General Psychiatry

Scoping survey of dietetic resourcing for eating disorders: why is the dietitian's role marginalised in community eating disorders?

Elizabeth Roberts [1], Mala Watts [2], Safiya Riley,[3] Kathryn Hart [3]

To cite: Roberts E, Watts M, Riley S, *et al*. Scoping survey of dietetic resourcing for eating disorders: why is the dietitian's role marginalised in community eating disorders? *General Psychiatry* 2024;**37**:e101604. doi:10.1136/gpsych-2024-101604

► Additional supplemental material is published online only. To view, please visit the journal online (https://doi.org/10.1136/gpsych-2024-101604).

Received 12 March 2024
Accepted 11 November 2024

[1]Child and Adolescent Mental Health Service - Community Eating Disorders Service, Somerset NHS Foundation Trust, Taunton, UK
[2]Community Eating Disorders Service/ARFID, Hywel Dda University Health Board, Carmarthen, Wales, UK
[3]Department of Nutrition, Food & Exercise, Faculty of Health and Medical Sciences, University of Surrey, Guildford, UK

Correspondence to
Dr Kathryn Hart;
k.hart@surrey.ac.uk

Eating disorders (EDs) like anorexia nervosa (AN) and bulimia nervosa (BN) are conditions characterised by severe and persistent disruptions in eating behaviours. Nutritional rehabilitation is the main goal of many therapies, for example, family therapy for AN, enhanced cognitive–behavioural therapy and the Maudsley Model of AN Treatment for Adults. Dietitians should play an essential role in the multidisciplinary team that treats people with EDs, and dietetic intervention in ED has been associated with improved weight gain.[1] Patients and their families often need advice around mealtime management and menu planning, as well as tailored advice on energy input and output. However, McMaster *et al*[2] reported that ED specialists were less likely than carers and those with lived experience of an ED to endorse dietetic involvement as a standard component of treatment. In particular, ED specialists were less likely to agree that 'all patients should receive a multi-disciplinary assessment at the start of treatment, including nutritional assessment by a dietitian' (53% agreed vs 100% with lived experience or caring for a person with an ED) and that 'all patients diagnosed with an ED should be referred to a dietitian for assessment, education and guidance about nutrition' (48% vs 87% patients/carers).

It might be assumed that clinicians working with EDs have a good working knowledge of basic nutrition, but this is not always the case. Cordery and Waller[3] surveyed 65 clinicians (dietitians, nurses, clinical psychologists, psychiatrists) working with EDs to determine their nutritional knowledge. Dietitians had the highest level of basic nutrition knowledge followed by psychiatrists; the nutritional knowledge of clinical psychologists and nurses was similar to that of the lay group. In a survey of nutritional literacy in mental health professionals spanning 52 countries and 1056 participants, all participants believed the diet quality of individuals with mental disorders was poorer compared with the general population, yet the majority of psychiatrists (74.2%) and psychologists (66.3%) reported having no training in nutrition.[4] Nevertheless, many of them used nutrition approaches with their patients (58.6% recommended supplements, 43.8% recommended specific diet strategies). Only 0.8% of mental health professionals rated their education regarding nutrition as 'very good'.

Manualised interventions, which are commonly used, often do not provide evidence-based nutritional information,[5] which is at odds with the general principles of evidence-based healthcare. Dietitians are highly skilled in providing this evidence-based dietary information and can effectively support behaviour change in this client group, including those who are ambivalent or hard to engage. The younger age group who are undergoing growth and pubertal development are more vulnerable to nutritional insults and therefore even more in need of evidence-based dietetic input.

In 2015, in recognition of the importance of properly staffed multi-disciplinary teams to manage these complex conditions, the National Collaborating Centre for Mental Health (NCCMH) set out expected staffing levels for different professional groups, including dietetics, specifically focusing on community ED services (CEDS) for children and young people (CYP).[6] Their recommendations were accompanied by funding to support implementation. It has been suggested that money in mental health services has not been distributed equally across all disciplines.[7] It is also questioned whether increases in adult service funding

are used equitably to expand the service offer across the different professions.

In response to these concerns and to the evidence of insufficient service and funding and inequity, we conducted a scoping review of dietetic staffing in ED services in England, aiming to understand the current provision, referrals, caseload, staffing and proportion of patients seen by a dietitian in CEDS and to identify differences in provisions between adults and CYP and between regions.

Data were collected through Freedom of Information (FOI) requests to all NHS trusts in England, excluding ambulance and specialist trusts, submitted between December 2022 and March 2023. The final sample included 193 NHS trusts, with 56 having adult and/or CYP-CEDS. The data collected included service provision ('Does your trust provide a service to adults/children and adolescents with AN or BN?'), number of referrals ('How many adults/CYP with AN or BN were referred to the service over the 1-year period (between 1 April 2021 and 31 March 2022)?'), caseload ('How many adults/CYP with AN or BN were on the trust caseload on 31 March 2022?'), whole-time equivalent (WTE) dietitians ('How many registered dietitians (in WTE/full time equivalent (FTE)) were working exclusively with this caseload of adults/CYP with AN or BN on 31 March 2022?') and percentage of patients seen by a dietitian ('What percentage of adults/CYP with AN or BN received into the service were seen by a dietitian over the 1-year period (between 1 April 2021 and 31 March 2022)?'). Data were requested for patients with AN and BN specifically, although some trusts provided data for all patients with ED instead of, or as well as, AN and BN separately. Data analysis was conducted in SPSS (V.27). Descriptive statistics were performed and comparisons between adult and CYP services were made using independent T-tests or Mann-Whitney U-tests as appropriate. Spearman's rank-order correlations were used to investigate relationships between caseload/referrals and staffing. Benchmarking of dietetic resourcing in CEDS-CYP services was carried out against the NCCMH predicted staffing. Ethical approval was not required as FOI data are publicly available. However, FOI requests may be refused partially or fully where an exemption applies,[8] for example, if the anonymity of the data subject may be jeopardised (section 40(2) of the FOI act) because a low number of patients (0–9) was linked to specific medical conditions and disclosure would significantly increase the risk of individuals being identified, potentially breaching their data protection rights. Requests may also be refused if disclosure of information would give rise to an actionable breach of confidence (section 41 (1)). To ensure confidentiality in reporting, data were de-identified after collation and so could not be linked back to specific individual trusts.

Thirteen trusts exclusively provided services to CYP, six to adults, 35 trusts offered services to all ages, and two did not specify the age group they served. No regional variations were found in service provision across England; however, substantial ranges were observed for all variables. Comparing adult and CYP CEDS (for those reporting for AN/BN specifically), there were no significant differences in the median number of referrals (219 vs 107), staffing levels (1.00 WTE for both), or proportion of patients seen by dietitians (42% vs 43%). However, caseloads for services reporting for all EDs were significantly higher in adult services than for CYP (342 (207.6) vs 203 (140.0), p=0.036). A strong correlation between referrals and caseloads was noted in all services surveyed (all p≤0.002); however, most services showed no correlation between referrals or caseload, and staffing. A considerable proportion of CEDS-CYP responding for all EDs (76%, n=18) and for AN and BN specific services (61%, n=18) were below the 0.8 WTE/50 referrals recommended by the NCCMH.

The findings of this scoping exercise support the view that dietitians are under-represented in CEDS-CYP and that staffing is not proportional to caseload in most CEDS, with many services under the recommended WTE/referrals. The recommended dietetic staffing for CEDS-CYP is 0.8 WTE (50 referrals/year), 1.5–1.6 WTE (100/year) and 2.3–4.8 WTE (150/year).[6] Possible reasons for this discrepancy include cultural issues (how and whether dietetic input is valued) and commissioning arrangements. For example, while dietetic intervention has been shown to improve weight gain and nutritional intake[1] and early weight gain predicts outcome in adolescent anorexia treatment,[9 10] weight gain is not measured by central commissioners in England. Dietetic under-representation may also be due to beliefs about the impact of early dietetic involvement on the clinician–patient relationship. In a survey of 20 clinicians working in an outpatient adolescent ED service, concerns were identified regarding a negative impact on the therapeutic patient–clinician alliance if a dietitian was involved too early in treatment and some respondents suggested dietetic involvement may undermine parental confidence.[11]

Conversely, the results of the McMasters' study[5] clearly show that service users and carers do value dietitian input, and dietitian input probably influences weight gain and dietary intake. Despite this, services are not resourcing dietetics to meet the recommendations of access and waiting times,[6] and our survey demonstrates that the resource is even less in adult services. Apart from anecdotal evidence that ED services do not value dietitians on an equal par with other professional groups, further research is required in order to understand this fully. Changes in commissioning metrics including weight and weight change, obvious quality markers of ED services, might also redress this balance.

Health Education England has already identified uneven increases in staffing across professional groups in the under 18s mental health sector as a whole, with, for example, psychology and psychotherapy seeing increases of 22% and 18%, respectively, from 2019 to 2022, while occupational therapy saw a drop of 14%.[7] Dietetics is not included separately in the report

data, but the current study indicates that staffing is inadequate.

Given the demand from patients and carers for dietetic input and the role of this in weight gain, the current staffing picture from this scoping exercise would be expected to be detrimental to patient care. Weight restoration is a challenge for most patients and their families, and evidence-based advice delivered confidently by clinicians who are skilled in nutrition and dietetics and behaviour change may provide the best chance for full weight restoration. A study from Madrid confirmed that sustained and meaningful dietetic intervention over a period of 15–20 sessions leads to significant changes in weight, Body Mass Index, calorie intake and intake of starchy foods, oils and fats, and dairy foods.[12]

The current study is inconclusive with respect to regional variation when assessed at the level of the Strategic Health Authority; however, individual trusts with high/low resourcing were identified, and these warrant further investigation with respect to patient outcomes.

FOI requests offer researchers the potential to access large amounts of raw, unpublished data to answer specific questions in a cost-effective manner,[13] particularly beneficial for making comparisons across authorities or trusts, as in the current project. However, there is also the potential for misinterpretation or inappropriate refusal of the requests which may introduce bias. Although the current study requested data for patients with AN and BN specifically, the questions were interpreted differently by different trusts, with some providing data only for those with the clinical label AN or BN on their medical record, whereas others included all patients under their ED services. While the authors have analysed these data separately, there is the potential for some data to have been misclassified if the subgroup (AN/BN-specific or all EDs) was not clear. The proportion of patients seen by a dietitian gives no information on the details of dietetic intervention and specifically whether this was a one-off appointment or sustained interventions/episodes of care. Lack of clarity around what exactly dietetic intervention in EDs consists of has been highlighted in two recent systematic reviews[1 5] and so would warrant further research.

We propose adhering to the staffing recommendations that exist for CEDS-CYP and increasing staffing fairly across dietetics and all other disciplines, to meet demand. In adult services, there are currently no guidelines, and these are urgently required. There is a lack of standardisation and transparency in reporting variables for CEDS services, which prevents accurate benchmarking and therefore appropriate comparison and evaluation of services. Research is needed to understand how patient outcomes differ between services with higher and lower levels of dietetic staffing and to confirm the components of successful dietetic interventions. This review shows substantial variation in service provision which would be expected to impact patient care and outcomes in this area, where demand continues to grow. A repeat of this scoping exercise will be useful in the future to monitor how dietetic staffing in adults and CYP CEDS changes over time.

X Elizabeth Roberts @docrobertsdiet

Contributors All authors conceived the study, developed the protocol and reviewed the manuscript. KH and SR sent out the FOI requests. SR collated and analysed the data. MW, ER and KH drafted the manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

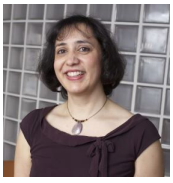
Provenance and peer review Not commissioned; externally peer reviewed.

ORCID iDs
Elizabeth Roberts http://orcid.org/0009-0008-4651-728X
Mala Watts http://orcid.org/0009-0000-5749-7618
Kathryn Hart http://orcid.org/0000-0001-7494-9866

REFERENCES

1 Yang Y, Conti J, McMaster CM, *et al*. Beyond refeeding: the effect of including a dietitian in eating disorder treatment. A systematic review. *Nutrients* 2021;13:4490.
2 McMaster CM, Wade T, Franklin J, *et al*. Development of consensus-based guidelines for outpatient dietetic treatment of eating disorders: a Delphi study. *Int J Eat Disord* 2020;53:1480–95.
3 Cordery H, Waller G. Nutritional knowledge of health care professionals working in the eating disorders. *Eur Eat Disord Rev* 2006;14:462–7.
4 Mörkl S, Stell L, Buhai DV, *et al*. “An apple a day”?: psychiatrists, psychologists and psychotherapists report poor literacy for nutritional medicine: international survey spanning 52 countries. *Nutrients* 2021;13:822.
5 McMaster CM, Fong M, Franklin J, *et al*. Dietetic intervention for adult outpatients with an eating disorder: a systematic review and assessment of evidence quality. *Nutr Rev* 2021;79:914–30.
6 NHS England. Children and young people’s eating disorder access and waiting time commissioning guide. 2015. Available: https://www.england.nhs.uk/mental-health/cyp/eating-disorders/ [Accessed 22 Feb 2024].
7 Health Education England. Children and young people’s mental health workforce census. 2023. Available: https://www.hee.nhs.uk/sites/default/files/documents/Children%20and%20Young%20People%27s%20Mental%20Health%20Workforce%20Census%202022_National%20Report_24.1.23.pdf [Accessed 17 May 2024].
8 Information Commissioners Office. Freedom of information. Section 40 and Regulation 13 – personal information. 2024. Available: https://ico.org.uk/for-organisations/foi/section-40-and-regulation-13-personal-information/part-one-is-the-request-for-personal-data/ [Accessed 13 Jun 2024].
9 Madden S, Miskovic-Wheatley J, Wallis A, *et al*. Early weight gain in family-based treatment predicts greater weight gain and remission at the end of treatment and remission at 12-month follow-up in adolescent anorexia nervosa. *Int J Eat Disord* 2015;48:919–22.
10 Le Grange D, Accurso EC, Lock J, *et al*. Early weight gain predicts outcome in two treatments for adolescent anorexia nervosa. *Int J Eat Disord* 2014;47:124–9.
11 Brennan C, Baudinet J, Simic M, *et al*. The role of the dietitian within family therapy for anorexia nervosa (FT-AN): a reflexive thematic analysis of child and adolescent eating disorder clinician perspectives. *Nutrients* 2024;16:670.
12 Loria Kohen V, Gómez Candela C, Lourenço Nogueira T, *et al*. Evaluation of the utility of a Nutrition Education Program with Eating Disorders. *Nutr Hosp* 2009;24:558–67.
13 Savage A, Hyde R. Using freedom of information requests to facilitate research. *Int J Soc Res Methodol* 2014;17:303–17.

Elizabeth Roberts is a clinical dietitian working in a community adolescent eating disorders service in NHS Somerset in the UK. She obtained her MSc from the University of Bristol in the UK in 2005 and her PhD from Bournemouth University in the UK in 2015. Her main research interests include the biology of anorexia and dietetic and nutritional interventions in anorexia treatment.



Mala Watts is a specialist clinical dietitian working in Community Eating Disorders/ Avoidant restrictive food intake disorder (ARFID) at Hywell Dda University Health Board, Wales. She obtained her BSc from Cardiff University in 1999. Her main research interests include ARFID, specifically outcome measures for dietitians, and Anorexia Nervosa.