



Submission to the Senate Community Affairs Committee regarding the Inquiry into Commonwealth Funding and Administration of Mental Health Services 2011.

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Topic: Consequences of the 2011-12 Federal Budget changes to Better Access to Mental Health Program and its impact on the Treatment of those suffering from Eating Disorders.

### **About The Australia and New Zealand Academy for Eating Disorders (ANZAED)**

The Australia and New Zealand Academy for Eating Disorders (ANZAED) is the peak body representing and supporting the activities of clinicians, academics and other professionals working in the field of eating disorders and related issues.

ANZAED is a multidisciplinary organisation with membership including Clinical Psychologists, Psychologists, Psychiatrists, General Practitioners, Paediatricians, Social Workers, Occupational Therapists, Dietitians, and Nurses. ANZAED currently represents around 200 members. Membership is drawn from both the public and private sector.

ANZAED is a key member on the Steering Committee of the National Eating Disorders Collaboration.

### **Eating Disorders and Mental Illness**

It is the position of ANZAED that Eating Disorders are serious mental illnesses. Eating Disorders warrant the same level and breadth of health care coverage as other conditions currently categorized in this way (e.g.: schizophrenia, bipolar disorder, depression, obsessive-compulsive disorder). Eating disorders have significant heritability; are influenced by alterations of brain function; significantly impair cognitive function, judgment, and emotional stability; and restrict the life activities of persons afflicted with these illnesses.<sup>1</sup> Accordingly, the denial or restriction of access to the treatment that is necessary to avert the serious health consequences and risk

of death is untenable. It is the contention of ANZAED that the current proposed changes to the Better Access to Mental Health Scheme (BAMHS) has an unintended, but unacceptable, consequence of reducing access to appropriate and timely treatment services. It is likely that this will result in increased suffering to those affected by eating disorders and deterioration in outcome for patients.

The term “Eating Disorders” (ED) in this submission refers to a collection of psychiatric disorders that involve serious disturbances in eating, and which also manifest with serious medical complications. They include Anorexia Nervosa, Bulimia Nervosa, and Eating Disorder Not Otherwise Specified (EDNOS), as outlined in the Diagnostic and Statistical Manual of Mental Disorders IV<sup>2</sup>. The category of EDNOS includes a range of disorders that resemble Bulimia Nervosa and Anorexia Nervosa, and binge eating disorder, and are associated with similar levels of disability as the other eating disorders. All types of eating disorders involve serious disturbances in thinking, behaviour, physical functioning, and social role functioning.

## **Prevalence of Eating Disorders**

Eating Disorders are not rare illnesses. Eating disorders and disordered eating affect a significant and serious percentage of individuals in the Australian community<sup>3</sup>. Epidemiological data suggest that approximately 15% of Australian women develop a clinically significant eating disorder within their lifetime<sup>4</sup>.

Anorexia Nervosa is the third most common chronic illness affecting adolescent women<sup>5</sup>.

There has been a two-fold increase in eating disorder behaviours in the past decade. Data from 2005 provide staggeringly high prevalence. Among youth between ages 15 and 24 years, 29.3% are binge eaters, 13.6% are purging and 20% are on strict diets or fasting<sup>6,7</sup>. The increase of obesity has been recognised as a serious public health problem with an increased prevalence between 1995-2005 of 5% to 7%. The increase in eating disorder behaviours far surpasses this over the same time period. This upward trend is apparent for both males and females, and cuts across age groups from youth through to older adult<sup>8</sup>. Disordered eating is the most common pathway into eating disorders.

Eating disorders often go undetected and untreated for long periods, and may be misdiagnosed<sup>9,10,11</sup>.

## **Mortality and Eating Disorders**

Anorexia Nervosa has the highest mortality rate of ANY psychiatric illness, with 20% of patients dying from the illness after a prolonged history. Up to 10% of patients with Anorexia Nervosa will die as a direct result of their disorder<sup>5, 12, 35</sup>. The weighted mortality rate (i.e. deaths per 1000 person years) is 5.1 for Anorexia Nervosa, 1.7 for Bulimia Nervosa and 3.3 for EDNOS<sup>13</sup>. This means, for example, that those with a diagnosis of Anorexia Nervosa have a death rate five times higher than the general population matched for age.

The Standardised Mortality Ratio (the ratio of observed to expected deaths) in Anorexia Nervosa has been shown to be as high as 12.8<sup>14</sup>. Studies in other psychiatric disorders have found SMR of around 2.5 in schizophrenia, 2.1 in bipolar disorder and 1.6 in major depression<sup>13</sup>. There is a clear pattern of SMR across ages at presentation for treatment for Anorexia Nervosa. There is an SMR of approximately 3 in children; 10 for adolescents aged 15 - 19 years and close to 18 in those 20 -29 years and approximately 6 in those who present for treatment age 30 and older<sup>13</sup>. This SMR data highlights the importance of access to early outpatient interventions as a measure to prevent death as an outcome in Anorexia Nervosa.

## **Death from Suicide**

Tragically, one in five deaths from Anorexia Nervosa is due to suicide. Death from suicide is 32 times higher than expected in the general population (for comparison, patients diagnosed with major depression are 20 times more likely to die from suicide)<sup>5</sup>.

## **Burden of Eating Disorders**

Eating disorders carry significant economic and social burden. Bulimia Nervosa and Anorexia Nervosa are the 8<sup>th</sup> and 10<sup>th</sup> leading causes, respectively, of burden of disease and injury in females aged 15 to 24 in Australia, as

measured by disability-adjusted life years<sup>7</sup>. Eating disorders are the 12<sup>th</sup> leading cause of hospitalisation costs due to mental health within Australia<sup>15</sup>. The annual health care expenditure on eating disorders for year 1993/1994 was reported to be \$A 22 million dollars.<sup>15</sup>

The Eating Disorders are often chronic and debilitating illnesses. On average, patients with Anorexia Nervosa have a similar level of disability to those suffering from Schizophrenia and Borderline Personality Disorder. In a systematic review of the literature eating disorders are shown to have one of the highest impacts on health related quality of life of all psychiatric disorders<sup>7</sup>. Individuals with eating disorders, if not treated effectively, present with major psychosocial disability. For example, one study indicated that 9 to 14-years after treatment; 20% - 25% of patients were unable to support themselves independently<sup>16</sup>. Similarly, a second study found a 25% rate of severe disability, indicating that even mild, early onset cases of Anorexia Nervosa can develop into persons with chronic disability if adequate treatment is not received as an adolescent.<sup>17</sup>

## **Access to Outpatient Treatment.**

International best practice guidelines suggest that most people with eating disorders can be managed on an outpatient basis. Outpatient treatment is to be preferred to inpatient treatment wherever possible. However, access to treatment for eating disorders is already alarmingly low, with only 22% of sufferers receiving specialist treatment for their eating disorder.<sup>18</sup>

It is of further concern that changes made to the BAMHS were based on data that did not specifically investigate the diagnosis of eating disorder. Correspondence with Professor Pirkis of the School of Population Health at the University of Melbourne has indicated that it is impossible to identify the utilisation patterns of patients with a diagnosis of eating disorder as they were relegated to “other” category. ANZAED is concerned that a decision affecting patients with eating disorders has been based on patients with a diagnosis of depression and anxiety.

ANZAED is concerned that if access to appropriate outpatient treatment is decreased as a result of changes to the BAMHS, hospital admissions to the public sector will increase. Given the already inadequate resource provision for public inpatient treatment of eating disorders this is of serious concern. If the changes to BAMHS proceed, the government will be required to significantly increase resources to this sector. This will present a significant *increase* in costs to the Government. The cost in dollar terms of treatment of an episode of Anorexia Nervosa comes second only to the cost of cardiac artery bypass surgery in the private hospital sector.<sup>19</sup> This is due to the complex psychiatric and physical comorbidity, the protracted length of treatment, and the requirement of specialist care. The Department of Mental Health in South Carolina estimates that cost of inpatient treatment of an eating disorder in the US ranges from \$US500 per day to \$US2,000 per day. Australian data indicates that spending on both private and public inpatient services for eating disorders was significantly greater than the annual cost of outpatient care and specialist community mental health services for eating disorders in Australia.<sup>15</sup> As changes to BAMHS are likely to increase the number of admissions to public inpatient units, ANZAED would highlight that this change is likely to be significantly cost *ineffective*.

Treatment for Anorexia Nervosa is more likely to be successful if the illness is recognised early, before weight loss becomes too severe and protracted<sup>20</sup>. Illness duration has been shown to be an important predictor of outcome with patients who have had Anorexia Nervosa for over a 3 year period being overrepresented in patients who do not have a good outcome<sup>21</sup> With a decrease in access to appropriate outpatient treatment within the private sector, ANZAED is concerned that this will translate into increased waiting lists for public outpatient treatment. Longer times without adequate treatment will result in a greater length of illness duration and poorer treatment outcomes for patients when they eventually receive treatment.

It is predicted by ANZAED that the changes to the BAMHS will delay the treatment of patients which may deleteriously effect the treatment of eating disorders, particularly Anorexia Nervosa.

## **The Outpatient Treatment of Children and Adolescents with Anorexia Nervosa.**

The existing BAMHS allows up to 18 funded treatments with allied mental health professionals per annum. It is widely accepted within the eating disorders treatment sector that the minimum number of sessions recommended for sufferers of eating disorders is a minimum 20 sessions in a 6-12 month period. This recommendation is based both on clinical experience and the existing scientific literature. Decreasing access to

outpatient treatment by reducing BAMHS funding to 10 sessions is woefully inadequate for the effective treatment of patients with eating disorders.

The treatment of choice for adolescents with Anorexia Nervosa is Maudsley Family Based Therapy (MFBT). This is a manualised outpatient therapy that is described as taking **20 - 24 sessions** over a 12 month period. The outcome data for this therapy is strong with around 70-80% of patients undertaking MFBT achieving a good recovery after 12 months and up to a 90% recovery rate at 5 years<sup>22</sup>. This compares favourably with the natural history of Anorexia Nervosa which shows a recovery rate of less than 50% at 5 years<sup>35</sup>. This therapy is most effective for patients who have a short duration of illness.<sup>21,22</sup>

Data from The Children's Hospital at Westmead in NSW indicate that treatment using, on average, 30 sessions of MBFT was effective in improving outcome from Anorexia Nervosa, including halving rates of readmission to their inpatient unit.<sup>23,24</sup>

The changes to funding proposed would reduce access to this treatment by reducing funded treatment from the current 18 sessions to 10 sessions when offered within the private sector. This is effectively less than half to one-third of an effective 'dose' of treatment. By decreasing access to private treatment options within the sector patients will be moved to public sector services. This serves to increase the resources needed to be provided by the public sector and thus an increased cost to government. It is recognised in the eating disorders sector that there is a need for both public and private services to be available for patients with eating disorders. Private services are typically more able to rapidly respond to patients with eating disorders, and will often have significantly shorter waiting lists for access to services. The need to have patients on a waiting list potentially increases the chronicity of illness prior to access to treatment. Of concern in the case of children and adolescents with Anorexia Nervosa is that they often present to hospital in a highly medically compromised state and there are potentially disastrous consequences to this delay<sup>25</sup>.

## The Outpatient Treatment of Bulimia Nervosa

Cognitive-behaviour therapy (CBT) is a time limited manual-based therapy that addresses abnormal cognitions (beliefs) and behaviours that are thought to promote and maintain the eating disorders<sup>26,27</sup>. The length of treatment recommended by the treatment outcome literature is 18 - 20 sessions.

The NICE<sup>28</sup> guidelines state "Cognitive behaviour therapy for Bulimia Nervosa (CBT-BN), a specifically adapted form of CBT, should be offered to adults with Bulimia Nervosa. The course of treatment should be for 16 to 20 sessions over 4 to 5 months" (p4). This recommendation received an 'A' rating for the quality of the evidence to support this statement which is the highest grade of recommendation.

Therefore, best practice treatment for Bulimia Nervosa is the provision of a minimum of **16 – 20 sessions** of Cognitive Behavioural Therapy on an outpatient basis.

## The Outpatient Treatment of Adult Anorexia Nervosa

There have been a number of studies relating to the outpatient treatment of Anorexia Nervosa<sup>29</sup>. A recent Cochrane review indicated that, at present, no specific treatment could be recommended over any other. The review indicates that a reasonable **minimum** treatment period for patients with Anorexia Nervosa is 20 sessions. Of the studies included in this review, the number of sessions provided ranged from **20 – 50 sessions**.

Data from studies using CBT-E (Cognitive Behavioural Therapy – Enhanced) completed after the Cochrane review indicate that for patients with a restricting disorder, but whose BMI is greater than 17.5, between 20 – 25 sessions were required for around 66% of patients who completed treatment to have a 'good outcome.'<sup>30,31</sup>

For patients who begin treatment with a BMI below 17.5 (i.e.: make formal diagnosis for Anorexia Nervosa), an Australian study indicates that 69% of patients had a good outcome following between 40-50 sessions of CBT-E.<sup>31</sup> Similarly, the developers of CBT-E for Anorexia have reported that 50% of patients who received 40 sessions of CBT-E with an original BMI below 17.5 had a good outcome.<sup>32</sup>

Studies that have investigated rates of relapse following hospitalisation for Anorexia Nervosa may also be helpful in determining an adequate treatment dose for adult patients with Anorexia Nervosa. Two studies that have investigated this have indicated that rates of relapse were reduced following a further 50 sessions of outpatient CBT for Anorexia Nervosa after discharge from hospital.<sup>33,34</sup>

The above review of the treatment literature indicates that even the current level of funding under BAMHS (18 sessions under special circumstances) is inadequate to provide the 20 - 50 sessions that is warranted for the treatment of eating disorders. Reducing the number of available sessions under BAMHS to 10 is unwarranted based on outcome data for patients with eating disorders, is likely to be cost ineffective for the Government and has the potential unintended consequences of increasing to the chronicity of illness and adversely impacting on clinical outcomes. These consequences, although unintended, are unacceptable.

### **The Need for a Highly and Specifically Trained Workforce in the Treatment of Eating Disorders.**

One suggestion that has been made is that funding may be made available under the ATAPS system. ANZAED would like to highlight that that system will adversely affect the treatment of patients with eating disorders. ANZAED believes that there is a need to develop a highly skilled and specifically trained workforce to provide adequate treatment for those suffering from eating disorders. As currently articulated, ATAPS allows the treatment provider a rebate of \$110 and prohibits a copayment. Using the profession of Clinical Psychology by way of example, the recommended fee for service is \$212 per session.

This change affects those ANZAED members providing treatment to patients in the private sector by failing to adequately remunerate them for treating patients with eating disorders. ANZAED believes that many of these practitioners will withdraw from the sector. This was reflected in a number of comments made by ANZAED members treating patients within the private sector.

“I fear that that would make it even more difficult for patients to find specialist clinicians trained in the provision of ED treatment - already a difficult task, given the difficulty of the population. At a professional level, I fear this would discourage training psychologists to pursue work in the field of ED's and greatly deplete the field”.

“After more than 9 years of training, it would also be an undervaluation of specialist services provided. If this model was adopted, I would HAVE to keep the number of ED patients in my practice to a minimum”

“I cannot sustain my business with ATAPS rates. Running a private practice of our size costs money, and the ATAPS rate is nowhere near enough to keep it viable”.

“Our specialist private practice in Sydney employs a number of highly trained clinical psychologists who specialise in a very difficult area of treatment. We would not be able to see people under ATAPS. If ATAPS was the primary method to get people with an eating disorder seen, highly trained and experienced psychologists would not be able to see them. This means that less experienced and less trained psychologists would see these people, and poor results are inevitable”.

Similar concerns were reflected by members working in the public sector:

“It would increase waiting list times at our service as patients would not be being seen for long by private practitioners”

“Very few of the families that I see could cope with that extra cost and all our patients would then be referred back to CAMHS”

ANZAED is concerned that changing the source of funding from BAMHS to ATAPS will lead to a deficit of highly and specifically trained practitioners in the private sector and again lead to increased demand on the public sector; as well as resulting in private outpatient treatment being delivered by more junior practitioners who are willing to accept the ATAPS rebate. It is of concern to ANZAED that both these options will result in decreased outcomes for patients suffering eating disorders.

## Summary:

ANZAED has significant concerns regarding the unintended consequences of the proposed changes to the BAMHS in the 2011-2012 Federal Budget on patients with Eating Disorders.

- ANZAED believes there is a need for both vibrant public and private treatment options in the eating disorders sector.
- The scientific literature indicates that, on average, the minimum number of sessions required to provide adequate treatment for a patient with an eating disorder is 20 sessions. In cases of patients with Anorexia Nervosa, this is more likely to be around 50 sessions.
- ANZAED is concerned that the proposed changes will deleteriously affect access to treatment within the private sector. This will increase pressure on public sector resources which are already inadequately resourced. It is likely that waiting list time will increase as will the need for expensive inpatient admissions.
- Delays in access to treatment will result in poorer treatment outcomes for patients with eating disorders.
- A highly trained and specifically trained workforce is required for the effective treatment of the eating disorders. ANZAED is concerned that the proposed changes in funding models will result in a decrease in access to a highly trained and specifically trained workforce within the private sector.

## Recommendations:

- ANZAED recommends to the Senate Community Affairs Committee that, at a minimum, the current BAMHS funding is retained for patients with a diagnosis of eating disorder.
- ANZAED also recommends that there are grounds for considering patients with eating disorders as requiring a special item number to access an adequate number of treatment sessions annually within the private sector.
- ANZAED suggests that an extension to Medicare Item 319 may be helpful. This item number allows for a Medicare benefit for a 45 minute consultation with a Psychiatrist for patients suffering from a small number of serious mental health issues including Anorexia Nervosa and Bulimia Nervosa. At present, this item number is available only to psychiatrists. ANZAED would recommend that access to this item number be extended to those professions who are already eligible for a Medicare provider number under the existing BAMHS arrangement. It is insufficient for this item number to be retained only for psychiatrists as it is imperative that the current multidisciplinary workforce in the private sector be maintained.

The Australia and New Zealand Academy for Eating Disorders would be pleased to talk to these recommendations in person at the Senate Community Affairs Committee sittings.

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