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Turning Eating Disorders Screening in Primary Practice into Treatment: A clinical practice approach

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Abstract

Objective: The rate of screening for eating disorders (EDs) by general practitioners (GPs) in primary health care is low. We examined an approach to increase screening and the impact on referrals.

Method: Low cost assessment/treatment pathways were established in February 2019 for patients with an ED. Between October 2020 and June 2021 information was sent to GP practices about screening for EDs, along with provision of an online screening tool and training.

Results: Of the 44 GP practices invited to participate in the screening initiative, 42 (95.5%) agreed. Only 12 (27%) had referred patients before the initiative, 53 patients over 19 months (2.8/month). Over the 10-month initiative 90 patients were referred and started treatment from 50% of the practices (8.2/month); 73 (81%) had an ED and 6 had disordered eating but not an ED. Qualitative feedback from GPs suggested they would not screen for a condition if there were no readily identifiable treatment pathway available.

Discussion: Results suggest that the three elements of the initiative (provision of assessment and treatment pathways, access to a screening tool, provision of information on screening) increased the likelihood that GPs would use a screening tool, leading to an almost three-fold increase in referrals.

Key words: screening, early identification, general practice, primary health, qualitative

Public Significance Statement: An initiative used to translate screening for an eating disorder to treatment in primary health care had three components. First, provision of an easy referral process to assessment as well as treatment. Second, screening tools were made available on computer desktops. Third, information and training provided to GPs was used to support their clinical observation and increase confidence in initiating screening. Adoption of this initiative almost tripled referrals for assessment.

While general practitioners (GPs) have a recognised role in screening to prevent serious illnesses (Australian Government Preventive Health Taskforce, 2009), there is a noted lack of recognition of eating disorders (EDs) in primary health-care settings (Waller et al., 2014). Further, the US Preventive Services Task Force (2022) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for EDs in adolescents and adults. We report on an initiative aimed to support GPs to identify patients with EDs and examine the impact on referrals for treatment.

The Sunshine Coast ED Access projecT (hereafter known as SCEDAT) aimed to improve access to evidence-based treatment for people in one regional area in Australia by creating pathways between GPs who wished to refer people with EDs for psychological assessment and increasing the numbers of treatment providers who had skills in delivery of low cost ED assessment and treatment (partially subsidised by the national Medicare scheme). A care navigator was employed through the project to liaise between the GPs and treatment providers. Treatment eligibility criteria for patients were (1) meeting the DSM5 diagnostic criteria for an ED, (2) residing in the health network area; (3) aged 14 years and over; (4) referral finalised by a GP; and (5) assessed as safe to receive community-based treatment by a medical professional and a mental health professional.

Referrals were accepted by SCEDAT from February 2019 to June 2021 from 200 GPs (out of around 250 available GPs). A screening initiative was introduced from October 2020 to August 2021 for a subset of GP practices to identify patients with EDs and thus increase the proportion of earlier intervention referrals to SCEDAT. Qualitative data was collected to investigate GPs' opinions and practices of screening and to identify functional barriers and facilitators of screening practice.

Method

Participants

Information about the screening initiative was promoted to 44 GP practices in the region between October 2020 and May 2021 with an initial phone call to the GP using pre-screening questions (**Supplement 1**) followed by emailed information (**Supplement 2**). Forty-two practices decided to participate (95.5%).

The screening initiative

The screening initiative consisted of three active elements. First, the practices were reminded of their access to the SCEDAT pathway. Each GP received at least 3 to 4 reminders, where at least two of these were email reminders and the remainder were phone calls. The pathway consisted of two assessment sessions provided by a psychologist, supplemented with the EDE-Q (Fairburn & Beglin, 1994), along with access to a low-cost 20-session course of treatment for eligible patients. Additionally, a dietetic care pathway of three sessions was introduced for people identified as having disordered eating who did not meet the diagnostic criteria for an ED.

Second, the use of the *Screen for Disordered Eating* (SDE; Maguen et al., 2018) was promoted with this tool being made available to GPs on their desktops. Some GPs preferred to use the SCOFF (Morgan et al., 1999), the Eating Disorders Examination questionnaire (EDE-Q; Fairburn & Beglin, 1994) or their own practice approach. GPs were told to initiate screening if they received a "no" to the following question: "Are you satisfied with your eating patterns?" While GPs were encouraged to screen all patients, this was not monitored.

Third, GPs received individual information (written format) on how to screen and were also offered a follow-up training session in June 2021 to consolidate learning on identifying, and supporting people with, an ED.

Data Collection

First, we used de-identified patient information from referral forms submitted to SCEDAT. Second, brief semi-structured qualitative telephone interviews with GPs were used as well as a focus group for six GPs. Third, we received feedback from participants attending the training session for GPs. Inductive thematic analysis was applied by LC to identify the shared priorities and practices of GPs when making decisions about screening and referral for EDs. The research was approved by the Bellberry Human Research Ethics Committee, Application No: 2018-09-728-FR-1.

Results

General practitioner referrals for assessment

Only 12 of the 42 (27%) practices had previously referred patients with EDs (n=53) in the 19 months before the initiative (2.8 patients/month). Of the 73 GPs across the 42 practices, twenty-nine (40%) participated in the training session. During the 11 months of the screening initiative 21 practices, representing 39 GPs, referred 90 patients for assessment (8.2 patients/month). The timelines and patients referred are summarised in ***Figure 1***. We did not capture data about time between screening and referral, but once referrals were received, a treatment team assigned within 48 hours, and then there was a wait for up to 2 weeks for assessment.

Screening and diagnosis

Of the 73 patients with an ED, 68.8% were identified using the SDE tool either alone or followed by the EDE-Q, 19% with the SCOFF and 14.4% with GPs using their own approach. Of the 90 patients referred for psychological assessment, 73 (81.1%) met the diagnostic criteria for an ED and started treatment. Six (6.67%) were identified as having disordered eating but not an ED and received a brief dietetic care intervention. Only 10 (11.11%) were found not to have an ED or disordered eating at this time. Use of any screening tool identified 40 (61.5%) people in the first three years since onset of symptoms of an ED and 75 (83.3%) people who had never received treatment for an ED before. Further demographics for the patients are presented in ***Table 1***.

Qualitative feedback from general practitioners

Five themes were identified across all sources of feedback from GPs. The first was *early case identification*. Screening tools were exclusively used with individual patients (rather than across high risk population groups) based on a greater awareness of the need to probe about eating even when the patient's presenting symptoms were not severe. One GP reported: *I realize that eating disorders are lot more complex than most GPs are aware of. The project made me more aware of sub-clinical because there was a pathway we could use. When there is nowhere to go there is no point in referring. We need to start earlier with awareness of nutrition and wellbeing, rather than waiting until someone meets the diagnostic criteria for an eating disorder*. Feedback from GPs who did not refer people suggested that they had not used screening because they did not think that they had patients with

disordered eating and that the "index of suspicion" was broadened in that symptoms not previously explored in relation to disordered eating (e.g., fatigue) triggered a screen.

Second, *introducing the idea of ED to the patient*. GPs expressed concerns about raising the issue of eating habits or ED with patients. Those who chose to use the SDE tool reported that it offered a comfortable way of initiating conversations with people with larger body sizes. One GP reported: *The project has definitely made me more empathetic to patients of all sizes. I recognise that you don't have to be skinny. I have greater insight into overweight patients. I understand how difficult it is to be told to 'just go on a diet' when the weight issues are embedded in an eating disorder. I now have a much lower threshold for looking for an eating disorder*.

The third theme was *time constraint and priorities*. All participants discussed the difficulties in introducing additional topics and screening tools in a brief consultation session. Fourth, *referral pathways*. All participants noted that they would not choose to screen for a condition if there were no readily identifiable treatment pathway available: *The Trial has been helpful. It is really useful to have a basic referral template that only takes 5 minutes to complete. Having access to a care navigator who can triage referrals and be the problem solver and connector is the most useful part of the project.*

The fifth theme was *reluctance to diagnose*. GPs adopted a cautious approach to initial diagnosis, being more willing to identify possible disordered eating than diagnosing an eating disorder, even when the patient presented with clinical symptoms sufficient for a diagnosis of anorexia nervosa. One GP reported: *The average GP will only see one or two cases a year. We need backup to make sure we are diagnosing and supporting correctly.*

Discussion

The model used in the screening initiative to support translation from screening to treatment had three critical components. First, provision of an easy referral process to assessment as well as treatment. Second, screening tools were made available on computer desktops. Third, information and training provided to GPs was used to support their clinical observation and increase confidence in

initiating screening questions. Adoption of this initiative almost tripled referrals for assessment, which translated to more people with EDs receiving treatment.

It is well established that GPs can find diagnosing EDs a challenge (Johns et al., 2019; Marks et al., 2003), with limited opportunity to develop confidence if they are only seeing a small number of cases each year. While providing sufficient education to GPs that fits with their usual approach to practice has been shown to be important in other areas of screening such as depression (e.g., Braunschneider et al., 2021), two key aspects of the project may have further increased incidence for screening and referral. The first was the provision of a low-cost assessment pathway that reduced the burden on GPs to make a final diagnosis and the second was provision of clear referral pathways (Banas et al., 2013).

GPs in Australia typically use screening tools for case finding rather than for population screening (RACGP, 2015) and this was the case for some GPs despite being encouraged to screen all patients. Qualitative feedback suggested that the benefit of the training was to encourage GPs to use a screening tool with patients whose symptoms they had not previously classed as an ED, such as people living in bigger bodies.

Managing the limited time available in an appointment session was a key theme. This is consistent with research into GP priorities in brief consultation session which has shown that GPs are most likely to prioritise physical health issues and least likely to consider mental health or contributory lifestyle factors such as diet (Andre et al, 2012; Cohidon et al., 2019; Junius-Walker et al., 2012; Zhang et al., 2020).

The results should be interpreted in the context of the following factors and limitations. The model examined in this report may not be replicable in other settings. The results were achieved in the context of a popular and well-resourced larger project that is likely to have influenced the rate of GP engagement. Access to low-cost treatment options through SCEDAT also influenced patient decisions to engage in treatment. Similar translation of GP screening to referral to treatment may be achieved through factors idiosyncratic to specific GP practices without an assessment and treatment pathway,

influenced by wait time, rapport with the GP who did the screening, and subsequent GP follow-up with the patient they referred. Further limitations include limited patient demographic data which did not enable us to examine provider biases in screening, assessments were not conducted using standardised diagnostic tools (except for the EDE-Q for 72% of the patients), and only one rater derived qualitative themes.

While in many communities throughout the world there are not government funded programs for screening and low-cost treatment, the results of the study suggest that translating screening in primary health settings requires multiple components regardless of such funding. Provision of low-cost assessment and treatment pathways were in place before the screening initiative, but the use of screening and consequent referral only increased when these pathways were assertively communicated, along with making online screening tools available and linked with information and training on screening for GPs. The feedback from GPs, however, suggested these two latter components would have been insufficient without clear referral pathways that resulted in treatment. Governmental failure to adequately fund mental health care services should not be a barrier to experts calling for the need to make such funding more widely available given the benefits for people with EDs.

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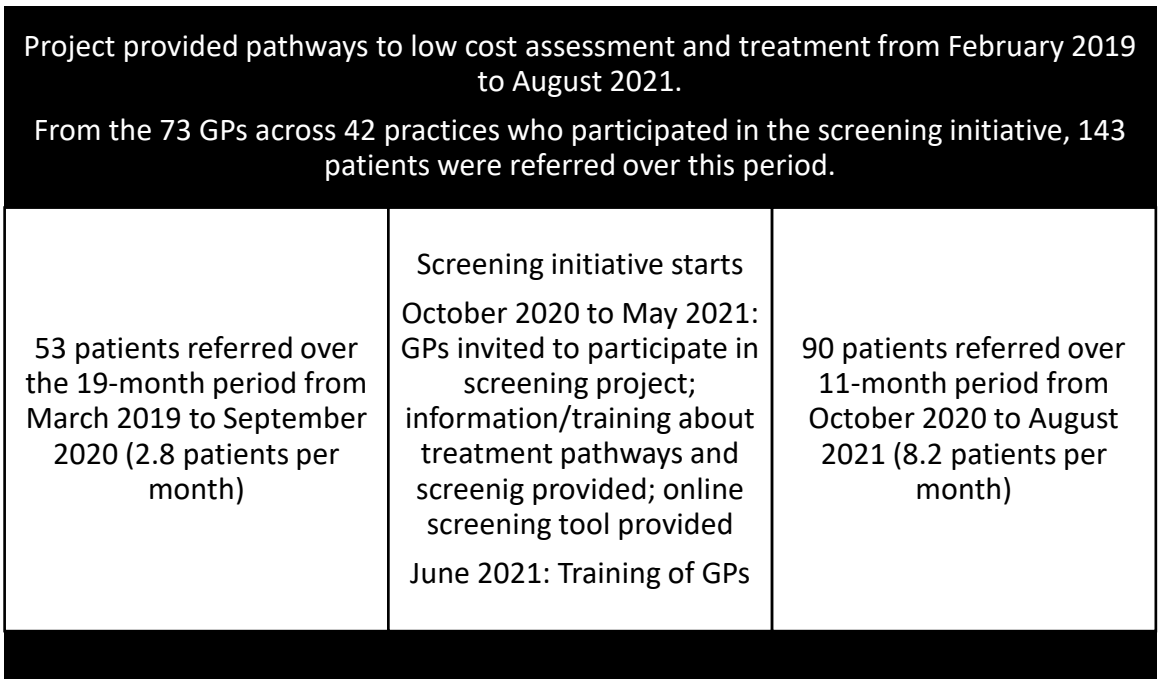
Table 1: Profile of Screening Referrals

Variable	Categories	N (%)
Duration of illness	*Early Intervention*	
N = 90	0 – 12 months.	31 (34.44%)
	1-3 years	11 (12.22%)
		42 Early Intervention (46.66%)
	Later Intervention	
	3 – 10 years	14 (15.55%)
	10 years or longer	23 (25.55%)
	No useable data	11 (12.22%)
EDE-Q Global Scores	Equal to or greater than 3	40 (61.53%)
N = 65	2.0 to 2.96	12 (18.46%)
	Less than 2.0	13 (20.01%)
Age	14 – 17 years	37 (41.1%)
N = 90	18 – 29 years	27 (30.0%)
	30 to 50 years	13 (14.44%)
	Over 50 years	11 (12.2%)
	Not eligible (under 14 years)	2 (2.22%)
Previous Treatment	No previous treatment	75 (83.33%)
N = 90	Previous ED treatment	11 (12.22%)
	Not determined	4 (4.44%)

Note: Information included in referrals was variable therefore sample sizes vary

Figure 1: *Timeline of the project and referral of patients*



Supplement 1

SCEDAT– Pre-screening Service Provider Questions

Clinician name: **Date:** Click here to enter a date.

Type of service:

☐	GP
☐	Dietician
☐	Psychologist
☐	Mental Health Social Worker
☐	Headspace intake
☐	Others (please specify):

Where is your practice located? (postcode)
How long have you worked in the Practice?
How many years ED experience do you have?

Baseline questions

What would trigger you to suspect & ask about disordered eating symptoms?
Have you previously screened for eating disorders?
If yes, how do you screen (e.g. SCOFF)?
Do you screen clients for eating disorders now?
If yes, how do you screen & how often do you use a screening tool? (e.g. SCOFF)?
How many clients with a diagnosed eating disorder would you usually see in a year?
How many new eating disorder presentations have you seen in the past 3 months?
How confident do you feel about early detection of eating disorders (on a scale of 1: not confident to 10: very confident)
What other info or tools would be useful to assist you to screen for disordered eating or eating disorders?

Supplement 2

Hi Dr…… Great to speak with you today. Thanks for completing the pre-screening questions for disordered eating. Please find attached information on our Disordered Eating Screening initiative for those age 14 years up including easy to use Screening Tool Questions you can print out & use.

Also check out the Link to PHN eating disorders page to find out more: https://www.ourphn.org.au/eating-disorder-access-trial/ (no longer accurate)

Below is other Info you might find helpful on the Sunshine Coast Eating Disorder Access Trial (SCEDAT):

- *Accepting referrals since January 2019 for those with Eating Disorders or suspected Eating Disorders.*
- *Since the introduction of the MBS items in Nov 2019 the Trial shifted its focus to its original aim of early intervention & Eating Disorder diagnosis for people (age 14 years up) with mild to moderate presentation & comorbidities **(e.g. The Trial accepts those who aren't eligible for EDP under Medicare).***
- *Research shows people in the early stages of developing an eating disorder rarely volunteer information to health professionals on their eating behaviours making early identification challenging.*
- *For this reason SCEDAT is providing information & outreach to GP Practices, and other Service Providers on ways to promote screening practices for high risk groups in order to, among other things improve early identification of an eating disorder. Enclosed are **screening tools** (see attachments) which can be used to help identify those at risk.*
- *The emphasis will be on '**disordered eating'** as an indicator of risk for eating disorders and the medical consequences for several high risk groups of people including people with: weight related health issues, depression, diabetes & infertility to name a few.*

The Sunshine Coast Eating Disorder Access Trial (SCEDAT) will provide:

1. ***Two psychology assessment sessions** for anyone with a **'yes'** response to **two** or more of the disordered eating screening questions or those with suspected ED.*
2. *Care Navigation & acceptance into the Trial for those identified (after 2 assessment psychology sessions) as having a DSM-5 Eating Disorder, mild to moderate presentation. They will receive **20 ED evidenced based psychology sessions** & **10 dietetic sessions**.*
3. *Up to 3 dietetic sessions for those with '**disordered eating'** only & **don't qualify for a DSM-5 Eating Disorder**.*
4. *The Trial will provide GP's one Case consult / Client with the Psychologist & dietitian (in addition to other Medicare case consults) to encourage collaboration & multidisciplinary care at $117.50/ case consult.*

SCEDAT Processes:

After receiving a referral the Care Navigator confirms & where needed, organises the Client care team, which consists of a psychologist & dietitian, plus their GP. We then notify the Client of the treatment team and that they will be contacted, first by the Psychologist to begin assessment sessions and later by the Dietitian or Practice to begin dietetic supports (unless referred in by dietitian).

We also identify any existing barriers which may need to be worked through so the Client can be given every opportunity to complete a full course of treatment.

In order to ensure best practice and collaboration, the Psychologist generally notifies the dietitian when it is best to begin dietetic input. The Care Navigator will confirm GP medical clearance if this hadn't been done at time of referral by referring Clinician.

Under the Trial Clinicians can also provide Telehealth & video conferencing sessions as needed. Clients will still be entitled to use MHCP for other comorbidities should they be eligible and not have exceeded the Governments requirements.

Please find Attached:

1. *SCEDAT Screening Disordered Eating Referral Form – (Referral for patients, complete and email SCEDAT or fax)*
2. ***Disordered Eating Screening Tool Questions** – (these can be printed & used by GP's, Practice Nurse)*
3. *GP, Nurse, GO's & Other Health Providers Disordered Eating Fact Sheet (to be shared)*

4. *Disordered Eating Screening Tool Questions tick box (Patients can fill out in waiting room/ or with Nurse/GP)*
5. *Disordered Eating Fact sheet for Participants of all ages including adolescents (hand out)*

Please let me know if you would like for more info re: claiming financial rebates for case consults for Patients accepted into the Trial.