63	0.63
Total hours	4	20	14	62	162	239	0.67	0.64

SD: standard deviation.

more likely to report feeling competent and confident (OR=2.7, CI=95%, $p<0.05$).

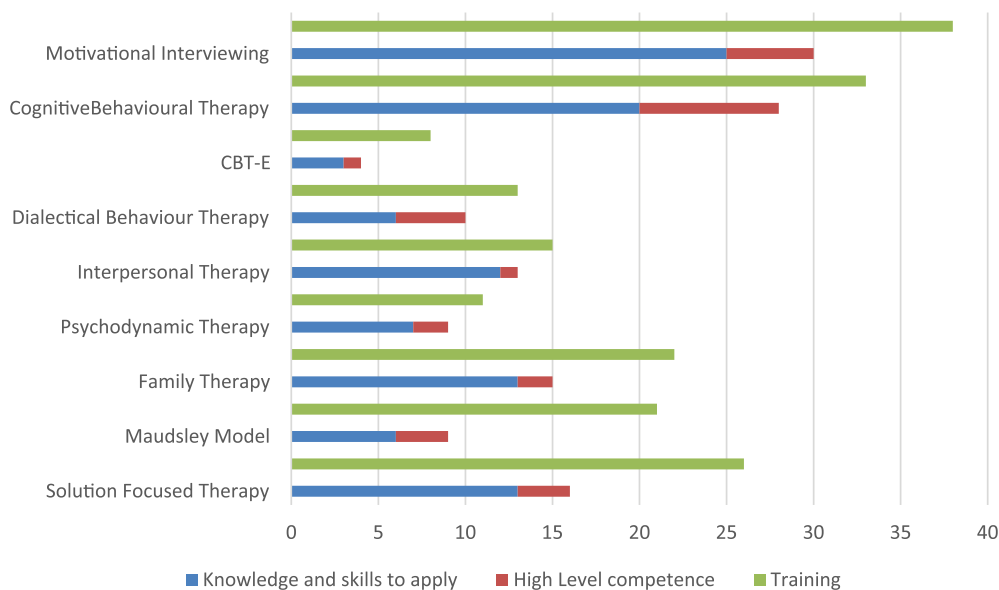
Respondents were asked whether they had formal training in particular areas of ED knowledge and practice, and 100 respondents completed all questions and were included in the analysis. Sixty-seven reported some formal training in at least one knowledge domain (mean=3.2 domains), although no more than 40 respondents reported training in any one area (the highest being “assessment” and “food avoidant behaviours”). The mode for confidence for all items was 1. Thirty-six or fewer respondents considered themselves competent in any one area (see Table 3). Nutrition and dietetics was the lowest reported domain of competence ($n=16$) although all dieticians ($n=7$) reported competence in that area. Only 22 nurses (35%) reported competence and confidence in nursing care of the population group and meal supervision. Eight out of nine medical doctors reported being confident and competent in assessment whereas none reported feeling competent in nutrition and dietetics.

Half of respondents ($n=50$) reported some training in one or more evidence-based psychotherapy. Motivational interviewing, cognitive behavioural therapy and solution-focused therapy were the approaches most often identified (see Figure 2). In all instances there were more people trained than reported being competent. Those competent or expert in psychotherapeutic approaches to EDs reported that they rarely worked with people with EDs. Between 7 and 15% of people competent in therapy (that is only one or two people) trained in any one modality saw people often (“usually every week”).

Respondents were asked for suggestions to improve services for people with EDs. Increasing opportunities for on the job training was mentioned by more than half of respondents. Some identified particular groups such as assistants in nursing (AINs) who often provide meal supervision of people with anorexia nervosa in hospital as needing training. Improving access to specialist services including psychotherapy was an overarching theme. Some observed that it was difficult to access

Table 3. Self-rated competence and confidence in domains of knowledge and practice with eating disorders (n=100)

	Any Training	Reported competence			Reported confidence		
		Competent	Mean	Mode	Confident	Mean	Mode
Assessment	40	30	2.6	2	31	2.2	1
Care planning	37	34	2.6	1	30	2.1	1
Nutrition and dietetics	23	16	2.3	2	20	1.8	1
Effects of starvation	39	31	2.7	2	31	2.1	1
Food avoidant behaviours	40	32	2.6	1	29	2.1	1
Body image distortion	39	31	2.6	4	27	2	1
Meal supervision	36	30	2.6	2	33	2.1	1
Nursing care of people with eating disorders	39	24	2.5	2	28	2	1
Physical complications of eating disorders	45	32	2.8	4	31	2.1	1
Prevention and management of re-feeding syndrome	39	36	2.6	4	31	2.1	1

**Figure 2. Numbers who reported competence in psychotherapeutic approaches to eating disorders (n=100).**

specialist services in the community and whilst a massive investment was made on hospital stays, minimal or no community follow-up was provided. Some respondents perceived that those with EDs were treated differently or inconsistently depending on the treating team and proposed more prescriptive guidelines and explicit care pathways. Nineteen respondents suggested that a local specialist ED service was required to provide a multidisciplinary, coordinated response for people hospitalised and also adopt responsibility for ongoing care.

Discussion

Locally the survey suggested that a small number of people had training, expertise and confidence in providing evidence-based psychotherapeutic services but appeared under-deployed in that they were not seeing people with EDs in their roles. With the exception of the Maudsley Model of Family Therapy utilised in youth services it is unclear what psychotherapeutic model of engagement people with EDs receive post hospitalisation. Yet people appear to have the skill sets to engage with people in

Specialist Supportive Clinical Management and small numbers report being competent and having received training in other empirically supported treatments.¹³

This survey was unique in asking people to estimate the amount of training they received, and supports the proposition that education, training and supervision contributes to self-reported confidence and competence. It suggests that best investment to improve competence and confidence is regular dissemination of practice guidelines and a combination of approaches for ongoing staff development such as regular seminars, workshops, case discussions and clinical supervision. Some unregulated members of the workforce such as AINs may benefit from a more focused induction training and supervision. Interdisciplinary models of networking and continuing education have been found to improve knowledge and confidence elsewhere.¹⁴

The primary limitation of this survey is that it excluded private practitioners, who play pivotal roles in ongoing care and follow-up in the Australian health care context. Some disciplines (particularly psychiatry and mental health inpatient nurses) also appeared to be under-represented in this survey. However, the findings were remarkably in accord with a survey of clinicians in an embryonic ED service in the UK.¹¹ The overall level of perceived competence and confidence was generally higher in the UK sample, but this may have been because their sample saw people with EDs more regularly. There was also a similar pattern of training in evidence-based psychotherapies, with the greatest number having received training in motivational interviewing, cognitive behavioural therapy and solution-focused therapy.

Given the relatively small numbers, but apparently under-utilised pool of highly competent clinicians in this survey, and the resource intensive nature of those with serious EDs in a regional area, there appears to be a good argument for considering creating a stand-alone ED service to deliver both outpatient medical management, psychotherapeutic services, consultation liaison services and consult on in-patient management.

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