An Exploration of General Practitioners' Knowledge of Eating Disorders: A Pilot study in Cork City and County

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CARL Research Project

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An Exploration of General Practitioners’ Knowledge of Eating Disorders: A Pilot study in Cork City and County

Chapter One: Introduction

This study will focus on the knowledge of eating disorders among general practitioners (GPs) in Cork city and county. There is a substantial amount of evidence available which indicates that GPs do not have sufficient knowledge to tackle the treatment of eating disorders or do not feel that they have adequate resources to treat eating disorders (Clarke & Polimeni-Walker, 2004, Hoek & van Hoeken, 2003, Linville et al, 2010, Mond et al, 2012, Ogg & Millar, 1997, Whitehouse et al, 1992,). However research also overwhelmingly suggests that primary care facilities such as GPs’ offices, are ideally suited to early identification of eating disorders (Clarke & Polimeni-Walker, 2004, Linville et al., 2010, Mond et al., 2010, Ogg & Millar, 1997).

This study is both timely and relevant as research has shown that eating disorders are very serious illnesses, and can have severe consequences if left untreated. The serious impact of eating disorders is highlighted by Welch, Ghader & Swenne (2015) “[they] are serious disorders that have a negative impact on both the psychological and physiological well-being of the individual afflicted” (p 1). Hudson, Hiripi, Pope, Harrison & Kessler (2007) also highlight the major public health concern that eating disorders present, due to the fact that they are frequently associated with other psychopathology and role impairment, and the fact they are frequently under treated. According to research carried out by Turnball et al (1996), the rates of eating disorders are increasing. This research was carried out in the UK using a computer diagnosis system called the General Practice Research Database (GPRD). While the study did not explicitly mention any reasons for the increase, it is very important in terms of this research that the prevalence of eating disorders is increasing.

As a result of a review of the available literature, a hypothesis for this research has been drawn up. This hypothesis states that GPs in Cork do not receive very much training with regards to eating disorders during their studies. It also states that GPs are not confident in terms of diagnosing and treating eating disorders.

This research employed a mainly quantitative approach, including one qualitative interview which took place with Trish Shiel, the clinical manager of the Eating Disorder Clinic Cork (EDCC). 200 questionnaires were sent out to randomly selected GPs in Cork. These questionnaires included both quantitative closed-ended questions and qualitative open-ended questions. The methodology for this research will be discussed in more detail further on in the paper.

The research found that a large amount of GPs did not receive very much training with regards to eating disorders. However it also found that a large proportion of GPs were confident with diagnosing eating disorders and with their knowledge of eating disorders in the general population. It found that GPs are not sufficiently aware of the local services which are available to individuals with eating disorders and that GPs feel more services are required. An important finding was that GPs are willing and interested in taking part in further training in this area.

This research is being carried in partnership with the Eating Disorder Clinic Cork (EDCC) through Community-Academic Research Links (CARL). CARL is an initiative in UCC which allows students and community/voluntary organisations to collaborate in order to produce a piece of research. Community based research is separate from other types of research because it "tackles issues that are relevant to people belonging to, or with interests in, a community or place (e.g. local residents, community activists, members of community groups, staff of NGOs or other service providers" (Durham Community Research Team, 2011, p.4). other features of community based research is that it validates various different sources of knowledge and promotes the use of multiple methods of discovery and distribution of any knowledge which is produced, it is a collaborative initiative between academic researchers and members of the community, and its main goal is social action and social change (Strand et al, 2003). Community based research values the knowledge and input from every group involved in the research. One of the most important features of community based research is that it offers community/voluntary organisations and agencies a strong information base from which to plan and act upon (Strand et al, 2003). Another distinctive feature of community based research is that it usually incorporates a mixed methods approach (Strand et al, 2003). While this particular piece of research is mainly quantitative, it does also include a qualitative interview meaning that it draws slightly on a mixed methods approach.

Chapter Two: Literature and Policy Review

2.1: Classification of eating disorders

Although the Diagnostic and Statistical Manual of Mental Disorders Five (DSM-V) (2013) identifies six different feeding and eating disorders: pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa and binge eating disorder, this research will focus on anorexia nervosa, bulimia nervosa and binge eating disorder, because they are the three most frequent disorders (DSM-V). According to the DSM-V the diagnostic criteria for anorexia nervosa includes the following; an intense fear of gaining weight, persistent behaviour that interferes with weight gain although the individual is already at a significantly low weight, restriction of energy intake relative to requirements resulting in a significantly low body mass index (BMI), disturbance in the way in which one's body shape is experienced, persistent lack of recognition of the seriousness of one's current low body weight, or undue influence of body weight or shape on self-evaluation. The twelve month prevalence of anorexia nervosa among young females is 0.4 percent of the general population. There is not much known about the prevalence among young males however it is thought to be significantly less, with the male to female ratio around 1:10.

Anorexia nervosa is particularly worrying because it is associated with an elevated suicide risk of around 12 per 100,000 of the population (DSM-V). Anorexia nervosa also has the highest premature mortality rate of any psychiatric disorder (Harris & Baraclough, 1998) which again highlights the need for GPs to be able to properly identify the disorder and treat it accordingly. A study by Birmingham, Su, Hlynsky, Goldner & Gao (2005) conclusively "confirms the association of anorexia nervosa with a clinically important increase in mortality rate" (145, 2005).

Bulimia nervosa is also discussed in the DSM-V. The diagnostic criteria are described as followed; recurrent episodes of binge eating, recurrent inappropriate compensatory behaviours with the aim to prevent weight gain (for example self-induced vomiting; misuse of laxatives, diuretics or other medications), fasting or excessive exercise. Much the same as anorexia nervosa, one of the criteria frequently associated with bulimia nervosa is also the fact that one's self evaluation is unduly influenced by body shape and weight. The twelve month prevalence for bulimia nervosa of 1 to 1.5 percent is higher than that of anorexia nervosa. Furthermore, much less is known about the prevalence of bulimia nervosa in young men, but it is thought to be approximately a ratio of 1 male to 10 females (DSM-V, 2013). Once again the risk of suicide is elevated in cases of bulimia nervosa, which of course presents a major public health concern and highlights the need for these conditions to be properly identified and treated.

In terms of binge eating disorder, the DSM-V criteria for diagnosis specifies recurrent episodes of binge eating, evidence of marked distress regarding binge eating and that the binge eating occurs at least once a week for three months. It is also highlighted that the binge eating is not associated with the repeated use of unsuitable compensatory behaviour as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa. Binge eating itself is described as eating in a discrete period of time an amount of food that is larger than what most people would consume under similar circumstances in a similar time period, or a sense that one has no control over their own eating during the episode. The 12 month prevalence of binge eating disorder is notably higher than that of anorexia nervosa, and also slightly higher that the prevalence of bulimia nervosa, being 1.6 percent and 0.8 percent for females and males respectably (DSM-V). In the interview with Trish Shiel, she highlighted that in her experience that the prevalence of binge eating disorder appears to be increasing in Ireland (Shiel, 2016).

From these findings it is clear that eating disorders pose major public health risks. Although they are not hugely prevalent within present-day society, they pose major risks for sufferers. Hoek and van Hoeken (2003) also highlighted the fact that it is very difficult to yield completely accurate findings from research and that more than likely case finding methods yield an "underestimate of the true incidence" (p 393). Therefore, although the prevalence of anorexia nervosa is reported to be around 0.4 percent in young females, it may be significantly higher, as with the prevalence for bulimia nervosa and binge eating disorder.

2.2: GPs role in relation to eating disorders

It is clear from research that individuals with an eating disorder are much more likely to visit their GP quite frequently, most likely with presentations other than the eating disorder itself. Ogg and Millar (1997) found that individuals with eating disorders consulted their doctors significantly more frequently than control subjects over five years prior to their diagnosis. According to Ogg and Millar patients with an eating disorder presented a variety of symptoms including gastrointestinal, gynaecological and psychological complaints. Another study which emphasised the key role which GPs play in the early intervention and treatment of eating disorders was carried out by Mond et al (2010). They found that more than eighty percent of individuals suffering from an eating disorder sought treatment from a health professional for symptoms of anxiety or depression. Eighty percent is an overwhelmingly high figure and these findings give strong evidence that GPs are in an excellent position to identify eating disorders early on, but they also highlight the types of presentations that GPs should be more aware of. Mond et al also discovered that while individuals were unlikely to seek help or treatment for their eating disorder specifically, they were very likely to visit their

GP for treatment in relation to symptoms of general psychological distress and or medical complications associated with disordered eating or being overweight.

One could assume that general practitioners are in a somewhat more favourable position than other healthcare professionals to identify eating disorders early on and arrange for the provision of treatment, however, findings suggest that GPs do not have a sufficient knowledge of eating disorders in order to benefit from this.

2.3: Challenges GPs face in relation to diagnosing eating disorders

According to Linville et al (2010) data signifies that nearly seventy-eight percent of medical providers had patients with eating disorders that they were unsure how to treat. Hoek and van Hoeken (2003) found that only one out of every ten patients with bulimia nervosa are recognised and subsequently treated.

Research carried out by Linville, Brown and O'Neill (2012) on GPs found that sixty-eight percent of respondents to their survey did not screen for an eating disorder because it was not the presenting concern and fifty-nine percent did not feel that they had the skills necessary to help patients with eating disorders. Seventy-seven percent of respondents also reported that they had patients with eating disorders whom they could not treat due to a variety of different reasons, including time constraints and lack of skills.

Mond et al (2010) highlight that only one-third of individuals with eating disorders had ever been asked about a problem with eating by a primary care practitioners. They maintain that their findings show that efforts must be made to improve practitioners understanding of eating disorders, in order to achieve early and appropriate interventions.

Clarke and Polimeni-Walker (2004) identified the major challenge which is presented to healthcare professionals, including GPs, when dealing with eating disorders. "With their myriad of serious and occasionally life-threatening physical sequel, in addition to their complex and emotional issues, individuals with eating disorders can be among the most challenging a physician may see in primary practice" (p 293). They also found that approximately eighty percent of GPs who encountered individuals with disordered eating felt that there were some patients whom they could not treat. There was a variety of reasons identified which included limited time and resources; lack of physician skills; problems with patient co-operation; and the severity of the patient's illness.

In terms of the demographics of GPs, Ogg and Millar (1997) suggested that more senior GPs may have limited awareness of eating disorders than their younger colleagues, simply because they are relatively new conditions which have been increasing significantly in recent years. However for this particular piece of research it was decided not to explore the demographics of sample population. The reason for this being, in the interview with Trish Shiel she mentioned that medical students still receive very little training with regards to eating disorders. Therefore it was decided that it was not necessary to look at the ages of the sample population.

A study by Allen, Fursland, Watson and Byrne in 2011 produced results which challenged most of the existing evidence around GPs knowledge of eating disorders. They found that most primary care practitioners were accurate in identifying cases of anorexia nervosa and bulimia nervosa, but they were inaccurate in identifying atypical presentations. This research was carried out in Australia, therefore further research should examine the Australian healthcare system with regards to healthcare and specifically in terms of mental healthcare, to determine if their training for GPs is different to that of Ireland or other countries. This may give an indication as to why GPs are accurate at diagnosing typical eating disorder presentations, and their system could provide inspiration on how to improve the current system in Ireland. While these results are contrary to the hypothesis of this particular piece of research and do not follow the general theme of findings relating to eating disorders, they are important in terms of looking at the significance of GPs' knowledge around atypical presentations as well as typical presentations of eating disorders.

2.4: Policy in Ireland

Throughout the entire health sector in Ireland, not just the mental health sector, there is an intertwined and interdependent relationship between the statutory sector, the private sector and the voluntary/community sector. Powell and Guerin (1997) note the unique relationship between the voluntary/community and statutory sectors in Ireland and point out that it has been a 'defining feature of Irish social policy for the past twenty years" (p. 133). Considine and Dukelow (2009) also emphasise the vital role that the private sector plays in the Irish healthcare system, highlighting the fact that approximately fifty percent of the population pay for private health insurance.

Historically in Ireland, mental health policies have not been seen as significant for governments and were usually afforded a very low priority. While this is certainly changing and there has been an increasing awareness of the importance of the notion that mental health underpins aspects of health and well-being in the past decade (Heenan, 2009), the specialised area of eating disorder treatment is not receiving as much recognition as other areas. Golightly and Kirwan (2015) also stress the fact that there is a lack of positive policies in terms of supporting mental healthcare in public sector funding.

Because of the major lack of public sector funding, a void was created which was subsequently filled by the voluntary/ community and private sectors. Upon reviewing the different options available to individuals with eating disorders, a number of points are overwhelmingly clear. Firstly, there is a severe lack of specialised public services available in the country. In terms of treatment centres which are equipped to promote specialised treatment for eating disorders, there are only a handful available in Dublin (Lois Bridge Eating Disorder and Treatment Centre, Rutland Centre, Sandyford Wellness Centre, Goldsmith Clinic), and outside of Dublin there is only one specialised eating disorder clinic which is located in Cork City, the Eating Disorder Clinic Cork. While all of these centres provide treatment for eating disorders, they are not all specialised services and also they all require payment in order to avail of the services.

During the interview with Trish Shiel, she revealed that with specific regards to eating disorders, the private sector is largely responsible for providing services. While public sector provisions are improving, the quality of care provided by the public sector in such a specialist area remains to be seen (Shiel, 2016).

In Ireland, eating disorders fall into the category of healthcare, more specifically mental healthcare. While healthcare overall usually takes up a large section of government funding, mental health services have been less well funded. In the 2015 budget healthcare was the second highest section of expenditure, behind only social protection, with projected spending at 13,079 million out of the entire budget of 53, 626 million (Government of Ireland, 2015) “Historically, mental health policies in Ireland have been afforded a relatively low priority in the health and social care agenda. Stereotypes, prejudice, stigma, and a lack of knowledge meant that mental health was largely a taboo subject” (Heenan, 2009, p.1). The Irish attitude towards mental health in the past and the effect that this had on the provision of services for mental health is extremely evident, especially in light of the recent economic crisis. Golightly and Kirwan (2015) argue that “the lack of positive policies towards mental health services and the impact of cuts in public sector funding have created an abyss of indifference” (p. 1). The impact of the economic crisis had a major impact on the provision of mental health services in Ireland. A sector which was extremely neglected to begin with only began to be recognised as important around the same time that government funding was cut drastically across almost every sector. Therefore, while recognition of mental health and its importance to society is becoming more common in recent years, the sector has not been able to expand as much as it required.

Along with wholly funding the public sector, the government also provides substantial funding for the voluntary and community sector, which provides a great deal of services relating to health in general, including mental health. Harvey, 2012 highlighted that "Voluntary and community services in Ireland have a long history and can be traced back to medical and welfare charities in the 18th century" (p.10). The 'Vision for Change' document was published in 2006 and is a very important document in terms of mental health in Ireland, and will be discussed in more detail further on in this chapter. A Vision for Change highlights the importance of the voluntary and community sector with regards to mental health service provisions. It further acknowledges that the majority of mental health services are carried out in the community and in publicly funded mental health services. Community and voluntary sector agencies are in fact ideally positioned to seek change and improvements in the area of mental health care because they are "formally organised, privately owned, self-governing, non-profit driven and autonomous" (Department of Health and Children, 2006, p.53). Voluntary groups and organisations can also be vital instruments for change with regards mental health services because they highlight the inadequacy of statutory services and hold a strong advocacy role at local, national and international levels (Dept. of Health and Children, 2006). It is clear that the voluntary and community sector have a very important role to play in terms of mental health services. However their ability to fulfil this role is being constantly challenged by cuts to government funding, reductions in public donations and increased demand for services (Harvey, 2012). Between 2008 and 2012 government funding for health services in the voluntary and community sector fell by 29 percent. As a result voluntary and community organisations were forced to sharply reduce their spending which included laying off staff and the closure of some services. In the meantime, public spending on healthcare was also reduced, which placed a higher demand on the sector to provide services, despite reduced income (Harvey, 2012). Because the voluntary and community health services in general suffered so much, this impacted heavily on mental health services, which in turn had a knock-on effect on services for eating disorders.

2.5: A Vision for Change

‘A Vision for Change’ is a report by the Expert Group on Mental Health in Ireland. While it is largely about mental health in general, it does address eating disorders specifically in a small section at the end of the document. A Vision for Change is essentially the only policy document in Ireland which specifically relates to mental health. In terms of legislation relating to mental health, which is what shapes mental health services in Ireland, there is very little specific legislation. The first effort of the state to address mental health was the Mental Treatment Act, 1945. This was followed by the Health Act, 1970 and the legislative process was completed with the passing of the Mental Health Act, 2001. With the original legislation of 1945 receiving its first specific update some fifty-six years later it is hardly surprising that in the interim mental health services were held at a very low priority and remained extremely underdeveloped. Some of the barriers to the development of mental health services were; lack of services; lack of education, training and awareness; and the lack of legislation mentioned previously (Dept. of Health and Children, 2006). The Expert Group have highlighted that awareness of mental health is improving and it is becoming increasingly recognised that there is a very high cost associated with mental illness for the individuals concerned, their loved ones and society in general.

One of the main themes of A Vision for Change is that the relationship between mental health services, primary care facilities and community support (including informal supports such as family and friends) should be improved. The Expert Group recommended that a consultation/liaison model should be adopted to ensure formal links between community mental health teams and primary care facilities. While it is important to recognise the importance of these links at a national level, it is also important to ensure that "protocols and policies [are] agreed locally by primary care teams and community mental health teams- particularly around discharge planning" (Dept. of Health and Children, 2006, p. 66). However, in order for this system of linking specialist services and primary care facilities to work effectively, it is essential that primary care providers such as general practitioners have a sufficient knowledge of the area. The Expert Group highlights that most GPs in Ireland do not have specific training relating to mental health and that they should be provided with training on mental health in order to allow them to provide the mental health services described in the policy. Service users should be involved in the provision of training and education to ensure that it is relevant (Dept. of Health and Children, 2006). This area of policy relates specifically to this research and is very important because it recognises the vital role that GPs play with regards to mental health in general, and subsequentially in terms of eating disorders. It also emphasises the fact that GPs do not have sufficient knowledge in terms of mental health in general, which can lead to serious problems. The importance of GPs ability to identify and diagnose mental health problems is highlighted in the report. "When an individual experiences a mental problem, contact with their GP is usually their first formal attempt to seek help. This contact can be the key to a timely and successful resolution of their mental health problem, if the problem is identified and treated by the GP or referred on to local mental health services" (Dept. of Health and Children, 2006, p.60).

The Expert Group also reported a serious lack of specialist mental health services in Ireland. Services for eating disorders fall into this category of specialist mental health services, which is extremely underdeveloped due to many different problems including a lack of resources at a national level and an insufficient number of multidisciplinary teams in many different areas. Another major problem with regards to specialist mental health services is that availability of resources is geographically uneven, leading to inequality and resulting in some people having access to specialist services denied to others (Dept. of Health and Children, 2006). It is usually in urban areas where services are available meaning that individuals in rural areas are usually unable to access specialist services and therefore may not be treated.

An important point in A Vision for Change is the distinction between services for adults and for children. A Vision for Change states that Child and Adolescent Mental Health Services (CAMHS) teams, as well as Adult Mental Health Services (AMHS) teams should be available in all catchment areas. CAHMS provide mental health services to all individuals aged 0-18, while AMHS provide services to those aged over 18. These catchment areas should be established with populations of between 250,000 and 400,000 and should take in to account current social and demographic realities. The theme of integration which was mentioned previously is very important with regards to the different catchment areas. The management teams of each of the catchment area should facilitate integration between mental health services and other community/voluntary programmes available in the area (Expert group on mental health). The Report also emphasises that particular care should be taken when transferring individuals from CAMHS to AMHS once they reach 18 years. The availability of age appropriate services are improving, especially in the last decade. While the services available used to be very poor (NCCMH, 2004), there are now inpatient CAMHS units available in Dublin, Cork and Galway (HSE 2016) and Community CAMHS teams available throughout the country (HSE, 2016).

Another point highlighted by the Report is positive mental health promotion. This is "concerned with promoting well-being among all age groups of the general population and addressing the needs of those at risk from, or experiencing, mental health difficulties" (Expert group on mental health, 2006, p. 44). The ideal of prevention is very important internationally and was highlighted by the World Health Organisation (WHO) as "the only sustainable method for reducing the burden caused by [mental health] disorders" (WHO, 2004, p. 14). The international policies on mental illness and eating disorders in particular will be discussed further on in this chapter.

While A Vision for Change is predominantly based on mental health in general, it does contain some information on eating disorders. It identifies the prevalence of eating disorders at approximately 4.18 per 100,000 of the population in 2006 (Department of Health and Children). Eating disorders, like all other mental illnesses, have a very high social, personal and economic cost. When considering the impact of eating disorders, the Expert Group (2006) highlighted that one must take in to account "the disruption to education, vocational training, social isolation and loss of opportunity in so many spheres of human participation" (p.255). The Report recommends that for both child and adolescent eating disorder teams and adult eating disorder CMHTs there should be one unit available per 1,000,000 of the population, or 4 units for the entire population, one in each region. There are plans to construct 8 inpatient beds and a 12 bed general inpatient unit in the New Children's Hospital which will be located on the grounds of St James's Hospital in Dublin. It is estimated that this could be completed by 2017 or 2018 (HSE, 2012). This would be an extremely important addition to the CAMHS already available.

Hence, while the availability of specialist public services in Ireland has historically been very poor, significant improvements have been recognised in recent years. Despite this, services are still not at the level which is required, and it is evident that more work needs to be done in this area.

2.6: International Policy

The need to promote positive and effective mental health policies on an international level is well recognised by many different sources (Heenan, 2009, WHO, 2004). “Mental and behavioural disorders are not exclusive to any special group: they are found in people of all regions, all countries and all societies” (WHO, 2004, p.15). Essentially, mental illness is truly a global issue and therefore it is important to take into consideration what is being done globally to tackle this issue. Many WHO reports emphasise the increasing prevalence of mental health problems and also the need to develop appropriate strategies and policies because of the massive scale and cost of mental health (Heenan, 2009). Due to the fact that mental health is such a broad topic and covers so many different conditions it is easy for specific mental illness, especially those which are less prevalent like eating disorders to become lost. This could result in a lack of policies and strategies relating to them. With regards to eating disorders specifically the ‘Academy for Eating Disorders” (AED) is global professional association which is committed to leadership in research, education, treatment and prevention of eating disorders. The vision of the AED (2016) is to “provide global access to knowledge, research and best treatment practices for eating disorders”.

The World Health Organisation (WHO) is also involved in developing policies with regards to mental illness. One policy option which has been explored by the WHO is that of intervention. According to a publication released by the WHO (2004) there is a lot of evidence available from the social, biological and neurological sciences which indicates that preventive measures can work very effectively in terms of treating mental health problems. Mental health promotion is the practice of considering mental health as a resource, as valuable in its own right, and a basic human right. There are many reports of mental health promotion working as effectively, if not more so, than treatments which address mental health only once it has become a problem. Along with usually being more clinically appropriate, these preventative treatments are also more cost effective (WHO, 2004). This preventative approach is not very common in the Irish context and could potentially be explored further. Recent initiative such as using the hashtag “Mind Your Health” on social media are improving in this area, however more state intervention is required. With regards to eating disorders specifically in terms of intervention suggested measures include targeting students in school, particularly at primary and secondary levels and interventions involving media literacy and advocacy with regards to appearance (WHO, 2004).

In the United Kingdom, the voluntary sector plays a crucial role in shaping mental health services (Dinsdale, 2007). In 2013, the four UK health departments and other organisations involved in the independent and voluntary sector formed a formal network known as the National Collaborative (Thomas, 2013). This type of collaboration could provide a framework for the type of partnership between different sectors set out in the ‘Vision for Change’. The National Institute for Clinical Excellence (NICE) guidelines in the UK for eating disorders are for use by patients, professionals, and anyone with responsibility for planning services. They make recommendations for the identification, treatment and management of eating disorders. Along with this information the guidelines also set out how they will be implemented. Local healthcare groups are expected to put a plan into place and identify the resources available based on the national guidelines. Along with this a multidisciplinary team should translate the implementation of the plan into local protocols, taking in to account the recommendations set out in the guidelines and the priorities in the National Service Framework (NICE, 2004). This type of detailed explanation regarding exactly how the plans set out in the National Guideline should be implemented could be very valuable in an Irish context.

As mentioned previously, the Australian model of providing education and training to GPs seems to be very effective (Allen et al, 2011). Similar to the UK, Australia also has a policy specifically dedicated to eating disorders. The National Eating Disorders Collaboration (NEDC) is an initiative of the Australian government department of health. In Australia a mixture of inpatient programmes, outpatient programmes, day programmes, community treatment and community supports are used to treat eating disorders (NEDC, 2016).

In the USA, the National Eating Disorder Association (NEDA) is a voluntary/community based organisation. Its website provides information on eating disorders in general, access to help and support for people suffering from eating disorders and information on the prevalence of eating disorders in the population (NEDA, 2016).

2.7: Conclusion for Literature and Policy Review

The literature reviewed in this chapter has highlighted the seriousness of eating disorders and the need for early intervention and treatment. Another important point in terms of the validity of this research which is evident in the literature is that people with eating disorders are much more likely to visit their GPs more often than people without, usually presenting with related symptoms such as fatigue, gastrointestinal complaints or psychological problems. This puts GPs in an ideal position to facilitate early intervention and diagnosis, meaning that it is extremely important to explore their knowledge of eating disorders and strive to improve it.

In terms of the literature available on general practitioners' knowledge of eating disorders, the overall consensus is that GPs have a lack of knowledge in terms of how to identify and intervene. While some literature argues that GPs are confident in identifying typical presentations of eating disorders, but struggle when faced with atypical presentations, the majority in fact oppose this and support the idea the GPs have insufficient knowledge of eating disorders.

This chapter has also provided evidence of the policies in place both in Ireland, and internationally regarding to eating disorders. As a result it has produced several different conclusions. Firstly, provisions specifically relating to eating disorders, are very poor. There are not enough services available to people with mental health problems, including eating disorders, in Ireland. Mental healthcare as a whole is generally provided by the voluntary/community sector along with the private sector. However for treatment of eating disorders specifically, the private sector provides most of the services. While public sector services are improving, there is still a long way to go before they are sufficiently providing services to treat eating disorders. A Vision for Change is the main policy document in Ireland regarding mental health. It was published in 2006 and is shaped by the Mental Health Act, 2001. A Vision for Change relates to mental health in general and only contains a very small section which refers specifically to eating disorders. For a highly specialised subject like eating disorders, the fact that there is no specific policy formulation around it is a major problem.

Another important point which came from reviewing the different centres available to deal with eating disorders is the point that there is very little involvement from the state. The private and voluntary/community sector have a large majority of responsibility in the sector, with the statutory sector seriously falling behind. While this is changing in recent years and the state is taking more responsibility in this area, major improvements are needed. While we have seen in the literature that eating disorders only affect a small cohort of the population, it is evident that they are very serious illnesses and the services available which are devoted to providing treatment are simply not sufficient.

There are many international examples of specific documentation relating to eating disorders, which Ireland can learn from, such as the UK, the US and Australia. There are also examples of the public sector, the voluntary/community sector, and the private sector being responsible for the provision of services relating to eating disorders in various different countries.

Chapter Three: Methodologies

3.1: Quantitative Research

This paper is based on a quantitative approach. While it does include an interview, which brings in a mixed methods approach, the focus is mainly on quantitative research. Creswell (2009) highlights that various different social research issues require different approaches, for example "if the problem calls for the identification of factors that influence an outcome, then quantitative research is required" (p.18).

Silverman (1998) describes quantitative research as "a methodology in the social sciences that uses numerical data to reach its findings" (p. 94). Therefore this research falls into the category of quantitative research because its aim is to gather numerical information on general practitioners' knowledge of eating disorders in Cork city and county. Quantitative research is designed to examine the facts or causes of a social phenomenon. By examining previous research it was discovered that in most cases GPs have little knowledge about eating disorders, including how to treat them and how to diagnose them. This research is attempting to find out firstly what knowledge GPs in Cork have of eating disorders, and secondly what type of training they received and are continuously receiving with regards to eating disorders. Quantitative research is also rigorously designed and objective which is very important in terms of this research to ensure that facts are accurately presented with no bias.

Data gathered from quantitative research is aims to be reliable and generalizable provided that it is gathered from a sufficient sample and depending on how it is gathered. This is important in terms of this type of study because it is vital to examine as much of the population as possible, and in terms of being able to replicate the study. Due to time constraints and other factors, this is a pilot study to gauge the views of GPs is in relation to eating disorders. It would be desirable for more detailed studies to be carried out in the future with regard to this subject.

Another definition of quantitative research which has been provided by Creswell (2009) is "[it] is a means for testing objective theories by examining the relationship among variables. [These] can be measured, typically on instruments so that numbered data can be analysed using statistical procedures" (p. 5). This, again, provides an excellent framework for how this research will be carried out. It will use different variables such as the training that GPs or medical students receive in relation to eating disorders and measure them in numerical terms.

Quantitative methods consist of predetermined questions, which will be in the form of questionnaires for this particular piece of research, and statistical analysis or interpretation, which will be conducted using Statistical Package for the Social Sciences (SPSS) software.

This research is not only aiming to discover what knowledge GPs have about eating disorders, but also what training or instruction they receive, to learn about the service that are available to them, and how they may be improved upon. Essentially this research is aiming to discover the root of any problems which may be present, along with possible ways to address these problems, as opposed to simply looking at the problems themselves.

There have been many criticisms of quantitative research. For example it is argued that quantitative researchers can attempt to look at people in a social vacuum and do not take the environment or surroundings in to account (Bryman, 2001). Also quantitative research can overlook in-depth view, opinions and experiences (Pol and Lampard, 2002). In order to alleviate this particular problem a mixture of qualitative and quantitative questions have been included in the questionnaires. It is hoped that by doing this, the questions gather information in as much detail as possible. Other criticisms of quantitative research include; the artificial nature of the measurement process, the overreliance on instruments and procedures, and the analysis of relationships between procedures which does not take into consideration people's lives. (Creswell, 2009). However again it is important to note that this particular piece of research is not attempting to discover the influence of certain aspects of a GPs life on their knowledge of eating disorders.

3.2: Mixed Methods Research

Because of the use of an interview to gain more in depth knowledge on the subject of eating disorders this research does include a small element of qualitative research. For this reason it can also be approached from a mixed methods viewpoint. Mixed methods research "resides in the middle of the continuum [between qualitative and quantitative research] because it incorporates elements of both qualitative and quantitative approaches" (Creswell, 2009, p.3).

The benefits of using a mixed methods approach include the fact that it can use the strengths of both a quantitative approach and a qualitative approach to provide the best understanding of a research problem, or alternatively if either approach is inadequate by its self (Creswell, 2009).

Creswell (2009) noted that quantitative data is usually random, while purposeful sampling is used in qualitative data collection and candidates are often selected for a particular reason. This is the case for this research. In order to gather an unbiased and general view of GPs knowledge of eating disorders in Cork, a random sample of the population was selected. The population as a whole refers to all registered GPs in Cork. Another reason why this was necessary was because it was beyond the scope of this research project to attempt to gather information from every GP in Cork. However in terms of the qualitative interviews, the candidate for the first interview was selected because she had an in-depth knowledge of eating disorders which was very useful in terms of the researcher being able to understand these disorders more.

3.3: Ethical Issues

According to Diener and Crandall (1978) there are four main areas relating to ethics. These are; harm to participants, lack of informed consent, invasion of privacy, and deception involved. These four areas and other issues relating to this particular research will be discussed in this section.

In terms of this survey, because the sample consisted of service providers and medical professionals, as opposed to service users or particularly vulnerable individuals, many ethical issues were avoided. Creswell (2009) identified many vulnerable populations, for example; prisoners, minors, mentally incompetent participants, persons with neurological impairments or pregnant women. While this list is not exhaustive, it does provide a good example of the various different vulnerable populations in which special attention would be required. Due to the time constraints of this particular research, the decision was made to exclude vulnerable sections of the population in order to avoid having to seek permission from the ethics committee of University College Cork, which would be very time consuming and beyond the scope of this research project. Although the research will not be dealing directly with any service users, or vulnerable members of the population, there are still several important ethical issues which must be taken in to account.

Firstly it is vital to avoid deception when conducting the interview and in the questionnaires. Creswell (2009) stated that “deception occurs when participants understand one purpose but the researcher has a different purpose in mind” (p, 89). It is important to ensure that every participant fully understands the nature of the research and its aims. Also it is important to ensure that the researchers do not actively deceive any participants.

Another important issue is in terms of the language use throughout the research and in the final report. No language which is discriminatory or biased towards anyone, particularly vulnerable groups should be used (Creswell, 2009). Because this particular research is based on eating disorders, which are a mental health issue, it is important to use appropriate language at all times.

Finally another ethical issue involves "suppressing, falsifying or inventing findings to meet a researcher's or audience's needs" (Creswell, 2009, p.92). It is important to acknowledge that while the findings of this research may not support the original hypothesis, they still must be presented exactly as they appear.

3.4: Data Collection and Analysis

The two methods of collecting information which were utilized for this piece of research are quantitative questionnaires and a qualitative interview.

The benefits of utilizing questionnaires include the fact that they are cheaper and easier to administer, more convenient for the researcher to distribute and analyse and also convenient for the respondent. They eliminate the interviewer effect and ensure there is no interviewer variability (Bryman, 2001). Because there is a limited amount of time and very limited resources available for this research, it is essential to be as efficient as possible. Since there is an extremely large population of GPs in Cork it would be beyond the scope of this research to attempt to access every one of them. Due to the fact that questionnaires are much more efficient for reaching a large sample than interviews, they were chosen in order to get feedback from as much of the population as possible, therefore ensuring that the overall population was well represented. A postal survey was chosen because, again, this is a much more efficient way than handing out the questionnaires in person, to reach as much of the population as possible. It would be too time consuming to personally deliver all of the surveys. While it would be more cost efficient and less time consuming to email the surveys to GPs, this option was not selected because it would have been too difficult to obtain email addresses for all of the GPs. In order to select the sample 200 hundred GPs were randomly selected from a list of registered GPs in Cork found on the HSE website. Random sampling involves selecting participants at random from the population as a whole, and means that each individual has an equal probability of being selected. Random sampling also means that the sample selected can be generalized to the larger population because it represents the population more accurately than purposeful sampling (Creswell, 2009). Because of the fact there were more than 200 GPs on the HSE website, systematic random sampling was used to select the 200 GPs which the questionnaires would be sent out to. According to Pole and Lampard (2002) systematic random sampling is when "a case is randomly selected from the first few cases on the list and further cases are selected at random intervals as you go down the list" (p. 49). For this research out of the entire list of GPs found on the HSE website, every 5th GP was deleted until the number was reduced to 200.

In terms of postal surveys it is acknowledged that the response rate is usually quite low. However there are many ways to improve the response rate. One example of this is a four phase administration process provided by Salant and Dillman (1994). The first step is to post out a short advance-notice letter. The second step is to post out the actual survey. The third step is to post out a postcard-style follow up, and the final step is to send out a personalised cover letter with a handwritten signature, the questionnaire and a preaddressed return envelope with postage. While this method is proven to yield high response rates, it is far too time consuming and costly for this piece of research. However certain elements can be taken from it, for example the questionnaire will be sent out with a cover letter and a preaddressedstamped envelope. Other measures to ensure the highest response rate which will be utilized are; keeping the questionnaire short, easy to understand and answer, providing clear instructions and using mostly closed questions with very few open questions (Bryman, 2001). Another measure which was taken to ensure the highest response rate was to pilot the questionnaire before it was sent out to the participants.

In order to come up with the questions for the questionnaire, I met with Trish Shiel from the Eating Disorder Clinic Cork and we discussed what aspects we felt were important and needed to be included. Most of the questions were based on reading of existing literature and Trish's personal experience of working with people who experience eating disorders. It was decided to us the Likert Scale to present most of the closed-ended questions in order to make it easier for the respondents to fill out the questionnaire and to analyse the data. Before the questionnaires were sent out to the sample population, Dr Rory Glynn, a local GP of the researcher, piloted the study. This was very useful as it ensured that all of the questions were appropriate, that nothing important had been left out, and that the questions made sense from a GPs point of view. Following this pilot, the questionnaires were amended and sent out to the sample population, along with a cover sheet and a copy of the SCOFF questionnaire (all of which can be found in the appendices). The SCOFF questionnaire is screening tool designed to aid GPS in diagnosing an eating disorder. It was included because one of the questions asks GPS if they would be willing to include it in their patient screening, and there was a possibility that the GPs might not have been aware of it.

In addition to sending out the questionnaires, it was also decided to carry out a qualitative interview. This interview took place with Trish Shiel, who was working in partnership with the researcher throughout the entire process. Trish was able to provide invaluable information with regards to issues including eating disorders in general, the policy around eating disorders in Ireland, and the importance of GPs' roles in diagnosing and treating eating disorders.

In terms of an interview there are many advantages over questionnaires. For example the interviewer can probe the respondents. These probes can be verbal, such as responsive follow up questions to elicit more information, or non-verbal, such as a pause or a gesture (Legard, Keegan & Ward, 2003). Other advantages of an interview include the fact there can be more open-ended questions, the interview does not follow a strict structure like the questionnaire which allows for more data which the researcher may not have anticipated to be collected, and there is a much higher response rate (Bryman, 2001).

When considering both qualitative interviews and quantitative questionnaires, it is important to take into account the use of both closed and open ended questions. Closed ended questions they are helpful because they easy to answer and administer and also they may clarify the meaning of questions for respondents who are unsure. However there are also several problems with closed-ended questions. For example it is difficult to make the answers exhaustive, it can be difficult to make forced choice answers mutually exclusive, there is a loss of spontaneity in respondent's answers and it may be irritating for respondents who cannot find a category to suit them.

Open-ended questions can be very beneficial because respondents can answer in their own terms, unusual answers can be derived, and they are useful for exploring areas which the research may have a limited knowledge. However there are also some negative aspects to open-ended questions, such as they are very time consuming to administer and analysis, they require greater effort from the respondent and answers may not always be accurately recorded in an interview situation (Bryman, 2001).

However it is hoped that by employing a slightly mixed method approach, and incorporating aspects of both closed-ended and open-ended questions in both the questionnaires and the interview, that this piece of research will provide a thorough insight in to GPs knowledge of eating disorders in Cork.

In order to analyse the closed ended questions a computer system called Statistical Package for the Social Sciences (SPSS) will be used. This involves inputting the data into a computer and then allows results to be analysed and different types graphs to be formed. This is very useful for displaying the data and understanding it easily (Pallant, 2013). The open ended questions will be analysed manually. This is possible because there are only three open ended questions. If it is the case that there is a very wide variety of responses and analysing the data manually is not possible, a computer system called NVivo will be used instead NVivo supports the analysis of data in five key ways which are; managing data; managing ideas; querying data; producing graphs; and reporting from the data (Bazeley,2007).

Chapter Four: Results

4.1: Response Rate

The response rate for this questionnaire was 36.5 per cent, or 73 responses from 200. Given that postal surveys generally yield quite a low response rate and also the resources available for this piece of research were somewhat limited. This is a satisfactory rate of response, well within the parameters for accepted social science methodology. As mentioned previously there are several steps which can be taken in an attempt to yield a higher response rate with regards to postal surveys which the researcher would advise other researchers to use if they are carrying out a similar survey.

4.2: Results

Question one: On a scale of 1 to 5, with 1 being very little and 5 being a great deal, how much did you learn about eating disorders during your medical training?

Only 13.9 percent of GPs responded that they had received ‘some training’, while none at all identified having received a great deal of training. The highest response category was ‘little’ training followed by ‘very little’ and then an ‘average amount’. This backs up the original hypothesis in terms of training and highlights that there is not enough training in medical schools around the topic of eating disorders.

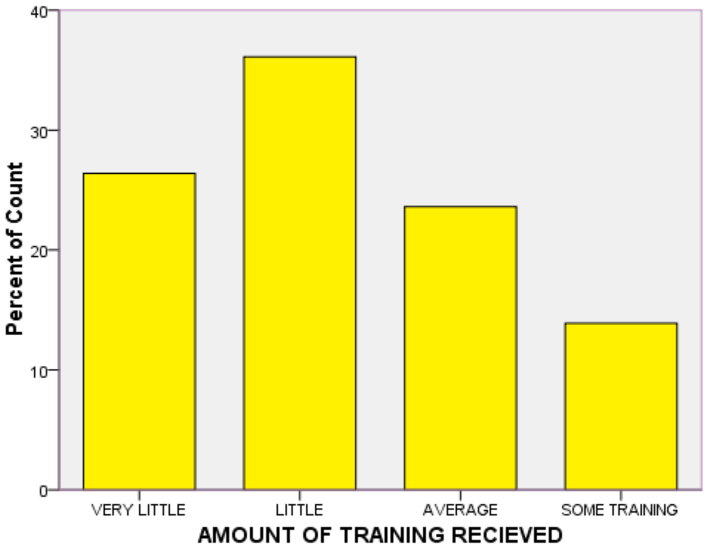
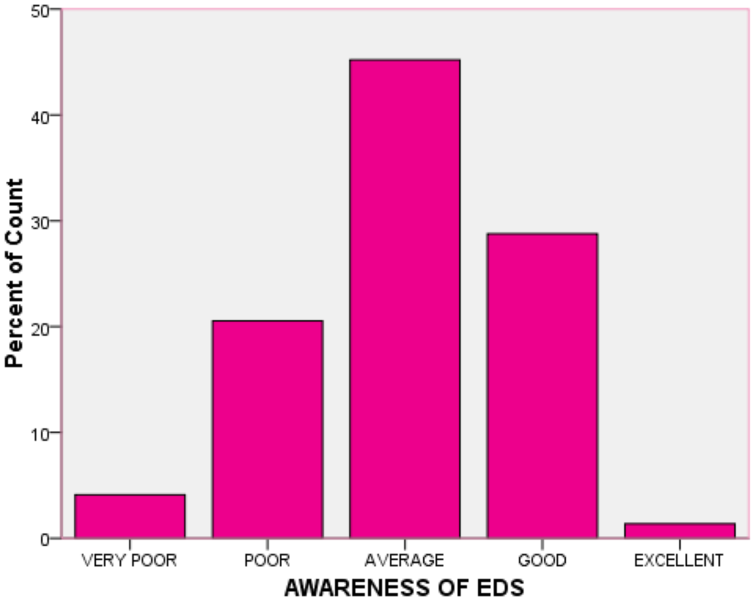


Figure 1: Amount of Training Received

Question two: On a scale of 1 to, again with 1 being poor awareness and 5 being excellent awareness, how would you rate your awareness of the prevalence of eating disorders in the general population?

In relation to question two, which aimed to find out how confident GPs are with their awareness of eating disorders in the population, the majority of GPs, 44.4 percent responded that they had average awareness of eating disorders. Interesting the second highest category was a good awareness of eating disorders at 29.2 percent. This was followed by poor awareness, very poor awareness, and excellent awareness.

Figure 2: Awareness of Eating Disorders



Question three: On a scale of 1 to 5, with 1 being not at all confident and 5 being extremely confident, how confident would you be in identifying eating disorders?

For question three, GPs were asked to rate their confidence in identifying and diagnosing eating disorders. Similarly to question two, the majority of respondents, 44.4 percent declared that they had average confidence in terms of identifying eating disorders. 36.1 percent replied as being fairly confident, which is a rather high number, especially when taking in to account the responses from question one. 16.7 percent disclosed that they were not confident with identifying and diagnosing eating disorders, while a very small amount was recorded for both answers ‘not at all confident’ and ‘extremely confident’, at 1.4 percent each.

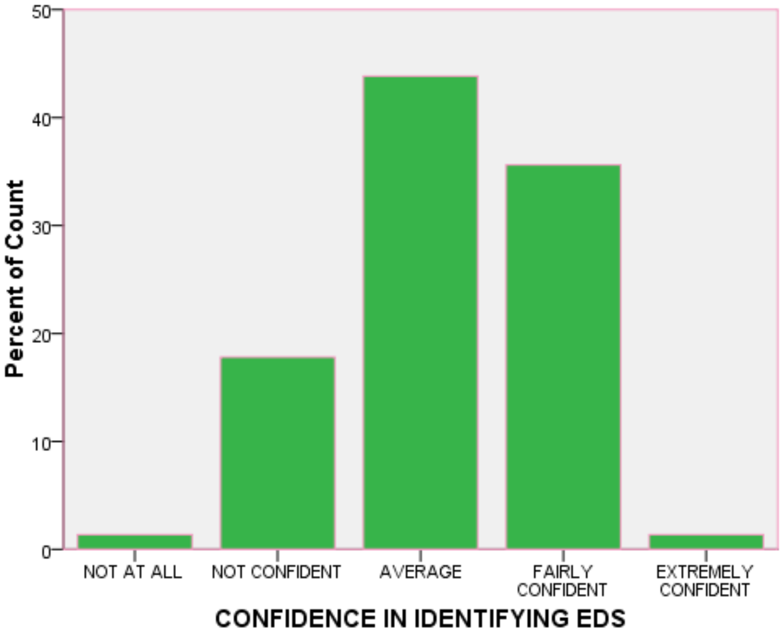
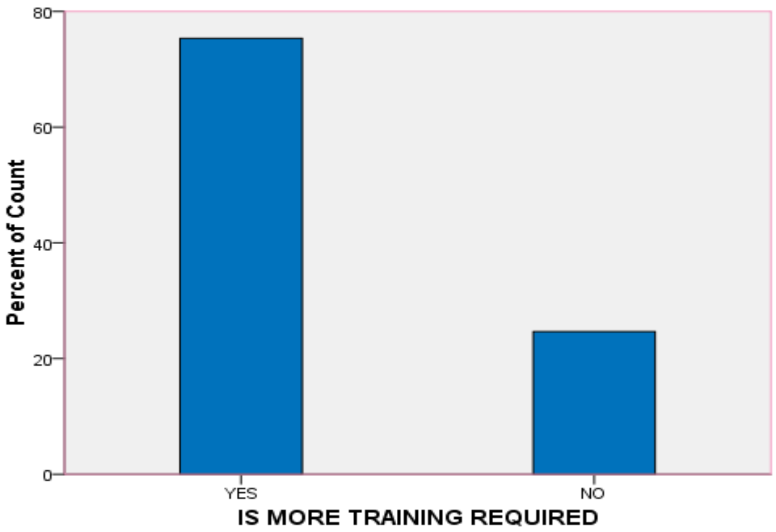


Figure 3: Confidence in Identifying Eating Disorders

Question four: Do you feel that more training is required in order for you to be confident in diagnosing eating disorders?

Question four attempted to discover whether or not GPs thought that there was a demand for more training with regards to eating disorders. An overwhelming majority, 75 percent, did feel that there is a need for more training in this area.

Figure 4: Need for Extra Training



Question five: would you be interested in undertaking some further training with regards to diagnosing eating disorders?

Question five was designed to discover if GPs had a particular interest in taking part in further training themselves. Once again a very high majority, 68.1 percent of GPs, identified being interested in taking part in further training.

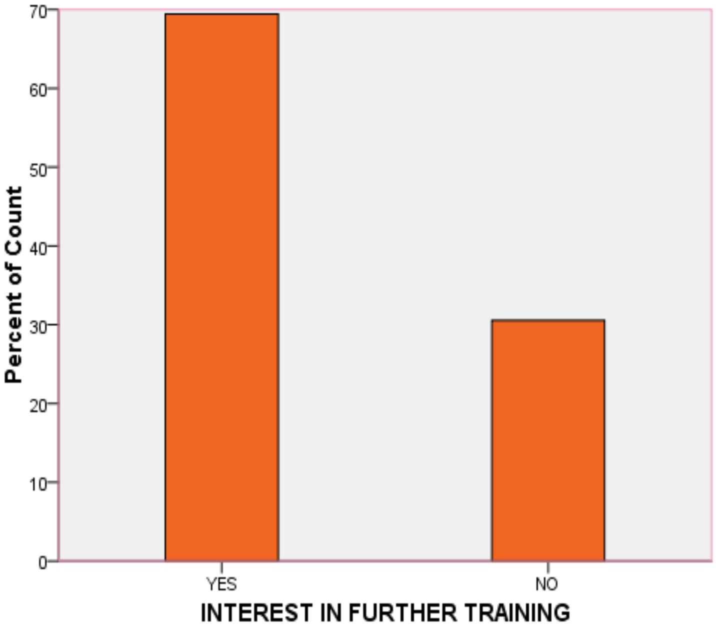


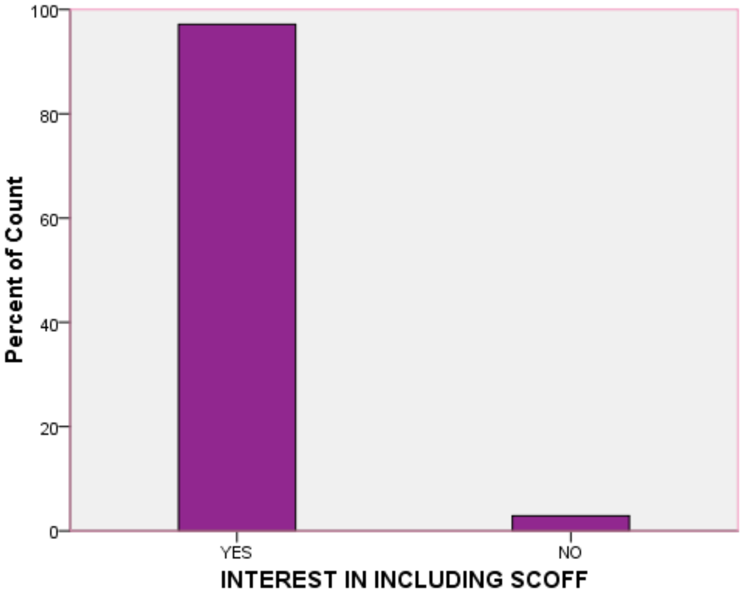
Figure 5: Interest in Further Training

Question six: What are the standardised test which you use for diagnosing eating disorders?

Question six was the first opened ended question and therefore it brought about a much wider array of answers than any of the previous questions. It asked GPs what the standardised tests which they use to diagnose eating disorders are. For this question some GPs responded with just one answer, while some responded with several different answers. The most frequent answer was that no standardised tests of any kind were in use, with 23 GPs or 31.9 percent of respondents in this category. The next most frequent answer was to examine the patient's medical history, with 20 GPs or 27.7 percent of GPs in this group. Other answers which regularly occurred were checking patient's body mass index, checking patient's blood, monitoring weight, using the SCOFF questionnaire (which is a useful screening tool containing five questions, which is designed to clarify suspicion that an eating disorder might exist), and routine examinations. Some GPs said that they asked questions similar to those found the in SCOFF questionnaire, but not exactly the same. Other responses which only occurred very few times were; having discussions with family members; assessing the patients mood; looking for signs of overeating; lack of periods or amenorrhea; hair condition; bio profile; dental examination; bone densitometry; an interview with the patient; a psychological exam; using the DSM V; looking out for signs of a distorted body image; and looking for evidence that the patient has an eating disorder. As mentioned previously some GPs included several of these answers, while some only gave one answer, hence the large array of different responses.

Question seven: If you do not already, would you be willing to include the SCOFF questionnaire as part of your patient screening?

Question seven asked GPs if they would be willing to include the SCOFF questionnaire as part of their patient screening. 93.1 percent of respondents said that they would be willing to include the questionnaire.



Willingness to Include SCOFF Questionnaire

Question eight: What are the main ways, in your experience, in which people with eating disorders, or their family members/friends, seek help with regards eating disorders?

Question eight was also an open ended question and asked GPs what they think are the main ways in which individuals with eating disorders, or their family members, seek help with regards to their condition. The most common answers for this question were the individual's family member(s) or friend(s) become worried about them and seek help from the GP on their behalf, or the individual themselves seek help. 29 GPs, or 40.3 percent of GPs said that the individuals family member or friend came to them with a concern, while 26 GPs or 36.1 percent said that the individual themselves came to them. Other answers which regularly occurred were the individual seeks help online, they present to their GP with co-existing psychological issues, or they present to their GP with physical problems as a result of the eating disorders. Other answers which appeared a few times were: the individual presents with excessive weight loss: the individual presents through other HSE services: the individual visits a counsellor: the individual reports with menstrual irregularities such as amenorrhea: school or college professionals are suspicious: the individual attempts suicide: the individual visits a dietician: a crisis occurs meaning they are forced to visit their GP: via outpatient services: and individuals rarely seek help. As with question six, some GPs gave various different answers, resulting in a wide range of responses. It is interesting to note that some of the responses actually conflict each other. This will be discussed further in the analysis section.

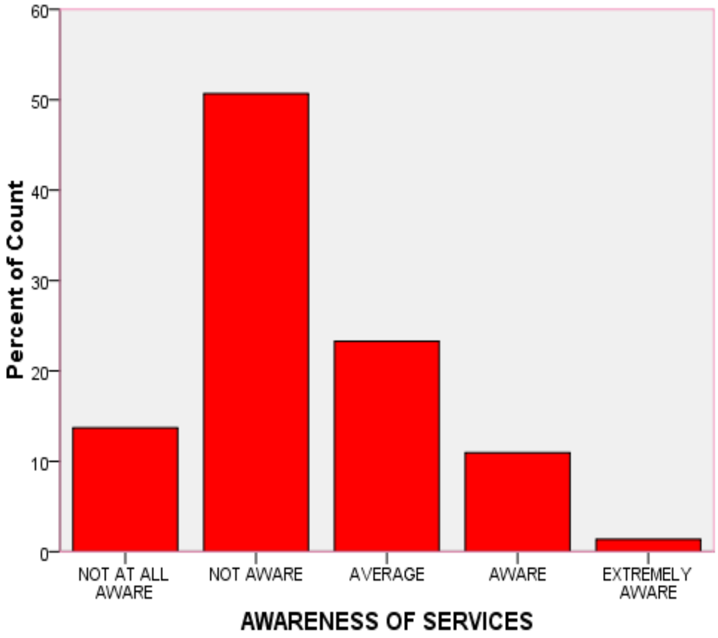
Question nine: What resources do you feel you need in order to effectively diagnose and treat eating disorders?

Question nine asked GPs what resources they think are required in order for them to be able to treat and diagnose eating disorders effectively. The most frequent answers for this section were access to specialist services such as multi-disciplinary teams and a quick and effective referral pathway. 28 GPs, or 38.8 percent, said that access to specialist services were needed, while 16 GPs, or 22.2 percent, said that a quick and effective referral pathway was required in order for them to effectively diagnose and treat eating disorders. Other answers which featured quite regularly were; more time; counselling service; input from a dietician; more training; support groups; and access to psychological services. Similarly to questions six and eight, because this was an open-ended questions it gathered several responses which only once or twice. These responses were: better screening tools: cognitive behavioural therapy (CBT): use of inpatient units: family therapy: the option to refer patients on: HSE funded treatments with follow-up care: better access to specialist clinics: and medical input such as endocrinology.

Question ten: On a scale of 1 to 5, with 1 being not at all aware and 5 being extremely aware, how aware are you of support services available in your area for individuals with eating disorders?

Question ten asked GPs to rate their awareness of the services specifically dedicated to eating disorders in their area. 63.9 percent of GPs revealed that they were not aware of the services available. 1.4 percent were extremely aware of the services available which was the lowest of all five categories.

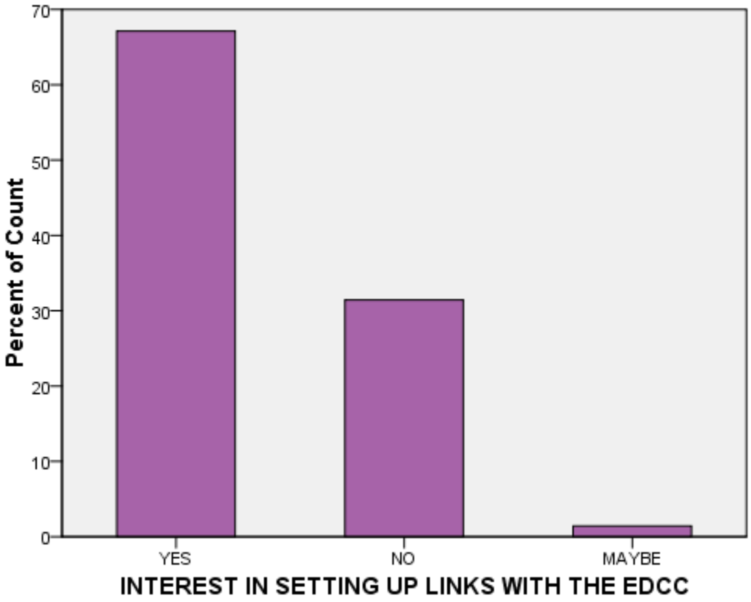
Figure 6: Knowledge of Services



Question eleven: Would you be interested in setting up links with the Eating Disorder Centre Cork in the future?

Finally, question eleven asked the GPs of they would be interested in setting up links with the Eating Disorder Clinic Cork in the future. 65.3 percent of respondents said they would be interested. A small minority 1.4 percent said that they would be willing to set up links with the EDCC if they were given more information about the organisation.

Figure 7: Interest in Setting up Links with EDCC



4.3: Summary of Analysis

In terms of these results it is interesting to note that the results from question one and question two are actually quite different. In question one the overall results were that GPs did not feel that they received enough training with regards to eating disorders, with almost two thirds reporting little or very little training received, however in question two a significant number of GPs responded that they were at least of average confidence when it came to their knowledge of eating disorders. It stands to reason from the results of these two questions that in between their original training and when they filled out the questionnaire, some of the GPs gained a certain degree of knowledge about eating disorders. Whether this knowledge is gained from practical experience, from extra training, or by other means is an issue which this researcher feels should be explored further. Overall GPs do not feel that they receive enough training in relation to eating disorders, which confirms one of the points of the original hypothesis. As a result it is clear that more training should be provided when GPs are studying followed by continuous professional development training. The fact that a great deal of GPs identified that they had at least an average awareness of eating disorders actually goes against the original hypothesis, which presumed that their awareness was poor. Similarly to questions one and two, questions one and three also had different results, as many GPs declared being at least of average confidence in terms of diagnosing eating disorders. This also goes against the original hypothesis, which predicted that GPs would have a poor level of confidence in terms of identifying eating disorders. Therefore, despite the low training levels that GPs receive, they have average confidence in terms of diagnosing eating disorders which could be due to any number of factors, which should be explored further.

It is clear from these results that more training is required, which does support the original hypothesis. Another important point to note is that most GPs would be willing to take part in further training if it was required or available. This is an important fact when it comes to policy making in this area because the desire and the ambition for improvement are both evident, therefore putting concrete measures in place should be given a high priority, in order to capitalise on this enthusiasm.

One worrying statistic to emerge from these results is the fact that such a large amount of GPs do not use any form of standardised tests in relation to eating disorders. Whilst this result derives from a qualitative rather than a quantitative question this research estimates approximately one third of GPs do not use any standardised test to diagnose eating disorders. This shows a major lack of knowledge in an area which is very important and highlights the need for GPs to be provided with some type of screening tool for eating disorders. As shown in the literature, individuals with eating disorders are most likely to present to their GP before any other medical professional, even if it is due to a problem other than the eating disorder itself. As a result it is vital that GPs have some form of screening tool in place. However in relation to this point, the fact that an overwhelming majority of GPs acknowledged that they would be willing to include the SCOFF questionnaire as part of their patient screening is most encouraging. This could help to ensure that GPs are more equipped to identify individuals with eating disorders in future. Steps to promote the use of the SCOFF questionnaire should be taken as a matter of urgency.

An interesting point that emerged from this research is that GPs cited the internet as one of the main ways which individuals with eating disorders seek help in relation to their condition. This provides an obvious opportunity for policy makers and service providers to make practical, focused assistance available online for persons seeking help with eating disorders. Some of the answers regarding how individuals or their loved ones seek help in relation to eating disorders are quite conflicting. For example a large majority of GPs responded that individuals seek help themselves, which actually goes again the original hypothesis. However a small number of GPs responded that individuals would be very unwilling to seek help for the problem themselves. While the literature supports the latter point, further investigation specific to Ireland is needed to clear up this point. One GP highlighted the fact that patients usually do not present with eating disorder problems until a crisis has occurred. Another specific point that was made by one GP is that it can take a number of visits before the extent of the problem becomes evident. Also the fact that individuals presenting with co-existing psychological or physical symptoms as a result of their eating disorder are featured less in the GPs responses than the individuals themselves or their loved ones presenting to the GP, may not be because it actually occurs less. Instead it may be that GPs actually miss these types of presentations and do not discover the eating disorder.

Another point which was taken from these results is in relation to the question regarding what GPs need in order to effectively diagnose and treat eating disorders. It was stressed that improving the availability of and access to services is essential. Many GPs highlighted that there were not enough services available, and those that were available were difficult to access. The provision of additional services such as support groups or dieticians should be addressed. Several GPs highlighted the fact that public services should be available. One GP also suggested making eating disorder services available by phone. Another point relating to services made by several GPs was that there should be age specific service particularly available to teenagers, such as Child and Adolescent Mental Health Services (CAMHS). More training and more time were highlighted as being very important by many GPs. While the provision of more training is relatively simple to address, the issue of time is more difficult. Possible solutions to these problems will be addressed in the next chapter. It is also important to acknowledge that for this particular question the researcher realised when analysing the data that the question was not phrased as well as it should have been which may have caused some confusion. The question asked "what resources do you feel you need in order to effectively diagnose **and** treat eating disorders". In hindsight these two questions should have been separated from each other, as they are in fact different.

It is also clear from these results that GPs are not aware of the services which are available with regards to eating disorders. It is not entirely clear if the issue here is that GPs are unaware of the services which are available, or if there are actually very little services available. Many GPs expressed an interest in setting up links with the Eating Disorder Clinic Cork so this is definitely an area which should be explored further.

Chapter Five: Conclusions and Recommendations

5.1: Conclusions

As a result of reviewing all available literature on the subject, a hypothesis for this research project was formed. This hypothesis was that, in general, GPs do not have sufficient knowledge about eating disorders and therefore are not sufficiently confident when it comes to identifying, treating and diagnosing eating disorders. The hypothesis also declares that there is not enough training available to GPs with regards to eating disorders. This is despite the fact that most research has shown that primary care facilities, such as GPs or family doctors, are in an ideal position to identify eating disorders early on. Literature has also shown that eating disorders are very serious illnesses and can have a major impact on the individual suffering from the eating disorder, their friends and family member, and society as a whole.

A review of the policy on eating disorders, and mental health in general, in Ireland found that while it is improving, it is still very poor when compared with international standards. The publication of 'A Vision for Change' in 2006 was a major step forward in terms of policy on mental health in Ireland, however there is still the need for a specific document on eating disorders like what is available internationally.

For the research itself, there was a response rate of 36.5 percent which is decent but could be improved upon. There are several different ways in which it could be improved upon. For example using a more extensive postage system, similar to what was mentioned in the methodologies chapter. Also it would be advised to utilize other forms of data collection, such as interviews, focus groups or handing out surveys in person. This would allow more substantial information to be gathered and enable researchers to develop on the points which were uncovered during this research. As mentioned in the title, this research is a pilot study and therefore lends itself to further research in this particular area.

The results from this survey were very interesting because while some of them supported the original hypothesis, some of them did not. For example most GPs did not learn very much about eating disorders during their training. However most GPs have average confidence when it comes to diagnosing eating disorders, and feel that they have a fairly good awareness of the prevalence of eating disorders in the general population. This result is an example of more research could be carried out, in order to determine why this discrepancy between the training of GPs and their knowledge and awareness occurred. Many GPs thought that more training on eating disorders is required and most of them would be interested in taking part in further training. Also a substantial amount of GPs said that they would be interested in setting up links with the EDCC. Many GPs do not use any form of standardised test, which highlights a lack of knowledge in the area. There was a lot of variation in the answers given by GPs with regards to what standardised test they use for determining if an individual has an eating disorder. This, again, highlights a lack of knowledge and emphasises the need to put in place firm policies and guidelines for GPs with regards to eating disorders. Almost all of the respondents said that they would be happy to include the SCOFF questionnaire as part of their patient screening. This reinforces the point that there is a need for specific policies and guidelines and shows that GPs would largely be willing to cooperate with such measures.

In terms of how people with eating disorders present to their GP, there was some contradictions in the responses for this answer. While most GPs said that the individual themselves are most likely to come to their GP seeking help, several said that the individual would be very unwilling or unlikely to seek help and it would typically be a friend or family member with concerns who first makes contact. Another common answer to this question was people usually present to them with coexisting physical or psychological symptoms, and not with the actual eating disorder. This is a point which was highlighted in the literature and it emphasises the importance of introducing a standardised test for GPs in order to allow them to recognise eating disorders patients which present in this way. Another interesting answer to this question which appeared frequently was that a lot of people search for help with their eating disorder online. This provides an excellent opportunity to utilize online resources to aid in the treatment and diagnosis of eating disorders. Again there was a very broad range of answers given to this question.

When asked what resources are required to effectively diagnose and treat eating disorders, the most common responses were: more time: more access to specialist services: and a quick and efficient referral pathway for such services. The issue of time appeared in the literature and was stresses as a necessity for treating eating disorders. There was also an emphasis on ensuring that public services in particular are made available. This backs up the findings of the policy chapter that there are a lack of public services committed to the provision of services for eating disorders in particular. Finally, with regards to their knowledge of the services available to people with eating disorders in Cork, many GPs were not aware of any services, with several pointing out that they had never actually heard of the EDCC.

The results of this research are very interesting and can provide some very useful recommendations with regards to the identification and treatment of eating disorders in future.

5.2: Recommendations

The first recommendation of this research is to conduct further, more in-depth research in this area. Due to the fact that this was a pilot study with limited time and resources, there is scope to explore this topic in much more detail. It is suggested that further research should incorporate both qualitative and quantitative aspects. This could take the form of more in-depth questionnaire, interviews or focus groups, etc. Any additional research should examine some of the more varied answers given by GPs in this particular questionnaire. It should also aim for a response rate higher than the rate for this survey, to ensure that a wider array of GPs opinions are collected.

The next recommendation coming from this research is to provide more training for GPs, both when they are studying for their degree along with continuing professional development. This is a long term measure which requires the implementation of specific policies and strategies. Although it would be initially difficult to put in place, it would bring about drastic improvements in provision of services for individuals with eating disorders. There is also evidence that GPs feel there is a need for more training, and would be willing to take part in it, which is very important. This could be done either on a larger scale by policy makers or on a smaller scale, by organisations like the EDCC.

Another recommendation which has been established as a result of this research is to put in place policies or produce documents specifically relating to eating disorders. There is nothing like this in Ireland at the moment, however, there are several international examples which could be drawn from. This research has highlighted that eating disorders are very specific and should not be treated as a general mental illness. There are also examples internationally of specific programmes and documents working very effectively in terms of improving the standard of care for eating disorders.

Another recommendation is to increase the amount of specialised services for eating disorders. It is clear that there is a very intense need for additional services in this area, particular outside of Dublin. Along with setting up the services it is important to ensure that there are quick referral pathways to ensure that people can actually access these services and in a timely manner. In addition to this point it is important to emphasise the need for public services in particular. As there are currently no specialist public units available it is usually the responsibility of private companies. This can often result in care being quite expensive and therefore it is not accessible to everyone. Also it is important that GPs are made aware of any services which are available, to allow them to refer patients to the services.

A recommendation of this research for the EDCC is to follow up with the GPs who said that they would be willing to set up links with the centre. It is vital that this opportunity is maximised to its true potential.

Chapter Six: Conclusions of the Research

This research has investigated GPs knowledge of eating disorders in Cork city. As a result of a thorough literature and policy review of this area it hypothesized that GPs do not receive enough training with regards to eating disorders and as a result they are not confident in terms of diagnosing and treating eating disorders. In order to gather this information a questionnaire was sent out by post to 200 GPs in Cork City. The response rate was 36.5 percent which is satisfactory and means that the results can be generalised to the larger population of GPs in Cork. The research found that GPs did not receive sufficient training regarding eating disorders during their studies. It also found that most GPs are confident in terms of their awareness of eating disorders and also in terms of diagnosing and treating disorders. it found that there are not enough services for individuals with eating disorders in Cork City and also that the majority of GPs are not aware of the services which are available. Additionally it found that many GPs are interested in taking part in further training in relation to eating disorders and that they would be interested in setting up links with the EDCC.

This research has generated some very interesting and valuable findings about GPs knowledge of eating disorders in Cork city.

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Appendices

Questionnaire on Eating Disorders

Please fill in spaces and circle the answers where appropriate

1. On a scale of 1 to 5, with 1 being very little and 5 being a great deal, how much did you learn about eating disorders during your medical training?

1 2 3 4 5

2. On a scale of 1 to 5, again with 1 being poor awareness and 5 being excellent awareness, how would you rate your awareness of the prevalence of eating disorders in the population?

1 2 3 4 5

3. On a scale of 1 to 5, with 1 being not at all confident and 5 being extremely confident, how confident would you be in identifying eating disorders?

1 2 3 4 5

4. Do you feel that more training is required in order for you to be confident in diagnosing eating disorders?

Yes No

5. Would you be interested in undertaking some further training with regards to diagnosing eating disorders?

Yes No

6. What are the standardised tests which you use for diagnosing eating disorders?

____

____

____

7. If you do not already, would you be willing to include the SCOFF questionnaire (attached) as part of your patient screening?

Yes **No**

8. What are the main ways, in your experience, in which people with eating disorders, or their family members/ friends, seek help with regards eating disorders?

____

____

____

9. What resources do you feel you need in order to effectively diagnose and treat eating disorders?

____

____

____

10. On a scale of 1 to 5, with 1 being not at all aware and 5 being extremely aware, how aware are you of support services available in your area for individuals with eating disorders?

1 **2** **3** **4** **5**

11. Would you be interested in setting up links with the Eating Disorder Clinic Cork in the future?

Yes **No**

If 'yes' please fill in your address, email or phone number:

Email: ____

Address:____

Phone Number:____

Cover Sheet for GPs

EDCC - Eating Disorder Centre Cork
Treatment Centre for individuals, families & carers

Tel : 021 4539900 Email : info@edcc.ie www.eatingdisordercentrecork.ie

To whom it may concern:

My name is Hazel McDermott and I am currently in my final year of social science in University College Cork. As part of my final year I am carrying out a research project under the supervision of Dr Siobhan O'Sullivan in partnership with the Eating Disorder Centre Cork, (EDCC). My project is on general practitioners knowledge of eating disorders in Cork City. It is a pilot study, and while it is of a relatively small scale, it is hoped that it will gather some very important research in this area.

This piece of research is a Community-Academic Research Links (CARL) project. CARL is an initiative in UCC which provides independent research support to Civil Society Organisations, e.g. community and voluntary groups, in the region. The research is undertaken by students in collaboration with the community partners

I would be very grateful if you could fill out this survey, and return it in the addressed envelope which has been provided, on or before February 24th 2016. If you have any questions regarding this research, please do not hesitate to contact me on my email: 113307811@umail.ucc.ie.

Thank you very much for your participation,

Yours sincerely,

Hazel McDermott

SCOFF Questionnaire

(Useful Eating Disorder screening questions)

The SCOFF Questionnaire is a five-question screening tool designed to clarify suspicion that an eating disorder might exist rather than to make a diagnosis. The questions can be delivered either verbally or in written form.

S – Do you make yourself Sick because you feel uncomfortably full?
C – Do you worry you have lost Control over how much you eat?
O – Have you recently lost more than one stone (6.35 kg) in a three-month period?
F – Do you believe yourself to be Fat when others say you are too thin?
F – Would you say Food dominates your life?

An answer of ‘yes’ to two or more questions warrants further questioning and more comprehensive assessment

A further two questions have been shown to indicate a high sensitivity and specificity for bulimia nervosa. These questions indicate a need for further questioning and discussion.

1. Are you satisfied with your eating patterns?
2. Do you ever eat in secret?