

21<sup>st</sup> December, 2011

The Hon Mark Butler MP  
Minister for Mental Health and Ageing  
PO Box 2038  
Port Adelaide SA 5015

Dear Minister Butler

**Community Affairs Reference Committee  
Senate Inquiry into Funding and Administration of Mental Health Services**

We refer to our meeting of 31<sup>st</sup> October at your parliamentary office when we discussed the changes to the Better Access model which came into effect in November. The change of greatest concern to us in relation to the impact on those suffering with an eating disorder is the reduction in the number of sessions available from 18 pa (12 pa plus an additional 6 subject to conditions) to a maximum of 10 sessions pa (6 pa plus 4 for exception circumstances).

Subsequent to that meeting the Report of the Senate Community Affairs Reference Committee on the Inquiry into Commonwealth Funding and Administration of Mental Health Services was released and we have had the opportunity to review its findings.

Adopting the recommendations of the Chair, we urge the following:

- That the rationalisation of the number of rebatable allied health sessions under Better Access be delayed until it can be demonstrated that other programs (such as ATAPS) are adequately equipped to provide services to people ***with an eating disorder***
- That the Government consider putting in place an interim program through the MBS that would allow access to ***ten*** additional sessions under Better Access for consumers who meet tightened criteria based on the severity of their condition – ***those with an eating disorder; our estimated cost of this recommendation is less than \$10M pa***
- That the Government revise its scheduling for the 2011-12 Federal Budget changes to ensure continuity of care ***for people with an eating disorder.***

We enclose for your reference our rationale for supporting these recommendations, together with the submissions and information provided to the Senate Inquiry as the basis for Butterfly's oral representations.

We urge your consideration of these recommendations and would be pleased to meet with you and your department to discuss them further.

Yours sincerely

Christine Morgan  
CEO

Chris Thornton  
Past President, ANZAED

### **Eating Disorders**

Although we appreciate your understanding of Eating Disorders, to summarise:

- Eating disorders are serious and severe mental illnesses that result in physical, psychological and social impairment
- They include Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder and atypical presentations of each (Eating Disorders Not Otherwise Specified – EDNOS)
- Although peaking predominantly in adolescence, there is an increasing incidence of illness in younger and older age ranges (hospitalisation is occurring as young as 8 years old)
- Eating disorders afflict both females and males, with an increasing incidence in males
- They have the highest lifetime mortality rate of any psychiatric illness – mortality rates are 12 times higher for women suffering from an eating disorder than for unaffected women
- Suicide rates for those with an eating disorder are significantly higher than for the general population – 32 times higher for Anorexia Nervosa and 18-20 times higher for Bulimia Nervosa

### **Treatment for Eating Disorders**

Unfortunately, long term sufferers of eating disorders, particularly Anorexia Nervosa, often have poor treatment outcomes with less than 50% of those with Anorexia Nervosa recovering within 5 years of treatment. However, positive results are emerging with early intervention and treatment for young children. The Maudsley Family Based Therapy (MFBT) is showing improved recovery rates of 70% after 12 months and 90% are 5 years for children. Another effective treatment for Bulimia Nervosa (as well as adults with Anorexia Nervosa) is Cognitive Behavioural Therapy appropriately adapted for eating disorders.

Both Maudsley FBT and CBT-e are modularised and based on 20 sessions with an appropriate therapist, most commonly a psychologist.

### **Better Access Changes**

A person with an eating disorder suffers significant psychological distress. In making the changes to Better Access the rationale was that for such a cohort of consumers it may be more appropriate to either provide them with increased specialist services provided by psychiatrists, and / or to facilitate entry into the Access to Allied Psychological Services Program (ATAPS).

Additional access to psychiatrists will not be an answer for those with an eating disorder – the evidence based forms of treatment that have been made available to them under Better Access are not treatments that are traditionally delivered by psychiatrists. In addition, there is a very limited number of psychiatrists treating patients with eating disorders and this workforce limitation needs to be urgently addressed as it is showing no signs of improving.

The ATAPS services are designed to provide short term services to people with mental health disorders through fundholding arrangements delivered through Divisions of General Practice or Medicare Locals. Based on enquiries we have made with the eating disorders sector across Australia, we are not aware of any appropriate services currently being provided through ATAPS. Due to the capped funding arrangements the specialised services required for this illness are either not 'affordable' or are not available in the local area.

The Better Access initiative provides for recovery of a co-payment to a therapist – generally in the range of \$50-\$100 per session. In the usual course, co-payment recovery is not provided under ATAPS. This is a serious impediment for services for eating disorder patients. Eating disorder patients are highly complex and long term. The degree of specialisation needed for treating eating disorders requires additional ongoing training. Our sounding of the sector has indicated that if there is no capacity to recover a co-payment, therapists will not be able to afford to provide their services when taking into account the higher cost base of such training.

***Based on our enquiries, under current ATAPS arrangements there are no appropriate services available for patients with eating disorders, and there is no indication that this situation will change in the short to medium term (if at all).***

### **Findings and Recommendations of the Inquiry**

#### **(a) The Chair (pp.79-82)**

The Chair of the Committee made the following comments that are relevant to the issues for those suffering from eating disorders:

- A recognition that eating disorders are severe conditions and that the 18 sessions of Better Access have allowed for clinicians to provide a recognised treatment for such consumers, albeit this was not the intention of Better Access
- At this point there is no alternative to Better Access for such consumers and the situation will become worse for them once the changes to Better Access are implemented
- The changes to Better Access will “exacerbate existing service gaps for people with severe and persistent mental illness”
- The Committee was not provided with any evidence that the needs of these consumers will be met by ATAPS and, in fact, given that ATAPS is not designed to meet the needs of someone with severe mental illness it is not the appropriate program for sufferers of eating disorders
- This will result in an immediate loss of care
- “Until the Government provides an alternative, effective means to address the needs of people with a severe mental illness, it cannot justify excluding these people from accessing services under Better Access”

The Chair’s recommendations include (pp80-82):

- That the rationalisation of the number of rebatable allied health sessions under Better Access be delayed until it can be demonstrated that other programs (such as ATAPS) are adequately equipped to provide services to people with a severe or persistent mental illness
- That the Government consider putting in place an interim program through the MBS that would allow access to six additional sessions under Better Access for consumers who meet tightened criteria based on the severity of their condition
- That the Government revise its scheduling for the 2011-12 Federal Budget changes to ensure continuity of care.

**(b) Minority Report – Australian Labour Party**

The Labour Senators on the Committee, in their minority report, acknowledge that people must receive the most appropriate care for their needs. However, their suggestion that consumers who are currently receiving 18 sessions under Better Access be referred to Medicare subsidised consultant psychiatrists for up to 50 sessions per year is not an adequate solution for those suffering from eating disorders. As noted above, the two evidence based programs that are being used for such consumers under Better Access are not provided, in the normal course, by psychiatrists but rather by psychologists and/or family therapists. In addition, there are exceptionally few psychiatrists in Australia with a specialisation in eating disorders.

**(c) Dissenting Report by Coalition Senators**

The dissenting report by Coalition Senators also acknowledges that the changes to the Better Access program do not involve a full – or adequate – assessment of the impact on consumers (p.98).

They acknowledge that there is a difference of opinion on whether the needs of those with severe mental illness are best served by ATAPS or Better Access and agree with the Chair’s view that the rationalisation of the Better Access program will exacerbate existing service gaps for this group of consumers in the immediate term, and that ATAPS will not meet those needs in the short term.

As it has evolved, Better Access is being used for those with severe mental illnesses (accessing the 18 sessions) and “until the Government provides an alternative, effective means to address the needs of people with severe mental illness, it cannot justify excluding these people from accessing services under Better Access” (p101). In addition, they note that the capped nature of ATAPS funding results in patchy and often inadequate services, dependent upon the way the program is implemented and managed by the GP Division.

In their view there was serious doubt that ATAPS would be able to meet the needs of those who have been accessing Better Access and remains “concerned as to what happens to those consumers who require an extended level of care that will in future not be provided through the Better Access program” (p105).

**Possible Solution**

In the absence of appropriate specific data on the number of patients with eating disorders receiving treatment under Better Access (we understand this information is not available), we have made enquiries directly to the sector.

We know that the number of psychologists and therapists treating patients with eating disorders is limited. The membership of ANZAED is approximately 200 and this includes most clinicians in the sector, including psychiatrists, psychologists, therapists, social workers, dietitians and medical practitioners.

Our ‘working assumption’ is that there are 100 psychologists and therapists delivering the Maudsley Family Based Therapy and / or Cognitive Behavioural Treatment for eating disorders and that each therapist or psychologist has 30 patients.

Such treatment is being provided at an average cost of \$180 per session. The amount recovered from Medicare under Better Access is \$120 per session.

On this basis, the cost of providing an additional 10 sessions per client (allowing for payment of a Medicare rebate of \$120 per session) would be:

100 clinicians with 30 patients each @\$1,200	\$3.6M pa
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On the basis that the incidence of eating disorders is increasing and that we expect this trajectory to continue we then revise this estimate upwards to allow for a doubling in number of therapists working in this sector and increase the number of patients to 50 each:

200 clinicians with 40 patients each @\$1,200	\$9.6M pa
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***For less than \$10M pa the current needs of patients with eating disorders can continue to be met.***

### **Urgent Steps**

The needs of people suffering with an eating disorder are urgent and complex. To date, the services available to them have been severely lacking in terms of numbers of services, and accessibility and affordability issues. The Better Access arrangements, prior to the recent changes, provided a modicum of improvement. Although not designed for this purpose, it assisted in meeting the need.