10 July 2023

Final Report:
Evaluation of the Credential Professional Development Packages

The Credential Professional Development Packages (PD Packages) were funded by the Department of Health and Aged Care as part of the ANZAED Eating Disorder Credential Project. The PD Package Program was designed to incentivise mental health professionals and dietitians to become credentialed through access to free approved introductory and treatment model training and clinical supervision sessions. NEDC administered the PD Package program, providing training and/or supervision for 896 mental health professionals and dietitians. The program engaged 70 training providers and supervisors from across Australia to provide the training and supervision.

The PD Packages provided ANZAED and NEDC with the opportunity to test and evaluate a model for incentivising Credential uptake and for rapidly upskilling a large number of health professionals to be able to provide treatment for eating disorders based on the Credential criteria professional development pathway of training and supervision. The PD Packages also offered an opportunity to learn more about the demographics and needs of a subsection of the mental health professional and dietitian workforce willing to undertake training and supervision in EDs; Australian eating disorder workforce data from a large sample of clinicians that to our knowledge has never been reported on.

Evaluation aims:

a) Examine the impact of the PD Packages on ANZAED Eating Disorder Credential uptake;

b) Test the viability of the PD Package model for rapidly increasing clinician knowledge and skill to provide eating disorder treatment, and to increase eating disorder treatment provision capacity;

c) Report on the demographic and treatment provision characteristics of the sample as an opportunity to learn more about possible current and future eating disorder workforce trends and needs.

Method:

Clinicians completed online surveys reporting on demographic characteristics as well as their level of skill, knowledge, and willingness to provide treatment for people experiencing eating disorders prior to undertaking their PD Package (*n*=710) and after completing their PD Package (*n*= 242), as well as quality improvement feedback. A subset of clinicians who completed their package at least 6 months ago also completed a 6-month follow up survey (n=85).

Providers (*n*=41; 56% of the Total number of providers) completed an online survey following their provision of training and/or supervision under the PD Package program. Providers reported

demographic characteristics and perspectives on the key needs of PD Package clinicians to be able to safely and effectively provide eating disorder treatment, as well as quality improvement feedback.

Summary:

Preliminary data outlined in this report suggest that clinicians who undertook a PD Package experienced an increase in self-reported willingness, knowledge, and skill to provide treatment for people experiencing eating disorders. Clinicians also reported a substantial increase in the number of people they were able to provide treatment for, because of their participation in the program. This is promising, indicating that the PD Package program was effective in rapidly upskilling mental health professionals and dietitians in eating disorders treatment and care to improve the quality and reach of eating disorder treatment. This low-cost model and existing program infrastructure could be used to rapidly build the skill and size of different sectors within the eating disorder workforce into the future.

The data also suggest that the program was effective in supporting clinicians to become credentialed, and that most clinicians intended to renew and retain their Credential which promotes greater visibility and accessibility to skilled treatment providers for people experiencing eating disorders, their families and supports.

Clinicians identified several barriers to their ability to implement the skill and knowledge gained from their participation in the program, feeling particularly constrained by funding and the general skill and knowledge of staff within their services. Clinicians also identified key enablers related to workplace culture, leadership, and attitudes that they felt were enablers present within their workplaces.

The evaluation data provides useful insight into the characteristics and needs of this sample of clinicians to be able to provide safe and effective care and the characteristics of trainers and supervisors that could usefully inform future workforce development initiatives. Themes from the current sample suggest that efforts are required to expand workforce diversity, as well as supporting clinicians entering the workforce to become skilled and remain in the workforce. The outcomes from this evaluation may provide a useful guide for the development of further research examining the needs of the workforce to better attract, retain, and upskill clinicians in eating disorders treatment and care.

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SECTION ONE:
Credential Professional Development Packages

Clinician Outcomes

Clinician Data at Baseline

Clinician Demographic Characteristics

What are the characteristics of the clinicians who took up this opportunity?

710 clinicians completed online surveys reporting on demographic characteristics as well as their level of skill, knowledge, and willingness to provide treatment for people experiencing eating disorders prior to undertaking their PD Package.

Overview of Clinician Package types.

Descriptions of each package and the number of clinicians who completed surveys from each package are outlined below.

- **Package One:** Mental health professionals and dietitians who completed the survey that were new to providing treatment for people living with an eating disorder (Introduction to eating disorders training + evidence-based treatment training + supervision)
- **Package Two:** Mental health professionals and dietitians with some experience in providing treatment for people living with an eating disorder (evidence-based treatment training + supervision)*
- **Package Three:** Mental health professionals and dietitians with experience in providing treatment for people living with an eating disorder (supervision only)

**Note:* Some package 2 professionals also undertook introductory training to supplement their existing skillset or as part of an overall introductory and treatment model training package.

Demographic characteristics of these clinicians are outlined in Table 1 on the following page. These broadly align with proportions within the total sample of participants. There was minimal clinician gender diversity within the sample. Cisgender women were over-represented, with a small number of cisgender men, and very few clinicians identified as trans, non-binary or with another diverse gender identity. Aboriginal and Torres Strait Islander clinicians were also under-represented within this sample.

These data are reflective of broader diversity trends within the mental health workforce (Dune et al., 2021; MHCC, 2023; National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031; WHO, 2023). However, disparities may be more pronounced within the eating disorders, which have historically been viewed as impacting only white, affluent underweight cisgender girls and women, a perception which remains present despite substantial evidence that eating disorders affect people of all genders, ages, races, ethnicities, body shapes and weights, sexual orientations, and socioeconomic statuses (AED, 2023; Schaumberg et al., 2017).

Given the importance of diversity for gaining access to different perspective to inform and respond to the diverse needs of people with lived experience, further work is required to understand broader eating disorder workforce trends to discover barriers and to build opportunities to attract and retain a more diverse group of clinicians. In particular, there is opportunity to build the Aboriginal and Torres Strait Islander Mental Health workforce with by and for Aboriginal and Torres Strait Islander People across both Aboriginal Community Controlled Organisations and Western services and systems.

Table 1. Demographic characteristics of clinicians who completed the baseline survey prior to undertaking a PD Package (*n* = 710).

	n	% Sample
PD Package Completed		
Package One	354	50%
Package Two	258	36%
Package Three	98	14%
Clinician Age Group		
20-29 years old	183	26%
30-39 years old	241	34%
40-49 years old	160	23%
and 50+ years old	126	18%
Clinician Gender		
Cisgender woman	629	89%
Cisgender man	56	8%
Trans woman	0	0%
Trans man	2	<1%
Non-binary	8	1%
Gender not listed	7	1%
Prefer not to say	6	<1%
Aboriginal and/or Torres Strait Islander Participants		
Nonindigenous	702	99%
Aboriginal	7	1%
Torres Strait Islander	1	<1%
Aboriginal and Torres Strait Islander	0	0%
Languages Spoken		
English only	642	90%
Multiple languages	68	10%

Discipline. As shown in Figure 1, majority of clinicians who completed the baseline survey were psychologists (48%) followed by dietitians, then social workers, counsellors, mental health nurses, GPs (general practitioner), nurse practitioners, occupational therapists, psychotherapists, then psychiatrists.

The high level of participation by psychologists is in line with workforce data which shows this as the second largest mental health workforce professional group in Australia (AIHW, 2021). However, there was relative under-representation of mental health nurses, the largest mental health workforce professional group in Australia (AIHW, 2021), and under-representation of social workers (Jobs and Skills Australia 2021), Mental Health OTs and Counsellors. Further research examining whether this is indicative of broader workforce trends, as well as initiatives to target other mental health professional groups to increase the size and diversity of the workforce available to provide eating disorder treatment and care is required.

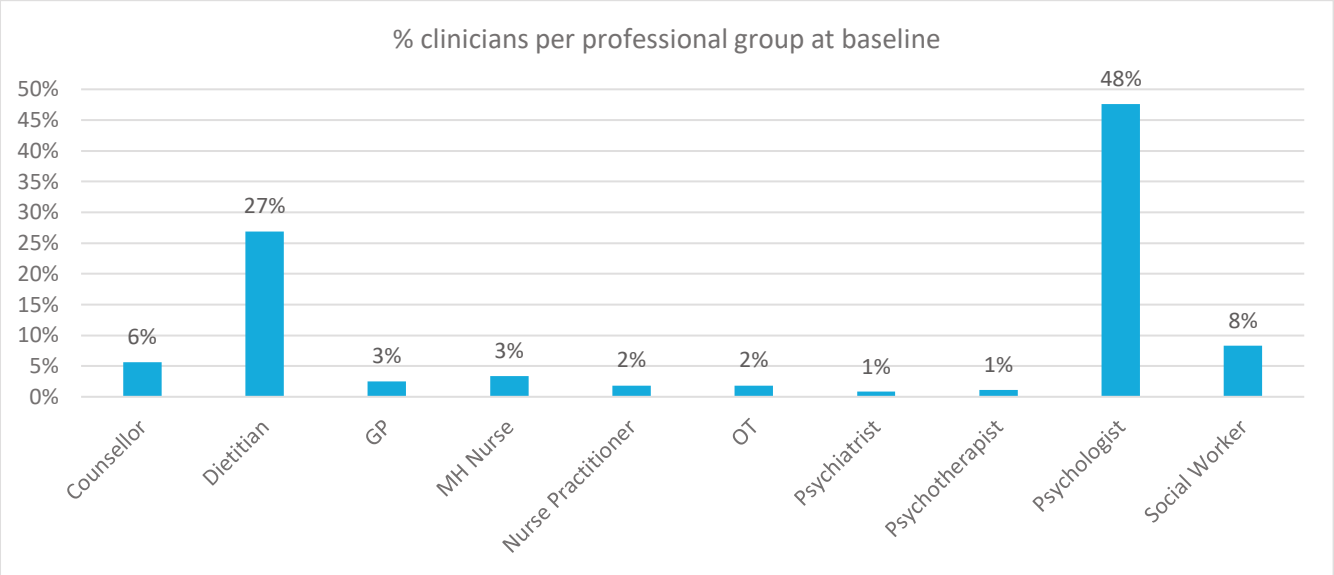


Figure 1. Percentage of clinicians within each professional group at baseline, prior to commencing a PD Package (or withdrawing from the program) *n*=710.

Clinician Service Settings

Where do these clinicians provide services?

State/Territory. As shown in Figure 2 below, mental health professionals and dietitians who completed the baseline survey did so roughly in proportion to ABS state and territory population data. There were three exceptions to this. In Queensland, the proportion of dietitians completing the survey was greater, and the proportion of mental health professionals lower, than what would be anticipated based on Australian population data. In both WA and NSW, the proportion of dietitians who completed the survey was lower than what would be anticipated based on Australian population data.

This broadly aligns with project aims to ensure appropriate and representative engagement in the program from across Australia, however the size and representativeness of the mental health and dietetic workforces across states and territories relative to population need is largely unknown and further investigation is warranted to inform future workforce development initiatives.

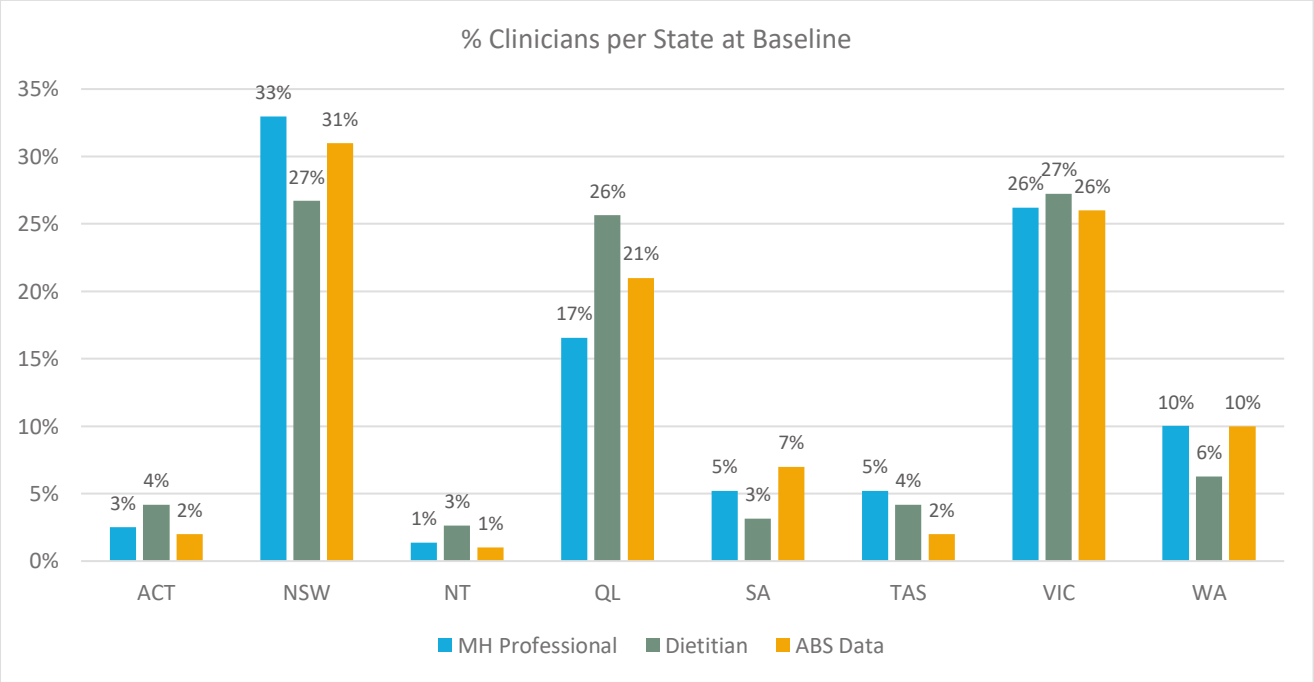


Figure 2. Percentage mental health professionals and dietitians who completed the baseline survey per State against ABS population data (*n*=710).

Geographical setting (MH professionals vs dietitians). As shown in Figure 3, most clinicians who completed the survey resided within metropolitan settings. The data suggest that the proportion of clinicians across geographical settings was roughly in line with Australian Population data, with slightly larger proportions of clinicians operating within rural/regional settings, and slightly less within metropolitan settings than what would be anticipated based on Australian population data.

This broadly aligns with project aims to ensure appropriate and representative engagement in the program across metropolitan, regional, rural, and remote areas. Continued efforts to engage clinicians in regional, rural, and remote areas and addressing the unique needs of this section of the workforce will be essential to addressing eating disorder treatment coverage across Australia.

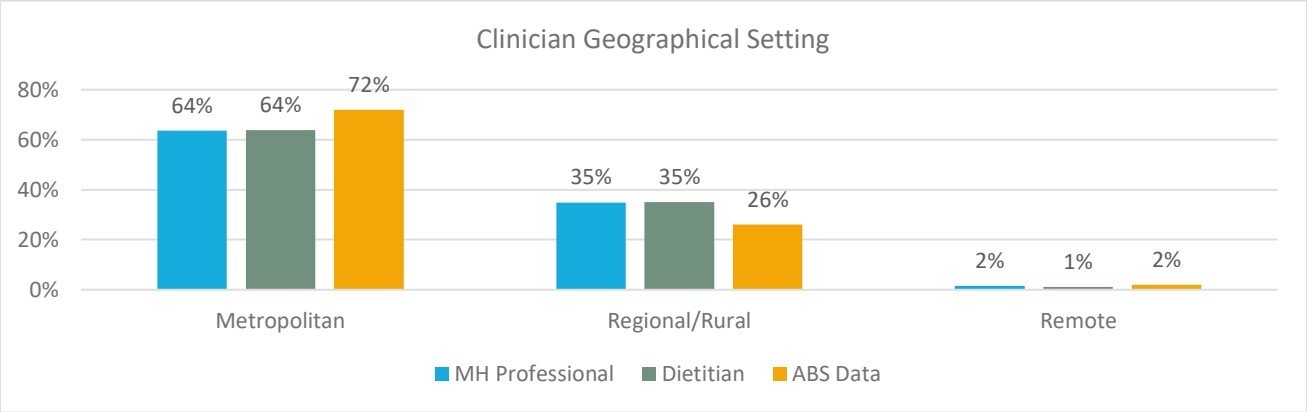


Figure 3. Percentage mental health professionals and dietitians who completed the baseline survey per geographical location against ABS population data (*n*=710).

Public vs private providers. As shown in Figure 4, more clinicians completing the baseline survey worked in private practice, compared to public health and other settings, and clinicians who worked across both settings. There was a greater proportion of dietitians working within private practice compared to mental health professionals).

There was a large proportion of this sample working within private settings. This could be due more clinicians in private practice being interested in becoming credentialled and therefore participating in the PD Packages in larger number than public clinicians. Thus, whilst further research examining whether this is indicative of broader trends is required, it is likely that future workforce development would benefit both from supporting the (likely larger) existing eating disorder workforce within private settings as well as increasing the size and skill of the workforce operating within the public system.

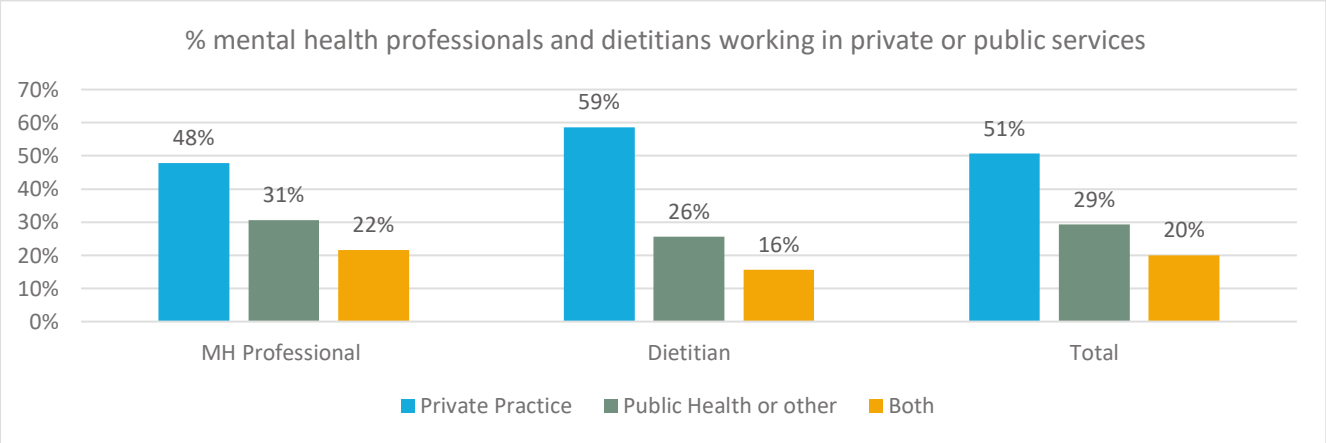


Figure 4. Number of mental health professionals and dietitians working in either private or public services as their primary workplace at baseline (*n*=710).

Service setting. As shown in Figure 5 below, most clinicians undertaking the PD packages worked within general health and mental health services, with only 13% for the sample working within eating disorder specific services. There was a greater number of mental health professionals working within general mental health settings compared with dietitians, and a greater number of dietitians worked within general health services than mental health professionals. There was a relatively equal number of dietitians to mental health professionals working within eating disorder specific services.

It is likely that the trend towards more dietitians than mental health professionals working within general health settings, and more mental health professionals than dietitians working within general mental health settings is reflective of broader patterns in how services are typically set up and operate based on splits between mental and physical health. Initiatives that seek to support care coordination across settings, or embedding the multidisciplinary care team within services will likely improve care team coordination and treatment outcomes.

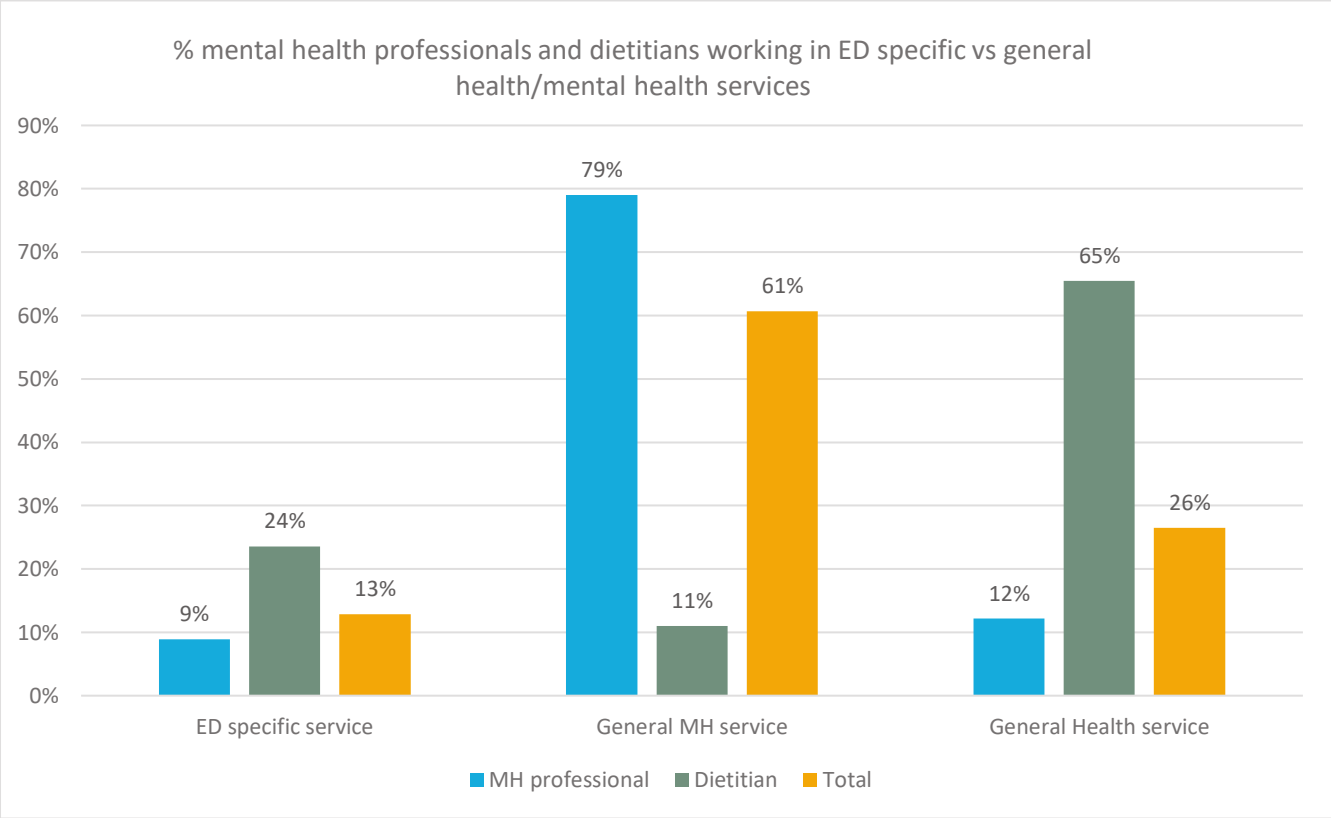


Figure 5. Number of mental health professionals and dietitians working in either eating disorder specific, generalist/broad health or generalist/broad mental health services at baseline (*n*=710).

Primary workplace setting. As shown in Figure 6, most clinicians operated within a private practice setting, with smaller proportions operating within a variety of other service settings including Headspace centres, GP clinics and primary care settings, hospitals, and community health and mental health.

Again, this shows that there was a large proportion of this sample working within private practice. The program intended to reach a diverse range of settings and communications were targeted specifically to non-eating disorder organisations as well as public and non-for-profit organisations. Despite these efforts, most clinicians were from private practice settings again reinforcing a need to better understand the different levels of willingness to become credentialled/engaged in eating disorder work and the development of initiatives that support workers in both private practice and public health to continue to build a skilled, willing, and diverse eating disorder workforce.

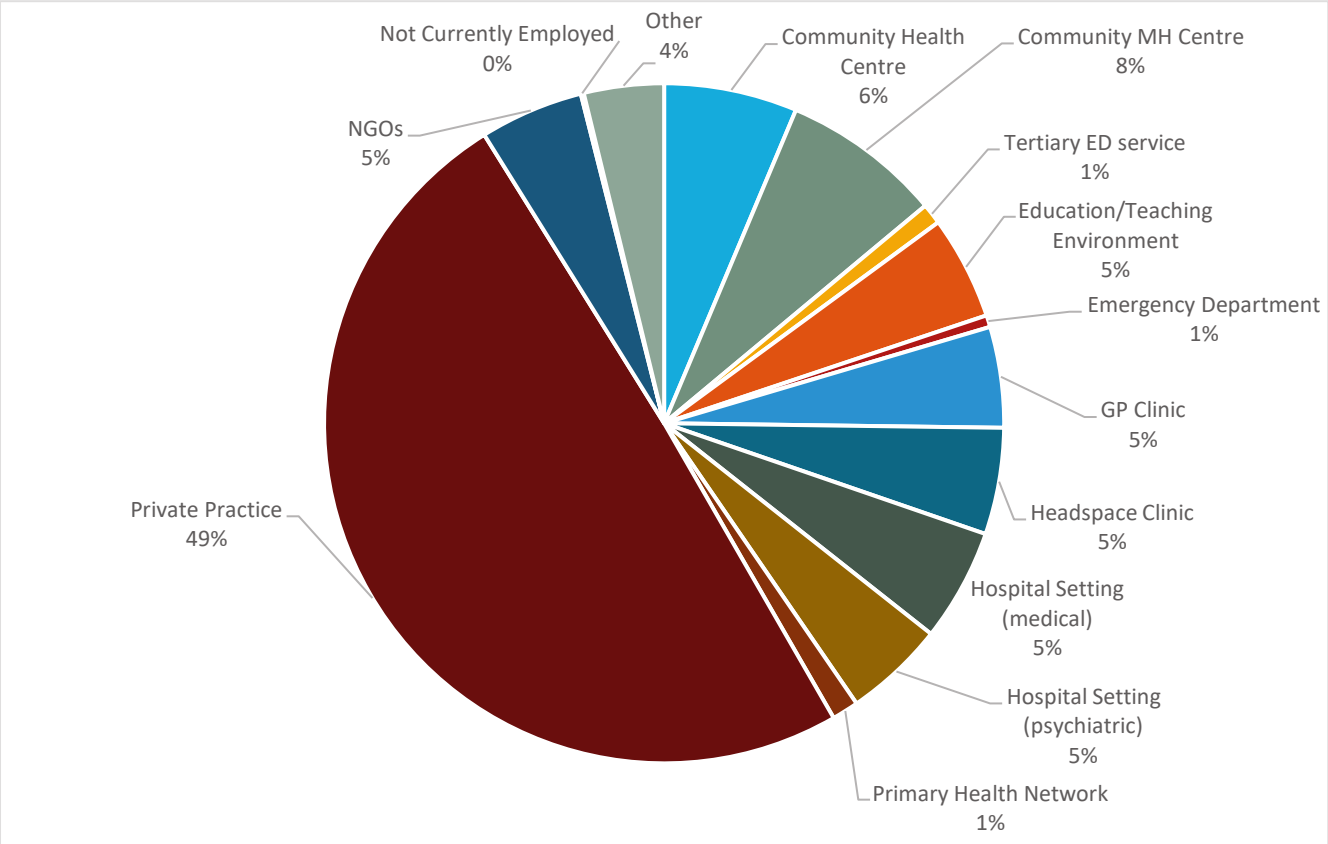


Figure 6. Percentage clinicians working within specific treatment settings at baseline (*n*=710).

Clinician Treatment Provision

What do we understand about treatment provided by clinicians undertaking a PD Package?

Length in profession. As shown in Figure 7, most clinicians undertaking a PD Package were within the first 1-5 years of their professional experience, with a spread of clinicians with greater time working in their profession across package types. Package 3 had a higher proportion of clinicians within the 11-15 years' professional experience group than the other three packages.

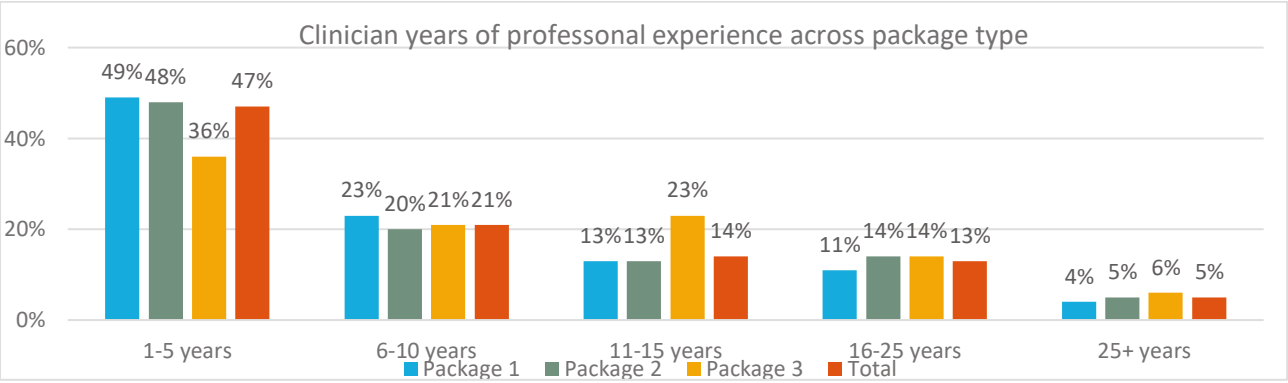


Figure 7. Percentage clinicians with 1-5 years, 6-10 years, 11-15 years, 16-25 years, and 25+ years professional experience across package type at baseline (*n*=710).

Years providing eating disorder treatment. As shown in Figure 8, the majority of clinicians undertaking a PD Package had been providing eating disorder treatment for 1-5 years, except for clinicians undertaking Package 1 where there was a greater proportion (44%) who did not yet provide treatment for people experiencing an eating disorder.

These proportions broadly align with the overall aims of the PD Packages, with Packages 1 and 2 designed to attract clinicians who were relatively new to eating disorder work. Notably, fully 46% of Package 1 clinicians (those indicating they have not received training in an evidence-based eating disorder treatment or introductory training) stated they had been providing eating disorder treatment despite not having received training. This suggests that the initiative attracted clinicians who with proper training, will be better placed to deliver treatment that is evidence-based.

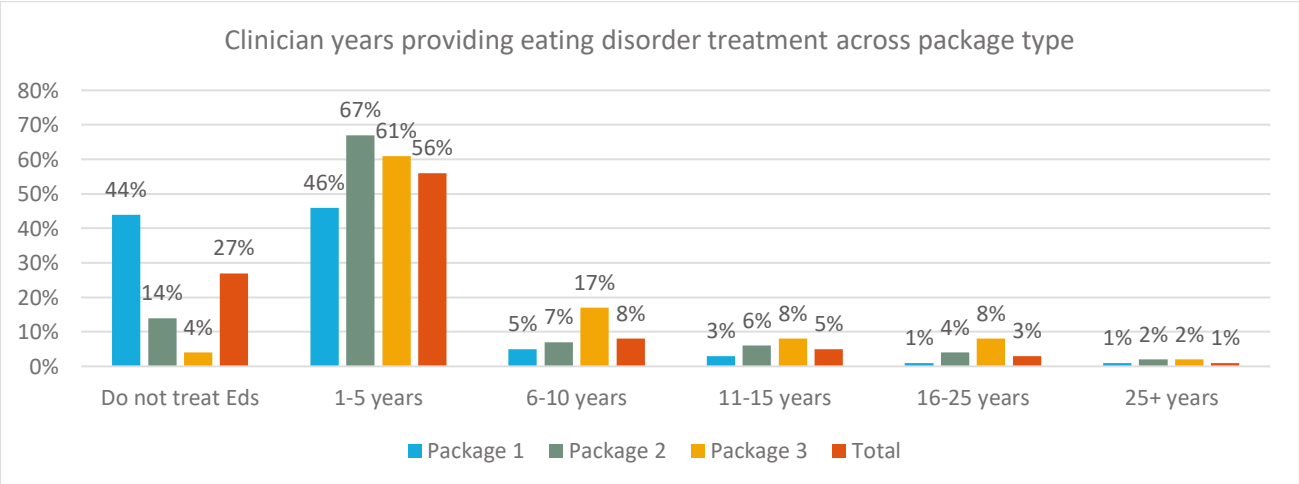


Figure 8. Percentage clinicians who do not treat eating disorders, and those who have provided treatment for between 1-5 years, 6-10 years, 11-15 years, 16-25 years and 25+ years across package type at baseline (*n*=710).

Number of people seen for eating disorder treatment per year. As shown in Figure 9, most clinicians undertaking a PD Package that indicated that they already provide treatment had been providing eating disorder treatment for 1-10 people per year, with about one fifth not providing any treatment, and another fifth providing treatment for between 10 to 20 people experiencing an eating disorder per year.

The data suggest that the clinicians attracted to the PD Packages are those who have an existing small eating disorder case load that is part of their broader work.

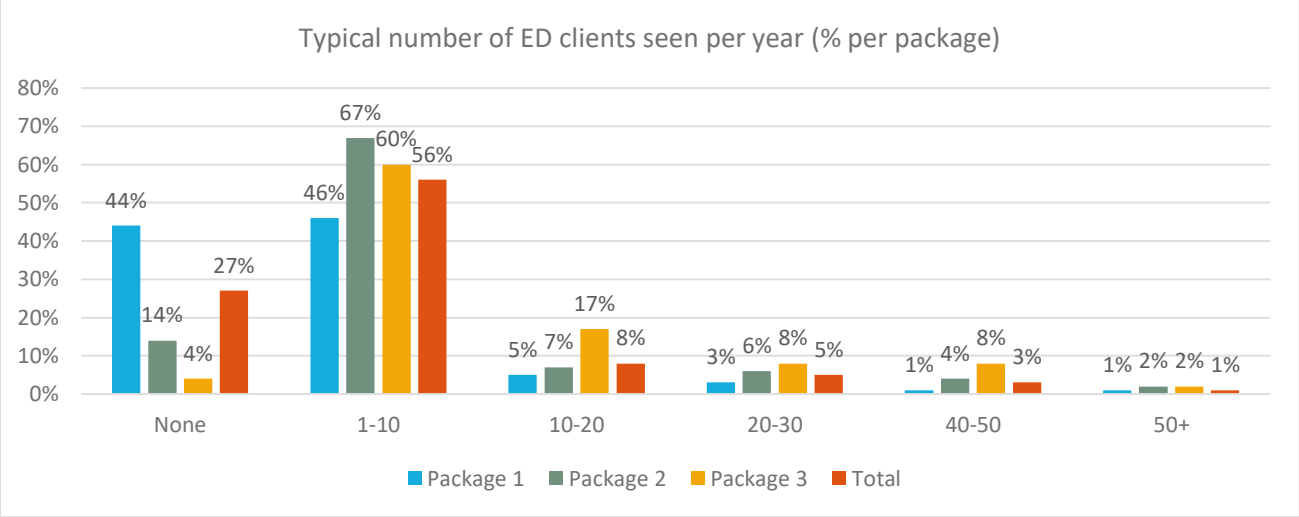


Figure 9. Percentage clinicians who do not provide eating disorder treatment, and those who provide treatment for between 1-10 people per year, 10-20, 20-30, 30-40, 40-50 and 50+ people per year at baseline (*n*=710).

Clinician supervision. As shown in Figure 10, most clinicians undertaking a PD Package were receiving between 1-2 hours of clinical supervision per month prior to starting their PD Package. However, over a quarter of dietitians reported not receiving any supervision. More mental health professionals than dietitians reported receiving between 3-5 and 5-10 hours of supervision per month.

Whilst again the degree to which this represents trends within the broader workforce requires further investigation, the data suggest that dietitians are receiving far less supervision than their peers in mental health, which may impact upon skill development and on retaining dietitians within the ED workforce. These clinicians may also struggle to meet the supervision requirements of the credential, limiting the ability of the public to find appropriately skilled dietitians.

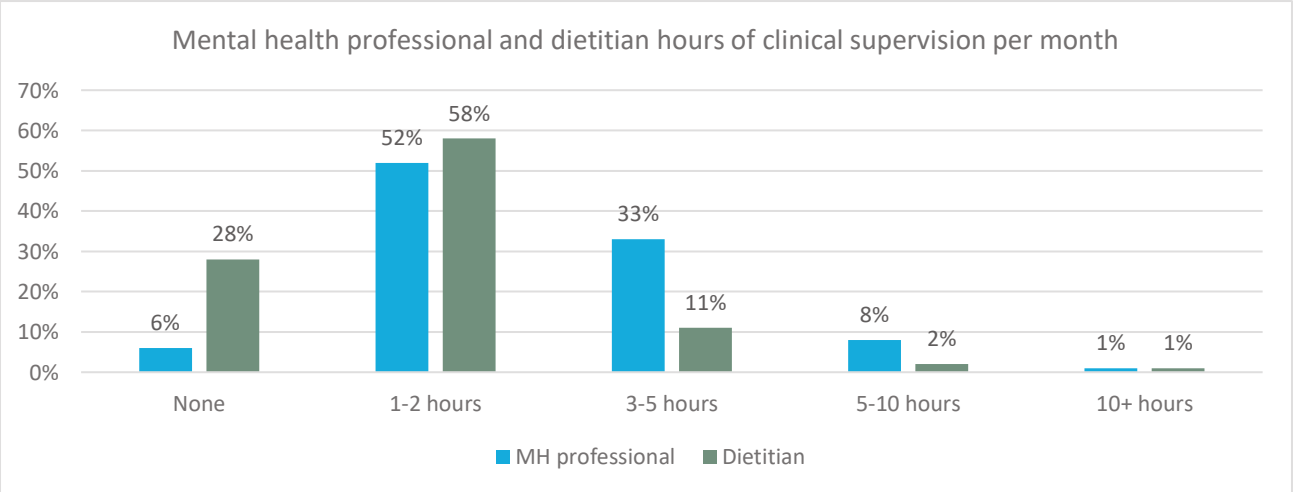


Figure 10. Percentage mental health professionals and dietitians who receive no supervision or, between 1-2 hours, 3-5 hours, 5-10 hours, or 10+ hours of clinical supervision per month at baseline (*n*=710).

Baseline Willingness, Knowledge, and Skill

Where did these clinicians start from?

Clinician willingness, knowledge, and skill to provide eating disorder treatment and care. Prior to undertaking the PD Package, clinicians rated their willingness, knowledge, and skill to provide treatment across a range of eating disorder presentations on a Likert scale from 1-5 (1 = very limited willingness/knowledge /skill; 5 = excellent level of willingness/knowledge/skill). Baseline eating disorder willingness, knowledge, and skill scores were calculated by taking averaging clinician willingness, knowledge, and skill score across binge eating disorder, bulimia nervosa, anorexia nervosa, and OSFED.

As shown in Figure 11, clinicians across all package groups reported a high level of willingness to provide treatment. Clinicians in Package One reported the lowest level of perceived knowledge and skill to provide treatment (between "limited" to "average" skill), whereas Package 3 clinicians reported the highest level of perceived knowledge and skill to provide treatment.

These self-ratings broadly align with the overall aims of the PD Packages to attract and match professionals to a package type according to their level of skill and experience, with Package 1 clinicians being the least experienced/skilled group.

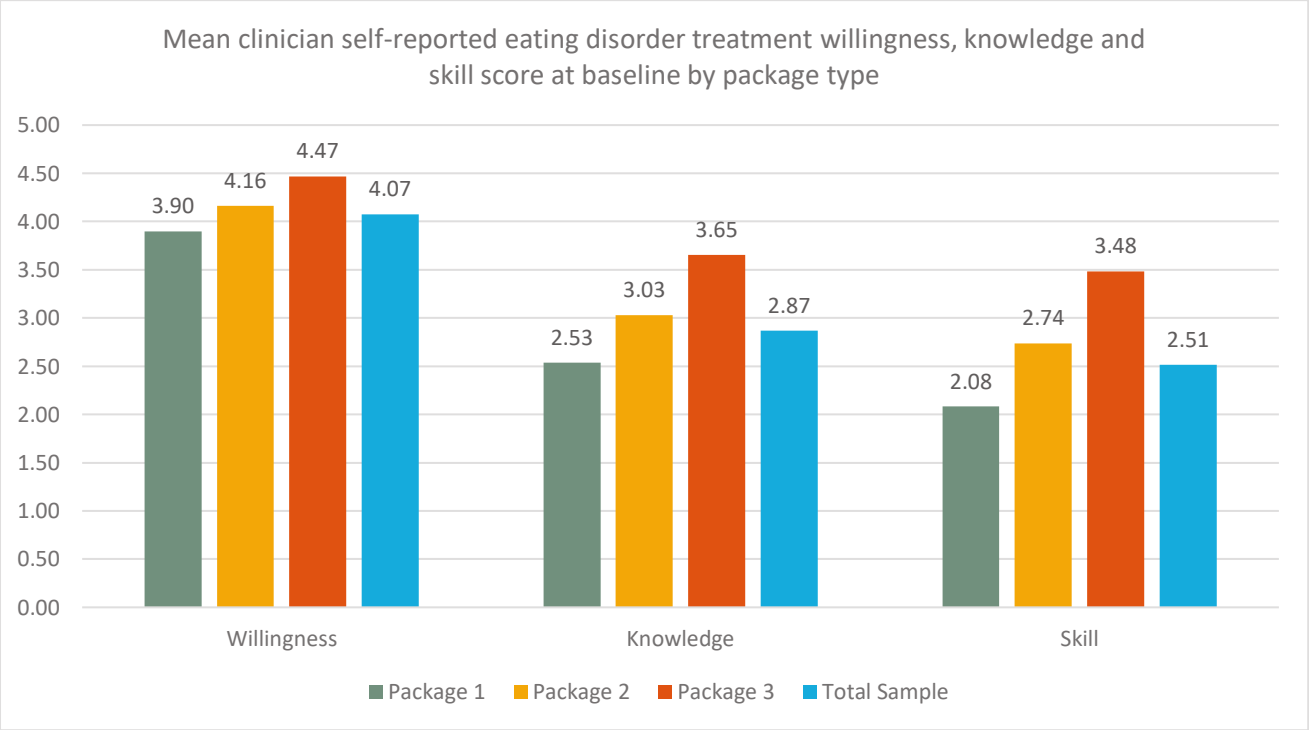


Figure 11. Mean clinician self-reported eating disorder treatment willingness, knowledge, and skill score at baseline across package types (*n*=710).

As shown in Figure 12, dietitians and mental health professionals scored themselves similarly across willingness, knowledge and skill in eating disorder treatment and care.

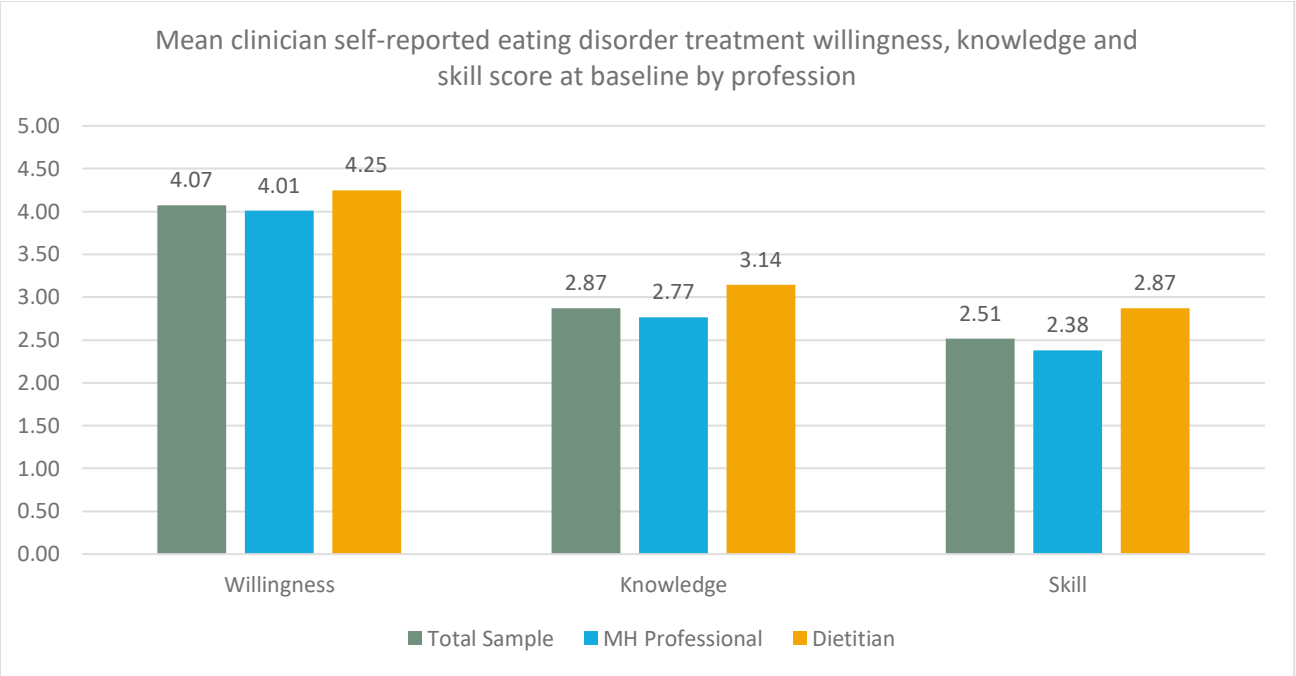


Figure 12. Mean mental health professional vs dietitian self-reported eating disorder treatment willingness, knowledge, and skill score at baseline (*n*=710).

Perceived Barriers and Enablers to using ED Treatment Skills

What do these clinicians think will help or hinder them in providing treatment when they return to their workplaces?

Barriers to providing treatment when returning to the workplace. To investigate the factors that might negatively impact on clinicians ability to use the skills and knowledge developed as part of the PD Packages, clinicians were asked to rate a list of 14 barriers on a scale from 1-4 (1= Not a barrier, 2 = Minor barrier, 3 = Moderate barrier, 4 = Major barrier) according to the level of impact the barrier has on being able to provide safe, effective, and sustainable treatment for people experiencing eating disorders within their workplace currently.

Figure 13 shows the total percentage of the sample that rated each of the 14 barrier items as a Major Barrier (4). Just under a quarter of the sample indicated that a lack of funding to deliver appropriate treatment and a lack of required knowledge, skills, and abilities in staff were major barriers to being able to provide safe, effective, and sustainable treatment for people experiencing eating disorders within their workplace currently. The next items most frequently rated as a Major Barrier were lack of access to appropriate training/supervision, no/poorly articulated policies, procedures, or guidelines to support intake/assessment and treatment of eating disorders (i.e., appropriate, and accessible triage and assessment protocols, service entry criteria) and Lack of time for care coordination.

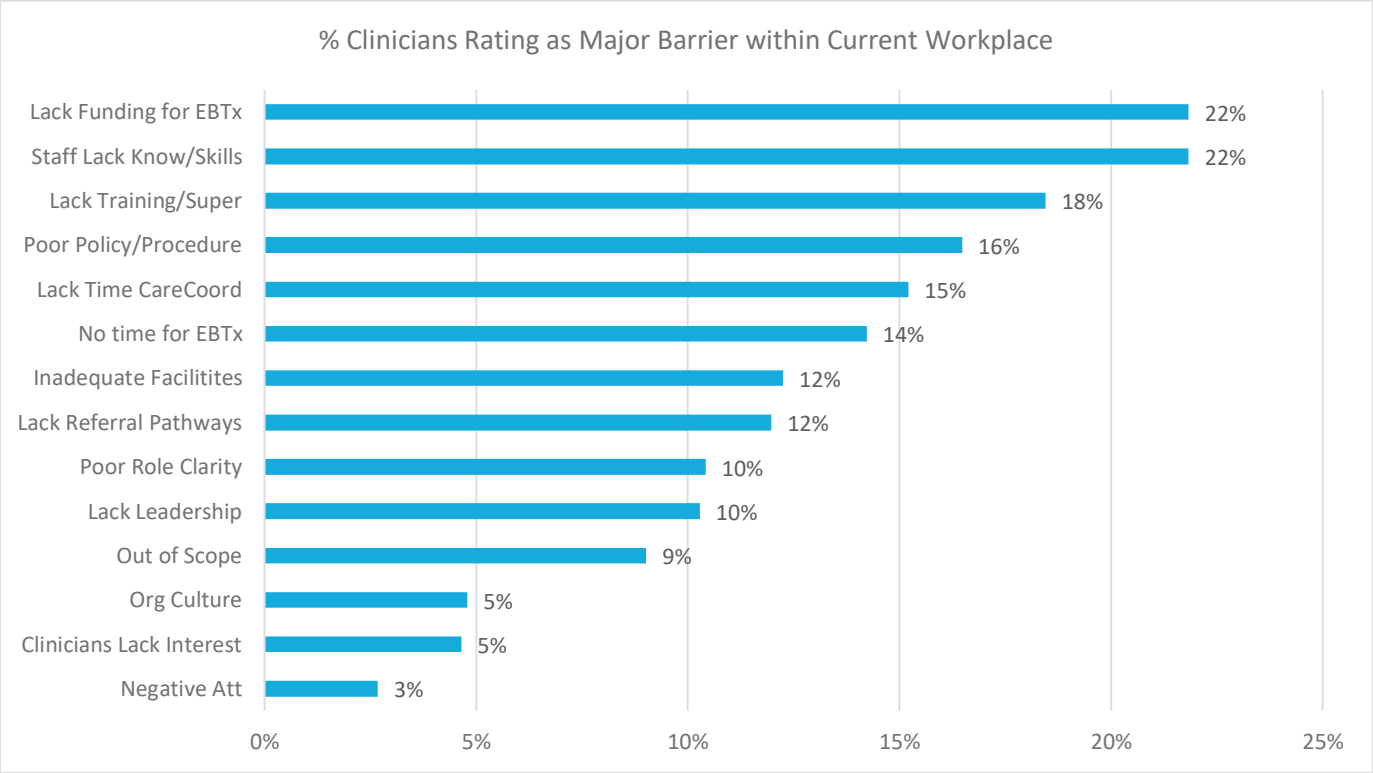


Figure 13 Percentage of clinicians rating each of the 14 barriers as a Major Barrier (4) to providing evidence-based eating disorder treatment and care within their current Workplace (*n*=710).

Enablers to providing treatment when returning to the workplace. To investigate the factors that clinicians perceived enhance their ability to use the skills and knowledge developed as part of the PD Packages, clinicians were asked to rate a list of 14 enabler on a scale from 1-4 (1= Not n enabler, 2 = Minor enabler, 3 = Moderate enabler, 4 = Major enabler) according to the level of impact the enabler has on being able to provide safe, effective, and sustainable treatment for people experiencing eating disorders within their workplace currently.

Figure 14 shows the total percentage of the sample that rated each of the 14 enabler items as a Major Enabler (4). The most frequently identified major enablers to delivering treatment included positive attitudes of other clinicians, as well as supportive organisational culture. The next items most frequently rated as a Major Enabler were the interest of other clinicians, leadership support, and access to training/supervision.

More clinicians identified major enablers within their workplaces than major barriers. However, enablers more likely to be cultural and attitudinal, whereas barriers were more funding and skill development/retention related.

Future analyses with this dataset will examine the differences in barriers and enablers across key groups, such as clinicians working within private vs public settings, general vs eating disorder specific settings and clinicians working in metropolitan versus regional rural and remote areas.

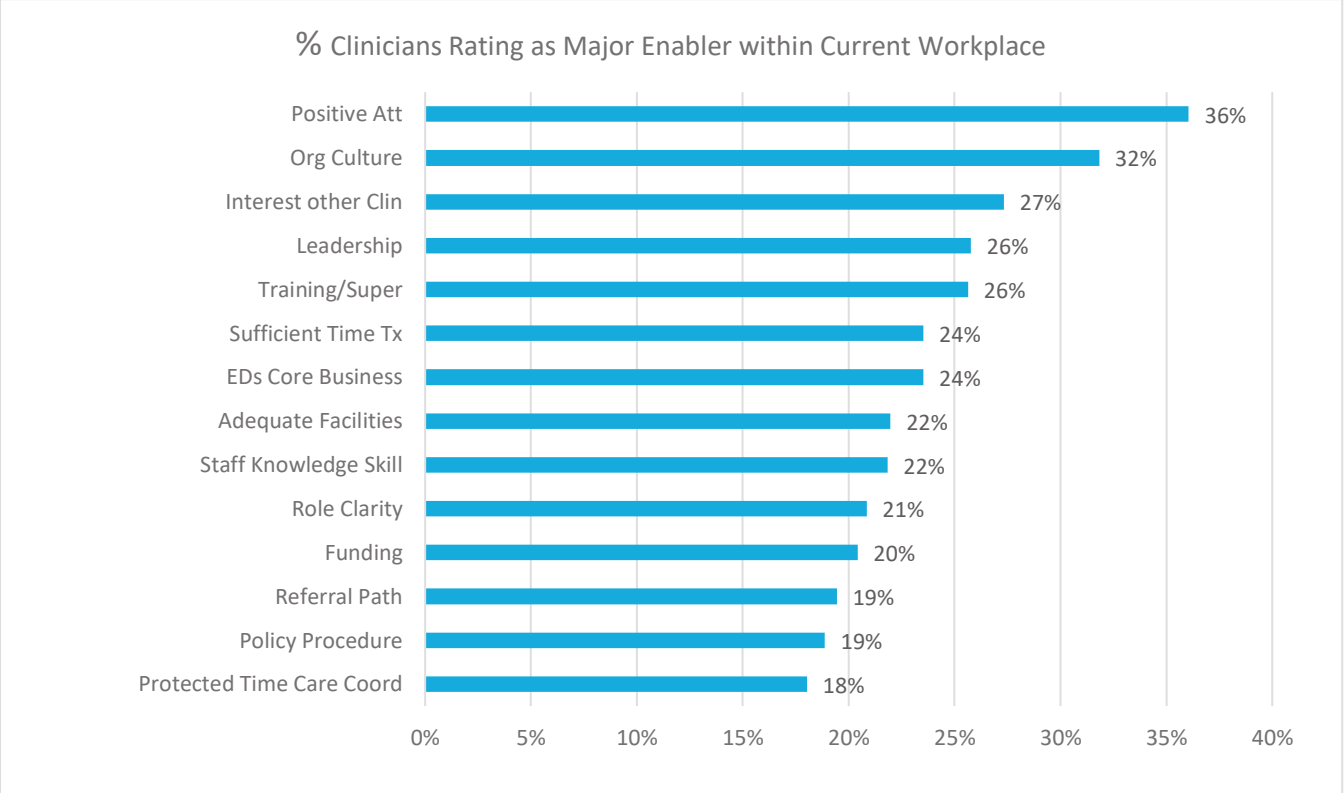


Figure 14. Percentage of clinicians rating each of the 14 enablers as a Major Enabler (4) to providing evidence-based eating disorder treatment and care within their current Workplace (*n*=710).

Post-PDP Clinician Willingness, Knowledge, and Skill

Where did these clinicians end up in their level of willingness, knowledge, and skill?

After undertaking a PD Package, 424 clinicians (60% of the baseline sample), completed the Post-PDP online survey.

Clinician willingness, knowledge, and skill to provide eating disorder treatment and care post-PDP. Clinicians rated their willingness to provide treatment for eating disorders, their knowledge about eating disorders and their skill to provide treatment for eating disorders on a Likert scale from 1-5 (1 = very limited knowledge /skill/not at all willing; 5 = excellent level of knowledge/skill/very willing).

As shown in Figure 15, clinicians across all package groups continued to report a high level of willingness to provide treatment. Differences in perceived knowledge and skill were less pronounced between package types.

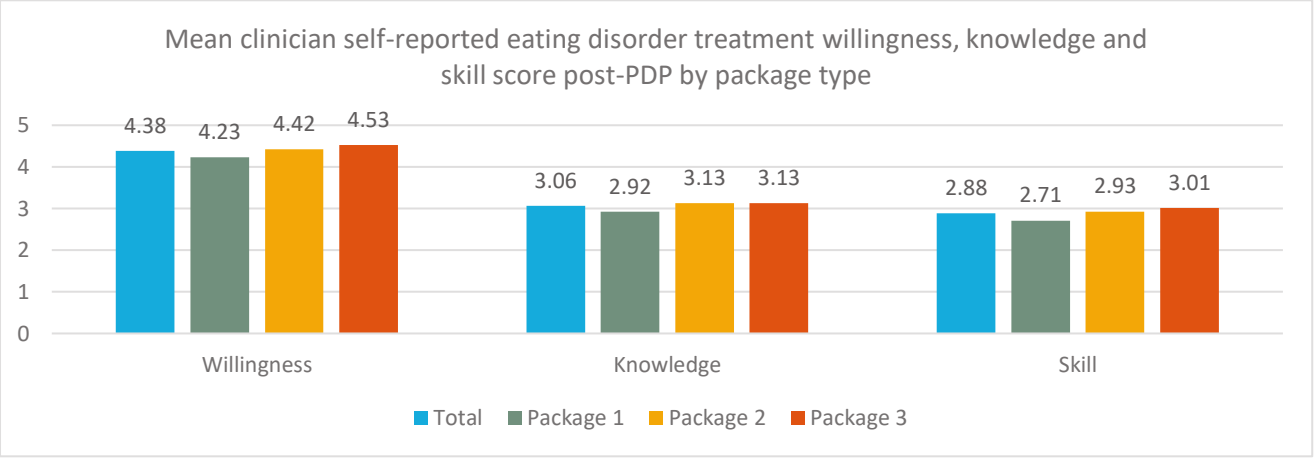


Figure 15. Mean clinician self-reported eating disorder treatment willingness, knowledge, and skill score post-PDP across package types (*n*=424).

As shown in Figure 16, dietitians and mental health professionals again scored themselves similarly across willingness, knowledge and skill in eating disorder treatment and care.

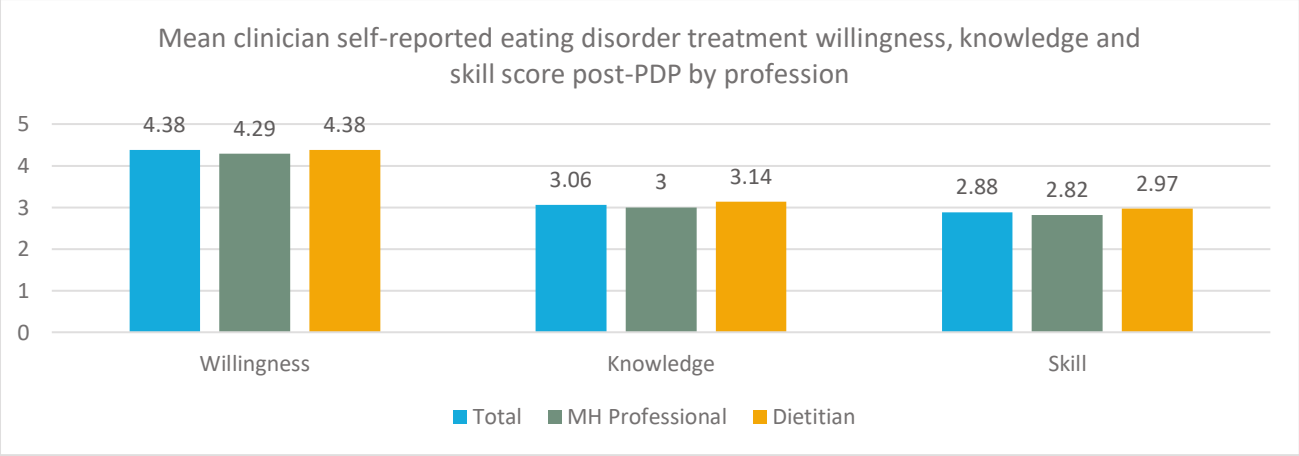


Figure 16. Mean mental health professional vs dietitian self-reported eating disorder treatment willingness, knowledge, and skill score post-PDP (*n*=424)

Increase in treatment provision.

Clinicians were asked whether they believed they would be able to provide treatment to more people experiencing and eating disorder, having completed a professional development package.

As shown in Figure 17, most clinicians anticipated being able to provide treatment to more people experiencing eating disorders because of undertaking a Professional Development Package

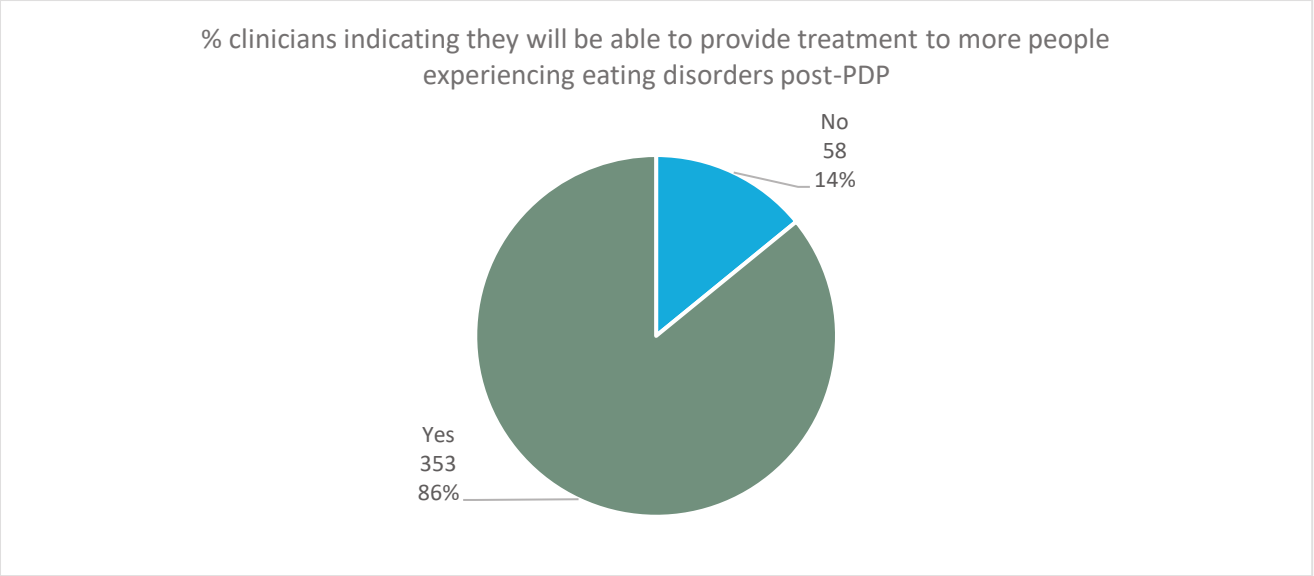


Figure 17. Number & percentage of clinicians indicating they anticipate being able to provide treatment to more people experiencing eating disorders post-PDP (*n*=424)

Of the clinicians (n=353) who responded indicating that they anticipate being able to provide treatment to more people experiencing eating disorders post-PDP, the total number of estimated additional treatment was 3794 people over the next 12 months; and average of 10 additional clients per clinician.

3,794

more anticipated treatment opportunities offered post-PDP

Clinician intention to become and remain credentialed.

Clinicians who completed the post-PDP survey were asked about their intention to become and remain credentialled.

Post-PDP survey completers who applied for the Credential. As shown in Figure 17, most clinicians who completed the Post-PDP survey reported that they had applied to become credentialed.

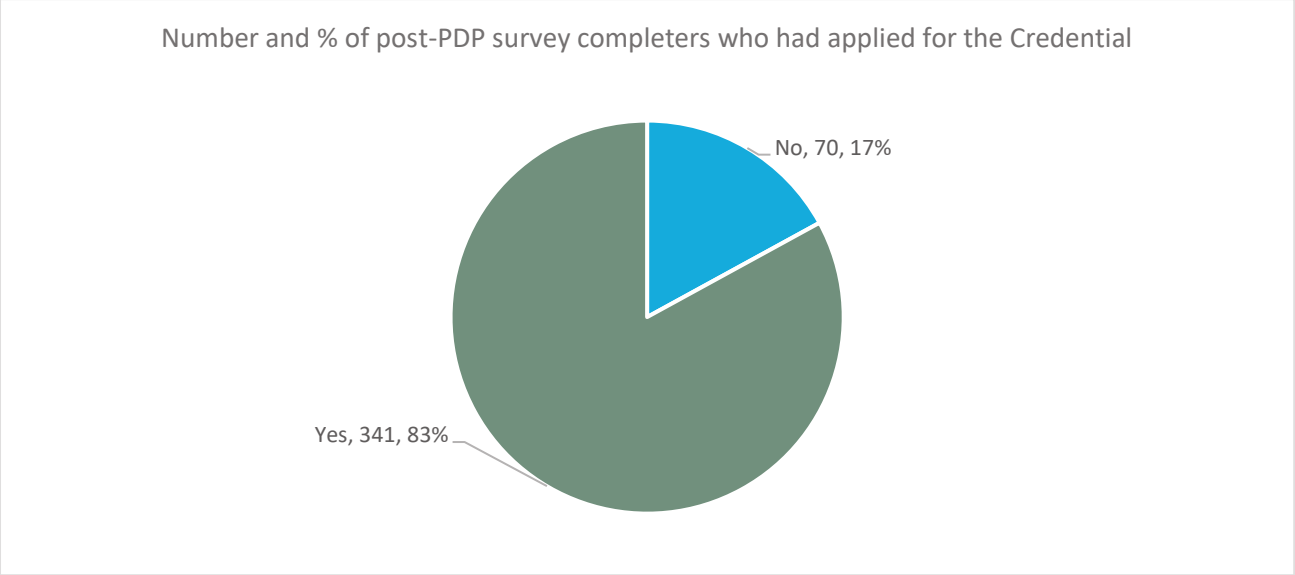


Figure 17. Number and % Post-PDP survey completers who applied for the Credential (*n*=424).

Post-PDP survey completers who intend to renew their Credential. As shown in Figure 18, most clinicians who completed the Post-PDP survey reported that they intended to renew their Credential.

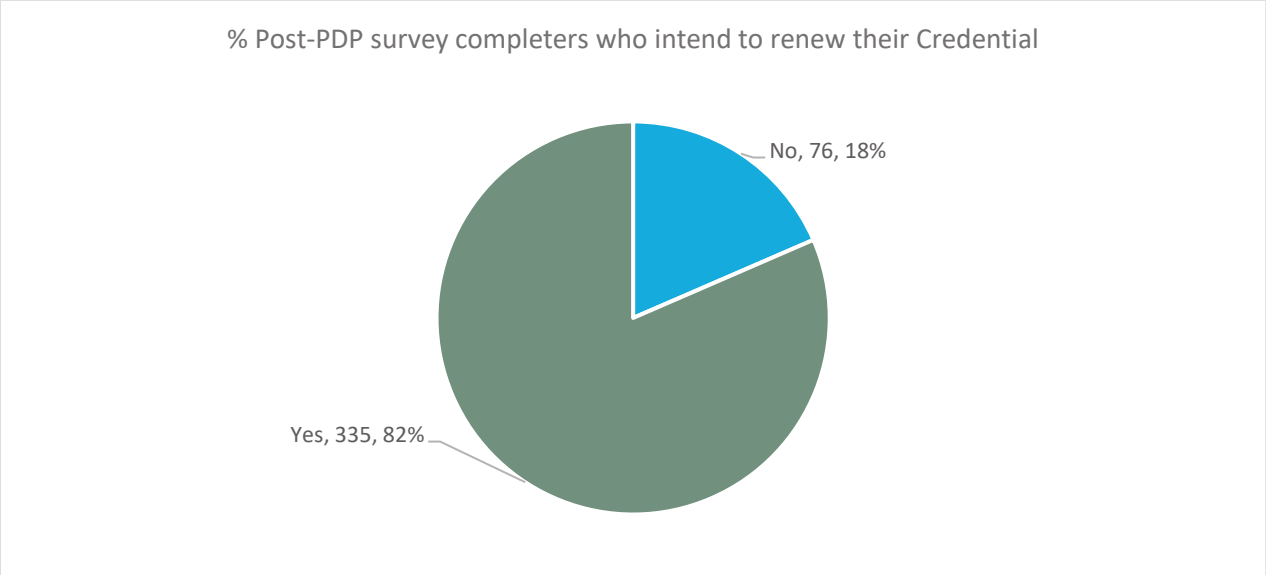


Figure 18. Number and % Post-PDP survey completers who intend to renew their Credential (*n*=424)

Length of time clinicians intend to remain credentialed. As shown in Figure 19, most clinicians who completed the Post-PDP survey were not sure how long they intended to remain credentialled. A large number reported that they intended to retain their Credential for upwards of 10 years, and 45 (10%) reported they did not intend to remain credentialed.

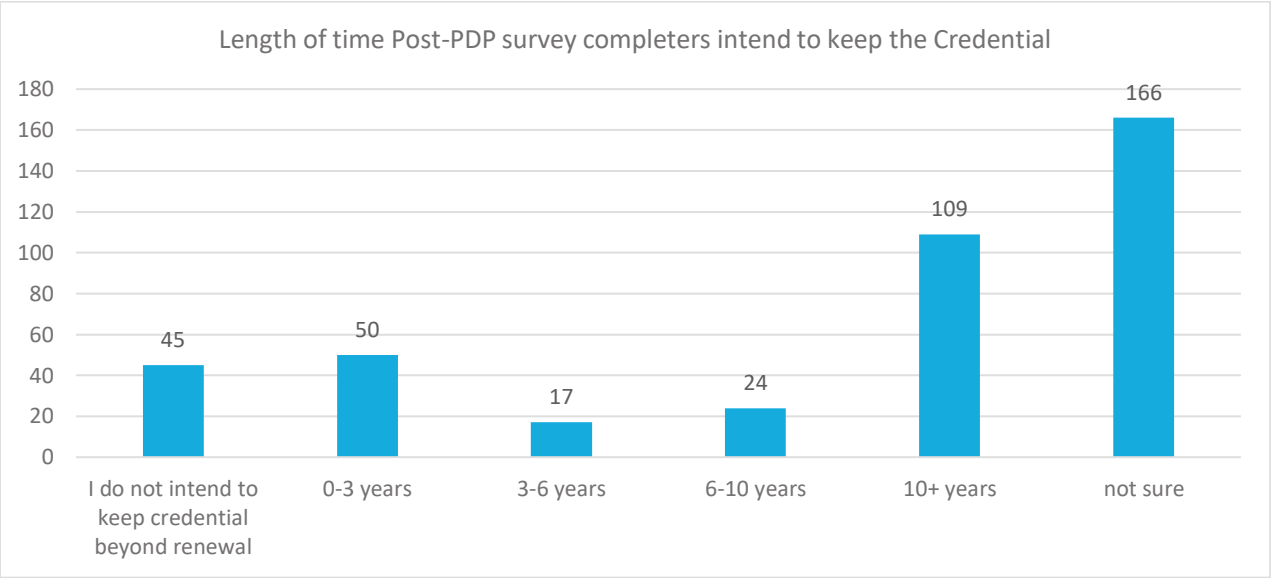


Figure 19. Length of time (% per group) Post-PDP survey completers intend to keep the Credential (*n*=358).

Pre-Post Analyses

Changes in clinician Willingness, Knowledge, and Skill Pre-to-Post PDP

Changes in clinician willingness, knowledge, and skill to provide eating disorder treatment. Clinician self-rated willingness, knowledge, and skill scores at baseline were compared against to their willingness, knowledge, and skill scores after completing a PD Package using Wilcoxon signed rank tests.

There was a significant difference ($Z = -4.29$, $p < 0.001$) between clinician self-reported willingness at baseline and post-PDP, with clinicians reporting increased willingness post-PDP. There was also a significant difference ($Z = -16.29$, $p < 0.001$) between clinician self-reported knowledge at baseline post-PDP with clinicians reporting increased knowledge post-PDP, and a significant difference ($Z = -16.56$, $p < 0.001$) between clinician self-reported skill at baseline and post-PDP with clinicians reporting increased skill post-PDP.

Mean self-rated willingness, knowledge, and skill scores at baseline and post-PD package are shown in Figure 20.

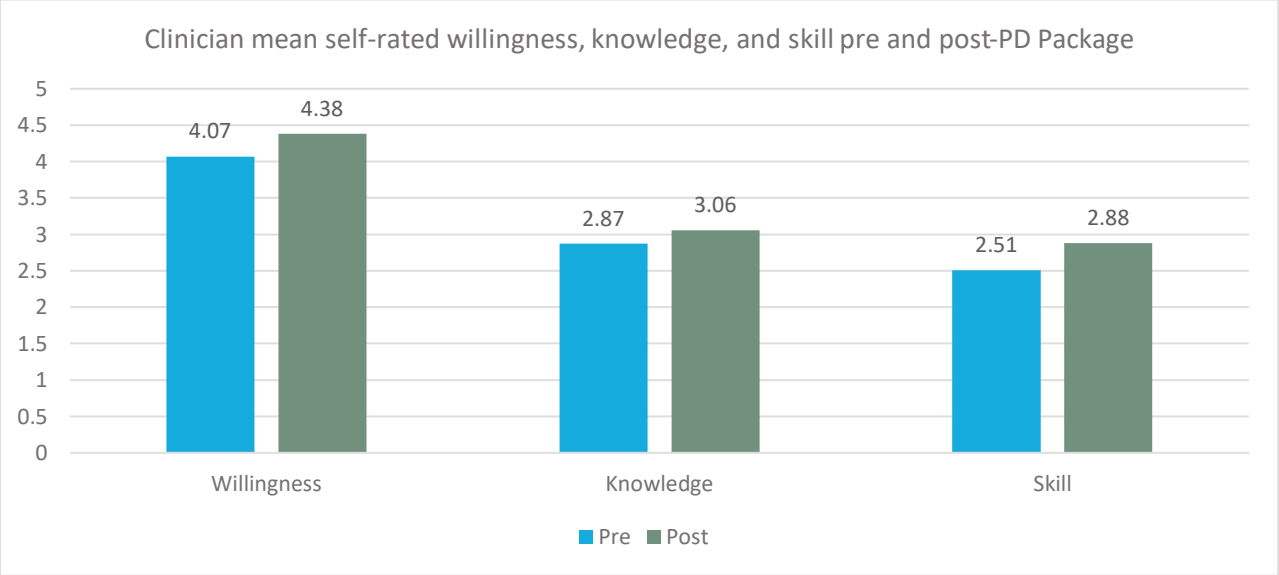


Figure 20. Mean clinician self-reported eating disorder treatment willingness, knowledge and skill score pre- and post-PD Package (*n*=424).

Clinician 6-Month Follow-Up Data

Impact of the PD Packages at 6-month follow up

Six months after undertaking a PD Package, 85 eligible clinicians (20% of the post-PD Package sample; 12% of the baseline sample), completed an online 6-month follow up online survey to understand the impacts of the PDP Program 6 months on.

Increase in number of people seen for treatment

As shown in Figure 21, most clinicians had provided treatment for between 1 and 20 people in the 6-month period following their PD Package, with package one clinicians seeing a smaller number of people compared to those in package 2 and 3.

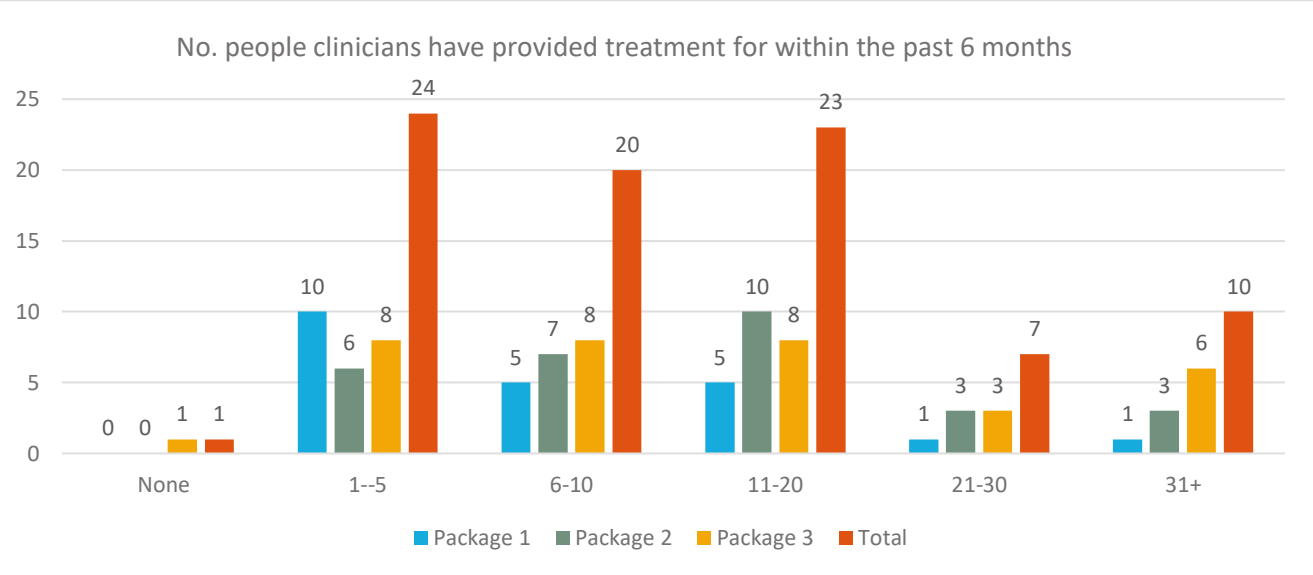


Figure 21. Number of clinicians who have not provided treatment or have provided treatment for, between 1-5 people, 6-10,11-20, 21-30 and 31+ people in the past 6 months since completing a PD Package (*n*=85).

Forty-four clinicians (52% of the 6-month follow up survey completers) responded indicating that they have been able to provide treatment to more people experiencing an eating disorder over 6 months post completing a PD Program, compared with the 6-month period before completing a PD Program. Within this group, the estimated number of additional people being seen for treatment was 322 in the past 6 months.

322

more people are receiving treatment compared to the previous 6-month period.

As shown in Figure 22, most clinicians report using the thinking and practices learned in the PD Program always or most of the time.

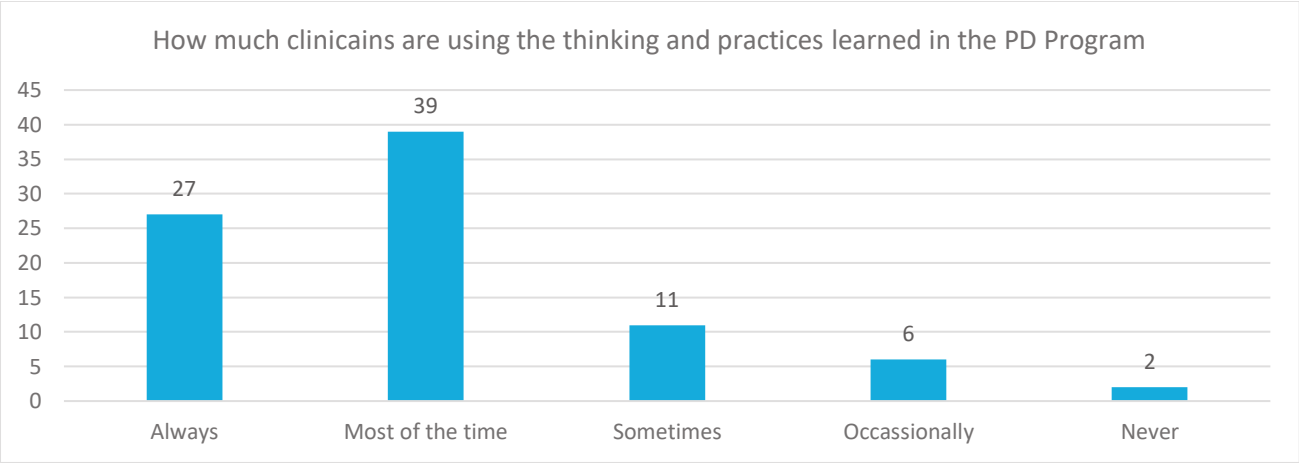
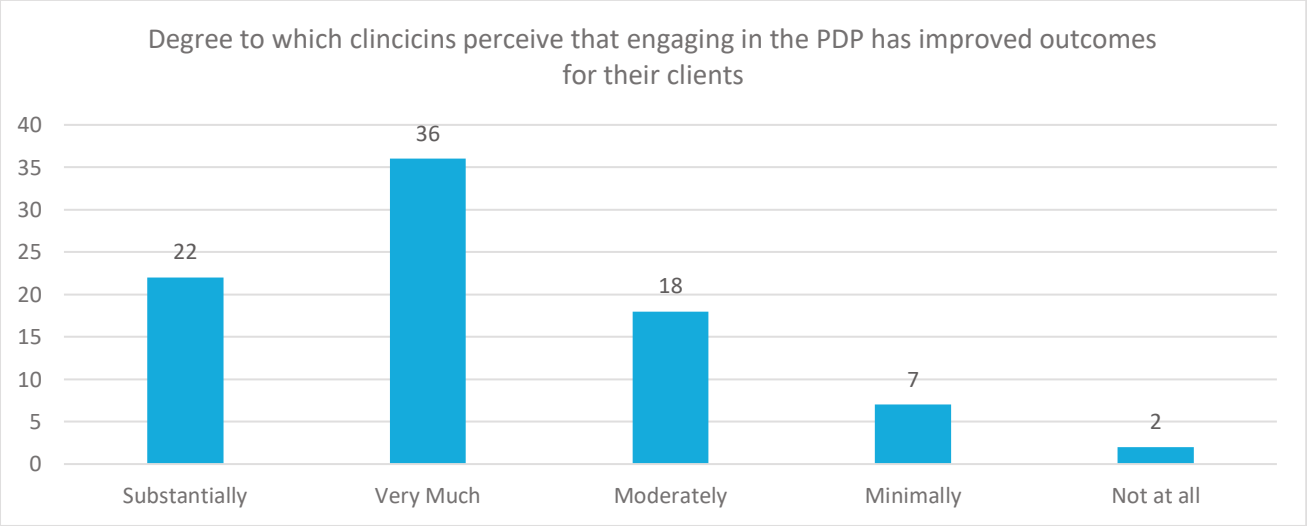


Figure 22. Number of clinicians who are using in the thinking and practices learned in the PD Program in the 6 months since completing a PD Package (*n*=85).

78% of clinicians

use the thinking and practices learned in the PD Program always or most of the time

As shown in Figure 22, most clinicians indicate that engaging in the PD Packages has either substantially or very much improved outcomes for their clients.



68% of clinicians

Say engaging in the PDP has either substantially or very much improved outcomes for their clients

Professional Development Packages Summary

The pre-PDP baseline survey captured demographic, practice, and self-reported competency information from a large group (*n*=710) of mental health professionals and dietitians who took up a program of free training and supervision to become eligible for the ANZAED Eating Disorder Credential. A further *n*=424 completed post measures, and *n*=85 completed survey 6-months post completion of their professional development package. The sample included representation from clinicians across states, territories, and jurisdictions, and across general and eating disorder specific private, public, and not-for profit services.

The evaluation aimed to examine the impact of the PD Packages on ANZAED Eating Disorder Credential uptake, test the viability of the PD Package model for rapidly increasing clinician knowledge and skill to provide eating disorder treatment, to increase eating disorder treatment provision capacity, and to report on the demographic and treatment provision characteristics of the sample as an opportunity to learn more about possible current and future eating disorder workforce trends and needs.

Impact of the PD Packages on ANZAED Eating Disorder Credential uptake.

Evaluation data suggest that the majority of clinicians who completed their post-PDP survey intended to apply for the credential, and most of these intended to renew. Furthermore, many clinicians reported intending to remain credentialed beyond the initial renewal period, though a substantial proportion indicated that they were unsure.

Test the viability of the PD Package model for rapidly increasing clinician knowledge and skill to provide eating disorder treatment.

Pre-post analyses showed that clinicians who undertook the PD Package and completed baseline and post-PDP measures experienced a statistically significant increase in willingness provide treatment for people experiencing eating disorders, and we as increased knowledge and skill to do so. This suggests that the low cost PD Package program model was effective in rapidly upskilling mental health professionals and dietitians in eating disorders treatment and care to improve the quality and reach of eating disorder treatment. Furthermore, Package 1 clinicians who indicated that they were providing eating disorder treatment despite not having received training in an evidence-based treatment approach are now more likely to be providing evidence-based care.

A subset of clinicians reported using the skills and knowledge from the PD Package within their work 6-month on, suggesting that changes in practice may be maintained over the longer term. Analyses of additional 6-month and 12-month post-PDP survey data will shed further light.

Test the viability of the PD Package model to increase eating disorder treatment provision capacity.

Clinicians reported substantial anticipated and actual increases in the provision of treatment for people with eating disorders. Low-cost rapid upskilling initiatives such as these may provide both an opportunity to set clinicians who are yet to work with people experiencing eating disorders up well to begin to build a case load, and support existing and experienced clinicians to take on a larger eating disorder caseload.

Possible current and future eating disorder workforce trends and needs

Workforce is a key driver to building and embedding the stepped system of care for eating disorders across health, mental health, and education social and community service settings, to improve the accessibility and quality of care for people with an eating disorder. Whilst it is not known whether the trends and outcomes of this sample are representative of the broader mental health and dietitian workforce, several important themes emerged that warrant further investigation.

Data from this sample suggest that efforts need to be made to attract a more diverse group of clinicians to become skilled to enter, and then be adequately supported within the eating disorders workforce. Ongoing investigation into the degree to which workforce size, skill and location match the needs of the local communities will be required to continue efforts toward providing timely and effective treatment for people experiencing eating disorders, their families supports and community no matter their gender, age, race, ethnicity, body shape and weight, sexual orientation, socioeconomic status, or where in Australia they live.

This initiative also showed that clinicians with experience in their field are interested to upskill in eating disorders, and that many have an existing small eating disorder case load that is part of their broader work. This should be a target group for workforce development initiatives, especially as these clinicians bring existing skills and competence to the work and may be able to move more quickly move into eating disorder specific leadership and supervisory positions to support the upcoming, newer workforce. However, these clinicians will require support to sustain this work and the current data suggest wide variation in access to supervision and disparities in the amount of supervision and support for clinicians across professional groups and settings.

Trends emerged that suggest some challenges to the workforce being able to match the care requirements of people experiencing eating disorders. A relatively small subset work within ED specific settings, this the majority of treatment providers are likely to be operating within multi-disciplinary teams across service settings. Embedding the multidisciplinary team within services, or seeking opportunities for cross-service/organisation collaboration, will likely assist workforce and care coordination. Additionally, workforces may be working within or coordinating across private and public settings, and workforce initiatives should seek to support the robust existing workforce within private practice as well as increasing the size and skill of the workforce operating within the public system.

Lastly, organisational readiness and other barriers and enablers will impact the ability of clinicians to translate the skill and knowledge developed in training and supervision into providing and sustaining an evidence-based treatment response. Clinicians identified different barriers and enablers, and further analyses will examine how these differentially impact particular groups based on service setting and location. Given the high level of willingness of the current cohort, with the right systems and organisational supports in place, especially additional funding, and opportunities to train and provide supervision to staff, more clinicians will be able to provide evidence-based treatment within their workplace.

The outcomes from this evaluation provide a useful direction for further research to underpin workforce development initiatives to attract, retain, and upskill clinicians in eating disorders treatment and care.

TWO:
Credential Professional Development Packages

Training and Supervision Provider Experience and Insights

Provider Characteristics

Provider Demographic Characteristics

What are the characteristics of the clinicians who provided training and supervision?

41 training providers and/or supervisors (56% of the Total 75 providers) completed an online survey following their provision of training and/or supervision under the PD Package program. Demographic characteristics of providers are shown in table 2 below.

Table 2. Demographic characteristics of training and/or supervision providers who completed the PD Package provider survey (*n* = 41).

	n	%
Provider Gender		
Cisgender woman	40	98%
Cisgender man	1	2%
Trans woman	0	0%
Trans man	0	0%
Non-binary	0	0%
Aboriginal and/or Torres Strait Islander Providers		
Nonindigenous	41	100%
Aboriginal	0	0%
Torres Strait Islander	0	0%
Aboriginal and Torres Strait Islander	0	0%
Languages Spoken		
English only	40	98%
Multiple languages	1	2%

State/Territory Location. As shown in Figure 23, most providers who completed the survey resided in either New South Wales (34%) or Victoria (27%). No providers who completed the survey identified as residing in the Northern Territory, though there were NT representatives in the broader group of providers.

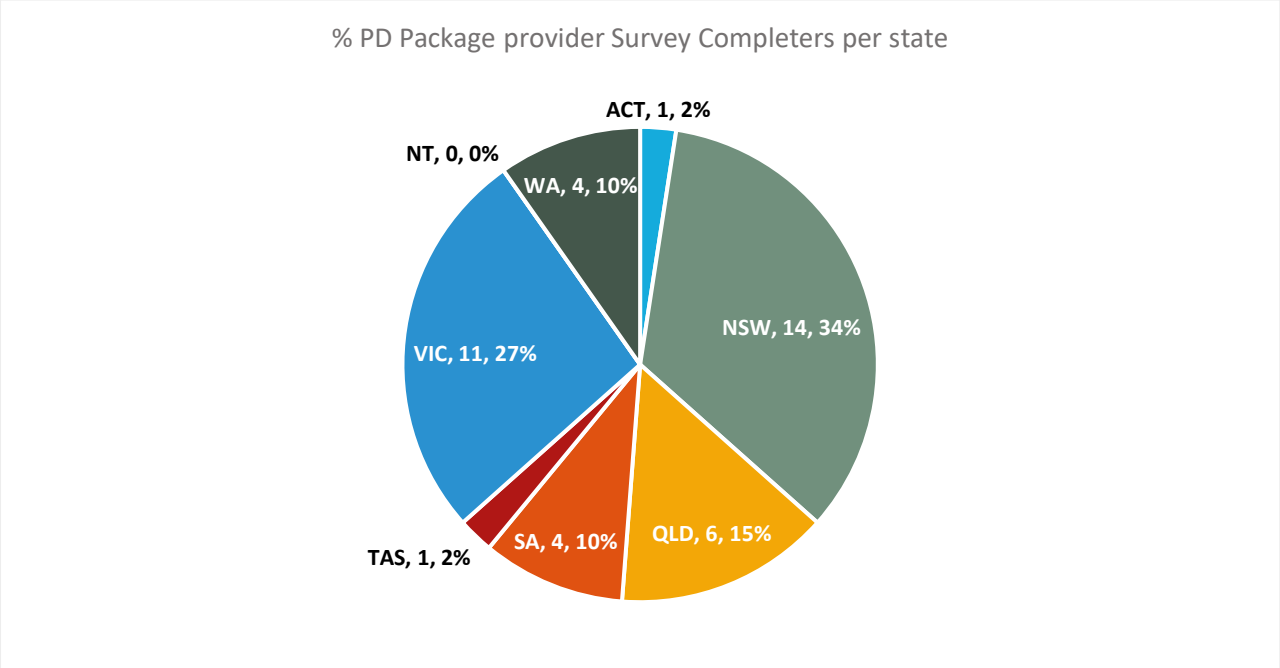


Figure 23. Percentage and number of PD Package providers per State (*n*=41).

Profession Breakdown As shown in Figure 24 most providers were either psychologists or dietitians.

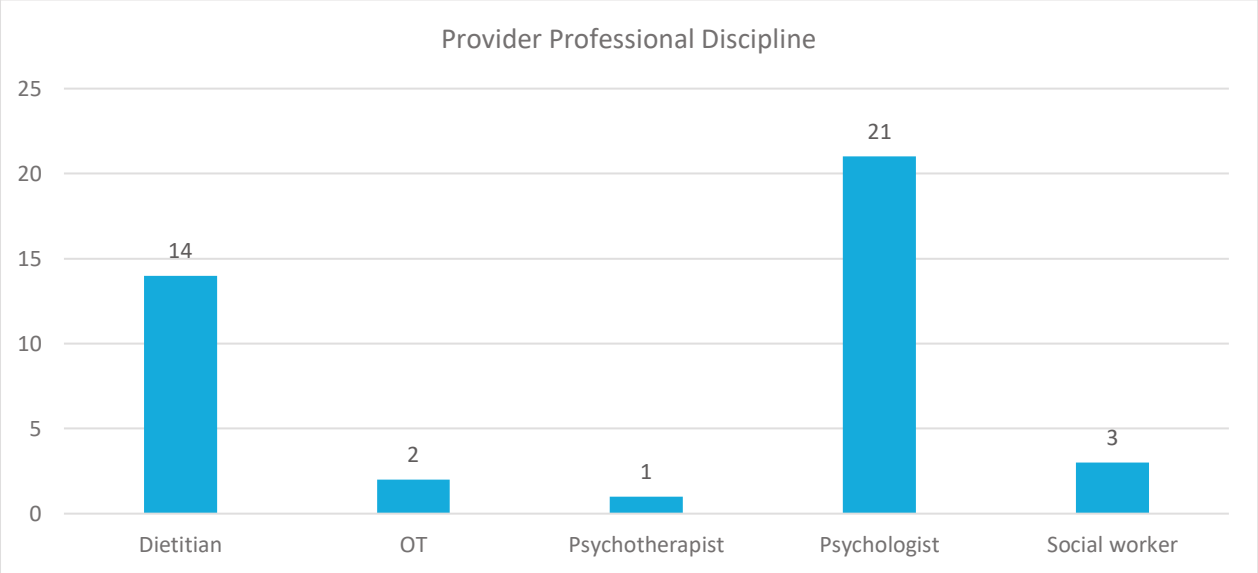


Figure 24. PD Package provider geographic location (*n*=41).

Geographic Location. As shown in Figure 25, Most providers who completed the survey resided in metropolitan regions.

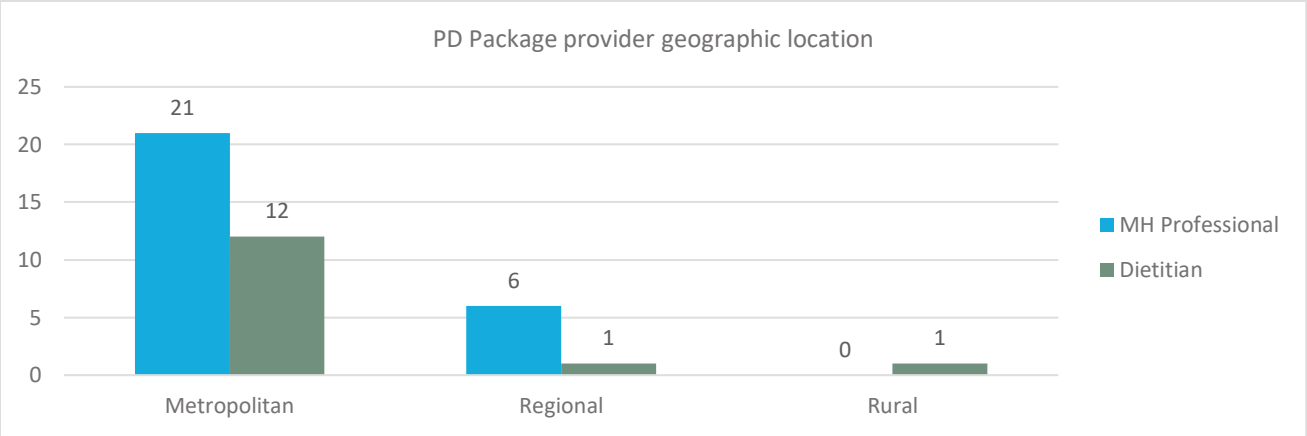


Figure 25. PD Package provider geographic location (*n*=41).

Private vs Public Service Setting. As shown in Figure 26, most PD Package providers who completed the survey operated within a private practice setting.

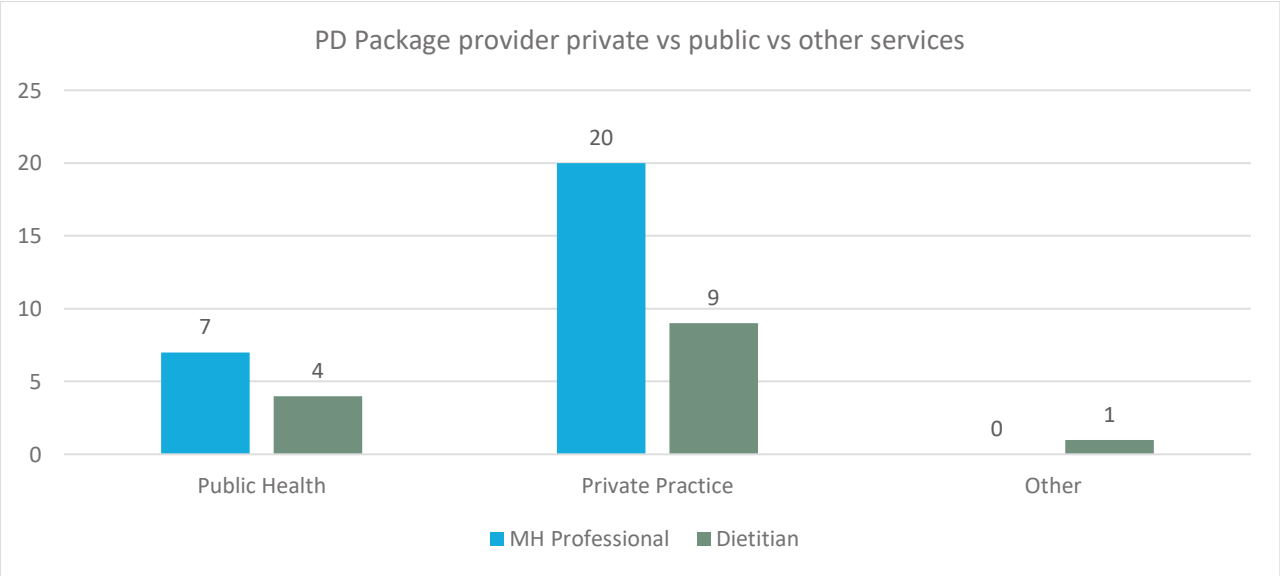


Figure 26. PD Package provider service setting (*n*=41).

Provider Primary Workplace Setting. As shown in Figure 27, of those providers who did not work within a private practice setting, settings included eating disorder specific services, community mental health services, psychiatric hospitals, GP clinics and education and teaching environments.

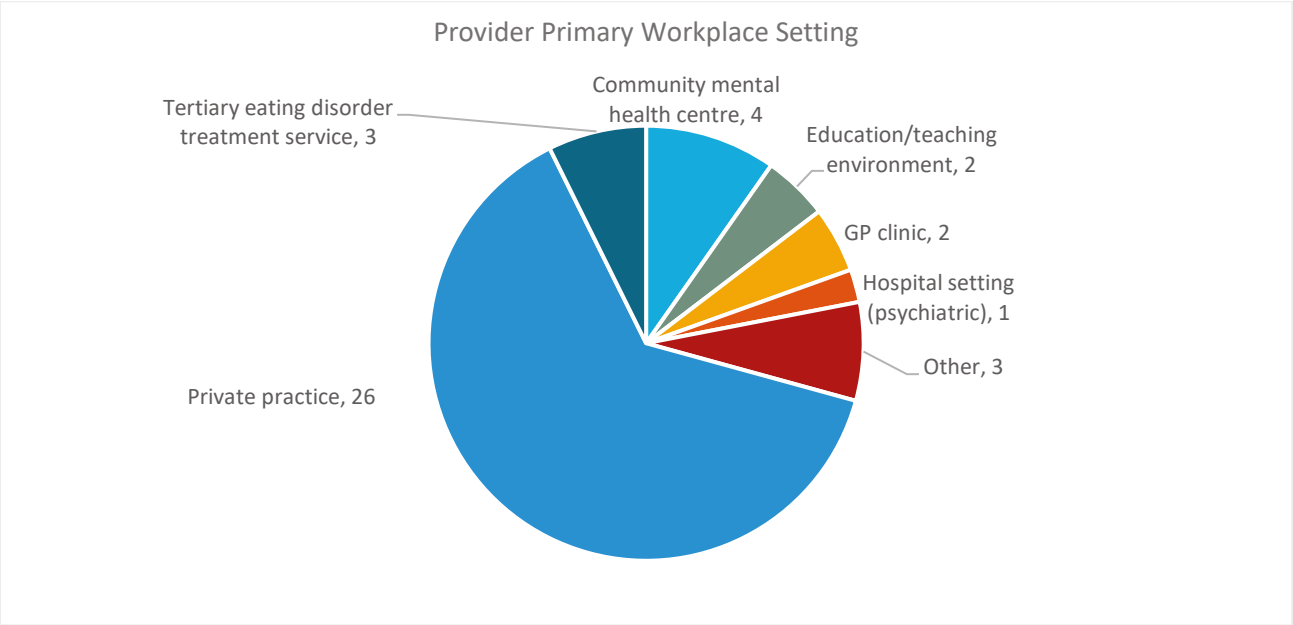


Figure 27. PD Package provider service setting (*n*=41).

Provider observations of clinician challenges and needs.

Clinician areas for development identified by providers.

Providers were asked to describe common gaps in clinician skill or knowledge that existed at the beginning of supervision/training. The following key themes were identified:

1. **Stigma, Stereotypes and Attitudes**

Stigma, Stereotypes and Attitudes were identified by several providers as an area for development for PDP clinicians. Themes included clinician weight bias influencing decision-making regarding eating disorder presentations and care, stereotypes relating to eating disorders on the one hand being 'too complex' and on the other hand being minimised as issues of appearance concern rather than mental illnesses with biopsychosocial underpinnings.

> **"A lack of confidence due to perceiving eating disorders as complex"**

2. **Missing and misdiagnosing eating disorders**

Providers identified that clinicians would pick up on other mental health diagnoses but struggle to identify signs of a co-occurring or differential eating disorder.

3. **Working with ambivalence**

Ambivalence and supporting motivation for change was identified as an area for clinician skill building and development. Providers noted that clinicians may not identify ambivalence and also needed to develop skills to work with/around ambivalence as part of treatment.

> **"Not understanding the ambivalence/ego-syntonic nature of eating disorders. Not realising the medical instability of EDs".**

4. **Formulation and treatment planning**

Providers reported challenges for clinicians in being able to formulate how an eating disorder may have emerged and what may be maintaining the eating disorder for a person to then appropriately diagnose and plan treatment. Themes also included a need to develop a practice of flexibly adapting treatment to fit the individual's needs.

5. **Core tenets of eating disorder treatment and maintaining fidelity**

Challenges in grasping foundational eating disorder specific psychoeducation and treatment practices were identified by providers. Clinicians needed to build skills and confidence to provide core interventions such as weighing and monitoring, and to develop and implement important therapeutic boundaries such as the implementation of treatment non-negotiables.

6. **Managing risk and medical monitoring, operating as part of a care team**

Providers identified that clinicians lacked awareness and skills to monitor and address risk in eating disorders. Clinicians were not aware of the importance of operating as part of a care team, including medical monitoring, and being clear in their responsibilities and scope of practice.

"I came across some clinicians new to the field, working individually in private settings, who were treating clients in the community with very low weight (i.e., BMI 12-13) and without medical monitoring in place!"

7. **Service and practice opportunity limitations**

Providers reported a theme in clinician inability to develop skills due to limited opportunities to work with people experiencing eating disorders within their service setting.

8. **Fears and concerns about engaging in eating disorders treatment**

Providers were asked to report on common themes in clinician fears or concerns about providing treatment and care for people experiencing an eating disorder that existed at the beginning of supervision/training. Themes included fearing managing medical risk, complexity, and working with people who were stuck/ambivalent and ultimately fearing a person under their care might die from their eating disorder.

"I don't know enough".
"I'll mess it up".
"All EDs are serious and life threatening".
"It's too much for me".

Providers perceived clinician fears related to feeling alone in the care of people and not being able to operate as part of a care team. Providers also noted fears related to being 'too directive' when setting boundaries and treatment non-negotiables.

"Always worried they will say the wrong thing or cause more harm".
"Lack of confidence in communicating concerns to the rest of the treatment team".
"Worried about how to be firm and directive whilst not damaging the therapeutic relationship".

Some perceived fears related to clinician's concern that they would need to rigidly adhere to a treatment model, may be unable to accommodate evidence-based treatment within their service, or may experience ongoing training and supervision as too costly.

"Not having appropriate supports in place in terms of workplace setting or engagement with multi-d team".

Clinician needs identified by providers.

Providers were asked to describe what they perceive to be the most important needs of clinicians who are new to providing treatment and care for people experiencing an eating disorder. The following key themes were identified:

1. Opportunity to consolidate skill through:
    - Ongoing, accessible, affordable supervision.
    - Opportunities to provide eating disorder treatment.
2. Organisations and service environments that adequately support clinicians to develop and maintain these skills.
3. Develop the key skill of balancing empathy and boundaries.
4. Develop knowledge regarding when and how to refer to higher levels of care.
5. Opportunities to work within a multi-disciplinary care team.

"Ongoing clinical supervision by someone experienced".
"Peer supervision with others new to the field".
"Adequate number of referrals so they can gain experience while their training is still fresh."

"Working in an environment that supports ED treatment: A lot of clinicians working in more generalist spaces, but seeing EDs, and feeling broadly unsupported with the complexity of the work."

"Need to develop the confidence to provide a balance of kindness and firmness in treatment."

Program feedback & QI

Providers were asked to give feedback about the PD Package program.

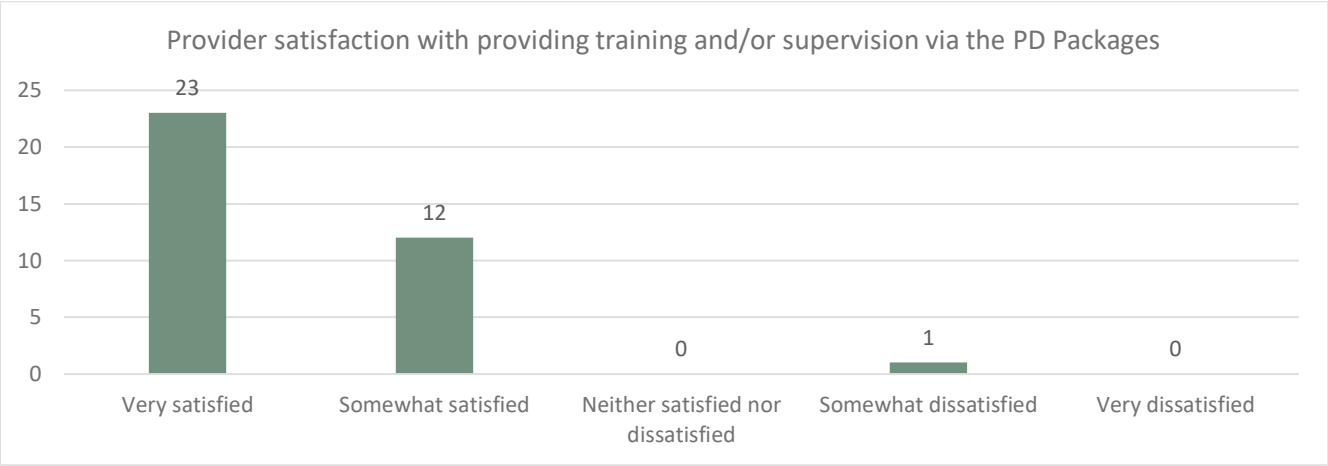


Figure 28. Provider satisfaction with providing training and/or supervision via the PD Packages (*n*=41).

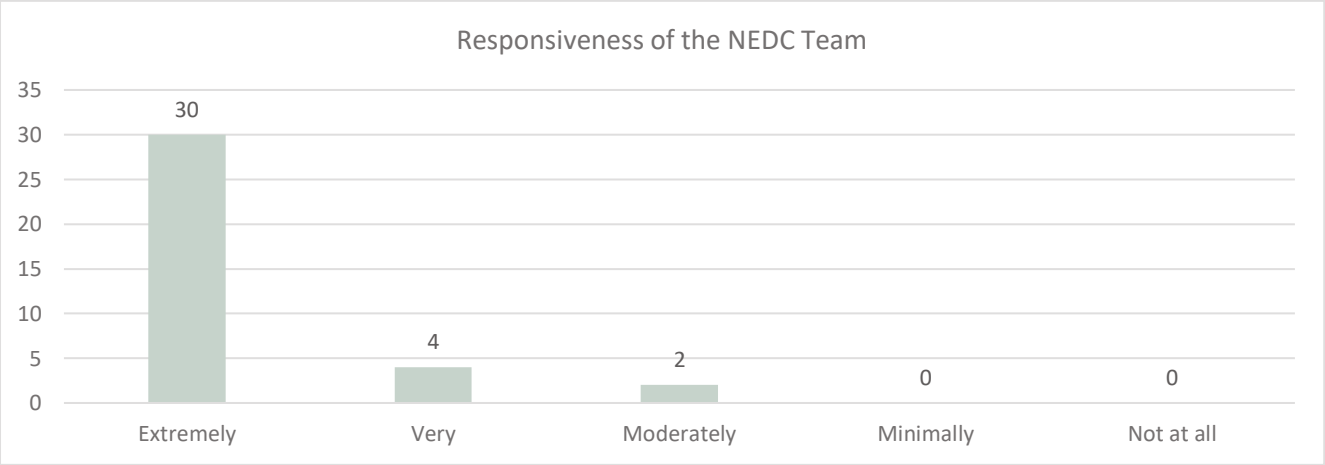


Figure 29. Provider rating of Responsiveness of the NEDC Team as part of the PD Packages (*n*=41).

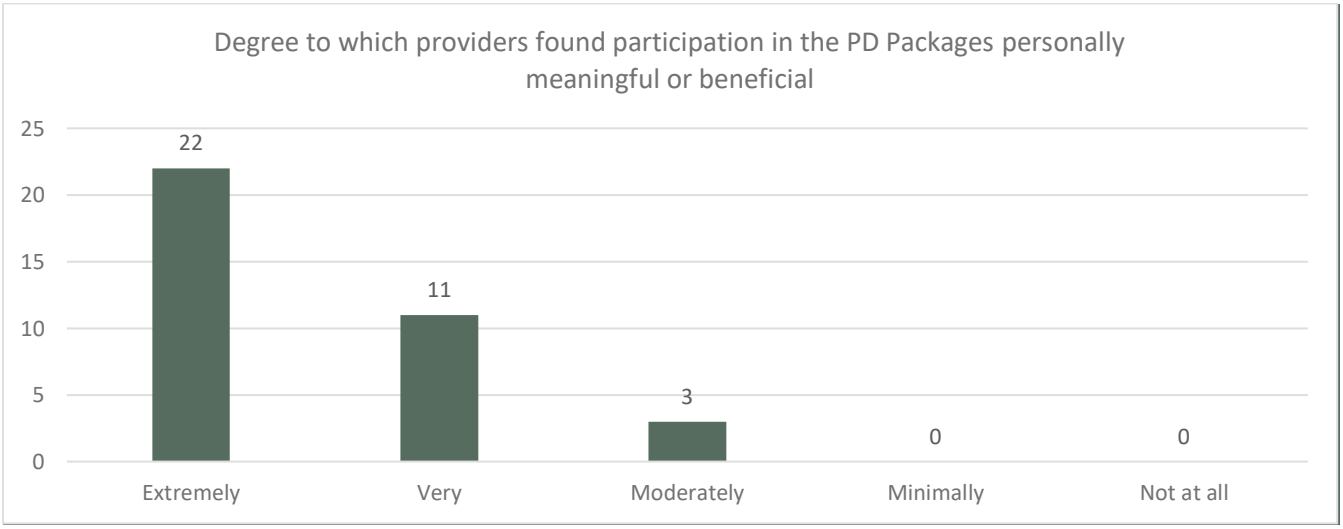


Figure 30. Degree to which providers found participation in the PD Packages personally meaningful or beneficial (*n*=41).

Provider Summary

41 training providers and/or supervisors (56% of the Total 75 providers) completed the Professional Development Packages provider survey following their provision of training and/or supervision under the PD Package program. The evaluation aimed to examine the demographic characteristics of the PD Package providers, as well as glean their observations of the strengths, challenges and needs of clinicians undertaking a package.

Demographic characteristics of the PD Package providers.

Providers were selected based on their demonstrated experience in providing eating disorders supervision and training. The sample included representation from providers across states, territories, and jurisdictions, and across general and eating disorder specific private, public, and not-for profit services.

Demographic data suggests that it would be of benefit to seek to attract trainers and supervisors from more diverse backgrounds to support the development of a skilled and diverse eating disorders workforce.

Identified challenges and needs of clinicians undertaking a package.

Providers identified a number of gaps in clinician skill or knowledge that existed at the beginning of supervision/training, including attitudes that may interfere with engagement, misinformation about eating disorders, and core skill and knowledge specific to working safely and effectively with people experiencing eating disorders.

Providers identified that clinicians need skill consolidation opportunities such as access to ongoing, affordable supervision, opportunities to provide treatment, supportive work environments and developing key knowledge and skills in empathy and boundaries, referring to higher levels of care and working within a multi-disciplinary care team.

The outcomes from this evaluation provide preliminary information about PD Package supervision and training providers and their perspectives on clinician needs that can be used to inform future workforce research and workforce development initiatives.