EVALUATION OF THE EATING DISORDERS MEDICARE BENEFIT SCHEDULE ITEMS 2024

FINAL REPORT

Prepared For :

The Australian Government Department of Health and Aged Care

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Acknowledgement of Country

In the spirit of reconciliation, we acknowledge the Traditional Custodians of country throughout Australia and their connections to land, sea, and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

Contents

Abbreviations and Glossary

Abbreviation	Meaning
AN	anorexia nervosa
ANZAED	Australia & New Zealand Academy for Eating Disorders
ARFID	avoidant/restrictive food intake disorder
BED	binge eating disorder
BN	bulimia nervosa
Department	Australian Government Department of Health and Aged Care
ED Working Group	Eating Disorders Working Group; the working group of the Medicare review taskforce assigned to consider inclusion of eating disorder specific items to Medicare
EDP	Eating Disorders Treatment and Management Plan; the name for the suite of items forming the eating disorders Medicare Benefits Schedule items; referred to as the Eating Disorders Plan throughout this report
ED-TAG	Eating Disorders Technical Advisory Group; advisory group of the Department of Health and Aged Care
GP	general practitioner
IOI	InsideOut Institute
IQR	interquartile range
M	mean; statistical average
MADIP	Multi-Agency Data Integration Project
MBS	Medicare Benefits Schedule
Md	median; statistical average
Medical practitioner	medical doctor; in this report medical practitioners include general practitioners, other medical practitioners, consultant psychiatrists, and consultant paediatricians
NEDC	National Eating Disorders Collaboration
OSFED	other specified feeding or eating disorders
Paediatrician	consultant paediatrician
PBS	pharmaceutical benefits scheme
PHN	Primary Health Networks; independent organisations funded by the Australian Government that support health professionals to improve patient care
the Plan	the Eating Disorders Treatment and Management Plan
Psychiatrist	consultant psychiatrist
SD	standard deviation; statistical measure of spread
SES	socioeconomic status
SSI	single-session intervention
Term	**Definition**
Uptake	total number of persons accessing Eating Disorders MBS items
Utilisation	total number of Eating Disorders MBS items accessed

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We also acknowledge the national, state and territory peak bodies and not-for-profit organisations who kindly helped to raise awareness of the evaluation and shared the opportunity to contribute to the findings.

It is acknowledged that there is no single set of terminology that suits all experiences and people. No exclusion or harm of people is intended by the terms used in this report. The report endeavours to use inclusive language. In parts of the report, language will be taken directly from the Eating Disorders Medicare Benefits Schedule (MBS) items. This language does not reflect the preferences of the evaluation team and it is recognised that it may not be appropriately inclusive.

The focus of this evaluation report is on experiences of treatment for eating disorders. As such, reference to people with lived experience of a current or past eating disorder in this report is most commonly regarding those who have had or are currently having treatment under the Eating Disorders MBS items, unless otherwise specified.

Datasets Contributed

- Person-Level Integrated Data Asset (PLIDA; formerly known as the Multi-Agency Data Integration Project [MADIP])
- Medicare Benefits Schedule – Eating disorders and mental health items (MBS)
- *Growing up in Australia*: The Longitudinal Study of Australian Children (LSAC)
- National Study of Mental Health and Wellbeing, 2020 – 2022
- EveryBODY

Reference to sex and gender in the report

These existing datasets have collected information on a person's sex and/or gender that may be different from the new data collected during this evaluation. Therefore, there will be inconsistencies through the report. For example, some data has female/male categories only, while other data includes requested free text responses. The full continuum of gender as identified by respondents is reflected where possible.

Conflict of Interest Declaration

Name	Position/Organisation	Declared conflict of interest
Dr Siân McLean	Academic/ Department of Psychology, Counselling, and Therapy, La Trobe University	Past President, ANZAED; chair, Credentialing Governing Council, ANZAED; member, Australian Eating Disorders Research and Translation Centre Governing Council; member, NEDC National Strategy Implementation Network; member, Butterfly Body Image and Social Media Working Group; member, Working Group Victorian Residential Eating Disorder Treatment Centre (Alfred Health); member, AEDRTC National Network Advisory Committee.
Prof Matthew Fuller-Tyszkiewicz	Professor/ Associate Dean (Research and Impact), Faculty of Health, Deakin University	None to declare
Prof Peter Butterworth	Professor, School of Psychology, Deakin University	None to declare
Prof Phillipa Hay	Chair of Mental Health Translational Health Research Institute, School of Medicine Western Sydney University; and	Phillipa Hay receives/has received sessional fees and lecture fees from the Australian Medical Council, Therapeutic Guidelines publication, and HETI (New South Wales and the former NSW Institute of Psychiatry) and

Name	Position/Organisation	Declared conflict of interest
	Director of Mental Health Research, South Western Sydney Local Health District, NSW.	royalties/honoraria from Hogrefe and Huber, McGraw Hill Education, and Blackwell Scientific Publications, Biomed Central and PlosMedicine. She has received research grants from Rotary Health, the National Health and Medical Research Council and Australian Research Council. She is chair of the National Eating Disorders Collaboration Steering Committee in Australia (2019-); past member of the ICD-11 Working Group for Eating Disorders; chair Clinical Practice Guidelines Project Working Group (eating disorders) of RANZCP (2012–2015). She is currently an Editor-in-Chief of the Journal of Eating Disorders. She has prepared a report under contract for Takeda (formerly Shire Pharmaceuticals) about binge eating disorder (July 2017) and has been a consultant to Takeda Pharmaceuticals.
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Name	Position/Organisation	Declared conflict of interest
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Prof Tracey Wade	Professor of Psychology, Flinders University; Director Flinders University Institute for Mental Health and Wellbeing, Flinders University Services for Eating Disorders, Blackbird Initiative; Credentialed Eating Disorder Clinician	None to declare
A/Prof Susan Hart	Eating Disorder Coordinator, St Vincent's Health Network; and ENRG (Eating disorders and Nutrition Research Group) Western Sydney University	None to declare
A/Prof Jaclyn Broadbent	Pro-Vice Chancellor Sessional Academic Experience and Deputy Head of School Psychology	None to declare
Dr Hannah Jarman	Research Fellow, Deakin University	None to declare
Mx Jeanette Chan	Lived Experience Consultant, La Trobe University	Member, Butterfly Collective (Butterfly Foundation)

Confidentiality

This evaluation presents findings that are informed by multiples sources. Of the studies, 7 involve new participant data. Studies 1 – 3 have used existing de-identified data. Studies 4 – 7 collected new data through surveys and interviews with stakeholder groups, including people with an eating disorder or who have had an eating disorder, people with a lived experience of caring for someone with an eating disorder or who have had an eating disorder, and health professionals. Any potentially identifying information has been removed prior to analysis, and care has been taken in presenting the research findings in a way that maintains the confidentiality of every person involved or represented.

Executive Summary

Evaluation of the Eating Disorders
Medicare Benefits Schedule Items 2024

Executive Summary

La Trobe and Deakin Universities, with partners from Flinders University, Monash University, and Western Sydney University, were commissioned by the Australian Government Department of Health and Aged Care to conduct an independent evaluation of the Eating Disorders Medicare Benefits Schedule (MBS) items.

This suite of items (known to service users as the *Eating Disorder Plan*) was introduced in 2019 (with subsequent changes due to COVID-19) in response to recommendations from the Eating Disorders Working Group of the Medicare Review Taskforce. The objective of the items is to provide specific support through Medicare subsidised services for people with anorexia nervosa and for people with bulimia nervosa, binge eating disorder, or other specified feeding or eating disorders who also have complex needs.

Subsidised services are intended to support a person-centred, stepped care approach to eating disorder treatment. Services encompass initial assessment of eligibility, treatment plan preparation, and referral for treatment by a medical practitioner; provision of up to 40 psychological treatment services by a mental health professional and provision of up to 20 dietetic health services by a dietitian within a 12-month period; and review of treatment progress by a general (or other medical) practitioner (at or before the 10th, 20th, and 30th psychological sessions) and by a specialist (psychiatrist or paediatrician; at or before the 20th psychological session).

The purpose of this evaluation is to assess if the Eating Disorders MBS items are meeting the needs of people experiencing an eating disorder, people caring for someone with an eating disorder, health professionals providing eating disorder services under the items, and the Australian Government. In line with the original intent of the initiative and broader principles for public funding of health services, the evaluation considers if the items i) deliver affordable and equitable access to best-practice eating disorder services, ii) are delivered by a skilled health workforce with the requisite knowledge and experience to identify, assess, and contribute to the treatment of eating disorders, and iii) provide value for individuals (e.g., delivery of services that are appropriate to the needs of the person with an eating disorder) and for the Australian Government (e.g., achieving improved value for the overall health system).

The evaluation seeks to meet the following five objectives outlined by the Australian Government Department of Health and Aged Care:

1. Examine the ***utilisation*** of the Eating Disorders MBS items
2. Examine the ***relationship*** between the Eating Disorders MBS items and other related MBS items
3. Consider whether the Eating Disorders MBS items have improved access to treatment services
4. Determine if the Eating Disorders MBS items improve patient outcomes
5. Develop recommendations to inform the ongoing success of the Eating Disorders MBS items

Key Findings

This evaluation found unequivocal support among people with lived experience of an eating disorder, people caring for someone with an eating disorder, and health professionals that the Eating Disorders MBS items are a substantial improvement on previously available Medicare services for eating disorder treatment. Key findings that informed this support were:

Symptom improvement and attribution of improvement to Eating Disorder Plan services

Clinical case review data showed improvements in eating disorder symptoms and psychological distress, and increased attainment of goals over the course of treatment. People who had received treatment supported by an Eating Disorder Plan reported significantly lower levels of eating disorder symptoms after treatment compared with prior to treatment and most indicated that the services they received were wholly or partly responsible for the improvement.

Therapeutic benefit attributed to number of treatment services offered under an Eating Disorder Plan

The average number of (psychological) services used under the Eating Disorders MBS items (13-14 services) was higher than the maximum number previously available through MBS under the Better Access Mental Health Treatment Plan initiative. Having a higher number of treatment sessions was associated with significantly greater eating disorder symptom improvement, satisfaction with treatment, and perceived helpfulness of treatment for recovery. An Eating Disorder Plan was viewed as allowing increased frequency of services which facilitated individually-paced, personalised, and comprehensive treatment. These elements were thought to result in more positive outcomes. Additionally, 93% of people who had received treatment for an eating disorder perceived the Eating Disorder Plan to be superior to a Mental Health Treatment Plan for providing sufficient sessions to work through concerns.

Access to knowledgeable providers within a multidisciplinary team provided by the Eating Disorders MBS items

Consistent with the aims of the Eating Disorders MBS initiative, views of people with lived experience of an eating disorder and people with lived experience of caring for someone with an eating disorder were that an Eating Disorder Plan was superior to a Mental Health Treatment Plan for providing access to 1) knowledgeable providers and 2) multidisciplinary care with medical, psychological, and dietetic providers. More people received both psychological treatment and dietetic health services than only psychological or only dietetic services, the latter not previously available for treatment of an eating disorder under a Mental Health Treatment Plan. This pattern of use suggests that the Eating Disorders MBS initiative fulfilled its goal of enhancing potential for receipt of coordinated care.

Health professionals endorsed as Credentialed Eating Disorder Clinicians had significantly higher eating disorder confidence, knowledge, and skill in providing eating disorder treatment than non-credentialed health professionals. In light of the importance to people with lived experience of an eating disorder and people with lived experience of caring for someone with an eating disorder that health professionals delivering services via the Eating Disorder Plan have sufficient eating disorder knowledge, skill, and experience, Credentialing offers an important avenue to expand the capacity of the workforce.

Appropriate inclusion of people with lived experience of caring for someone with an eating disorder

People with lived experience of caring for someone with an eating disorder valued involvement in the treatment process. This was seen as important to increase their understanding and competency to provide treatment support. Eating Disorder Plans were perceived to be significantly more helpful than treatment through other means for people caring for someone receiving eating disorder treatment for enhancing their understanding and competence in providing this care.

Decreases in use of other services, suggesting the Eating Disorder Plan better met needs than other initiatives

Following introduction of the Eating Disorders MBS items, more people transitioned from other pre-existing services (such as a Mental Health Treatment Plan or Chronic Disease Management Plan) into an Eating Disorder Plan than transitioned from an Eating Disorder Plan back to these other, pre-existing MBS services. This suggests that the Eating Disorder Plan is better suited to addressing the complex needs of people with a lived experience of an eating disorder than services that existed prior to the availability of the Eating Disorders MBS items.

Despite the observed benefits of the Eating Disorders MBS items initiative, several evaluation findings suggest that refinement is needed to maximise its potential. Identified problems were:

Low help-seeking and inequities of access that persist despite increased use of the Eating Disorders MBS items over time

Uptake of the Eating Disorders MBS items corresponds to approximately 1 in 5 people with an eating disorder; this possibly reflects an underrepresentation of people with bulimia nervosa, binge eating disorder, and atypical anorexia nervosa (within the diagnostic category of OSFED) who meet the high-risk criteria. Access to treatment and number of treatment sessions received was lower among people living in regional and remote areas, males, people with lower education and income levels, people who spoke a language other than English, and people of First Nations background.

Lower than expected uptake for some groups may be due to relative difficulty identifying non-underweight eating disorder presentations by GPs and confusion about eligibility criteria, and general lack of awareness of the initiative by health professionals and people experiencing an eating disorder. Broader barriers to access and uptake of treatment include the cost of services and perceptions by people with lived experience of an eating disorder that their problems were not sufficiently serious to require treatment.

Difficulties in coordination of care and treatment progression

The evaluation observed several points along the treatment journey (from plan preparation to receipt of treatment, course of treatment, and receipt of reviews) where people with an Eating Disorder Plan are most likely to disengage from the initiative. Of the 38,130 people for whom an Eating Disorder Plan was prepared from 2019 to end 2022, one third did not receive any treatment services (psychological or dietetic health sessions). While wait times were generally acceptable, for 25% of people with an Eating Disorder Plan, the time between plan preparation and treatment commencement was four weeks or longer. Lack of any availability or immediate availability (wait lists) for psychological treatment and dietetic health services and difficulties reported by GPs in finding appropriate health professionals who were available in a timely manner were commonly noted contributors to this delay.

Findings revealed likely ‘under-dosing’ of treatment where the average number of services received in a 12-month period was around 13-14 psychological services and 8 dietetic services, and that a high proportion of people continued to receive services across two or more years. Early cessation, influenced by the cost of treatment and mismatch with the health professional or their approach (for those who had received fewer than 10 sessions) and reluctance or difficulties in attaining a review (for those who had received 10-20 psychological treatment sessions) may contribute to under-dosing.

Several problems with the 20-session review were identified. These included cost and lack of clarity about the purpose of the review including perceptions that the review is punitive. Frequent difficulties were also reported by health professionals in finding appropriate psychiatrists or paediatricians with the knowledge, skills, and experience in eating disorders to conduct the review, contributing to delays which are disruptive to treatment continuity and progress. Additionally, lack of consistent data to inform the review may interfere with the potential benefits of a review of treatment progress.

Risk to the sustainability of the system – workforce capacity and capability

Despite increased awareness, understanding, and use of the Eating Disorders MBS items among health professionals since their introduction, the initiative’s sustainability remains at risk due to ongoing workforce capacity and capability issues. The evaluation found an uneven distribution of treatment service provision across providers. More than a quarter of all treatment services were delivered by around 5% of providers and around half of all services were delivered by inexperienced providers who each delivered fewer than 20 sessions in total.

Among those surveyed, less than a quarter of psychological treatment providers and about half of dietetic health service providers had immediate availability to take on new referrals. This may, in part, be driven by frustrations about the Eating Disorders MBS items initiative. Health professionals reported some frustration with the time required to provide the required services under the Eating Disorders MBS items and perceived the remuneration for some services, particularly assessment, to be inadequate. Low willingness to take on new clients may also stem from health professionals’ concerns about their suitability to deliver these services, with a significant minority of providers rating themselves low on knowledge, confidence, and skill in providing safe and effective eating disorder care.

Given these frustrations and uneven provision of services, there is a risk of experienced providers being unable to meet the service demands within the initiative. While increased provision of service by providers with less experience may ultimately enhance capability in the long-term, there are shorter-term risks to quality of care and risk of drop-out from treatment due to dissatisfaction with services. These risks are addressable yet need urgent attention to prevent negative impacts on the sustainability of quality care.

Recommendations in Brief

Based on the many benefits of the Eating Disorders MBS items initiative identified in this evaluation, we recommend retention of the maximum of 40 psychological treatment and 20 dietetic health sessions available within a 12-month period through this initiative. Additional recommendations are provided to ensure the ongoing success of the Eating Disorders MBS initiative. In particular, we identified a range of complementary strategies implementable over short- and longer-term to i) reduce cost-related barriers to equity of access, ii) extend workforce capacity and capability to meet expanding demand, and iii) enhance awareness and coordination of care available through this initiative. A full detailing of recommendations is provided in Chapter 7 and recommendations are also listed in full in Appendix 12; here, we summarise salient recommendations.

Reduce cost-related barriers to equity of access

We recommend increased access to bulk billing, particularly among geographic areas of greater socioeconomic disadvantage. Reductions in wait times both for service initiation and continued use, as well as promotion of weekly session delivery, are essential for facilitating timely symptom improvement, which in turn is likely to reduce the overall number of sessions required and overall out-of-pocket costs. Efficiency gains from more timely treatment would also enhance overall service availability.

Telehealth-based treatment delivery has emerged as an important and well-received component of the Eating Disorders MBS items initiative. We recommend promotion of telehealth as a viable option for treatment. Uptake of telehealth delivered services is also likely to provide indirect cost savings to people experiencing an eating disorder by reducing travel costs, need for childcare, and lost income costs. Time-zone differences could extend hours of availability of healthcare professionals via telehealth, offering greater flexibility that may be less disruptive to work and other commitments.

Enhance workforce capacity and capability to meet demands

We recommend offering higher MBS rebates for healthcare professionals who are Credentialed Eating Disorder Clinicians as a means of extending the reach of credentialing and incentivising health professionals to take up training required to meet standards (articulated under the ANZAED Eating Disorder Credential) for eating disorder treatment delivery. Providing incentives for more experienced health professionals to provide clinical supervision to recent graduates and health care providers inexperienced in eating disorder care is also recommended. This incentivised supervision is important for supporting workforce development and capability which, in turn, would facilitate distributing provision of treatment under the Eating Disorder Plan more evenly among health professionals.

Introduction and prioritisation of single session interventions delivered by mental health professionals (involving collaborative and individualised assessment and psychoeducation delivered with a hope-inducing stance) is recommended, especially where wait times exceeding four weeks are expected. Availability of these therapeutic sessions is important to help reduce the risk of symptom exacerbation and risk of drop-out. Importantly, provision of hope for change through single session intervention enhances motivation to change and commitment to treatment.

Enhance processes for care provision

We recommend amending the current eligibility criteria by removing the clinically underweight criterion, to reduce confusion among healthcare professionals in determining eligibility for the Eating Disorder Plan. This criterion is not required to be assessed for people with a diagnosis of anorexia nervosa and is not applicable for people with eating disorders other than anorexia nervosa. We also recommend streamlining the process by which eligibility decisions are made for people with bulimia nervosa, binge eating disorder, and other specified feeding or eating disorders (including atypical anorexia nervosa). These simplifications should improve the efficiency and accuracy of eligibility decisions and help to rectify relative under-representation of individuals with bulimia nervosa, binge eating disorder, and atypical anorexia nervosa in utilisation of Eating Disorders MBS items. These proposed supports for decision-making among healthcare professionals should also enhance the experience of those seeking help, by reducing the risk of treatment delays and disruptions due to being referred to inappropriately matched treatment services.

Provision of care coordinators is recommended to help individuals experiencing an eating disorder find suitable health professionals, book session appointments, and coordinate care across a multidisciplinary team of healthcare providers. This will help to alleviate difficulties with initiation and persistence with recommended treatment plans that were observed in the evaluation. People with lived experience of caring for someone with an eating disorder have an important – and under-utilised – role to play in facilitating care receipt, and we recommend strategies to support their routine inclusion across the treatment journey including in Eating Disorder Plan preparation sessions with GPs and treatment sessions. People with lived experience of caring for someone with an eating disorder also provide support to maintain motivation for treatment seeking and may thus limit early cessation of care.

We recommend the provision of tools and resources to support health professionals in assessing eligibility for the Eating Disorder Plan, identifying suitable health professionals for referral, and for coordinating review sessions to evaluate progress against treatment goals. A range of existing online resources and training opportunities developed by eating disorder organisations should be utilised for this purpose, with required modifications outlined in Chapter 7 to ensure maximum benefit from their application within the Eating Disorders MBS items initiative. Additionally, leveraging the important role of PHNs in making health professionals aware of relevant resources will enhance their uptake and utility.

Conclusion

This evaluation has ascertained the vital position of the Eating Disorders MBS items initiative in supporting access to eating disorder treatment. Usage has steadily increased over time and the availability of the initiative is strongly endorsed by people with lived experience of an eating disorder, by people caring for someone with an eating disorder, and by health professionals. Barriers along the user journey that obstruct the potential benefits of the Eating Disorders MBS items were identified, and recommendations were developed to address these barriers. It is envisioned that these recommendations will provide improved experience at pivotal stages of connection with the Eating Disorders MBS items initiative, enhancing access, uptake, treatment continuity, and clinical outcomes through the provision of a coordinated system of care that delivers value for money for all stakeholders.

1

Background

1 Background

1.1 About Eating Disorders

Eating disorders are complex and serious mental health illnesses that involve difficulties with behaviours, thoughts, and attitudes related to food, eating, and body weight or shape. Depending on symptomatology, eating disorders are classified into different types, including anorexia nervosa, bulimia nervosa, binge eating disorder, other specified feeding or eating disorders (which includes atypical anorexia nervosa), avoidant/restrictive food intake disorder, pica, rumination disorder, and unspecified feeding or eating disorder. Eating disorders are prevalent, costly, and under-treated.

A recent global burden of disease study estimated 55.5 million people worldwide currently experience an eating disorder, which incur a large disease burden in terms of years of healthy life lost (6.6 million disability adjusted life years) [1]. Recent reviews report that eating disorder incidence appears to be increasing and the age at which eating disorders first develop is becoming younger [2,3].

In Australia, it is estimated that up to 1 in 5 (22.2%) Australian adolescents currently experience an eating disorder. Of those, 6.2% have a full threshold diagnosis (i.e., anorexia nervosa, bulimia nervosa, or binge eating disorder) and 15% have other- or unspecified feeding or eating disorders [4]. Research conducted in South Australia estimates the 3-month prevalence of eating disorders in adults to be 16.3%. Of those, 6.7% have a full threshold diagnosis and 9.6% have other or unspecified feeding and eating disorders [5]. Of note, in these Australian estimates, anorexia nervosa was one of the least common eating disorders with prevalence rates of 0.7% and 0.5% among adolescents and adults, respectively.

People with eating disorders experience significant consequences to their physical and psychological health and functioning [2]. And eating disorders – particularly anorexia nervosa – are associated with the highest rates of psychiatric mortality [6]. These factors contribute to markedly higher healthcare costs for eating disorders (e.g., outpatient therapy, hospital stays, etc.) than other mental health illnesses [7,8]. Eating disorders have an annual Australian socioeconomic cost of up to $84 billion [9,10].

There are numerous personal and health system-related barriers to treatment that people with eating disorders face. Stigma and shame, denial of and inability to perceive symptom severity, and inaccessibility of healthcare are important factors that lead to difficulties seeking help [11]. As a result, the number of people accessing eating disorder-specific treatment is very low. For example, only 10 – 27% of adolescents with anorexia nervosa or bulimia nervosa have accessed eating disorder-specific care in Australia [12] and the United States [13]. People with eating disorders also face substantial delays in accessing appropriate treatment; the average length of delay between onset of symptoms and treatment seeking is estimated to be more than five years [14].

This average length of delay is especially concerning as remission is less likely the longer the time lapse between eating disorder symptom onset and treatment [15]. Early access to interventions is especially important for improving outcomes for people experiencing an eating disorder.

1.2 Scope of Evaluation

La Trobe and Deakin universities, with partners from Flinders University, Monash University, and Western Sydney University, were commissioned by the Australian Government Department of Health and Aged Care to conduct an independent evaluation of the support provided to people with eating disorders through Medicare subsidised services.

This report evaluates the 64 eating disorder-focused Medicare items that were introduced into the Medicare Benefits Schedule (MBS) in November 2019, collectively referred to as the Eating Disorders MBS items. The report also includes evaluation of subsequent additions made to the suite of items, termed the Eating Disorders Treatment and Management Plan (and hereafter referred to as the Eating Disorder Plan [EDP]). Appendix 1 contains the complete list of items, and Appendix 2 lists changes made to the items since November 2019. The intention behind implementing the items was to increase service provision. Accordingly, rebates were provided for a maximum of 40 psychological and 20 dietetic services within a 12-month period under the MBS for people with anorexia nervosa and for people with other eating disorders with complex needs.

1.3 Structure of this Report

This main report is structured with separate chapters to discuss evidence relevant for each of the first four objectives of the evaluation and concludes with a recommendations chapter (Objective 5). Recommendations are derived from several sources. These include key insights from data informing our response to objectives 1 – 4 outlined in chapters 3 - 6, emerging evidence in the research literature, plus additional work reviewing relevant reports that informed the implementation of the Eating Disorders MBS items. Key issues in delivering eating disorder treatment as well as best practice guidelines for treating eating disorders were also considered in forming recommendations.

Chapter 2 provides an overview of the methodology for the studies in this evaluation. Raw data, summary data, or related interview transcripts will be available via the Open Science Framework repository for studies generating new data. Access to raw data for studies based on pre-existing data (including from Service Australia) is not possible due to limitations on confidentiality. However, these data may be accessed through a formal request to Services Australia (as per studies 1 and 2) or data custodians (as per study 3).

Accompanying this main report is a Technical Report with detailed methods and analytic approaches for each of the empirical studies in this evaluation. Full findings of analyses for each of the studies are provided in the Technical Report. The Technical Report also has a separate Appendix document with relevant study documents.

1.4 History of the Eating Disorders MBS Items

1.4.1 Taskforce Review and Recommendations

In late 2017, as part of the MBS Review Taskforce program of work, the Federal Minister for Health requested the formation of an Eating Disorders Working Group. The purpose of the working group was to examine Medicare funding for the treatment needs of Australians with eating disorders and to develop recommendations to help MBS deliver affordable and universal access to best practice health services. The goal being delivery of value for people and the healthcare system.

The working group stated several principles to guide public funding allocation, including that:

- public funds should be used to support evidence-informed services that are accessible when and where they are needed
- services should be delivered by practitioners skilled in treating eating disorders
- the services should address prevention, identification, timely intervention, and treatment
- treatment should be multidisciplinary with integration between providers and involve and support people with a lived experience of caring for someone with an eating disorder in the treatment process.

The working group consisted of 14 members comprising an MBS Review Taskforce member (as chair of the working group) plus additional members with expertise in eating disorders who included: three psychiatrists, two psychologists, two general practitioners, one mental health nurse, one counsellor, one dietitian, two consumer representatives, and one occupational therapist.

Recommendations from the Eating Disorders Working Group

The Eating Disorders Working Group presented a series of recommendations based on: i) evidence from relevant literature and clinical guidelines; ii) consensus expert opinion; iii) the experience of the Working Group; and iv) submissions from stakeholder groups, including the Australian College of Mental Health Nurses, Australian Psychological Society, the Butterfly Foundation, and the Psychotherapy and Counselling Federation of Australia.

Noting the severity, complexity, and severe consequences of eating disorders, the working group formulated 11 key recommendations for improving the delivery of eating disorder treatment in Australia. Seven of these recommendations related specifically to the MBS, while the remainder focused on improving awareness of available services (recommendations 3.1, 3.4) and workforce capability and upskilling (recommendations 3.2, 3.3). Of specific relevance to this evaluation, Recommendation 1.2 proposed introducing new MBS items dedicated to providing treatment for eating disorders. This included supporting up to 40 psychological sessions and 20 dietetic sessions, with items also supporting assessment and referral by a medical practitioner, and review of progress by a medical practitioner and where required by a psychiatrist or paediatrician. Further details on the working group report and recommendations can be accessed here.

Stepped care model

Key to the recommendation for a new suite of Eating Disorders MBS items was the proposal for a patient-centric, stepped care approach to treatment where:

(i) treatment plans were to be formulated for the person, rather than based on generic formulations according to diagnosis
(ii) progress with treatment plans to be regularly reviewed
(iii) treatment plans to be extended and/or modified based on responsiveness to initial treatment plan and continued patient need.

Staged introduction and proposed evaluation

The Eating Disorders Working Group acknowledged that introducing a complete suite of MBS-supported services for all people with an eating disorder would be a large and complex undertaking. As such, it proposed the incremental introduction of the stepped care model. Initially this model would be made available to people with eating disorders for whom treatments supported by MBS items available at the time were at greatest need for increased support. These were people who were 'high risk' (see definition below). Once the viability and feasibility of this initial approach was demonstrated, it would be expanded to include all people with eating disorders.

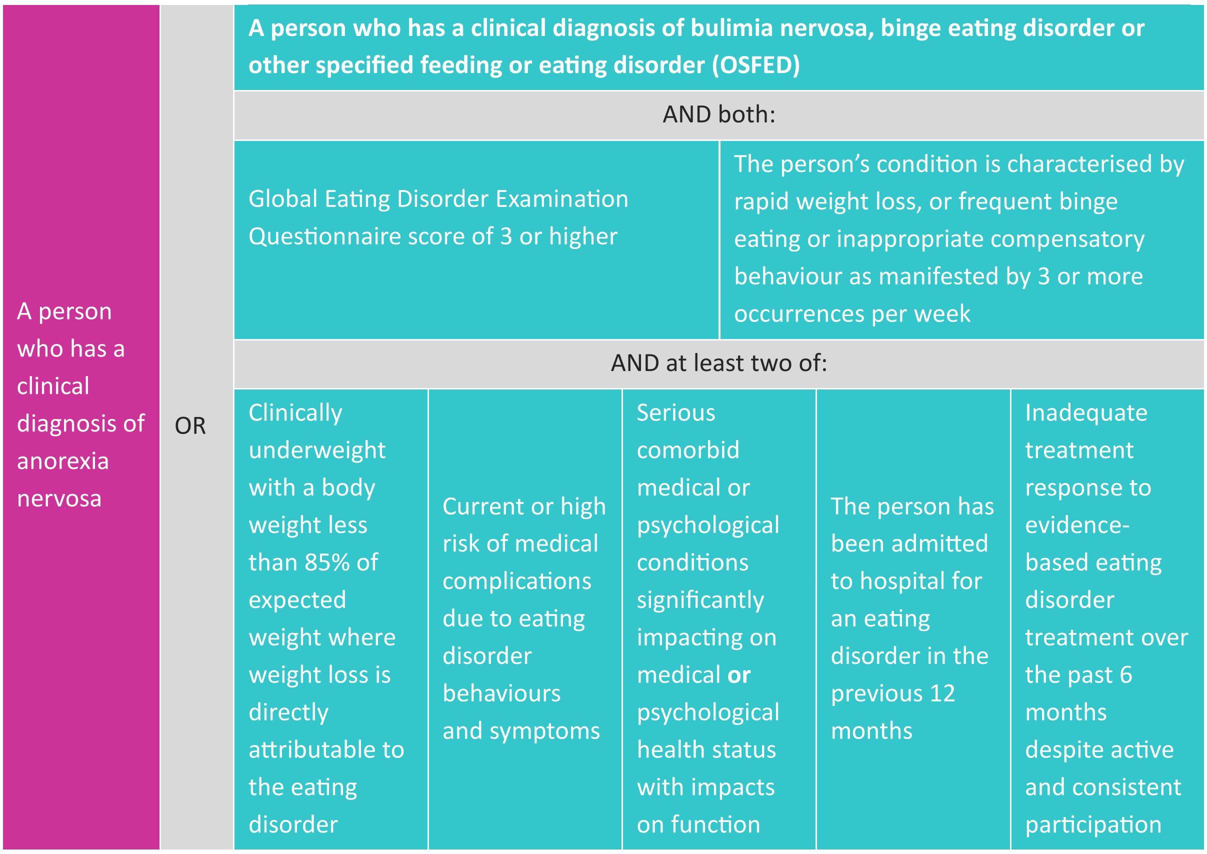
'High risk' status was determined to be the likelihood of a person to require repeat hospitalisation, taking into consideration the duration and severity of disease, and mortality risk. This definition, coupled with deficits in MBS service provision, led to the working group recommending the first phase of the new Eating Disorders MBS items be made available for: i) people with anorexia nervosa, and ii) people with bulimia nervosa, binge eating disorder and/or other specified feeding or eating disorders (OSFED) who were also at high need for increased services due to having complex needs, having not responded to lower intensity treatment, and being at high risk of serious medical and psychological complications.

The working group also recommended evaluating Eating Disorders MBS items within three years of initial implementation to i) determine whether the items enhanced treatment access and outcomes, and in turn ii) make the case for expanding Eating Disorders MBS item availability towards a complete stepped care model for all people with an eating disorder. This would mean delivery of future treatment support would align with evidence for appropriate treatment duration and dose (number of sessions).

1.5 Introduction of the Eating Disorders Medicare Benefits Schedule Items

The Australian Government introduced 64 MBS items focused on eating disorders in November 2019, following recommendations from the Eating Disorders Working Group that an Eating Disorder Plan was required and should encompass:

(i) initial assessment for eating disorder diagnosis, with treatment plan formulation and referral for eligible people (see Figure 1.1) provided by a medical practitioner
(ii) treatment services from specified health professionals (see Figure 1.2) to administer evidence-informed treatments (see Box 1.1)
(iii) case reviews conducted by a medical practitioner, to monitor progress and approve additional treatment services based on needs (as per a stepped care approach).



A person who has a clinical diagnosis of anorexia nervosa

OR

A person who has a clinical diagnosis of bulimia nervosa, binge eating disorder or other specified feeding or eating disorder (OSFED)

AND both:

Global Eating Disorder Examination Questionnaire score of 3 or higher

The person's condition is characterised by rapid weight loss, or frequent binge eating or inappropriate compensatory behaviour as manifested by 3 or more occurrences per week

AND at least two of:

Clinically underweight with a body weight less than 85% of expected weight where weight loss is directly attributable to the eating disorder

Current or high risk of medical complications due to eating disorder behaviours and symptoms

Serious comorbid medical or psychological conditions significantly impacting on medical **or** psychological health status with impacts on function

The person has been admitted to hospital for an eating disorder in the previous 12 months

Inadequate treatment response to evidence-based eating disorder treatment over the past 6 months despite active and consistent participation

Figure 1.1. *Summary of eligibility criteria for patients*

Health professionals eligible to provide services under the Eating Disorders MBS items (as shown in Figure 1.2) are expected to have the appropriate training, knowledge and skills, and experience in providing eating disorder care. This is to ensure competence in safely and effectively identifying, and responding to, eating disorders.

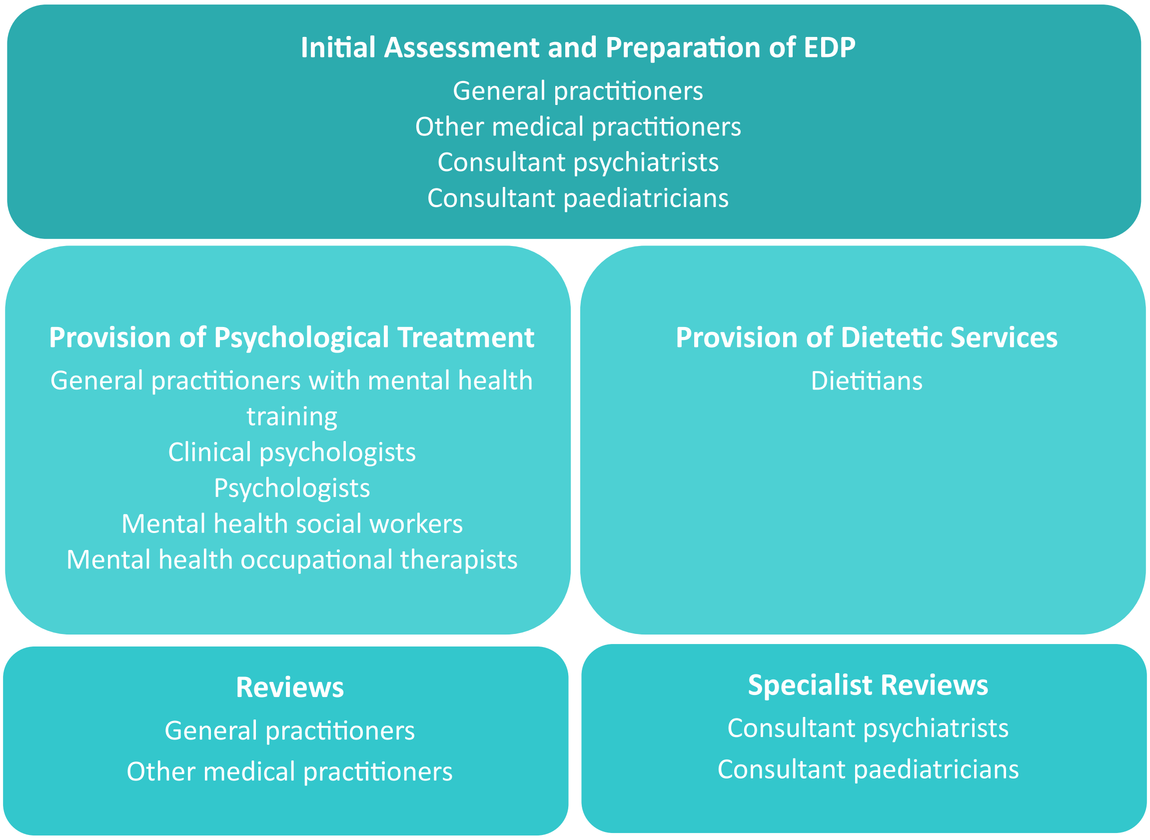


Figure 1.2. *Summary of eligible providers*

Several evidence-informed treatment models have been approved for providing eating disorder treatment within the MBS items. These are presented in Box 1.1.

Box 1.1. Summary of approved treatments

*Family-based treatment for eating disorders (including whole family, parent-based therapy, parent only or separated therapy)

*Adolescent-focused therapy for eating disorders

*Cognitive behavioural therapy for eating disorders

*Cognitive behavioural therapy – anorexia nervosa

*Cognitive behavioural therapy for bulimia nervosa and binge eating disorder

*Specialist supportive clinical management for eating disorders

*Maudsley Model of Anorexia Treatment in Adults

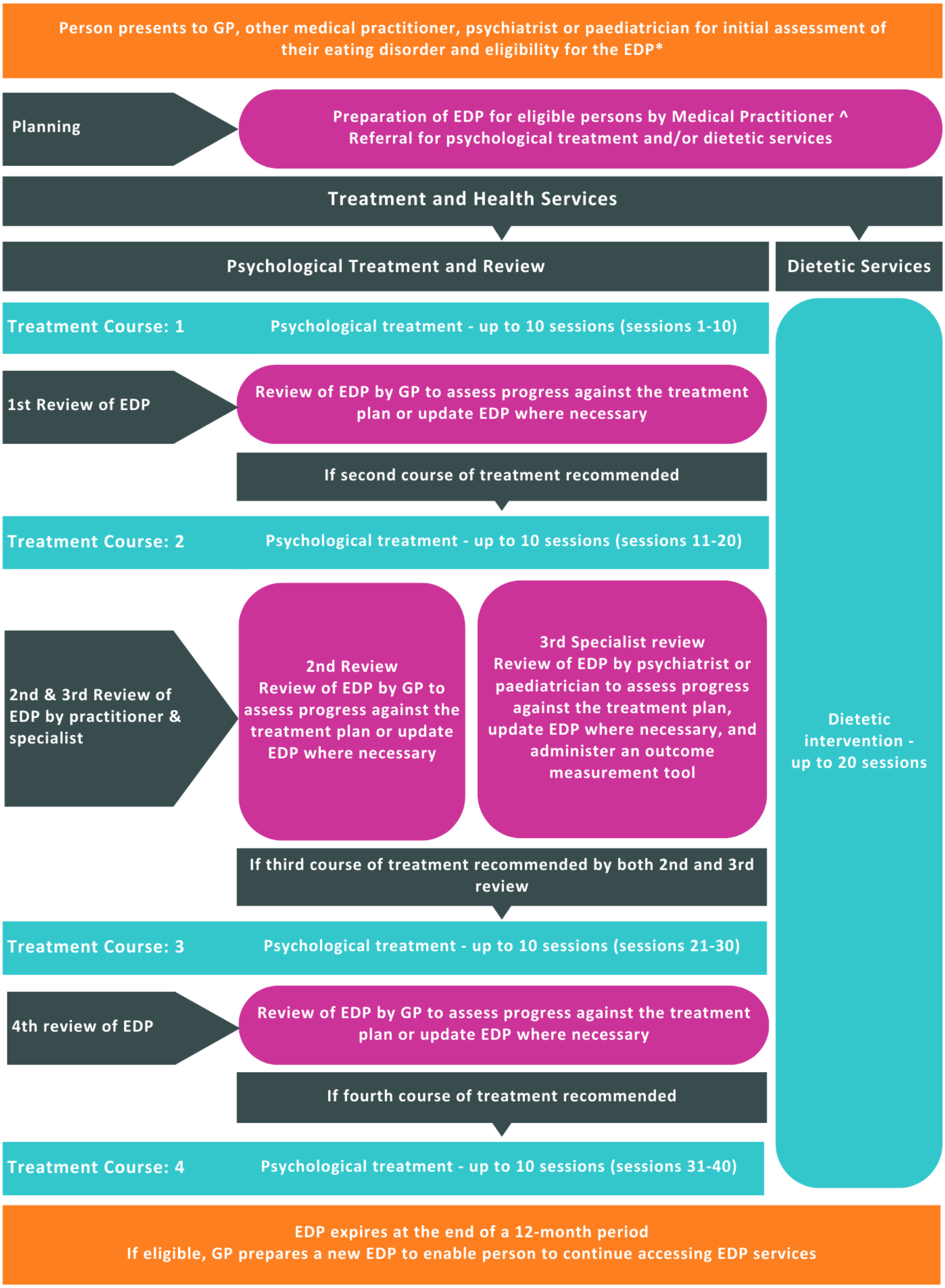
*Interpersonal therapy for bulimia nervosa, binge eating disorder

*Dialectical behavioural therapy for bulimia nervosa, binge eating disorder

*Focal psychodynamic therapy for eating disorders

People experiencing an eating disorder who meet the eligibility criteria are initially provided with an Eating Disorder Plan, which includes an opinion on diagnosis, treatment options, and recommendations and referral for treatment for the following 12 months. The initial referral for psychological treatment (if made) is for a maximum of 10 psychological treatment services (separate treatment sessions of 30-60 minutes duration), defined as a course of treatment, and 20 dietetic services (separate sessions of at least 20 minutes duration). At, or prior to, completion of the 10 psychological treatment services, the person receiving treatment must undergo a review with a medical practitioner, such as a GP, who may then recommend an additional 10 psychological services.

This *treatment* --> *review* --> *treatment* cycle can repeat for up to a maximum of 40 psychological treatment services within a 12-month period (dated from first point of access of treatment services rather than calendar year). The Eating Disorder Plan treatment cycle is presented in Figure 1.3.



* EDP = Eating Disorder Plan
^ Eligible medical practitioners include GPs, other medical practitioners, psychiatrists, paediatricians
# Reviews preferably conducted by managing practitioner – GP or other medical practitioner

Figure 1.3. *Treatment and review process under the Eating Disorder Plan*

1.5.1 Changes since November 2019 roll-out of Eating Disorders MBS items

The initial 64 Eating Disorders MBS items have been expanded since their first release in 2019. First, in an effort to reduce community transmission of COVID-19, the items were updated from March 13, 2020, to include telehealth (video and telephone) equivalents. An initial end date of September 30, 2020 was proposed, however, this has since been extended indefinitely. Second, several items introduced in the initial rollout and during COVID-19 have since been removed. Changes to these items are outlined in Appendix 2. Third, additional MBS items available for, but not specific to, patients under the Eating Disorder Plan were introduced on July 1, 2023 to facilitate multidisciplinary, collaborative, and coordinated mental healthcare.

The mental health case conferencing items are available for medical practitioners and allied health professionals providing dietetic or psychological treatment services to a person receiving treatment supported by the Eating Disorder Plan. The items are designed to bring together members of a multidisciplinary team to discuss and coordinate a patient's mental healthcare.

Several criteria must be met to claim the related MBS case conferencing items:

(i) a GP, other medical practitioner, psychiatrist, or paediatrician organises and coordinates the case conference
(ii) at least two other members of the multidisciplinary team attend the case conference
(iii) the patient agrees to the case conference taking place and to the participation of all attending health professionals.

The addition of these items came from recommendations from the Australian Government's Better Access Initiative evaluation report, the Productivity Commission Inquiry Report into Mental Health, and the House of Representatives Select Committee Inquiry into Mental Health and Suicide Prevention. Together, these sources identified unrealistic pressures under the current MBS arrangements for GPs to effectively coordinate care review across multidisciplinary teams without adequate compensation.

1.5.2 Relationship to Other Initiatives

The Eating Disorders Working Group identified a range of MBS items that, while not specifically designated for eating disorder treatment, may be accessed by people with an eating disorder. In particular, the Mental Health Treatment Plan (previously known as the Mental Health Care Plan) and the chronic disease management plan. These are other initiatives that people with an eating disorder may access for eating disorder treatment.

Ideally a person with an eating disorder would use a single plan (the Eating Disorder Plan for eligible persons) to support their treatment and not move between plans. However, in cases where sequential use of MBS items from different plans takes place, it is stipulated that the number of psychological treatment sessions received under these other plans would count towards the total number of services permissible in a 12-month period under the Eating Disorder Plan.

1.6 Evaluation Framework

This present evaluation, conducted in 2023-2024 and led by La Trobe and Deakin universities, is framed by the following five objectives set by the Australian Government Department of Health and Aged Care:

1. Examine the ***utilisation*** of the Eating Disorders MBS items
2. Examine the ***relationship*** between the Eating Disorders MBS items and other related MBS items
3. Consider whether the Eating Disorders MBS items have improved access to treatment services
4. Determine if the Eating Disorders MBS items improve patient outcomes
5. Develop recommendations to inform the ongoing success of the Eating Disorders MBS items

Addressing these objectives will provide a comprehensive understanding of the extent to which the Eating Disorders MBS items are operating as intended. That is, whether the items meet the needs of people with lived experience of eating disorders, the people with a lived experience of caring for someone with an eating disorder, health professionals providing eating disorder treatment, and the Australian Government.

1.6.1 Evaluation objectives

Aligned with each of the objectives shown in Figure 1.4, a series of key evaluation questions have been specified by the Department to be addressed in the evaluation (see Appendix 3 for a full list of questions). These questions are mapped below to show their connection to the five evaluation objectives.

Figure 1.4. *Evaluation framework*

Objective 1: Examine utilisation of the Eating Disorders MBS items

Objective 1 focuses on understanding the extent of use of the Eating Disorders MBS items and the ways in which the items are used by people in need of eating disorder treatment and support. To inform this understanding, we examined overall use of the suite of items and of specific items. From this, we determined patterns typical patterns of use and progression through the phases (as per Figure 1.3) of the Eating Disorder Plan (key evaluation questions 1.1, 1.2, and 1.3).

We evaluated the distribution of workload across the various health professions who were eligible to deliver services under the Eating Disorders MBS items. We also evaluated the distribution of services based on geographic location and considered changes to uptake and utilisation once telehealth items were introduced (key evaluation questions 1.5, 1.7, 5.5, 6.2).

Objective 2: Examine the relationship between the Eating Disorders Treatment and Management Plan and other related MBS items

Objective 2 explores the use of the Eating Disorder Plan alongside, before, or after other related Commonwealth-funded initiatives and support services. These other services include the Mental Health Treatment Plan (provided through the Better Access initiative), Chronic Disease Management Plan, the National Mental Health and Suicide Prevention Plan, and the National Disability Insurance Scheme (NDIS).

Although the Eating Disorders MBS items are designed to address eating disorder symptoms, people experiencing an eating disorder may engage with these and/or other healthcare services for managing their symptoms and recovery. Objective 2 seeks to understand common treatment pathways and combinations of service use for people with an eating disorder.

In addressing this objective, we considered several key evaluation questions to determine the proportion of people using the Eating Disorders MBS items who also accessed other healthcare services (key evaluation question 1.4). We also explored whether people with a lived experience of caring for someone with an eating disorder also accessed other services, such as a Mental Health Treatment Plan, while they were supporting a person with an eating disorder (key evaluation question 5.3). Health professional awareness of, and feedback on, the Eating Disorders MBS items were also explored to understand factors associated with various treatment pathways (key evaluation questions 4.3 and 4.4). These considerations informed our understanding of the effectiveness of the Eating Disorders MBS items in meeting the needs of the person with the eating disorder and the needs of people caring for those with eating disorders (key evaluation question 5.1 and 6.1). Finally, in considering the alignment and consistency between the Eating Disorders MBS items and other Commonwealth-funded initiatives, we sought to determine if there are other mechanisms or linkages to existing initiatives that may be developed to complement the Eating Disorders MBS items (key evaluation questions 3.1, 3.2, 3.3).

Objective 3: Consider whether the Eating Disorders MBS items have improved access to treatment services

Objective 3 explores:

(i) patterns of access to the Eating Disorders MBS items
(ii) factors that may influence access
(iii) what stakeholders – people with a lived experience of an eating disorder, people with a lived experience of caring for someone with an eating disorder, and health professionals – think about services supported by the Eating Disorders MBS initiative.

Questions focused on understanding which items are accessed and by whom. This was examined in relation to clinical diagnosis, extent of need, demographic profiles of service users, and involvement of people with a lived experience of caring for someone with an eating disorder (key evaluation questions 1.6, 2.4, 5.2). The roles of health professionals and approaches they take to supporting people accessing treatment were also addressed (key evaluation questions 4.1 and 4.2). In addition, perceptions of barriers and enablers to use from people with an eating disorder, people who care for those with an eating disorder, and health professionals were explored (key evaluation questions 1.7, 4.3, 4.4, 5.1, 5.5, 6.1, 6.2). Direct feedback from these stakeholders was also explored, to see if the availability of the Eating Disorders MBS items has been perceived to improve access to treatment (key evaluation question 2.1).

Objective 4: Determine if the Eating Disorders MBS items improve patient outcomes

Objective 4 focuses on determining if access to and use of the Eating Disorders MBS items improves outcomes for people experiencing an eating disorder. We defined ‘positive patient outcomes’ in terms of: i) improvements in eating disorder-related symptoms and engagement in other areas of life, and ii) reduced need for healthcare services. Our response was guided by questions to assess the effectiveness of the Eating Disorders MBS items in achieving positive treatment outcomes and in meeting the needs of people experiencing an eating disorder and the needs of people who care for those with eating disorders (key evaluation questions 2.2, 4.4, 5.1, and 6.1). We also sought to understand how the approaches of health professionals may have contributed to outcomes, including exploring the value of the specialist review at 20 sessions, the support and management provided by the GP or other medical practitioner, and the therapeutic techniques used in treatment (key evaluation questions 2.3, 4.1, and 4.2). Reasons for stopping an Eating Disorder Plan provided insight into outcomes (key evaluation question 1.5). Finally, we had intended to explore improvement in outcomes from the perspectives of people who cared for people with an eating disorder with different carer relationships (e.g., parent, partner, sibling) to the person with the eating disorder (key evaluation question 5.2). We were unable to address this question as meaningful comparative analyses could not be conducted in studies where low numbers of respondents with different relationships to the person with the eating disorder were available.

Objective 5: Develop recommendations to inform ongoing success of the Eating Disorders MBS items

The suite of Eating Disorders MBS items was introduced with the intention of i) facilitating provision of services aligned with clinical guidelines for best practice care, ii) funding services providing a stepped care approach to eating disorder treatment, and iii) supporting treatment for people with eating disorders with the greatest need. In conducting an appraisal of the extent to which the Eating Disorders MBS items meet these objectives, our evaluation identifies areas for improvement to enhance the likelihood of these MBS items meeting the needs of people experiencing an eating disorder, those who care for someone with an eating disorder, and health professionals. These needs include access to, and positive outcomes from, evidence-informed eating disorder treatment by trained and knowledgeable clinicians operating in multidisciplinary teams.

The identified areas for improvement are presented as a series of proposed recommendations to the Australian Government. Recommendations have been developed in response to empirical findings from Objectives 1 – 4, from existing literature, and from discussions with other key stakeholders.

In addition, we have identified gaps and limitations in the available data relevant to specific evaluation questions. Recommendations have identified changes to the delivery model or functions of the items required to improve outcomes, and suggested policies or programs that could be implemented to better support access to and improve usage and outcomes from engagement with the Eating Disorder Plan (key evaluation questions 7.1, 7.2, and 7.3).

1.6.2 Additional Commonwealth funded eating disorder-related initiatives

In addition to the Eating Disorders MBS items, the Australian Government has funded several complementary initiatives to expand eating disorder treatment capacity and capability. Although not part of this evaluation project, we refer to these projects here because the preliminary findings and ongoing activities from these initiatives have a bearing on our recommendations (Objective 5, Section 1.6.1).

The Australia and New Zealand Academy for Eating Disorders (ANZAED) and the National Eating Disorders Collaboration (NEDC) were commissioned to establish a non-compulsory credentialing system for Australian health professionals providing eating disorder treatment. The ANZAED Eating Disorder Credential is a formal system that recognises clinicians with the qualifications, knowledge, training, and experience to meet the minimum standards for delivery of safe and effective eating disorder treatment. The implementation of the credentialing system provided training and professional development support to clinicians to provide eating disorder treatment. The system also provides a public facing searchable website for people with an eating disorder, people with a lived experience of caring for someone with an eating disorder, and referrers to locate a mental health professional and/or dietitian for treatment provision. The credentialing system opened in late November 2021 for eligible clinicians who provide dietetic or psychological treatment for eating disorders. The ANZAED Eating Disorder Credential will be expanded in 2024 to include GPs for their role in assessing, diagnosing, and referring.

Additionally, the *Improved Access to Free and Quality Eating Disorder Care* initiative provided Commonwealth funding to upskill staff at headspace and Head to Health centres, facilitating the expansion of the eating disorder treatment-trained workforce.

Support for people with a lived experience of caring for someone with an eating disorder has also been provided through funding to Eating Disorders Families Australia’s Strive Carer Support program. This program, run by people with a lived experience of caring for someone with an eating disorder, runs online support groups to educate, encourage, and provide hope.

The NEDC – in partnership with KPMG – was commissioned by the Australian Government Department of Health and Aged Care to evaluate the design and delivery of current eating disorder-related tertiary training for health professional disciplines involved in providing eating disorder treatment. This work identified gaps and opportunities to improve the readiness of graduates so they can effectively engage with people with an eating disorder. This includes initial screening, identifying and assessing symptoms, through to treatment planning, delivery, and review.

Furthermore, several other Commonwealth initiatives contribute to the broader stepped system of care and enhancement of workforce capacity in eating disorder treatment. These include funding of residential eating disorder treatment centres in all Australian states, support for the Butterfly National Helpline, and funding of training for the primary care and public health workforce across Australia.

1.7 Governance Structure

This evaluation project was supported by a governance structure comprising three core elements. The first element was the team members across collaborating institutions (La Trobe, Deakin, Flinders, Monash, and Western Sydney universities) who led the completion of studies for this evaluation. In addition, a lived experience consultant complemented the evaluation team by providing guidance on survey and interview item formulation and contributed to policy recommendations arising from our study findings. Collaborations between members of the evaluation team and contributions to the project were managed by the evaluation project co-leads, Dr Siân McLean and Professor Matthew Fuller-Tyszkiewicz.

The second core element was the Australian Government Department of Health and Aged Care. Fortnightly meetings were held between staff of the Adult Mental Health Services (Eating Disorders) Section and co-leads Dr Siân McLean and Professor Matthew Fuller-Tyszkiewicz to discuss project progress.

The third core element was the Eating Disorder Technical Advisory Group (ED-TAG) that was independently set up by the Department and comprised people with lived experience of an eating disorder, those who care for someone with an eating disorder, researchers, key governmental officials with expertise in mental health research and practice, and health professionals. A total of four meetings were held with this group and provided an opportunity for co-leads Dr Siân McLean and Professor Matthew Fuller-Tyszkiewicz to receive feedback on the submitted project plan (March 2023 meeting), interim report (mid-July 2023), draft version of the final report (mid-October 2023), and interim final report (March 2024) documents.

2

Evaluation Methodology

2 Evaluation Methodology

2.1 Overview

We recognise that evidence quality is critical, and that no one study – or data set – can be relied upon as a single source to deliver the quality of evidence required to respond to the five evaluation objectives. To tackle this issue, we implemented a multi-study approach to leverage and extend existing data sources. We employed:

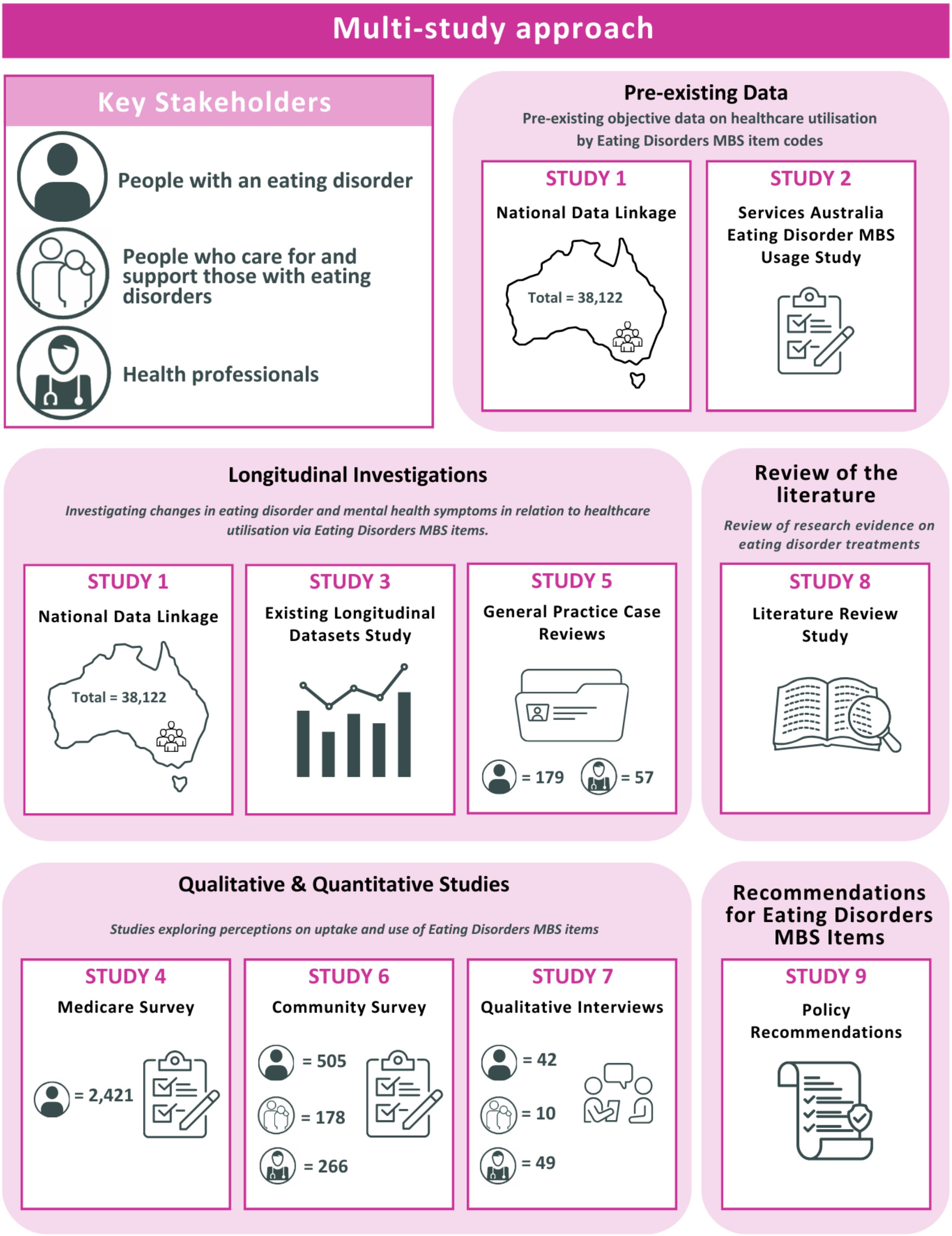
(i) a combination of qualitative interviews and quantitative surveys with key stakeholders, including people with an eating disorder, people who care for and support those with eating disorders, and health professionals, to understand correlates, barriers, and enablers to the Eating Disorders MBS items use (existing longitudinal datasets, Medicare survey, community survey, qualitative interviews)
(ii) use of pre-existing objective data on healthcare utilisation by Eating Disorders MBS item codes (national data Linkage, Services Australia Eating Disorders MBS Items usage [Studies 1 and 2])
(iii) cross-sectional exploration of associations between Eating Disorders MBS items use and mental health/eating disorder symptoms and demographics (Medicare survey)
(iv) longitudinal investigations of changes in eating disorder and mental health symptoms in relation to healthcare utilisation via the Eating Disorders MBS items (national data linkage, existing longitudinal datasets, general practice case reviews [Studies 1, 3, and 5]).

These data are also placed in the context of academic and clinical literature that outlines best practice guideline formulation (Study 8). A summary of the study methods is shown in Figure 1.5.

Our evaluation also covered Eating Disorders MBS item use across the lifespan, recognising that both children, adolescents, and adults use these services. The national data linkage study and Services Australia Eating Disorders MBS Items usage study enabled us to explore Eating Disorders MBS item use by age and geographic location. This meant our insights could also reflect additional factors, such as the relative remoteness of where a person lives. We approached age representation by recruiting for our other qualitative and quantitative studies (Medicare survey, community survey, and qualitative interviews [Studies 4, 6, and 7]) among people with an eating disorder or people who have had an eating disorder, as well as people with a lived experience of caring for someone with an eating disorder, and sampling people aged 16 and above. We recruited people with a lived experience of caring for someone with an eating disorder to report on children younger than 16.

To ensure representativeness of data, recruitment efforts for studies generating new data (Medicare survey, community survey, and qualitative interviews [Studies 4, 6, and 7]) sought to achieve representation across a range of demographic factors for whom subgroups may experience different levels of treatment access. This included considering geographic location (metropolitan vs rural/regional areas), gender, eating disorder diagnostic subtype, and culturally and linguistically diverse backgrounds. We also sought to ensure representation of people who were eligible but did not access the Eating Disorders MBS items to ensure we understood potential barriers to treatment by people who *had* versus *had not* engaged with the Eating Disorders MBS items for eating disorder treatment.

Evaluation Methodology



Multi-study approach

Key Stakeholders

People with an eating disorder

People who care for and support those with eating disorders

Health professionals

Pre-existing Data

Pre-existing objective data on healthcare utilisation by Eating Disorders MBS item codes

STUDY 1
National Data Linkage
Total = 38,122

STUDY 2
Services Australia Eating Disorder MBS Usage Study

Longitudinal Investigations

Investigating changes in eating disorder and mental health symptoms in relation to healthcare utilisation via Eating Disorders MBS items.

STUDY 1
National Data Linkage
Total = 38,122

STUDY 3
Existing Longitudinal Datasets Study

STUDY 5
General Practice Case Reviews
= 179
= 57

Review of the literature

Review of research evidence on eating disorder treatments

STUDY 8
Literature Review Study

Qualitative & Quantitative Studies

Studies exploring perceptions on uptake and use of Eating Disorders MBS items

STUDY 4
Medicare Survey
= 2,421

STUDY 6
Community Survey
= 505
= 178
= 266

STUDY 7
Qualitative Interviews
= 42
= 10
= 49

Recommendations for Eating Disorders MBS Items

STUDY 9
Policy Recommendations

Figure 1.5. *Summary of evaluation methodology for each study*

2.2 Individual Study Method Overview

National Data Linkage

The data of 38,130 people who had accessed any Eating Disorders MBS items from commencement in November 2019 through to December 2022 was available within the MBS dataset for analysis, through linkage to the Person-Level Integrated Data Asset (PLIDA; formerly known as the Multi-Agency Data Integration Project). This report represents some analysis of this dataset ("complete participant dataset") when considering MBS and Pharmaceutical Benefit Scheme (PBS) data only, and also analyses a subset of 35,111 of these respondents ("census-linked dataset") who were able to be linked to other relevant population level administrative datasets, such as the National Death Index and (most importantly) the 2021 Census data. This integrated dataset allowed us to examine the use of eating disorder services and treatments related to individual and family circumstances and sociodemographic factors.

Services Australia Eating Disorders MBS Items Usage Study

Aggregated, de-identified Eating Disorders MBS items data were sourced from Services Australia for the period between 1 November 2019 and 31 July 2023. From this, profiles of use of Eating Disorders MBS items services overall and for key item groups (e.g., eating disorder treatment and management plans, psychological treatment sessions), were developed for all Australian users and according to key consumer characteristics (e.g., age group, sex, and geographic area group). The data were converted to crude rates per 1,000 population and organised into reference periods defined by calendar years. This enabled us to address research questions relating to patterns of use (e.g., the extent to which the Eating Disorders MBS items have been taken up), accessibility (e.g., the extent to which access and patterns of use are impacted by where people live), affordability (e.g., bulk-billing rates and consumer co-payments), and typical trajectories of care under the Eating Disorder Plan (e.g., the proportion of eating disorder treatment and management plans that are followed by treatment services, type of health professionals seen).

Existing Longitudinal Datasets Study

Several existing studies were used to longitudinally assess the relationship between eating disorder symptom severity and help seeking. The Longitudinal Study of Australian Children tracks an initial sample of 1,000 children (5,107 aged 0 – 1 year and 4,983 aged 4 – 5 years at baseline) across 9 waves of data (2004 to present), with a range of self- and parent-report measures on psychological health, demographics, help seeking (formal and informal), and includes links to MBS data [16]. Eating disorder self-report items were introduced in wave 6 and allowed us to inspect how eating disorder symptoms relate to MBS item use over time. Inspection of self-reported help seeking behaviours also enabled evaluation of other, non-MBS based support avenues that people may have sought.

The EveryBODY project longitudinally follows a sample of adolescent boys and girls (baseline n = 5,071; male 49%; female 48%; M age = 14; age range = 11 – 19 years) derived from 13 schools across New South Wales. Many of the adolescents in the sample met (sub)clinical threshold for an eating disorder (22%) [4]. Where LSAC provides a rich evaluation of a nationally representative sample including people with varying levels of eating disorder symptoms, the EveryBODY project enables evaluation of the relationships among psychological health, disordered eating, and help seeking for a sample of individuals with a high prevalence of probable eating disorders.

Medicare Survey Study

An invitation letter to participate in this survey study was sent to 27,658 people who had used a Medicare Benefits Schedule (MBS) item for psychological services or dietetic services since 2019 as identified by Services Australia. A total of 2,421 people consented and completed the full online survey (8.75% response rate). Of this group, 279 were younger than 18 years old. Participants were primarily aged between 21 – 24 years old (18.5%), female-identifying (92.0%), and resided in New South Wales (31.6%) or Victoria (30.2%). Anorexia nervosa was the most common eating disorder diagnosis of participants at the time the Eating Disorder Plan was prepared (29.1%).

General Practice Case Review Study

The summary clinical file data of 189 people with an eating disorder were provided from 62 general practitioners who had initiated an Eating Disorder Plan. Extracted data were used to evaluate whether people who accessed the Eating Disorders MBS items experienced clinical improvement in their eating disorder symptoms and met the individual goals of their Eating Disorder Plan over the course of treatment. To access general practitioners, the Medical Directory of Australia database, social media advertisements, and researchers' professional networks were used. Of the 189 records obtained, the majority were female (93.7%) and a little over half aged between 15 – 25 years (57.9%). The most common eating disorder diagnosis was anorexia nervosa (48.9%), followed by other specified feeding or eating disorder (19.5%), binge eating disorder (17.4%), and bulimia nervosa (13.8%). Most GP practices were in advantaged socio-economic areas.

Community survey

A total of 949 participants, comprising 266 health professionals, 505 people with an eating disorder or people who have had an eating disorder, and 178 people with a lived experience of caring for someone with an eating disorder took part in a community-based survey study. The survey explored perceptions of the uptake and use of the Eating Disorders MBS items.

Participants were recruited via social media advertisements, researchers' networks, local and national community organisations, and publicly available professional eating disorder membership databases. Of the 505 people with lived experience of an eating disorder, 57.5% (n = 289) had received treatment under the Eating Disorder Plan, 27.0% (n = 136) had received treatment via other means, 7.6 % (n = 38) were currently seeking treatment via the Eating Disorder Plan, 1.2% (n = 6) were currently seeking treatment via other means, and 6.6% (n = 33) had not sought or received treatment.

Of the 178 people with lived experience of caring for someone with an eating disorder, 70.2% (n = 125) had cared for someone receiving treatment under an Eating Disorder Plan, 20.8% (n = 37) had cared for someone receiving treatment via other means, 6.7% (n = 12) had cared for someone currently seeking treatment via the Eating Disorder Plan, and 2.2% (n = 4) had experience caring for someone who had not received treatment.

The health professional group comprised 37.2% dietitians, 29.3% GPs and medical practitioners, 30.8% allied health professionals (excluding dietitians), and 2.6% psychiatrists and paediatricians.

Across all respondents to the survey, participants were primarily female-identifying (86.6 – 92.6%), born in Australia (78.6 – 86.1%), and of neither Aboriginal nor Torres Strait Islander origin (95.8 –

97.4%). People with a lived experience of an eating disorder had a lower average age of 28.9 years, compared to people who care for someone with an eating disorder (48.9 years) and health professionals (40.1 years).

Of the participants with lived experience of an eating disorder, the most common diagnosis of the person with the eating disorder was anorexia nervosa (53.3%). People with a lived experience of caring for someone with an eating disorder were predominantly parents/guardians (82.0%) and had the most experience caring for someone with anorexia nervosa (68.9%), followed by avoidant/restrictive food intake disorder (ARFID; 11.3%).

Qualitative interviews

A total of 101 participants, comprising 42 people with a lived experience of an eating disorder, ten people with a lived experience of caring for someone with an eating disorder, and 49 health professionals took part in qualitative interviews. These interviews explored the uptake and use of the Eating Disorders MBS items. Like the community survey, participants were recruited via social media advertisements, local and national community organisations, publicly searchable professional eating disorder membership databases, researchers' networks, and eating disorder clinics and private practices. In addition, the Australian Medical Publishing Company (AMPCo) was engaged to recruit psychiatrists, paediatricians, and GPs. People who participated in the community survey were also invited to express their interest in taking part in an interview. Of the participants with lived eating disorder experience and people with a lived experience of caring for someone with an eating disorder, most were female, with an average age of 32.6 and 45.1 years, respectively. Of the 42 participants with lived experience, 71.4% reported a diagnosis of anorexia nervosa with an average illness duration of 9.8 years, 4.8% had a diagnosis of atypical anorexia and 7.14% had a mixed diagnosis of anorexia with either bulimia, binge-eating disorder, or body dysmorphic disorder. The average illness duration across the sample was 9.7 years. All people with a lived experience of caring for someone with an eating disorder were female and predominantly mothers (90%) and mostly cared for someone with anorexia nervosa (90%). Of the healthcare professionals interviewed, 12 were GPs and 37 were allied health professionals (including dietitians), with the majority being female and aged between 24 to 63 years.

Literature Review Study

A scoping review of the literature was conducted to identify international clinical guidelines for the treatment of eating disorders. A search was conducted in July 2023 in three databases; PubMed, Cochrane Database of Systematic Reviews, and the International Guideline Library, for the following eating disorders: anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder, and other specified feeding or eating disorders. The search covered all ages, and no limits were set for language of the guidelines. Nine clinical guidelines were identified from the literature search covering both adults and those aged under 18. Guidelines were identified that predominantly covered the treatment of bulimia nervosa (n = 5), anorexia nervosa (n = 4), and binge eating disorder (n = 4).

2.3 Methodological Limitations

There are three key caveats in relation to obtained data for this evaluation project. First, the Eating Disorders MBS items were introduced in November 2019, shortly before the COVID pandemic. We acknowledge potential effects of consequent lockdowns and increased demand for healthcare during the pandemic on estimates of uptake and utilisation of Eating Disorders MBS items. Usefulness of telehealth items introduced in response to these COVID-related service disruptions is also difficult to assess because the control conditions needed to accurately quantify these effects (independent of COVID) were absent.

Second, the introduction of the MBS items to support case conferencing occurred towards the end of our evaluation period. Objective Medicare data that can explain the use of case conferencing for people accessing treatment through the Eating Disorders MBS items were not able to be collected within the time constraints of this evaluation. This limited our opportunity to include conclusions about uptake of these items, and their impact on the number of treatment services received or relative outcomes under the Eating Disorders MBS items.

Third, our evaluation is focused on MBS-based eating disorders treatment. We were not able to evaluate treatment services for this period that came from sources other than Medicare. Our evaluation does not attempt to draw conclusions about treatment accessed via non-Medicare supported services.

3

Objective 1: Utilisation of the Eating Disorders MBS Items

Evaluation of the Eating Disorders
Medicare Benefits Schedule Items 2024

3 Objective 1: Utilisation of the Eating Disorders MBS Items

Key Points

- Around one in five people with an eating disorder accessed Eating Disorders MBS items.
- GPs contributed most of the treatment plans and reviews, while psychologists delivered most treatment sessions, with dietitians having a slightly smaller role.
- On average, people with an eating disorder accessed around 14 psychological treatment services and around 8 dietetic services within a year, with a third of services extending beyond this 12-month period.
- Proportionally, rates of uptake were lower for people living in regional or remote areas of Australia, people with lower household income, people who speak a language other than English at home, people aged under 18 or 40 +, and lower for males relative to female.
- Cessation of treatment peaked at the 10th, 20th, and 30th psychological treatment sessions, coinciding with review sessions being due.

3.1 Overview

This chapter addresses Objective 1 and evaluates the use of Eating Disorders MBS items, as obtained from objective data sources (national data linkage, Services Australia), and survey and interview data from people with lived experience of an eating disorder, people who care for a person with an eating disorder, and health professionals.

We evaluated:

- *utilisation* (total number of these MBS items accessed) and *uptake* (total number of people accessing these MBS items) since the introduction of items in November 2019
- uptake and utilisation by item type; we have grouped items into the following process categories: making a treatment plan, treatment and intervention service delivery (psychological and dietetic), and the review of treatment progress
- Eating Disorders MBS item use against key demographic characteristics of people using these services: age, gender, language spoken at home, household income, and First Nations status.

3.2 Eating Disorders MBS Item Usage Patterns

3.2.1 Utilisation of Eating Disorders MBS items

From November 2019 to December 2022, inclusive, 544,368 total services were delivered using the Eating Disorders MBS items. This included 48,306 eating disorder (treatment and management) plans, 475,520 treatment services (psychological treatments 330,376; dietetic health services 145,144), and 20,542 eating disorder plan reviews. Psychological services accounted for 61% of the total number of services delivered.

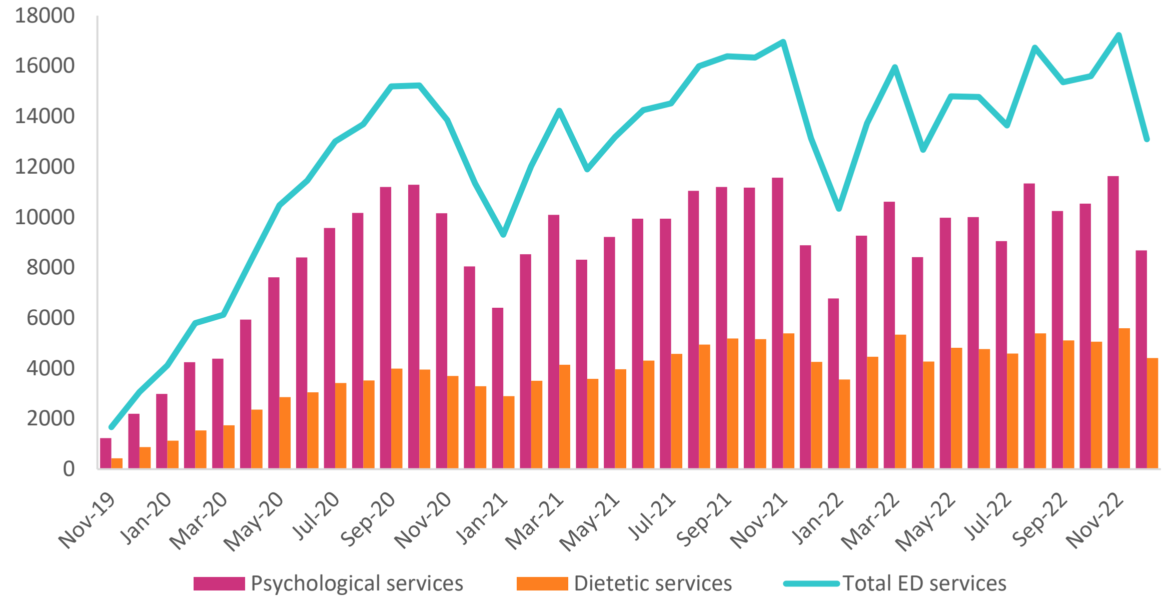
As shown in Table 3.1, there was a substantial increase in the number of treatment services delivered in 2021 relative to 2020 (the first two full years of service), and a more modest increase in services from 2021 to 2022. Table 3.1 also shows that roughly twice as many psychological services than dietetic services were delivered.

Table 3.1. *Utilisation of any Eating Disorders MBS treatment service, 2019 to 2022*

		2019	2020	2021	2022	Average annual change (%) 2020 - 2022
Any ED MBS treatment service	Services	4,739^	128,593	168,252	173,936	17.6
	Rate (per 1,000)	<1.0	5.8	7.4	7.5	
	% of all services	63.9	86.7	87.8	88.3	
Psychological services	Services	3,433^	94,023	116,347	116,573	12.0
	Rate (per 1,000)	<1.0	3.7	4.5	4.4	
Dietetic services	Services	1,306^	34,570	51,905	57,363	33.0
	Rate (per 1,000)	<1.0	1.3	2.0	2.2	

Note. Rates are crude rates per 1,000 total population. 'All services' refers to a service provided under the Eating Disorders MBS items in Appendix 1, and can be broadly grouped into plan, treatment, and review sessions. Population based on Australian Bureau of Statistics census data: 2020 population of 25,620,615, 2021 population of 25,760,867, 2022 population of 26,280,421. ^Note that 2019 figures are based on 2 months of data (November - December).

Figure 3.1 illustrates utilisation of eating disorders treatment services per month since introducing the items in November 2019. Periodic declines in service are observed around December – January for years 2020 – 2022, coinciding with typical holiday periods in Australia.



Note. Total ED services = psychological and dietetic services combined

Figure 3.1. *Treatment services (psychological treatment and dietetic intervention) delivered per month from inception to end of 2022*

In addition to potential seasonal effects in utilisation, the period 2019 – 2022 also included COVID impacts on the general population from early 2020 onwards. In response, in March 2020, the Australian Government introduced telehealth options for Eating Disorders MBS items.

As can be seen in Figures 3.2 and 3.3, there was rapid adoption and sustained use of telehealth treatment options for eating disorders from March 2020. On average (per month), telehealth items accounted for 35% of all psychological treatment services and 40% of all dietetic health services in the first year of availability (2020), with a slightly lower average (per month) for 2022 – 2023 (psychological services 27 – 28%; dietetic services 29 – 31%). This shows telehealth options have remained an important component of service delivery since they were introduced.

There is a substantial increase in the number of treatment services delivered in 2021 relative to 2020 (the first two full years of service) and a more modest increase in services from 2021 to 2022.

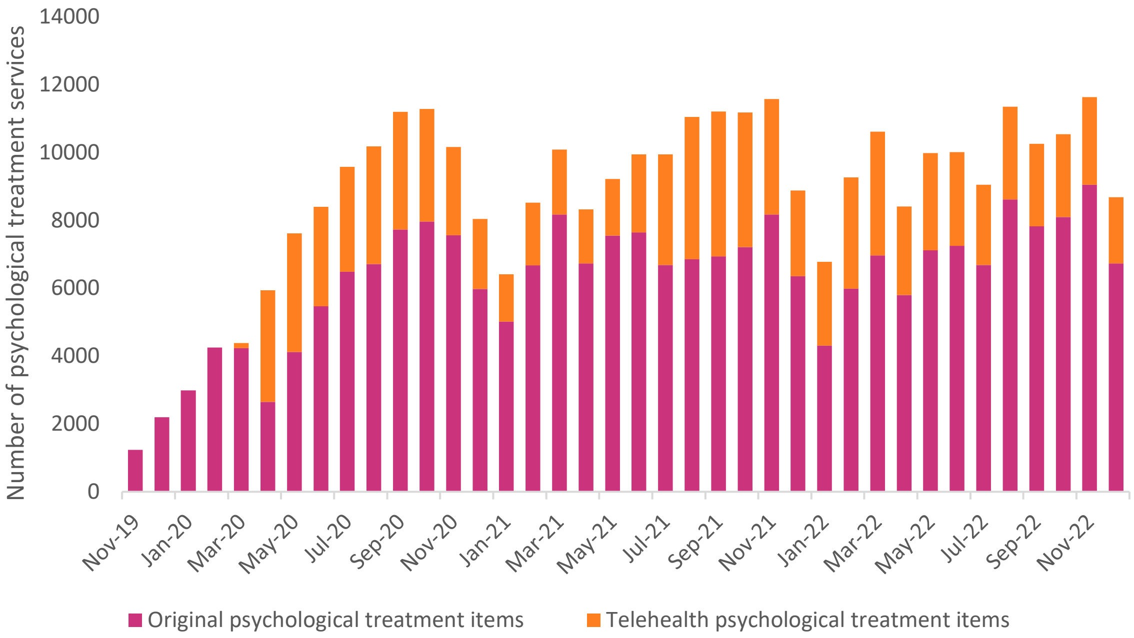


Figure 3.2. *Psychological treatment services delivered per month from inception to end of 2022*

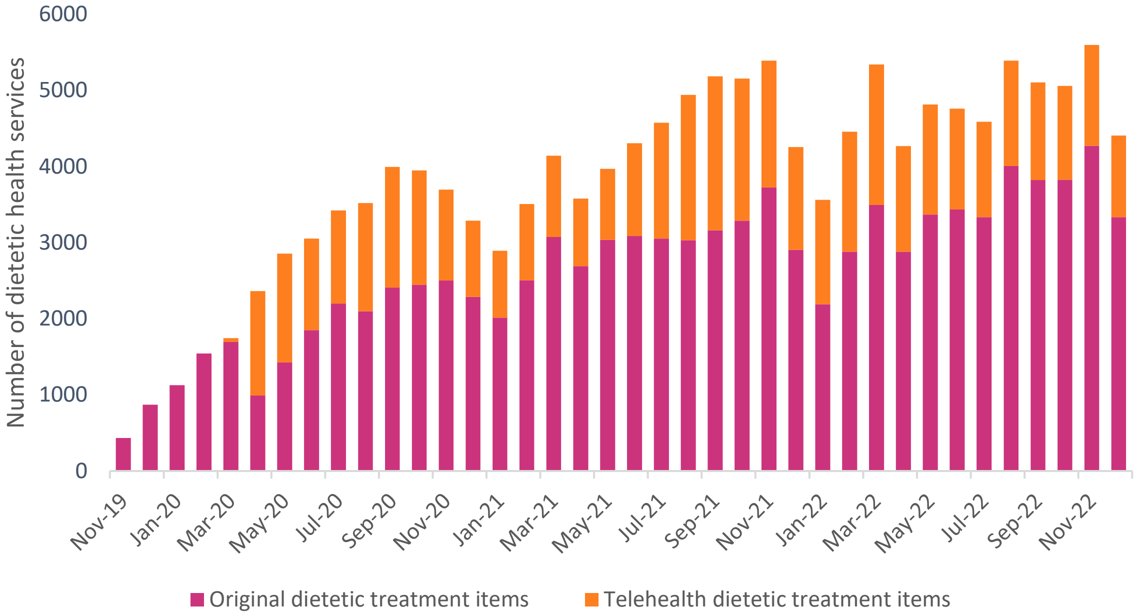


Figure 3.3. *Dietetic health services delivered per month from inception to end of 2022*

Utilisation by Provider Type

Finally, we found relevant health professions contributed to Eating Disorders MBS service delivery at different stages of treatment and to varying degrees. Most treatment plans were created by GPs (94%), with psychiatrists (3%), paediatricians (2%), and other medical practitioners with mental health training (1%) playing smaller roles. In accordance with Eating Disorders MBS item specifications, these are the only professions that can prepare an Eating Disorder Plan under this initiative. In contrast, most treatment and health services were delivered by psychologists (54%) and dietitians (43%), consistent with the focus of the Eating Disorder Plan on psychological and dietetic services. Social workers (3%), GPs and other health professionals with mental health training (<1%), and occupational therapists (<1%) also delivered services, but to a far lesser degree.

3.2.2 Uptake of Eating Disorders MBS items

3.2.2.1 Overall number of people using Eating Disorders MBS items

From November 2019 to the end of 2022, 38,130 Australians accessed Eating Disorders MBS items. This equates to roughly 1.4 per 1000 Australians, based on population figures from 2021 Australian census data. Based on recent synthesis of best available research literature, the estimated prevalence for eating disorders (anorexia nervosa, bulimia nervosa, binge eating disorder, and OSFED combined) equates to approximately 7.2 people with a diagnosis per 1000 people in the general population [1]. On that basis, the Eating Disorders MBS items are being used by approximately 1 in 5 individuals with an eating disorder in the Australian context.

As Figure 3.4 shows, most people who accessed an Eating Disorders Plan via MBS (80%) were in major cities the first time they engaged. Adjusting for an initial higher uptake in major cities in November 2019, monthly numbers for new people accessing Eating Disorders MBS items for the first time ranged from approximately 450 to 1300 (major cities) and 120 to 250 (other regions).

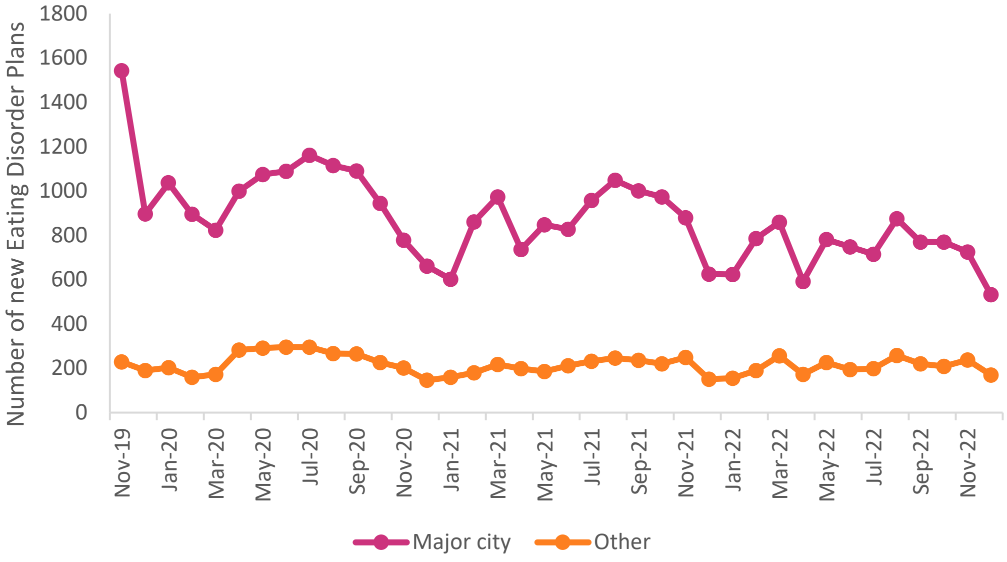


Figure 3.4. *Number of Eating Disorder Plans prepared by location and month (November 2019 – December 2022)*

3.2.2.2 Typical Usage Patterns for Eating Disorders MBS items

Of the 38,130 Australians who received at least one Eating Disorder Plan, 67% received at least one treatment or health service – whether psychological or dietetic. This represents a gap between referral to treatment whereby one third of people who receive an Eating Disorder Plan do not receive any treatment. Thirty per cent of the overall sample received both psychological treatment and dietetic services, 23% received psychological services only, and 14% received dietetic services only. Among individuals who received at least one treatment or health service, only 32% received at least one review of progress.

Among people who received at least one treatment or health service (psychological or dietetic), the average number of services received within any 12-month period was around 13 – 14 psychological services and around 8 dietetic services. The proportion of people who reached the threshold of maximum services (40 psychological treatment sessions, 20 dietetic health services) within a 12-month period was low for both psychological treatment (1 – 4%) and dietetic services (5 – 9%) (averaged per year across 2019 – 2022). Even so, the top 25% of users received 20 or more psychological treatment services and 12 or more dietetic services. Fifty percent of those who received services received 10 or more psychological treatment services and 6 or more dietetic treatment services, suggesting the Eating Disorders MBS initiative provided more services for the majority of recipients than are otherwise available through Better Access and Chronic Disease Management services.

Interestingly, as shown in Figure 3.5, many people continued to access services beyond the 12-month period (Year 2+, per Figure 3.5). Across the years 2020 – 2022, 29% of services delivered were for people in their second year or more of receiving Eating Disorders MBS services, and by December 2022 continuing users accounted for almost half of Eating Disorders MBS item utilisation.

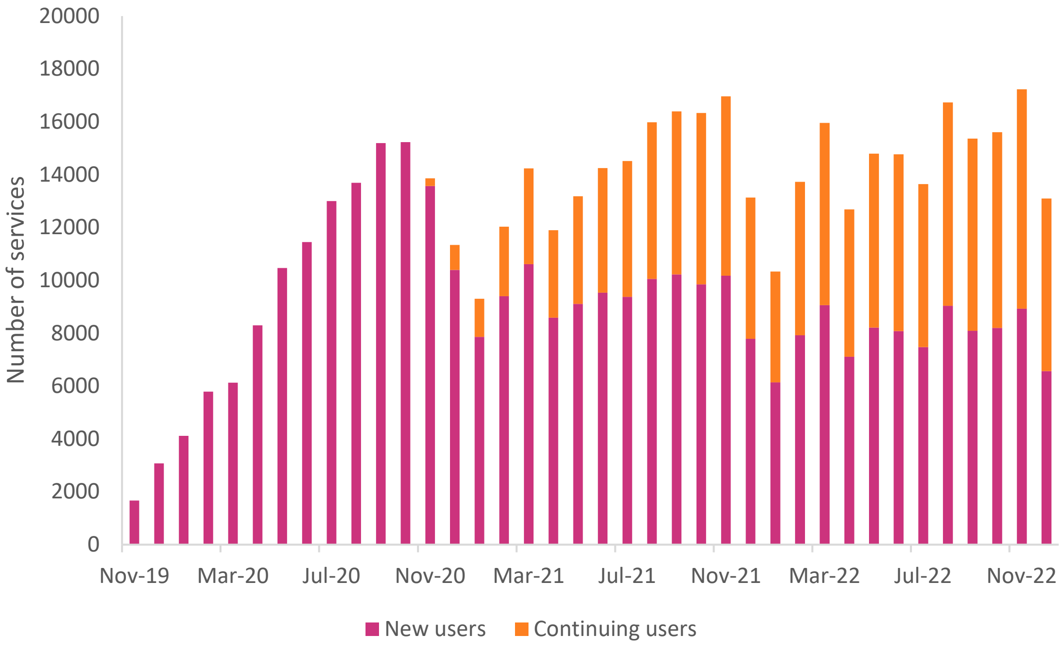


Figure 3.5. *Number of Eating Disorders MBS services delivered by month, and as a function of whether person is receiving first year of service (Year 1) or beyond (Year 2+)*

This pattern of findings in Figure 3.5 suggests the average number of sessions within 12 months does not adequately capture the full duration of treatment for almost one third of people who sought treatment via Eating Disorders MBS items. As covered in Chapter 5, data from Figure 3.5 may also reflect the barriers some people experienced to receiving services, making it difficult for them to complete the number of sessions needed to reduce their symptoms and recover within 12 months.

It is also clear from Figure 3.5 that the proportion of Eating Disorders MBS item use was almost evenly split between new and continuing users by the end of 2022. Statistical modelling (using regression) of this uptake shows the number of new clients entering the Eating Disorders MBS initiative has been declining over time, by around 10 people each month from 2021 to 2022, inclusive. It is possible that Eating disorders MBS services are functioning near maximum capacity, that providers are not recognising need beyond AN presentations, or that need for services is met, preventing further increases in the number of services provided. As covered in later chapters, workforce capacity issues rather than satisfaction with fewer sessions seems the more likely explanation for this pattern of results (see Chapters 5 and 6).

3.2.2.3 Associations between reviews and cessation of treatment

The average number of treatment sessions accessed across a 12-month period is fewer than expected given the maximum allowable psychological and dietetic services. As elaborated on in later chapters (Chapters 5 and 6), individuals with lived experience of an eating disorder identified the review as a potential reason for discontinuing services. Some individuals reported waiting for the 12-month period to elapse in order to start a new plan, avoiding the review (Chapter 5). Here we explore cessation as a function of session number with the national data linkage study to evaluate these possibilities.

Figure 3.6 shows the proportion of people who cease treatment after receiving a given number of psychological treatment sessions. For instance, of those who received an Eating Disorder Plan and proceeded to receive psychological treatment sessions, ~6% cease treatment after one session. Of those who continued beyond one session, around 5% cease treatment after two sessions. Figure 3.6 provides separate trajectories, grouping people according to whether they accessed services over a 12-month window (according to the intention of the Eating Disorders MBS items initiative) or over longer than 12 months (we used an 18-month window), recognising that some people continue to receive services beyond one year (as shown in Figure 3.5).

While there is a general upward trend such that higher proportions of people cease treatment as the number of sessions they receive increases, there are notable peaks in treatment cessation coinciding with the timing of 10, 20, and 30 session reviews for people who received their treatment sessions over a 12-month period. Peaks are also evident at 10 and 20 sessions among individuals who used services for more than one year, though these are less pronounced. A variety of factors may contribute to the less pronounced peaks for people who receive their treatment sessions over an 18-month period, including differences in cohorts with respect to capacity to find and afford reviews. The less pronounced peaks are also consistent with the notion that some individuals may receive a new Eating Disorder Plan after 12 months, which provides more treatment sessions before needing to seek review of progress. Cessation prior to review constitutes a missed opportunity for assessment of progress, and an additional opportunity for calibrating services to best suit individual needs.

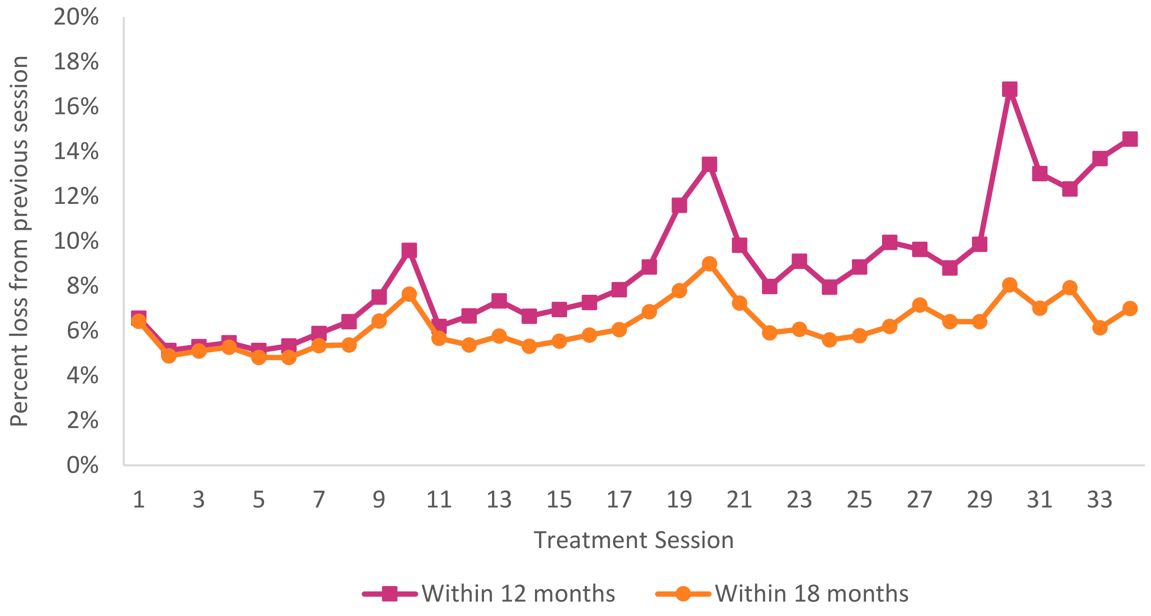


Figure 3.6. *Eating Disorders MBS items psychological treatment cessation rates by session number when considering first 12 or 18 months since commencement.*

3.3 Eating Disorders MBS item Uptake by Demographic Characteristics

We explored potential differences in Eating Disorders MBS item use by demographic characteristics of people seeking treatment: age, gender, First Nations background, education level, household income, and whether a language other than English is spoken at home. Chapters 1 and 2 of the Technical Report provide a detailed breakdown of overall (and item grouping) uptake and utilisation, and provider type as a function of these consumer characteristics. Here, we have summarised the key differences we found across these analyses, focusing on: i) the *proportion* of people who receive a plan and then go on to receive either psychological treatment or dietetic services via Eating Disorders MBS items, and ii) the average *number* of Eating Disorders MBS treatment and health services received (Figures 3.7 – 3.13).

We found several disparities in service use. Both the proportion of people who received treatment (relative to the total number having initially been provided with an Eating Disorder Plan) and the number of treatment sessions they received was higher among:

- people living in a major city relative to those living in regional and remote areas (Figure 3.7)
- females relative to males (and other non-female identifying gender; Figure 3.8)
- people with higher education levels (Figure 3.9),
- people in the highest household income band relative to other income levels (Figure 3.10),
- people for whom English was the main language spoken at home (Figure 3.11)
- people who do not have a First Nations background (Figure 3.12).

Figure 3.7. *Treatment service use by geographic region among those who received an Eating Disorder Plan*

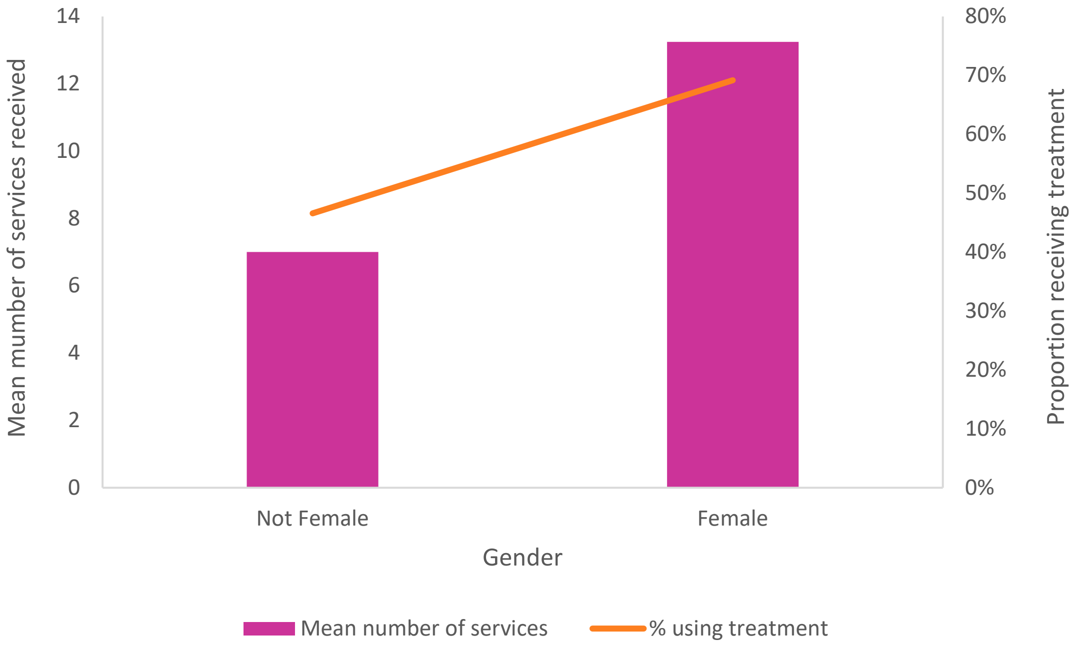


Figure 3.8. *Treatment service use by gender (dichotomised to Female vs Not Female) among those who received an Eating Disorder Plan*

Patterns for education level were complex. People with a tertiary degree utilised the greatest number of services on average and had the highest proportion of people transitioning from having an Eating Disorder Plan created to actually commencing treatment services (Figure 3.9). The proportion using, and average use, was lowest among those who had not completed high school and those whose education status was undefined in census data.

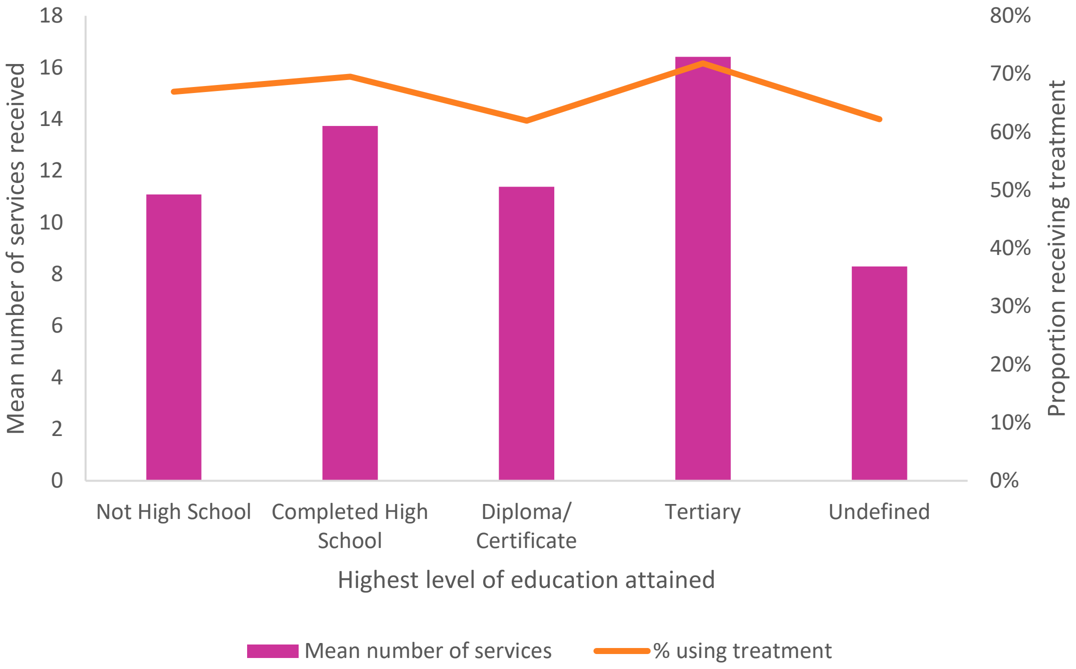
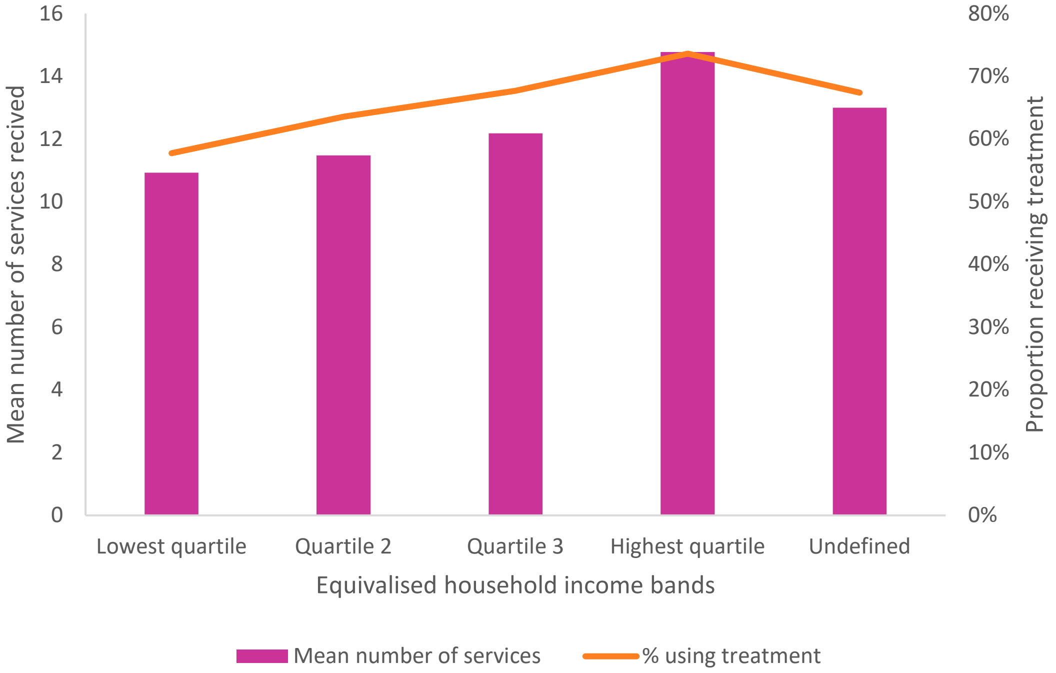


Figure 3.9. *Treatment service use by highest level of education attained to date among those who received an Eating Disorder Plan*



Note: quartiles are approximated from Australian Bureau of Statistics income categories

Figure 3.10. *Treatment service use by household income bands among those who received an Eating Disorder Plan*

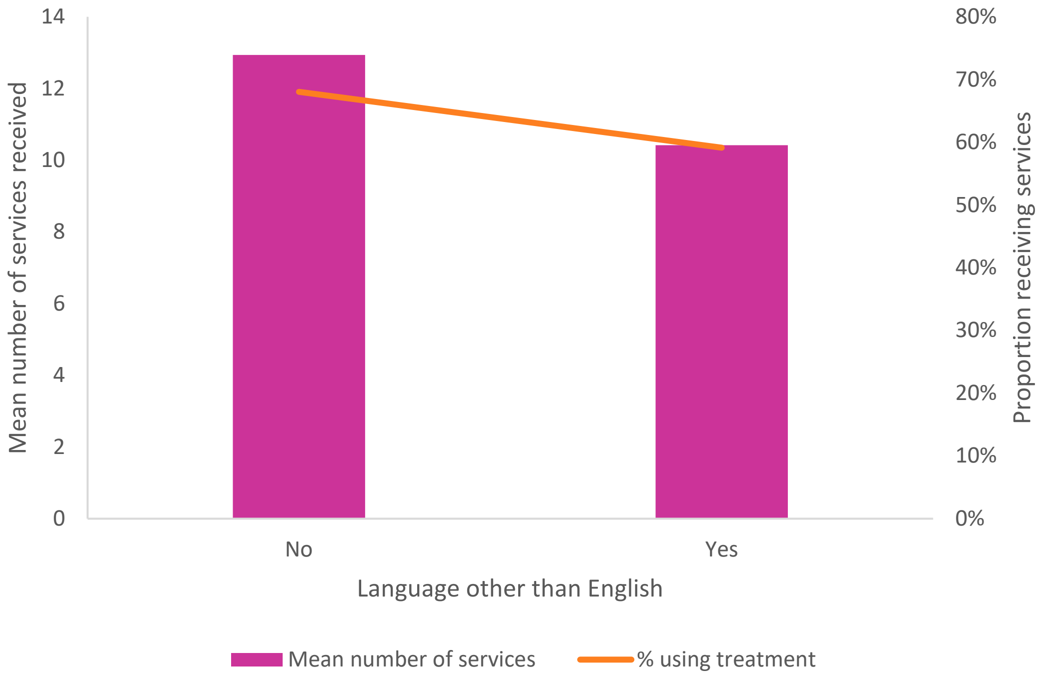


Figure 3.11. *Treatment service use by language spoken at home among those who received an Eating Disorder Plan*

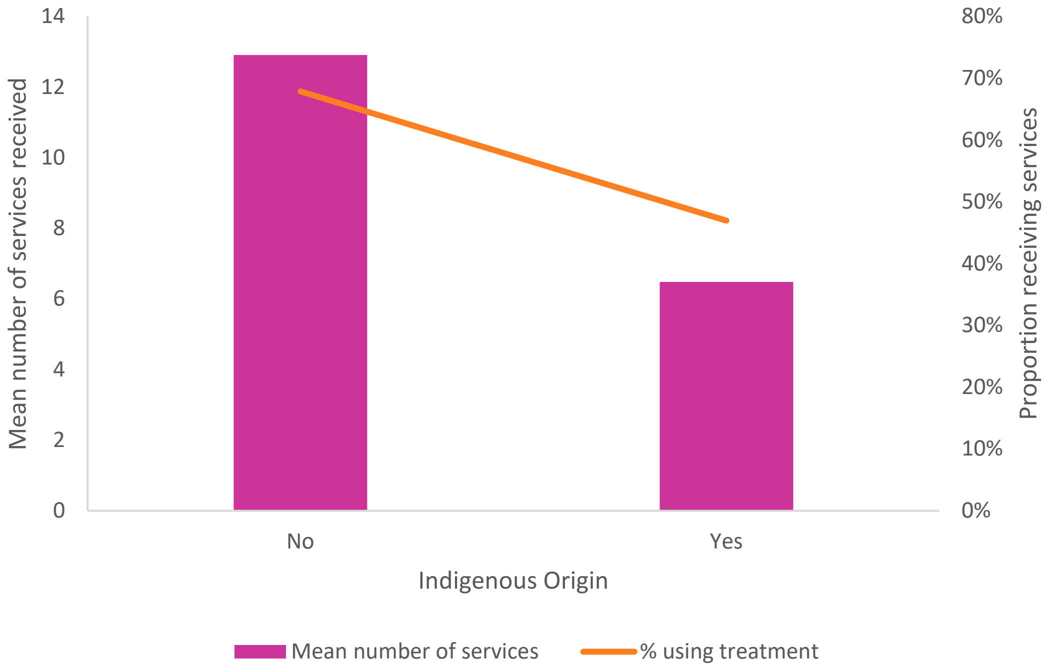


Figure 3.12. *Treatment service use by First Nations background among those who received an Eating Disorder Plan*

Patterns for age were also complex. The highest average usage of treatment services was found for people aged 19 to 39, with lower average use for those aged 18 or below or aged 40 and above (Figure 3.12). The 40+ age group was also less likely to transition from having an Eating Disorder Plan prepared to commencing treatment services as indicated by the proportion receiving treatment.

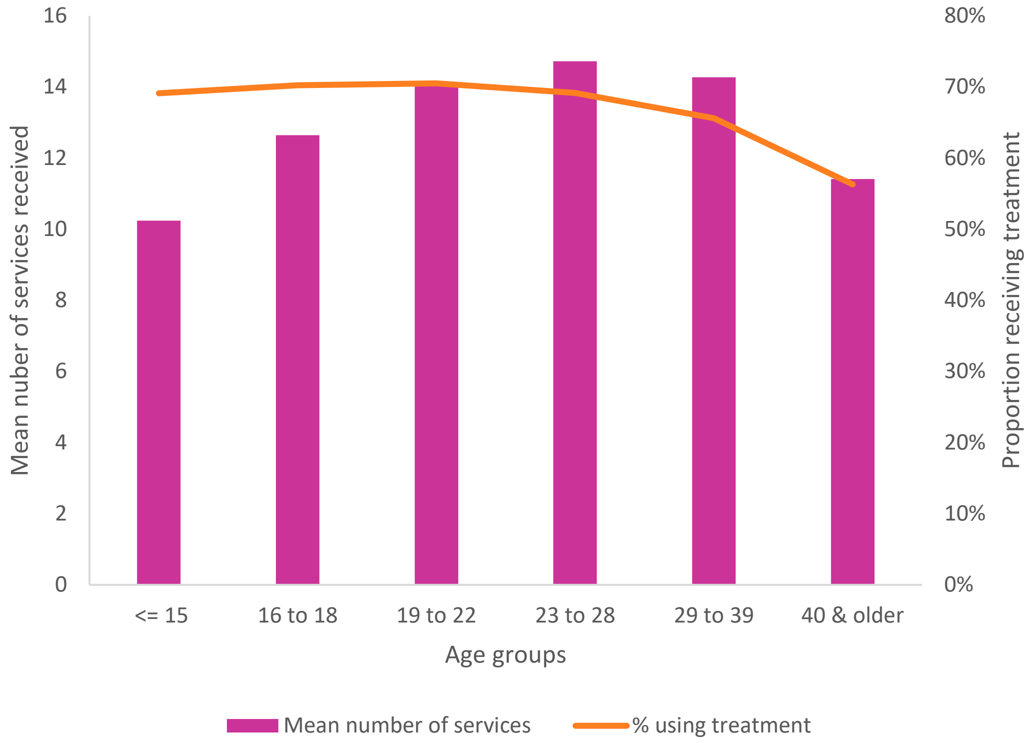


Figure 3.13. *Treatment service use by age among those who received an Eating Disorder Plan*

3.4 Summary

Uptake of Eating Disorders MBS items corresponded to approximately 20% of people with lived experience of an eating disorder accessing the items according to best available prevalence estimates. Most people accessed a combination of psychological treatment and dietetic health services, consistent with the notion that a comprehensive set of services is needed to improve symptoms for people with complex and severe eating disorders.

The average number of services received within a 12-month period was much lower than the threshold allowances (psychological services M = 13 – 14 relative to allowance of 40; dietetic services M = 8 relative to allowance of 20). A small number of people (psychological services 1 – 4%; dietetic services 5 – 9%) reached this threshold number of services within a 12-month period, though many continued to receive services beyond 12 months. This typical pattern of usage may reflect difficulties in completing the necessary number of sessions within a 12-month period – a point taken up further in Chapter 5 (*improved access*), and also supported by the high proportion of people who complete Eating Disorders MBS-related treatment sessions across two or more years. There was also evidence of treatment cessation around the time that reviews of progress were due. It may also reflect use of Eating Disorders MBS items in combination with other services; this is explored further in the next chapter (*complementary services*).

Introducing telehealth MBS items appears to have offset potential COVID-related disruptions to physically located services. The persistent use of the telehealth items suggests this remained a viable and attractive option for many people with lived experience of an eating disorder.

Our evaluation of Eating Disorders MBS item uptake by demographic factors revealed uneven distribution of use, particularly in terms of geographic location, gender, household income, and language spoken at home. These and other potential sources of inequity in healthcare service use are discussed in more detail in Chapter 5 (*improved access*).

Finally, service delivery data suggest treatment plans and reviews were provided primarily by GPs, while treatment and health services were delivered mainly by psychologists and dietitians. These findings are in alignment with the intended purpose and approach for the Eating Disorders MBS items. Chapters 5 (*improved access*) and 6 (*outcomes*) explore barriers to access by workload on these health disciplines. They also discuss the untapped potential of other disciplines and workforce capability uplifts as a means of enhancing the availability of services.

This chapter has provided an overview of use of the Eating Disorders MBS items. Consideration of issues required to improve the implementation of the suite of Eating Disorders MBS items is referred to in later chapters, with the full recommendations provided in Chapter 7 (*recommendations*).

4

Objective 2:
Relationship between the Eating Disorders Treatment and Management Plan and Other Related MBS Items

Evaluation of the Eating Disorders Medicare Benefits Schedule Items 2024

4 Objective 2: Relationship between the Eating Disorders Treatment and Management Plan and Other Related MBS Items

Key Points

- Prior use of other MBS/PBS (pharmaceutical benefits schedule) services was common for people who used Eating Disorders MBS items, with >50% of people who used the Eating Disorders MBS items also accessing one or more of these services.
- The most common services used were Better Access, GP visits, PBS medications for mental health concerns, and psychiatric treatment sessions.
- Many people with a lived experience of caring for someone with an eating disorder also reported using MBS-based psychological treatment services independently to address their own mental health concerns. They rated these services as necessary and helpful.
- Limited knowledge of the Eating Disorders MBS scheme, difficulties in identifying and ensuring availability of suitable services, and difficulties navigating the public healthcare system were common reasons for using services other than Eating Disorders MBS items.
- Broader integration of support networks outside typical MBS/PBS offerings, and coordination of tasks among disparate – and, at times, underutilised – healthcare professions were identified as areas in need of attention to fulfil the intention of the Eating Disorders MBS scheme.

4.1 Overview

This chapter addresses Objective 2 and evaluates the overlap between the Eating Disorders MBS items and other MBS services.

We evaluated:

(i) patterns and sequencing of use of other MBS services such as the Better Access initiative (Mental Health Treatment Plan), Chronic Disease Management, GP services unrelated to Eating Disorders MBS items, and psychiatric sessions via MBS among people with lived experience of an eating disorder

(ii) the extent to which people with a lived experience of caring for someone with an eating disorder independently sought MBS services to address mental health concerns that may have arisen from their role as carers

(iii) the role of health professionals in determining whether a person accessed the Eating Disorders MBS items versus other services.

4.2 Overlap with Other Services

The national data linkage study revealed most of the 38,130 people who accessed an Eating Disorder Plan via MBS from November 2019 to December 2022 (inclusive) had received other services via MBS in the 12 months prior to accessing the Eating Disorders MBS items (Figure 4.1). Consultations with a GP were common, as was use of Better Access treatment services. Chronic disease management and general psychiatry services were less commonly accessed (~20 – 30% of people). This indicates that initial uptake of the Eating Disorder Plan was driven by people already engaged in treatment by other services, suggesting that awareness of availability of treatment options is an important factor in uptake.

Mental health-related prescribed medication via the PBS was also common in the 12 months prior to Eating Disorders MBS item use (52%). Among these, antidepressants were the most prescribed medications (47%) compared with antipsychotics (8%), anxiolytics (11%), hypnotics/sedatives (5%), and psychostimulants (5%).

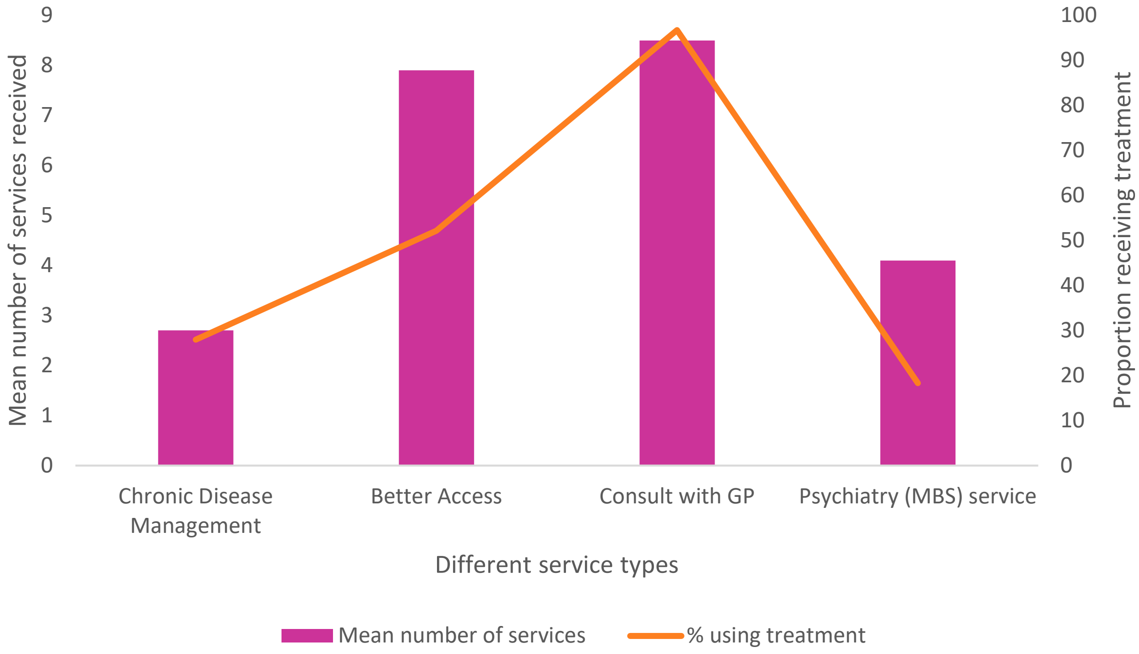
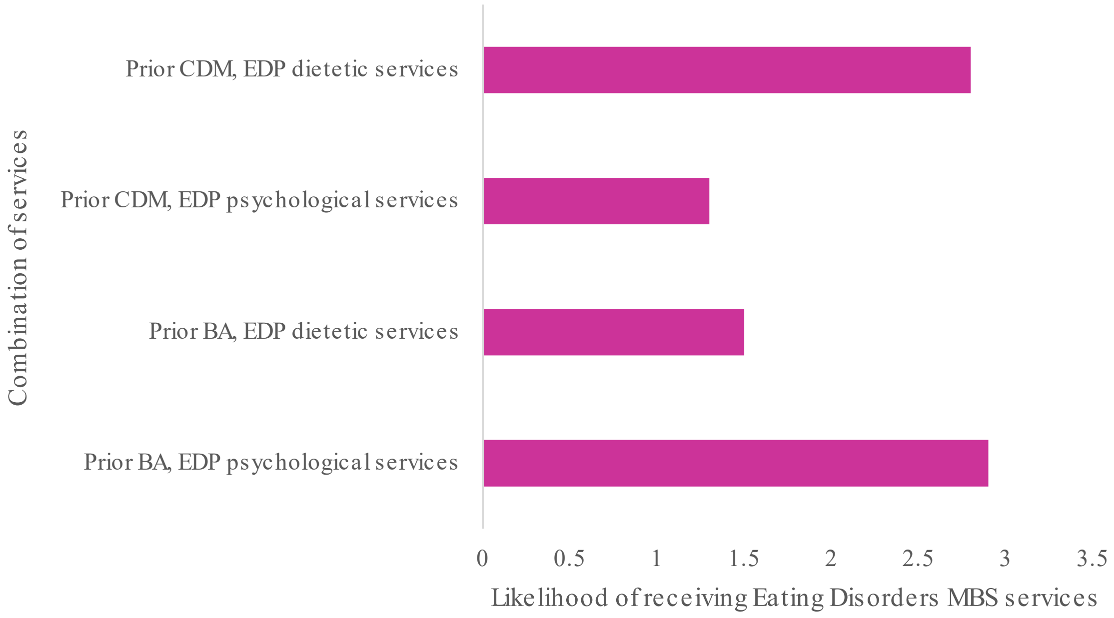


Figure 4.1. *Treatment services used in the 12 months prior to Eating Disorders MBS item access*

Prior use of Better Access or chronic disease management services was associated with greater likelihood of using psychological and dietetic services once an Eating Disorder Plan was created for the person. As shown in Figure 4.2, people with prior use of Better Access were almost three times more likely than those who had not used Better Access to utilise psychological services as part of their Eating Disorder Plan, and 1.5 times more likely to utilise dietetic services as part of their Eating Disorder Plan. People with prior use of chronic disease management services were nearly three times more likely than those who had not used chronic disease management services to utilise psychological treatment as part of their Eating Disorder Plan. This group was also slightly more likely (1.3 times) to utilise dietetic services as part of their Eating Disorder Plan.

This higher rate of uptake (psychological treatment services following Better Access, and dietetic services following chronic disease management services) could reflect a continuation of services for the same condition once the Eating Disorders MBS items became available. Additionally, this continuation could reflect a tendency for people to be more comfortable proceeding with types of treatment services with which they are already familiar.



Note. CDM = chronic disease management (plan); BA = Better Access; EDP = Eating Disorder Plan. Likelihood < 1 indicates less likely to receive Eating Disorders MBS services; likelihood of 1 indicates just as likely to receive Eating Disorders MBS services; and likelihood >1 indicates more likely to receive Eating Disorders MBS services. A value of 2 thus indicates someone is 2 times more likely to receive Eating Disorders MBS services.

Figure 4.2. *Likelihood of Eating Disorders MBS treatment service use (psychological and dietetic) for those who previously did versus previously did not use Better Access or chronic disease management MBS items*

The national data linkage study suggests it was far less common for people to utilise Better Access or chronic disease management services after receiving an Eating Disorder Plan. Twenty-four percent used Better Access, whereas 6% used chronic disease management services following receipt of an Eating Disorder Plan. Further to this, people who accessed Eating Disorders MBS items had almost twice the prevalence of mental illness (based on 2021 census data) compared to people utilising Better Access. This suggests that the Eating Disorders MBS items are catering to individuals with significantly greater need of services. The lower transition rates from Eating Disorders MBS items to Better Access (relative to the other direction) also suggests that the Eating Disorder Plan may better meet the treatment needs of people with an eating disorder than other initiatives. This could be because people are less likely to seek services from Better Access or a chronic disease management plan after receiving an Eating Disorder Plan than vice versa.

We examined the total number of psychological and dietetic services people used in the 12 months leading up to and 12 months after the creation of their Eating Disorder Plan (Figures 4.3 and 4.4). There were 1.6 times more psychological services and 4.2 times more dietetic services provided within the first month after obtaining an Eating Disorder Plan relative to the previous month. The increase in services peaked in the second month since obtaining the plan, with the number of psychological services 2.1 times higher, and number of dietetic services 7.2 times higher compared to the month immediately before obtaining the plan. These figures clearly show increased access to psychological and dietetic services facilitated by the Eating Disorders MBS items initiative, suggesting the initiation of the plan improved access to services among eligible people.

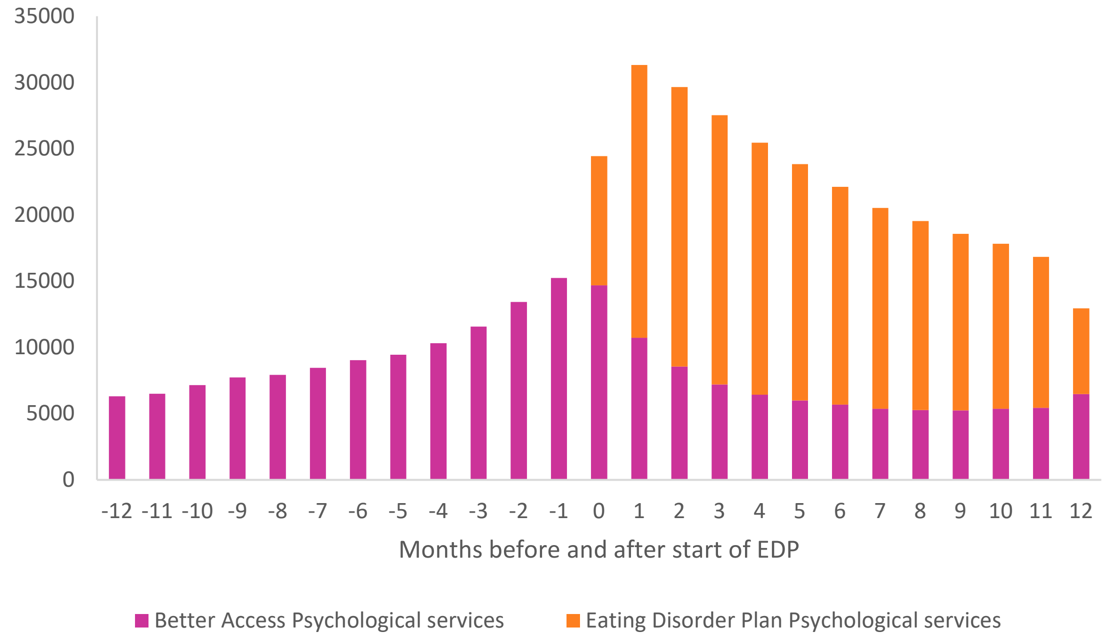


Figure 4.3. *Number of psychological services provided through Better Access and Eating Disorders MBS items before and after obtaining an Eating Disorder Plan.*

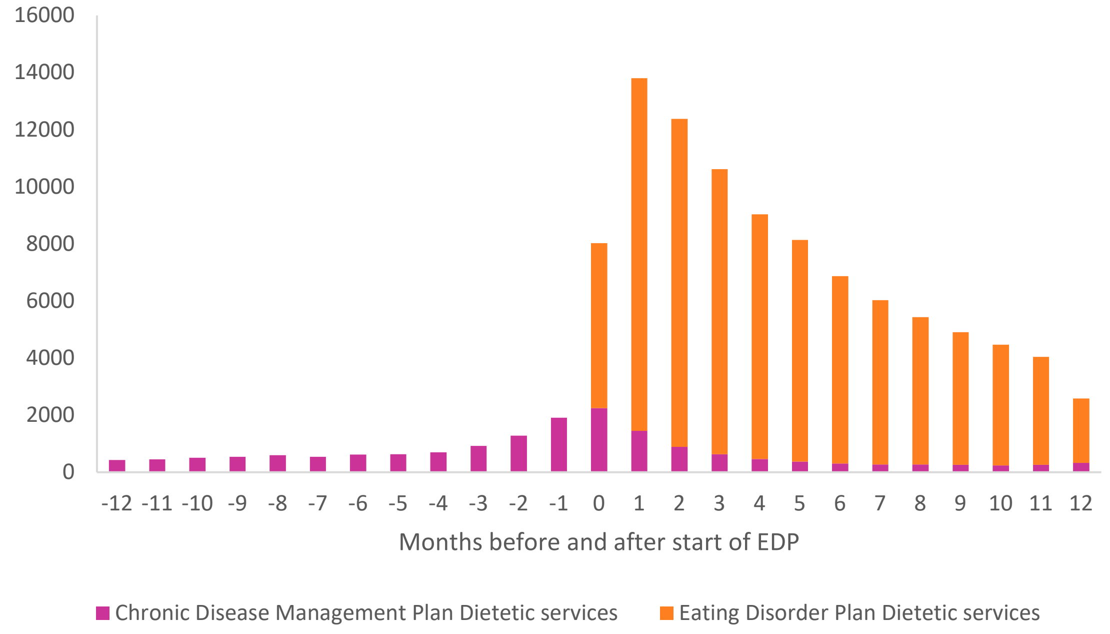


Figure 4.4. *Number of dietetic services provided through Chronic Disease Management and Eating Disorders MBS items before and after obtaining an Eating Disorder Plan.*

Findings from our Medicare and community surveys conducted for this evaluation are consistent with and extend these findings from the national linkage data study. Some people with lived experience of an eating disorder from the Medicare survey had used additional psychological or dietetic services since the rollout of the Eating Disorders MBS items in 2019. This varied from 31.4% and 6.6% of people having received psychological treatment through Better Access (Mental Health Treatment Plan) and community mental health services. About one in ten (11.0%) people had received psychological treatment from other sources. Use of dietetic services was lower with about one in ten (9.3%) people having used services through a chronic disease management plan and fewer having accessed dietetic services via other sources (6.5%).

Among community survey respondents who received treatment via the Eating Disorders MBS items, 67.1% had previously accessed treatment for their eating disorder through a Mental Health Treatment Plan via Better Access. Similarly, half of respondents with lived experience of caring for a person with an eating disorder (50.4%) reported that the person they care for had accessed eating disorder treatment through a Mental Health Treatment Plan prior to the Eating Disorder Plan. The most common reason for seeking treatment via a Mental Health Treatment Plan prior to an Eating Disorder Plan was because the Eating Disorder Plan was not available when they first needed treatment (endorsed by 59.0% of respondents with eating disorder lived experience and by 38.8% of respondents with caring lived experience). One quarter of respondents with lived experience of an eating disorder (25.6%) or of caring for someone with an eating disorder (22.4%) indicated they had not known the Eating Disorder Plan was available. In addition, almost a third of people with lived experience of caring for someone with an eating disorder (30.6%) indicated the person they cared for was not eligible for an Eating Disorder Plan at the time.

A subsample of people with lived experience of an eating disorder from the community survey (n = 131) had engaged with treatment but not through the Eating Disorder Plan. Among these people, most sought treatment via a Mental Health Treatment Plan (Better Access; 48.5%), public health services (40.4%), private health cover (31.6%), and/or other means (24.3%).

The reasons for accessing eating disorder treatment through means other than an Eating Disorder Plan are shown in Table 4.1. For a large proportion of people with an eating disorder and people who care for someone with an eating disorder, the Eating Disorder Plan did not exist at the time of engaging healthcare services, or they or their healthcare professional were unaware of its existence at the time.

Table 4.1. *Reasons for using services other than the Eating Disorder Plan*

Reasons	Eating disorder lived experience (n = 134)		Caring lived experience (n = 36)	
	Frequency	Percentage	Frequency	Percentage
The Eating Disorder Plan was not available when they first needed eating disorder treatment	69	51.5	12	33.3
They/we did not know the Eating Disorder Plan was available	61	45.5	19	52.8
The health professional they saw at the time did not know the Eating Disorder Plan was available	27	20.1	6	16.7
They/we did not think their eating concerns were serious enough to access eating disorder-specific treatment through the Eating Disorder Plan	23	17.2	0	0
The health professional they saw at the time did not know to use the Eating Disorder Plan	17	12.7	2	5.6
I/they were not eligible for the Eating Disorder Plan	14	10.4	7	19.4
It seemed too difficult to organise treatment through the Eating Disorder Plan	13	9.7	1	2.8
I/they wanted to get treatment from a health professional that is not available through the Eating Disorder Plan	6	4.5	1	2.8
I/they wanted to use a different type of treatment that is not available through the Eating Disorder Plan	4	3.0	0	0
Other reason(s)	29	21.6	4	11.1

Note. Multiple responses were permitted.

Findings from our qualitative interviews reiterate that it is relatively uncommon to access both the Eating Disorder Plan and other MBS items simultaneously. Those who used multiple plans noted that the other MBS items were used to access other health professionals for services that were distinct from those accessed for the treatment of eating disorders. In these cases, no communication or collaboration occurred between health professionals providing services across plans.

In qualitative interviews, mental health professionals reported seeing people under different plans during different phases of their treatment and recovery journey. Psychologists reported that once they recognised that the person they initially saw under a Mental Health Treatment Plan had an eating disorder, they transitioned to an Eating Disorder Plan. They then provided support to the person to assist them to access the plan via their GP. Similarly, GPs reported providing people with a Mental Health Treatment Plan to allow them to access services enabling them to further investigate whether more intensive treatment or support was needed under an Eating Disorder Plan.

Some dietitians used the chronic disease management plan, especially if the Eating Disorder Plan was stopped. Mental health professionals and dietitians reported that the type of plan did not change their treatment approach. People with lived experience reported using other MBS items during their recovery when a change or improvement in symptoms meant they no longer met the criteria for an Eating Disorder Plan.

4.3 Utilisation of Services by People who Care for Persons with Eating Disorders

In the community survey, people with a lived experience of caring for someone with an eating disorder indicated their use of additional services to support issues that arose as a result of their caring role. A little over half of respondents (54.1%) had attended sessions for themselves to seek support, without the person with an eating disorder present. Support was most commonly sought through community services or Better Access with a Mental Health Treatment Plan. Additionally, reflecting the extent of the need for support, smaller proportions indicated that they were currently trying to get support (5.7%) or would have liked to seek support but were unaware of what support was available (17.2%).

Qualitative interviews gave some insights into potential barriers for uptake of additional services, with people who have lived experience of caring for someone with an eating disorder reporting financial pressures, resulting in the need to choose between support for themselves or for the person they were supporting. They also expressed the belief that obtaining another plan would be difficult and burdensome. Some people who cared for someone with an eating disorder felt 'forgotten about' and noted that healthcare professionals failed to check in on their wellbeing or to provide information about available services for themselves.

Further emphasising the importance placed on accessing support by people with a lived experience of caring for someone with an eating disorder, 96.0% of this group believed that it is necessary (moderately 11.4%; highly 84.6%) for carers to access sessions for their own needs without the person with an eating disorder present. This finding aligns with the Scottish national clinical guidelines that recommends formal support be offered to people who are caring for a person with an eating disorder [17].

4.4 The Role of Healthcare Professionals in Treatment Pathways

Our community survey and interviews provide information about health professional inputs into treatment pathways. Among health professionals who provide psychological treatment services for eating disorders, on average, 70% of people they support have been accessing treatment under the Eating Disorder Plan. This is similar to the 66% for health professionals who provide dietetic health services. Among these health professionals, perspectives on reasons people with an eating disorder are not using the Eating Disorder Plan to access eating disorder treatment are shown in Table 4.2. Lack of awareness of the Eating Disorder Plan by both people with lived experience of eating disorders and referring doctors was strongly endorsed by dietitians as a key reason that the Eating Disorder Plan was not accessed for treatment.

Table 4.2. *Health professional perspectives on reasons for using services other than the Eating Disorders MBS items*

	Psychological treatment providers % (n)	Dietetic health service providers % (n)
Not applicable – all are using the EDP	12.9 (11)	7.2 (6)
Ineligible	55.3 (47)	60.2 (50)
Using a Mental Health Treatment Plan instead	63.5 (54)	13.3 (12)
Accessing public services	7.7 (7)	22.9 (19)
Using private health cover instead	16.5 (14)	27.7 (23)
Financial constraints	14.1 (12)	32.5 (27)
Cannot access services due to long waiting lists	17.6 (15)	8.4 (7)
People with eating disorders are not aware of the EDP	27.1 (23)	48.23 (40)
Referring doctors are not aware of the EDP	29.4 (25)	63.9 (53)
Other reason(s)	15.3 (13)	22.9 (19)

Note. EDP = Eating Disorder Plan. Respondents could choose more than one response.

In qualitative interviews, health professionals were asked to describe the process of initiating and developing an Eating Disorder Plan and delivering services under the Eating Disorders MBS items. GPs stressed the importance of obtaining a comprehensive history of the presenting patients' eating disorder symptoms as a necessary first step. Because obtaining sufficient information solely from that person could be difficult, seeking further information from people with a lived experience of caring for that person was often required. GPs reported that this initial step was time consuming and exceeded the time allocated for their Medicare rebate. In support of these comments, findings from the community survey note the average time required in consultation sessions to gather the required information was 53.6 minutes (SD = 17.9), with an additional 33.3 minutes (mean, SD = 18.8) needed to write the actual plan. This is longer than the maximum indicated time of 40 minutes for preparing plans under the Eating Disorders MBS items.

In qualitative interviews, some GPs shared the strategies they developed to minimise the time spent completing this initial step, such as providing an eating disorder questionnaire to patients to complete at home and return on their second appointment. Further, GPs reported that people seeking assessment for an eating disorder sometimes presented with additional mental and physical health concerns, and that the Eating Disorder Plan was only provided if the main diagnosis was an eating disorder. Once the diagnosis of an eating disorder had been made, GPs reported several factors needed to be taken into consideration, including the person's willingness to access eating disorder treatment and services, the accessibility and availability of these services, and the financial capacity of the person to pay for any out-of-pocket costs.

For other health professionals, their role in supporting people to access and use an Eating Disorder Plan depended on the knowledge and experience of the GP. While GPs were required to initiate and create the plan, most of the mental health clinicians and dietitians reported in the qualitative interviews that they often had to inform GPs about what to include in the plan for it to be actioned.

Many felt GPs had insufficient knowledge and experience in working with people with an eating disorder, lacked knowledge about how to initiate and complete an Eating Disorder Plan, and how and when reviews needed to be completed. The views of GPs on their awareness of the Eating Disorder Plan are presented in Section 5.3.1.

Health professionals providing psychological treatment or dietetic intervention reported in interview responses that many GPs were unaware of ways in which the Eating Disorder Plan differed from other MBS plans. As a result, they had to spend significant unpaid hours educating GPs, providing them with resources about the Eating Disorders MBS items and, in some cases, helping GPs correct plans that were completed incorrectly. This aligns with community survey responses from health professionals in these same roles, with many (55.4%) indicating they provided moderate to high levels of support to referring doctors to use the Eating Disorder Plan, with only 3.2% providing no support at all.

In addition, mental health professionals and dietitians reported in interviews that GPs did not know that occupational therapists and social workers could deliver psychological treatment through the Eating Disorder Plan and often only referred people with an eating disorder to psychologists. In several cases, even when a GP completed an Eating Disorder Plan, people with lived experience or those caring for a person with an eating disorder were left on their own to find health professionals to deliver treatment. People with lived experience indicated this was very difficult, stressful, and many did not know where to start. Many also indicated this required a lot of energy and self-advocacy, which was a challenge they had not anticipated.

4.5 Other Linkages that may Complement Eating Disorders MBS Item Use

In qualitative interviews, health professionals, people with a lived experience of an eating disorder, and those who care for them reported that the Eating Disorder Plan was positive in providing or increasing available treatment sessions. However, several limits were also identified, with recommendations suggested to better improve the plan, including the need to better support care coordination.

Adding an Eating Disorders MBS item for case coordination to enable and support interactions and communication between mental health clinicians and dietitians was strongly recommended. Health professionals who had raised the point about the additional administrative work required to implement the Eating Disorder Plan, also felt strongly about this change, suggesting it would better enhance treatment cohesion, ultimately leading to better health outcomes.

We note that although case conferencing items have been available since July 2023, they do not allow for attendance by a dietitian and mental health professional only. Case conferences must be organised and coordinated by a GP or other medical practitioner, highlighting barriers to effective use of these MBS items to support coordinated eating disorder care.

Health professionals and those with lived experience of an eating disorder also suggested that creating a system to assist and facilitate care coordination including session tracking and reminders about appointments and upcoming reviews, would be beneficial. This system could be accessed by the entire care team, including people with lived experience of an eating disorder and those who care for them. This could address feelings of isolation and concerns about being excluded from the

Eating Disorders Plan expressed by those with a lived experience of caring for people with an eating disorder.

4.6 Summary and Recommendations

Available evidence suggests that using other MBS-based treatment services is common for people with a lived experience of an eating disorder. While in many cases use of initiatives such as Better Access preceded the formal introduction of Eating Disorders MBS items (November 2019), this did not fully account for their use among this population. Lack of awareness of the Eating Disorders MBS items, concerns about the ability to access these services in a timely fashion, and the need for treatment services for concerns beyond eating disorder symptoms were noted by people with a lived experience of an eating disorder, people with a lived experience of caring for people with an eating disorder, and health professionals.

Many people with a lived experience of caring for someone with an eating disorder who were surveyed or interviewed reported using treatment services independently to address mental health concerns arising from their caring role. The importance of these resources was noted by most people with lived experience of caring for a person with an eating disorder. Those carers who were able to receive support for their mental health concerns arising from carer roles noted that the support they received was generally of high-quality. However, financial and time-related barriers were also noted among those who identified the value of treatment but felt unable to obtain this support whilst caring for a person experiencing an eating disorder.

Surveys and interviews also provided insights into existing barriers to cohesive treatment delivery and opportunities to enhance services. Difficulties navigating healthcare services, incomplete data to inform treatment planning, and poor coordination of services where multidisciplinary plans and multiple services were enacted were noted. Additional support structures (e.g., care coordinators), including a broader support network (primary carer plus friends and other family members) in information gathering for treatment formulation, and greater use of appropriately skilled yet under-utilised health professions (e.g., occupational therapists, social workers) would enhance treatment delivery, and reduce both workload pressures on GPs and psychologists and associated wait times for services. The lack of knowledge on the part of GPs about eating disorders broadly, and the Eating Disorder Plan more specifically, was identified by mental health clinicians and dietitians, while all health professionals reported the excess costs required to initiate, develop, implement, and review the plan. Potential solutions for these barriers to effective treatment delivery are covered in Chapter 7 (*policy recommendations*).

5

Objective 3: Improvement in Access to Treatment Services

Evaluation of the Eating Disorders
Medicare Benefits Schedule Items 2024

5 Objective 3: Improvement in Access to Treatment Services

Key Points

- Access appears to be higher among people with anorexia nervosa than for other eating disorders, because of perceptions that eligibility criteria most directly target anorexia nervosa and that health professionals are more confident diagnosing this condition.
- Barriers to treatment for some people included difficulties navigating health systems, limited awareness of availability of treatment, costs associated with treatment and review, and long wait times.
- Involvement in the treatment process was highly valued by people with a lived experience of caring for someone with an eating disorder, but some felt it was difficult to obtain the level of access and coordination with health professionals needed.
- The ANZAED Eating Disorder Credential and other professional development opportunities appear to be well subscribed and may have enhanced awareness of eating disorder symptoms and treatment options and capability in providing eating disorder care, ultimately increasing workforce capacity to address demand for treatment services.

5.1 Overview

This chapter addresses Objective 3 and evaluates whether availability of the Eating Disorders MBS items has improved access to treatment services for eligible people.

Specifically, we evaluated:

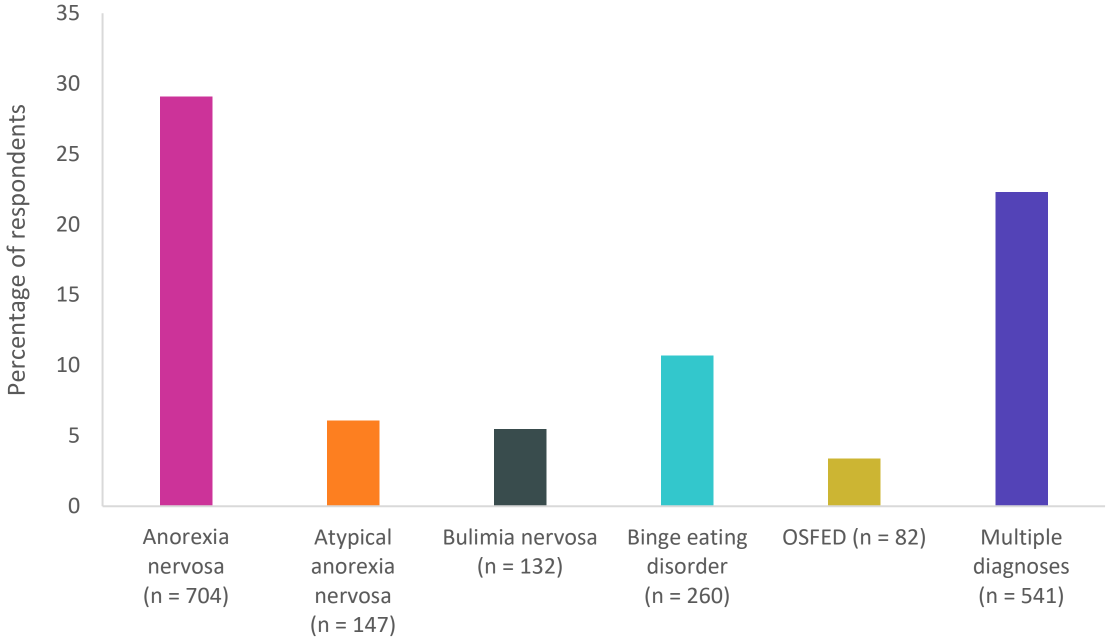
(i) the use of Eating Disorders MBS items according to eating disorder diagnosis, extent of need, and involvement of people caring for others with an eating disorder
(ii) the role of health professionals in ensuring access to the Eating Disorders MBS items, with particular focus on their levels of awareness, confidence, and professional development to deliver these services
(iii) factors that affect uptake of Eating Disorders MBS items. These include access issues such as geographic location, cost of treatment, and waiting times to access treatment. We also explored the role of level of awareness of the Eating Disorders MBS items, recognition of need for treatment, and factors related to therapeutic alliance in uptake.

5.2 Access to Treatment Services

Overall levels of uptake and utilisation of the Eating Disorders MBS items were reported in detail in Chapter 3. Here we explore the uptake of items for different eating disorder diagnoses, the relationship between uptake and extent of need, and the involvement in treatment of people who care for someone with an eating disorder to inform understanding of access to treatment services through the Eating Disorder Plan.

5.2.1 Uptake by eating disorder diagnosis and symptom severity

Medicare survey data shows utilisation of the Eating Disorders MBS (psychological treatment and dietetic health services) items according to diagnosis of survey respondents. The most frequently reported diagnosis was anorexia nervosa. A substantial proportion of respondents had more than one eating disorder diagnosis (see Figure 5.1). Among respondents with multiple diagnoses, comorbid diagnoses were anorexia nervosa and atypical anorexia nervosa (within the diagnostic category of OSFED; 1.3%), anorexia nervosa and bulimia nervosa (3.4%), anorexia nervosa and binge eating disorder (0.7%), bulimia nervosa and binge eating disorder (1.5%), bulimia nervosa and OSFED (0.4%), and other comorbidities (15.0%). Of note, a considerable proportion of survey respondents (17.6%) did not report a diagnosis.



Note. OSFED = other specified feeding or eating disorder. Additional diagnoses of avoidant/restrictive food intake disorder (2.7%); unsure (2.6%); and no diagnosis reported (17.6%) are not shown in the figure.

Figure 5.1. *Diagnoses of people with lived experience of an eating disorder accessing psychological treatment and dietetic services under the Eating Disorders MBS items from the Medicare survey*

Responses from people in the community survey with a current or past eating disorder show a slightly different pattern of diagnoses from the Medicare survey. In the community survey, most people who accessed the Eating Disorders MBS items had a diagnosis of anorexia nervosa (63.8%) or atypical anorexia nervosa (18.5%). Fewer people had diagnoses of bulimia nervosa (7.3%), binge eating disorder (4.6%), or OSFED (binge eating disorder with low frequency/limited duration; 0.4%); these were somewhat similar to the proportions observed in the Medicare survey.

A small proportion of respondents had diagnoses of avoidant/restrictive food intake disorder (ARFID; (3.5%) or other diagnoses (1.9%). It is noted that in the community survey, respondents selected only their current or most recent diagnosis type, whereas in the Medicare survey, respondents could select multiple diagnoses.

The pattern of access to the Eating Disorder Plan according to diagnosis type is somewhat consistent with the intent of the initial roll-out of the Eating Disorders MBS items and the eligibility criteria for the Eating Disorder Plan; to provide a treatment pathway for people experiencing greatest need and likely to be at higher risk. However, given the much higher prevalence in the community of bulimia nervosa and binge eating disorder relative to anorexia nervosa (i.e., approximately 8 to 12 times more prevalent [4,5]), it is possible that people with lived experiences of bulimia nervosa and binge eating disorder who meet the criteria of being at high risk are underrepresented and accessing the Eating Disorders MBS items at a lower rate than would be expected.

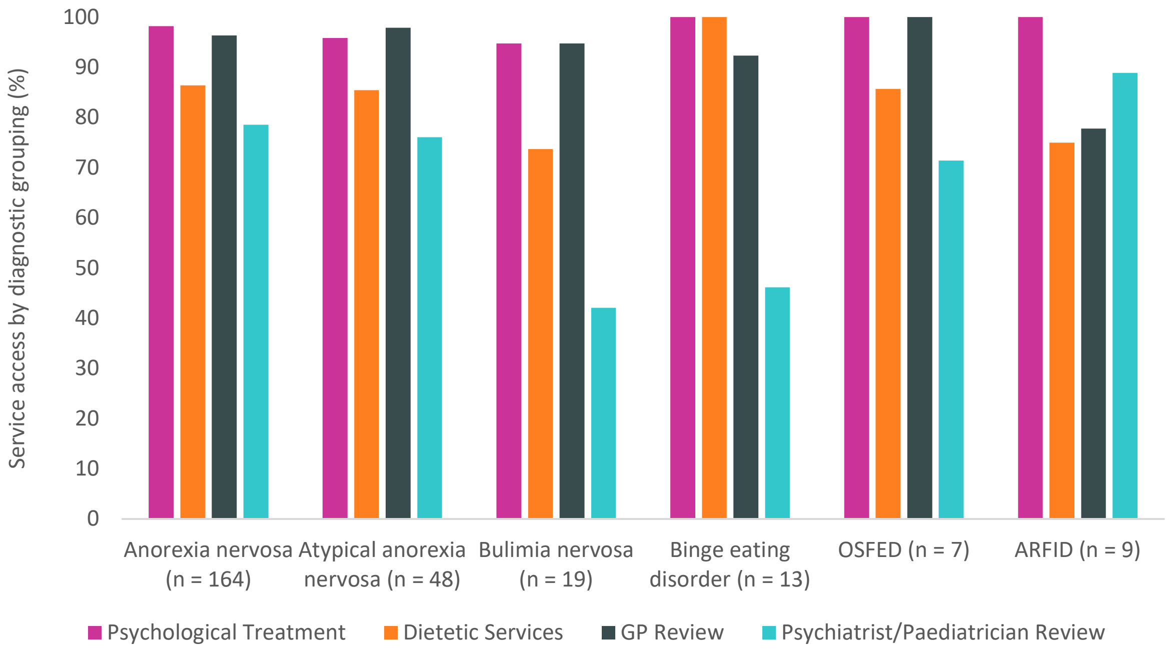
This possible imbalance across eating disorder diagnosis type was reflected in the qualitative interviews, where there were perceptions that: i) the Eating Disorders MBS initiative was targeted specifically or primarily for people with anorexia nervosa (people with lived experience of an eating disorder, people with lived experience of caring for someone with an eating disorder, and health professionals interviews); ii) anorexia nervosa is easier to identify in brief consultation sessions with GPs, particularly in terms of restrictive eating and low weight presentations (health professional interviews); and iii) more broadly, the eligibility criteria restricted or prevented access to Eating Disorder Plans for people with atypical eating disorder presentations, people living in a larger body, with severe and enduring clinical presentation, or for diagnoses not included in the eligibility criteria (such as those with a diagnosis of ARFID). Further exploration of views on the eligibility criteria will be presented later in this chapter in Section 5.4.4.2.

There was some indication from interviews and the community survey that people who did not meet, or who no longer met, eligibility criteria for the Eating Disorders MBS items received care through other services such as a Mental Health Treatment Plan via Better Access (see Section 4.2). However, as Services Australia data do not record the health condition for which people receive these broader psychological treatment services, it is difficult to identify the full extent of eating disorder coverage for those seeking help but denied access to an Eating Disorder Plan.

5.2.2 Uptake according to stage of treatment (plan, treatment, review)

As shown in Figure 5.2, regardless of diagnosis, most of the respondents to the community survey indicated they had received psychological treatment sessions and a review with a GP or other medical practitioner. A relatively high proportion had received dietetic health services. The exception to this pattern was seen among respondents with ARFID (note that eligibility criteria for an Eating Disorder Plan do not explicitly include ARFID), where a lower proportion of respondents received dietetic health services or a GP review than for other diagnostic groups.

Across all diagnostic groups, fewer people had received a review session with a psychiatrist or paediatrician that is required to access greater than 20 psychological treatment sessions, although more than three-quarters of respondents with anorexia nervosa, atypical anorexia nervosa, and ARFID had received this review.



Note. Respondents with atypical anorexia nervosa represented separately from other respondents with OSFED (other specified feeding or eating disorder).

Figure 5.2. *Use of the Eating Disorders MBS services according to eating disorder diagnosis among community survey respondents*

People with lived experience of an eating disorder who responded to the Medicare survey were asked about their use of psychological treatment and dietetic health services, but not review sessions. Figure 5.3 shows that across all diagnostic groups, most people used both psychological and dietetic services. A low proportion of respondents used dietetic services only and this was relatively consistent across eating disorder diagnoses (except where people were unsure of their diagnosis).

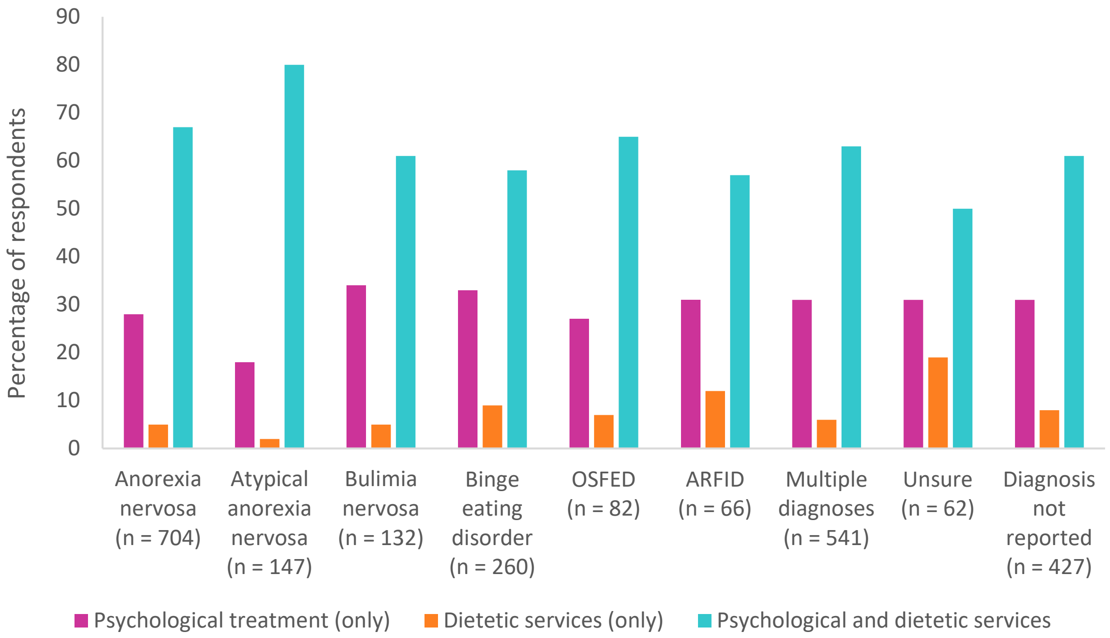
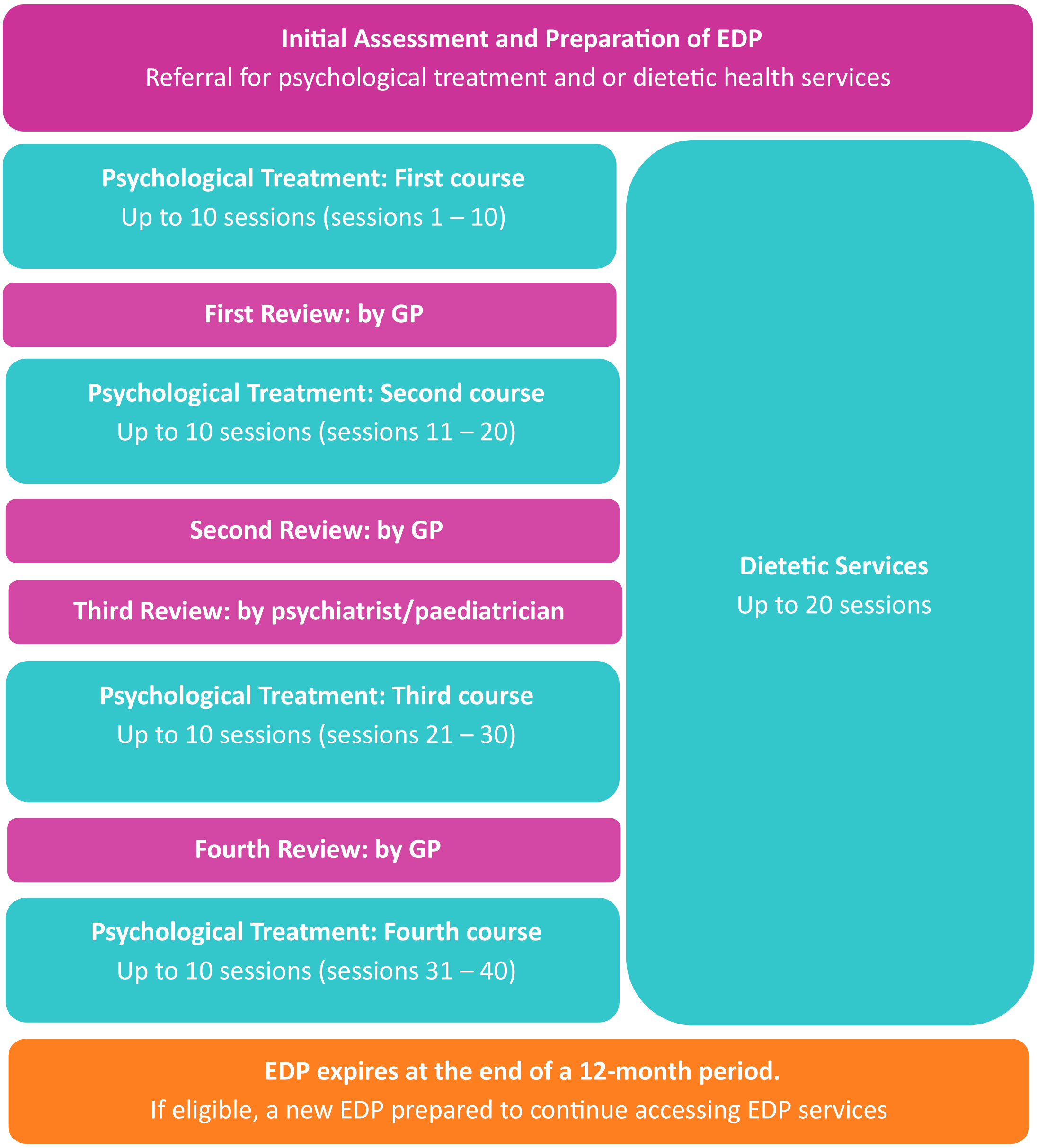


Figure 5.3. *Use of psychological treatment and dietetic services according to eating disorder diagnosis among Medicare survey respondents*

The community survey findings presented above contrasts data presented in Chapter 3 from the national linkage data study (Section 3.2.2.2). In the community survey, most people with lived experience of an eating disorder who received an Eating Disorder Plan also received psychological treatment and/or dietetic services, whereas the national linkage data showed a lower proportion, approximately two-thirds, of people who had received an Eating Disorder Plan had also gone on to receive any treatment services. The pattern observed among community survey respondents may reflect that participants were invited to complete the survey specifically to share their experiences of eating disorder treatment, and those who had received a plan but then not received treatment services may not have recognised themselves as having experiences that were relevant to the survey. In the Medicare survey, responses were only collected from people who received psychological and or dietetic services.

The required specialist review at the end of 20 sessions (see Figure 5.4 for a schematic of the treatment course process under the Eating Disorder Plan) was discussed by all participants in our interviews. Its relevance was questioned, with the need to see a psychiatrist for this review cited as a reason for stopping services. This may correspond with the lower uptake of the specialist review seen in responses to the community survey, shown in Figure 5.2. For some people with an eating disorder, interview responses indicated the significant financial cost, lengthy wait times, and inability to find a psychiatrist able to complete the review, meant the review could not be completed, and further services could not be provided. For others, traumatic experiences with past psychiatrists, having to attend appointments with a psychiatrist at a hospital, having to complete a review with someone they did not know, or fearing that the psychiatrist may admit them to inpatient care, meant they did not participate in the review process.



Note. EDP = Eating Disorder Plan

Figure 5.4. *Schematic of treatment and review process under the Eating Disorder Plan*

5.2.3 *Involving people caring for others with an eating disorder*

Involvement of people with a lived experience of caring for someone with an eating disorder who is accessing Eating Disorders MBS items is desirable where appropriate (as described in the Australian Department of Health and Aged Care [18] explanatory notes). This is consistent with clinical treatment guidelines from Germany, the US, and MEED [19-21] identified in our literature review study (see Chapter 8 of the Technical Report). These guidelines recommend that wherever possible those with a lived experience of caring for someone with an eating disorder should be involved in treatment, especially where the person receiving treatment is a young person.

It is also noted that health professionals should recognise the important role people who are carers play in treatment (see Chapter 8, Technical Report for further details on recommendations from international clinical guidelines) [21].

Formal participation in treatment via the Eating Disorders MBS items by people caring for someone with an eating disorder is not documented in Service Australia's records of service use. However, involvement in treatment for a person they care for was reported to a high extent by carer respondents to the community survey. This suggests that Eating Disorder Plans provided connection between people with a lived experience of caring for someone with an eating disorder and health professionals and provided a role for carers in the treatment process. For example, when asked about inclusion in treatment, only one person indicated they were not involved in treatment with the person they care for. Similarly, in the Medicare survey, more than half of people with lived experience of an eating disorder reported that they had been offered the opportunity for family or other supports to be involved in their psychological treatment (59.9%) or dietetic sessions (55.7%).

In addition, people who care for someone with an eating disorder were asked in the community survey if they accessed sessions with a health professional without the person they care for present. Among all respondents, more than half (60.2%) had done so for purposes of better understanding the experience of the eating disorder for the person they care for or to gain insights into how best to support the person they care for.

A higher proportion of people had sought this support among those with lived experience of caring for a person receiving treatment via an Eating Disorder Plan (68.9%) than receiving treatment via other means (47.8%).

Of those who had not accessed sessions, most were either trying to do so or would have liked to have done so but had not realised that option was available (55.1%). Of those people with lived experience of caring for someone with an eating disorder who accessed individual sessions, the majority (65.6%) had accessed more than 5 sessions.

Sessions accessed via the Eating Disorder Plan (without the person they care for present) were overwhelmingly perceived as positive, with most people with a lived experience of caring for someone with an eating disorder (88.9%) rating the sessions as helpful (moderately or very). A low number of respondents (3.7%) rated the sessions as unhelpful for better understanding the experience of the eating disorder for the person they care for or how best to support them.

Further data underline the importance of accessing support for people caring for someone with an eating disorder through their treatment. People with lived experience of caring for someone with an eating disorder were asked about the necessity for carers to access sessions without the person with an eating disorder present to be part of treatment via the Eating Disorder Plan. Almost all respondents (92.6%) rated this as necessary (moderately 8.9%; highly 83.7%) for better understanding of the person's eating disorder and how to support them.

Despite the general desire to participate in the treatment process and positive attitudes towards the importance of doing so, interviews with people who care for a person with an eating disorder revealed some barriers to participation.

Some people with lived experience of caring for someone with an eating disorder commented that it was more difficult to get information relating to treatment for people they care for over the age of 18 years, even if they had done so prior. They also reported feeling isolated and forgotten by health professionals, with little to no communication or collaboration between them that might otherwise have aided in successful implementation and ongoing management of the Eating Disorder Plan. As such, a significant amount of advocacy was reportedly required – both for the person with the eating disorder and those caring for people with an eating disorder – which was not anticipated. However, this experience may not be universal among people caring for a person receiving eating disorder treatment. For instance, in the community survey, 70.4% of respondents felt the Eating Disorder Plan was helpful (moderately or very) for being meaningfully included in treatment. It is perhaps among people like the 14.8% of people who care for a person with an eating disorder who felt that the Eating Disorder Plan was unhelpful (moderately or very) for being included in treatment that concerns about communication or collaboration arose.

5.3 Health Professional Approaches: Supporting Access and Use

The broader research literature highlights several key points relevant to the role of health professionals that promote help-seeking, engagement in treatment, and better treatment outcomes for people with eating disorders. These are the importance of i) first contact with a knowledgeable, competent health professional; ii) early response to treatment and monitoring of symptom progress to enable timely revisions to treatment plans; iii) use of evidence-based treatments; and iv) availability of a treatment manual for evidence-based treatments to support dissemination of these treatments [22,23]. The last point is likely to lead to greater capacity among health professionals to provide treatment that is supported by evidence as being effective.

This section explores health professional awareness, confidence, knowledge, and skill in applying treatment through the Eating Disorders MBS items. We also evaluated the extent to which they participated in professional development to increase awareness and improve treatment delivery.

5.3.1 Health professional awareness and confidence with the Eating Disorders MBS items

Health professionals in the community survey rated themselves as being aware of the Eating Disorders MBS items. Many medical practitioners who prepare Eating Disorder Plans (38.8%) and health professionals who provide psychological or dietetic sessions (57.1%) viewed themselves as highly informed about the Eating Disorder Plan and associated items.

Generally, people with an eating disorder and people with lived experience of caring for someone with an eating disorder were less positive in their assessment of health professionals' awareness of eating disorder treatment provisions through the Eating Disorder Plan. In the community survey, only 48.2% of people with a lived experience of an eating disorder and 56.0% of people with a lived experience of caring for someone with an eating disorder rated the health professional from whom they first sought help as well informed about the Eating Disorders MBS items. Few health professionals providing psychological or dietetic sessions viewed referring doctors as being highly aware of the availability of the Eating Disorder Plan (12.1%) or highly well informed about using the plan and associated items (4.5%). Medical practitioners who prepared plans were more positive in their perceptions of the professions to whom they refer, rating moderate proportions of those who provide psychological treatment (49.4%) or dietetic sessions (56.9%) as being highly informed about using the Eating Disorder Plan and associated MBS items.

Some health professionals reported in interviews that while initially confusing and hard to understand, those who used the Eating Disorders MBS items frequently now felt that providing services under the Eating Disorder Plan was largely straightforward, and they had confidence in using the items appropriately. However, for some GPs who saw people with eating disorders less frequently, a refresher was needed when setting up a new Eating Disorder Plan or when completing a review. Both infrequency and inexperience of use on the part of health professionals may have contributed to negative perceptions and experiences of people with an eating disorder and people with a lived experience of caring for someone with an eating disorder.

Some health professionals also reported confusion with item numbers, reporting they had difficulty finding the correct item numbers, or that some item numbers changed without notice. People with lived experience of an eating disorder and health professionals reported incorrect item numbers being added to plans, meaning rebates were not able to be applied. This was often discovered only at the time of payment and took significant time to rectify, meaning people with an eating disorder had to cover a larger payment. This item confusion was also found in the national data linkage study, where a small percentage of Eating Disorders MBS items were cancelled.

The discrepancy between perceptions of health professionals and people with lived experience of an eating disorder or of caring for someone with an eating disorder may reflect that health professional respondents to the community survey may be more engaged in eating disorder care than health professionals in general (see Section 5.3.3). The discrepancy may also reflect experiences earlier in the rollout of the Eating Disorders MBS items as reflected on by GPs in interviews.

Community survey data suggested that health professionals agreed with the importance of having appropriate knowledge, skills, and experience in providing eating disorder treatment through the Eating Disorder Plan, as required for service provision [18]. These ratings varied from 85.9% to 90.2% agreement (moderate or strong agreement), for preparing the plan and case review, respectively, and over 97% agreement with respect to mental health professionals and dietitians who provide treatment services under the Eating Disorders MBS items. In relation to their personal perceptions, overall, health professionals rated themselves moderately to highly confident (M = 74.5, SD = 17.7), knowledgeable (M = 76.3, SD = 16.8), and skilful (M = 74.6, SD = 17.7) in providing safe and effective eating disorder care (on a scale from 0 to 100). However, there was considerable variability in these self-assessments with ratings ranging from 8 – 100, reflecting that some professionals were less positive in their assessments of confidence, knowledge, and skill.

For specific tasks, medical practitioners did not find it difficult to determine eligibility overall (74.3%) or initial treatment recommendations and goals for psychological treatment (82.8%) and dietetic services (84.3%). However, ease of completing assessment of eligibility criteria for an Eating Disorder Plan was much lower for assessing people who did not fit the criteria for anorexia nervosa (59.4%).

This is consistent with views of people with an eating disorder and people with a lived experience of caring for someone with an eating disorder about difficulty in obtaining access to an Eating Disorder Plan when the diagnosis was other than anorexia. For example, community survey respondents with diagnoses of bulimia nervosa, binge eating disorder, and atypical anorexia nervosa found it significantly more difficult to have their eligibility for the Eating Disorder Plan determined by a doctor (M = 2.52, SD = 1.37) than respondents with a diagnosis of anorexia nervosa (M = 1.92, SD = 1.10).

5.3.2 Approaches of health professionals that support improved access to treatment with the Eating Disorders MBS items

General practitioners (and to a lesser extent paediatricians and psychiatrists) play an important role in setting the integrated care plan under the Eating Disorder Plan, including referral to psychological treatment and dietetic services. It is vital that recommended health professionals are appropriately trained and use evidence-based treatment options. Health professionals also play a crucial role in evaluating the progress of treatment under an Eating Disorder Plan in formal review processes to determine whether ongoing treatment sessions or an alternative approach are needed. Using review sessions to monitor early progress and, where necessary, modify the treatment approach is recommended to facilitate positive outcomes from treatment.

Findings from our evaluation studies reveal a less positive picture about implementation of and experiences with the review of treatment progress. Auditing GP documentation of treatment progress of people with lived experience of an eating disorder confirmed most GPs documented progress in terms of goals attained and the need for further treatment. However, data on symptom severity was not typically collated (or easily retrieved) at these review points. This is despite health professionals who deliver the evidence-based intervention generally reporting in interviews that they use eating disorder specific measures like the Eating Disorders Examination Questionnaire (a validated measure) to measure changes in symptoms in addition to noting goal attainment as a mark of progress.

For mental health professionals and people with lived experience of an eating disorder alike, the specialist (third) review (see Figure 5.4) was described in interviews as unnecessary and confusing. Psychologists did not always see the benefit in having a different mental health practitioner (with no existing relationship with the person experiencing an eating disorder) complete a review that they could do themselves with more in-depth knowledge of the person. Indeed, agreement with the importance of health professionals who provided review sessions having the appropriate knowledge, skills, and experience to provide eating disorder treatment was strong in the community survey responses among health professionals (90.2%), people with lived experience of an eating disorder

(88.4%), and people with a lived experience of caring for someone with an eating disorder (90.8%). However, health professionals reported finding such a provider to be difficult (see Section 5.4.4.2). As discussed in Section 5.2.2, the need to see a psychiatrist or paediatrician for the 20-session review was cited by people with lived experience of an eating disorder as a reason to stop services. They reported frustrations with financial burden, waiting lists, and a lack of therapeutic relationship with the person providing the review.

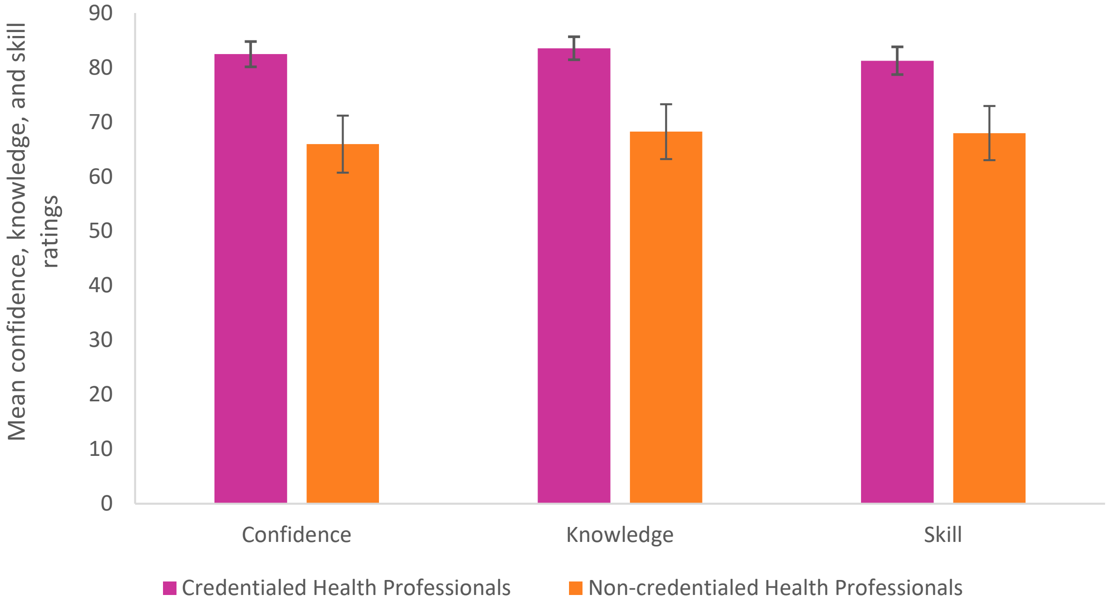
Mental health professionals, people with an eating disorder and those who care for them also felt this review was an arbitrary point in time or a 'tick-the-box' exercise. They felt this specialist review at that specific point was not supported by evidence, or if it was, it was not communicated properly. Depending on this review to obtain further sessions was a frustrating process for all and was especially stressful for people with an eating disorder and people with lived experience of caring for a person with an eating disorder.

5.3.3 Health professional experience and training in eating disorder treatment

Health services provided through the Eating Disorders MBS items (determining eligibility and preparing the plan, treatment, and review) are intended to be delivered by health professionals with the knowledge, skills, and experience to provide treatment to people with eating disorders. We explored health professionals' experience with eating disorders in their work, and engagement with training via tertiary curriculum and/or professional development opportunities.

Community survey data showed that our sample of health professionals had been practicing in their current profession for an average of 12.4 years (SD = 9.4; range 0.5 – 42), with 8.9 (SD = 7.8; range 0.25 – 42) of these years spent treating people with lived experience of an eating disorder. However, regular use of the Eating Disorder Plan was somewhat low among respondents. Most medical practitioners (83.8%) reported preparing two or fewer plans per month. Providers of psychological treatment and dietetic sessions were highly engaged in working with eating disorders. More than half of providers reported that 60% or more of the people they saw for treatment over the past year had an eating disorder. However, providing treatment through the Eating Disorder Plan was less frequent, with most psychological treatment providers (62.4%) and dietetic session providers (60.2%) reporting seeing five or fewer clients with a lived experience of an eating disorder through the Eating Disorder Plan per month.

Almost two-thirds (65.1%) of community survey health professional respondents who were eligible to apply to become a Credentialed Eating Disorder Clinician, were credentialed. This showed high engagement of health professionals in eating disorder work. These health professionals have been formally recognised as having the qualifications, knowledge, and training to meet minimum standards for delivering safe and effective eating disorders treatment. There was no difference in the length of time credentialed (M = 8.3, SD = 6.9 years) and non-credentialed (M = 8.9, SD = 8.1 years) health professionals had been working with people with eating disorders. However, perceptions of confidence, knowledge, and skill in providing safe and effective eating disorder care were significantly higher among those who were credentialed than those not (see Figure 5.5).



Note. Error bars are 95% confidence intervals.

Figure 5.5. *Mean self-ratings of confidence, knowledge, and skill by Credentialed Eating Disorder Clinicians and non-credentialed health professionals in the community survey*

Most health professionals from the community survey had completed eating disorder-specific professional development training (87.4%), with most training completed since the Eating Disorders MBS items were introduced in November 2019 (95.0%). Engagement in professional development opportunities is particularly important, given evident gaps in tertiary training for eating disorder-focused treatment. All health professionals who participated in qualitative interviews, irrespective of the discipline, agreed that the initial eating disorders training included in their entry to practice degree was insufficient. The training rarely exceeded a few hours and often focused on the description of the different eating disorders and some eating disorder-specific interventions. Eating disorder-specific placements were rare as has also been documented in the literature [24]. The lack of training about eating disorders, and the negative impact it can have, was highlighted in interviews with people with lived experience who reported being offered unhelpful and potentially detrimental information and interventions by their GPs to address their concerns with and manage their weight.

To build discipline-specific knowledge and skills, health professionals reported actively seeking out professional development focused on eating disorder assessment and treatment. This was supplemented by structured supervision with experienced practitioners to enhance their clinical competence and support the delivery of comprehensive and informed care. This process of seeking further professional development to enhance eating disorder capability aligns with the requirements under the ANZAED Eating Disorder Credential.

5.4 Factors that Affect Uptake of Eating Disorders MBS Items

5.4.1 Geographic Location

Across 2019 to 2022 inclusive, findings from the national data linkage study showed a general under-representation of people from inner regional (14.6% of Eating Disorders MBS items users vs 18% of general population) and outer regional/remote geographic areas (5.3% of Eating Disorders MBS items users vs 9.9% of general population) relative to their representation of the overall Australian general population. In contrast, for the same period of time, the proportion of people using Better Access was closer to these overall general population proportions (17.9% for inner regional and 7.8% for outer regional/remote), suggesting less uptake of services particularly for this specialised eating disorder service through MBS in regional and remote areas.

As shown in Table 5.1, there were modest increases over time in the proportion of people living outside of major cities who accessed Eating Disorders MBS items. These increases partially coincide with the introduction of telehealth and phone-based Eating Disorders MBS items. Figure 5.6 shows – for all years combined – that individuals in outer regional/remote areas were more likely to use telehealth options for Eating Disorders MBS psychological services (37.3% vs 34.6% in major cities). This uptake of telehealth in inner regional, outer regional, and remote areas was also higher than observed for Better Access, suggesting availability of telehealth treatment services may have had modest influences on enhancing Eating Disorders MBS items access for people in these areas since introduction of this option into the Eating Disorders MBS items initiative. Notably, telehealth options were taken up less frequently for dietetic services in inner regional, outer regional, and remote areas.

Table 5.1. *Eating Disorders MBS items use over time by geographic location*

Characteristics	n = 14,666	n = 10,849	n = 9,529
	Year 1 (+)	Year 2	Year 3
Remoteness			
Major city	81.4%	80.6%	77.9%
Inner region	13.6%	14.5%	16.1%
Outer region/remote	5.0%	4.9%	6.0%

Note. Year 1 (+) refers to 14 months of operation from the start of the Eating Disorders MBS items initiative from November 2019 through to the end of 2020

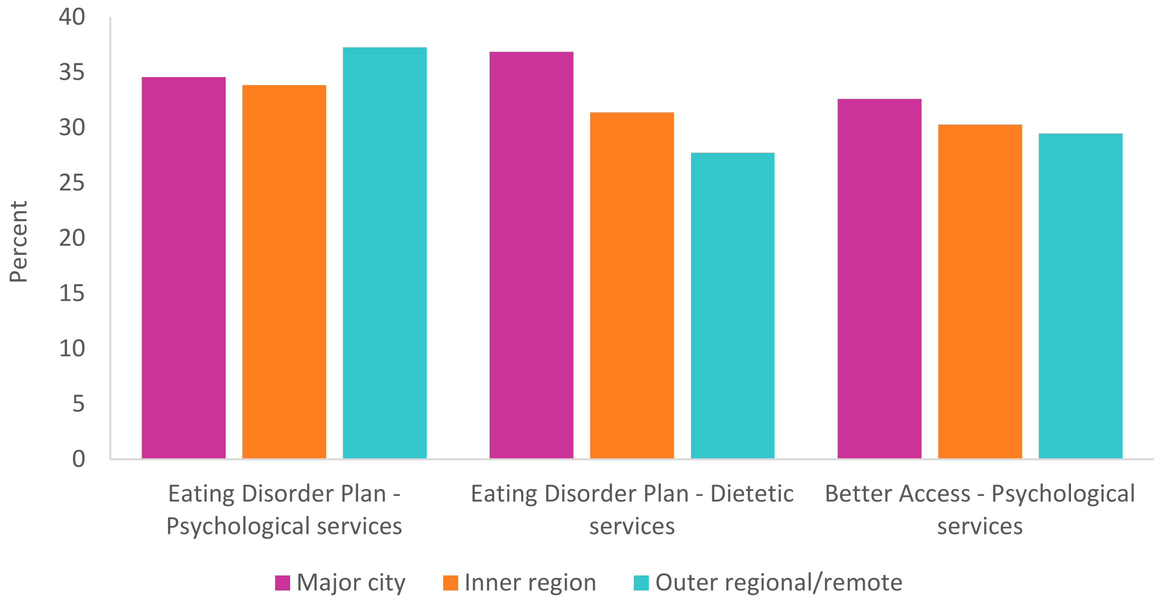


Figure 5.6. *Percent of services delivered by telehealth by treatment type and region*

5.4.2 Cost of services

Financial barriers to treatment arose across several studies in this evaluation. As detailed in Section 3.3, there was a clear gradient of use associated with household income, with people from households in the lowest income band reporting fewest services accessed. Among people with lived experience of an eating disorder who responded to the Medicare survey, almost half (46.6%) indicated that the direct out-of-pocket fee they had to pay for psychological treatment sessions was too expensive and a reason for not receiving all sessions available to them. Additionally, 10.5% also indicated that indirect out-of-pocket costs associated with treatment (e.g., transport, income loss) was a factor in receiving fewer than the available number of sessions. Cost was also identified as a factor for receiving fewer than the available number of dietetic sessions, with 33.3% endorsing the direct expense of treatment and 8.8% endorsing indirect costs as reasons for stopping dietetic health sessions.

Out-of-pocket co-payments were identified for 81% (n = 1,959) of respondents to the Medicare survey who provided consent to access their linked MBS data. Out-of-pocket costs were incurred for most psychological treatment services (90%) and dietetic health services (84%). The median per-service co-payment (AUD 2022-23) for those who incurred an out-of-pocket co-payment was $33 (interquartile range [IQR] $20 - $100) for psychological services and $29 (IQR ($19 - $79) for dietetic services. The national data linkage study also found that out-of-pocket costs were higher for psychological than dietetic services regardless of the characteristics of the person receiving the service, such as education level, household income, employment status, age, and region.

Total costs over the five-year period of available linked data were calculated in the Medicare study. The median total out-of-pocket co-payment for survey respondents who incurred a co-payment was $985 for those who received any psychological services, $338 for those who received any dietetic services, and $1,653 for those who received both psychological and dietetic services. A small difference was observed between the median total co-payments made by those who self-reported the perception that the fees for their psychological (Md = $876, IQR $304 - $1,828) or dietetic sessions (Md = $335, IQR $110 - 748) were affordable and those who perceived their fees paid for their psychological (Md = $934, IQR $293 - $1, 807) or dietetic sessions were too expensive (Md = $480, IQR $160 - $1,023).

The community survey also identified cost as a barrier to receiving services. When asked about the cost of treatment via the Eating Disorder Plan, about half of people who had received treatment supported by the Eating Disorder Plan said that they paid a fee that was too expensive (46.3%), and a further 17.6% of respondents indicated the fee was too expensive and they could not receive as much treatment as they wanted or needed. Similarly, people with lived experience of caring for someone with an eating disorder viewed the fee paid for treatment as too expensive (56.9%), with a small proportion indicating that the cost limited the treatment received (9.5%).

In qualitative interviews, financial constraints were commonly identified as a significant barrier to ongoing Eating Disorder Plan use, with numerous people with lived experience of an eating disorder reporting that while the plan provided a rebate for some of the cost of treatment, the gap payments were not financially sustainable. In addition, mental health professionals and dietitians reported that many people with an eating disorder referred to them by a GP were not aware they need to pay a gap payment. The cost of the specialist review at 20 sessions was often excessive, resulting in people with lived experience of eating disorder not getting the review and either paying for sessions privately or not accessing further sessions. Many chose to wait for the 12-month period to pass and initiate a new Eating Disorder Plan with their GP – a reflection that may help account for the number of people accessing Eating Disorders MBS items over multiple years (see Section 3.2.2.2).

Mental health professionals and dietitians indicated in interviews that they provided some bulk-billed services. The national data linkage study showed that this was limited to 15-16% of services on average, with people in lower income brackets more likely to receive psychological treatment and dietetic services at no out-of-pocket cost than those in higher income brackets. However, health professionals in interviews perceived bulk billing to be financially unsustainable. Dietitians, an occupational therapist, and social workers raised concerns about the lack of rebate available for additional tasks such as collaboration, report writing, and supporting GPs, such that it was not financially viable for them to provide bulk-billed services.

Although cost was viewed as impacting ongoing access to treatment, the availability of the Eating Disorder Plan appears to provide cost benefits over other pathways for treatment. For example, in the community survey, both those with lived experience of receiving treatment via an Eating Disorder Plan and those who care for a person who received treatment via an Eating Disorder Plan perceived treatment as significantly more helpful for reducing financial burden than those whose treatment experience was via other means (see Figure 5.7). This perception is supported by findings from the national data linkage study. These showed that among those who pay out-of-pocket costs, the average cost per session for psychological treatment ($56.68) and dietetic health services ($49.77) through the Eating Disorders MBS is slightly lower than comparable services through the Better Access mental health treatment plan ($66.27) or chronic disease management services ($51.52).

However, it is possible that recognition that a greater number of sessions are eligible for rebates under the Eating Disorder Plan than through other MBS initiatives may contribute to perceptions that the Eating Disorder Plan is more helpful for reducing financial burden. This may be particularly important for those who anticipate accessing, or have accessed, more than 10 psychological treatment sessions (the upper threshold for the number of sessions for which rebates are available through Better Access) or more than 5 dietetic health services (the upper threshold for the number of sessions for which rebates are available through chronic disease management services) and would otherwise have to pay the full cost of sessions for each session beyond these thresholds were the Eating Disorder Plan not available.

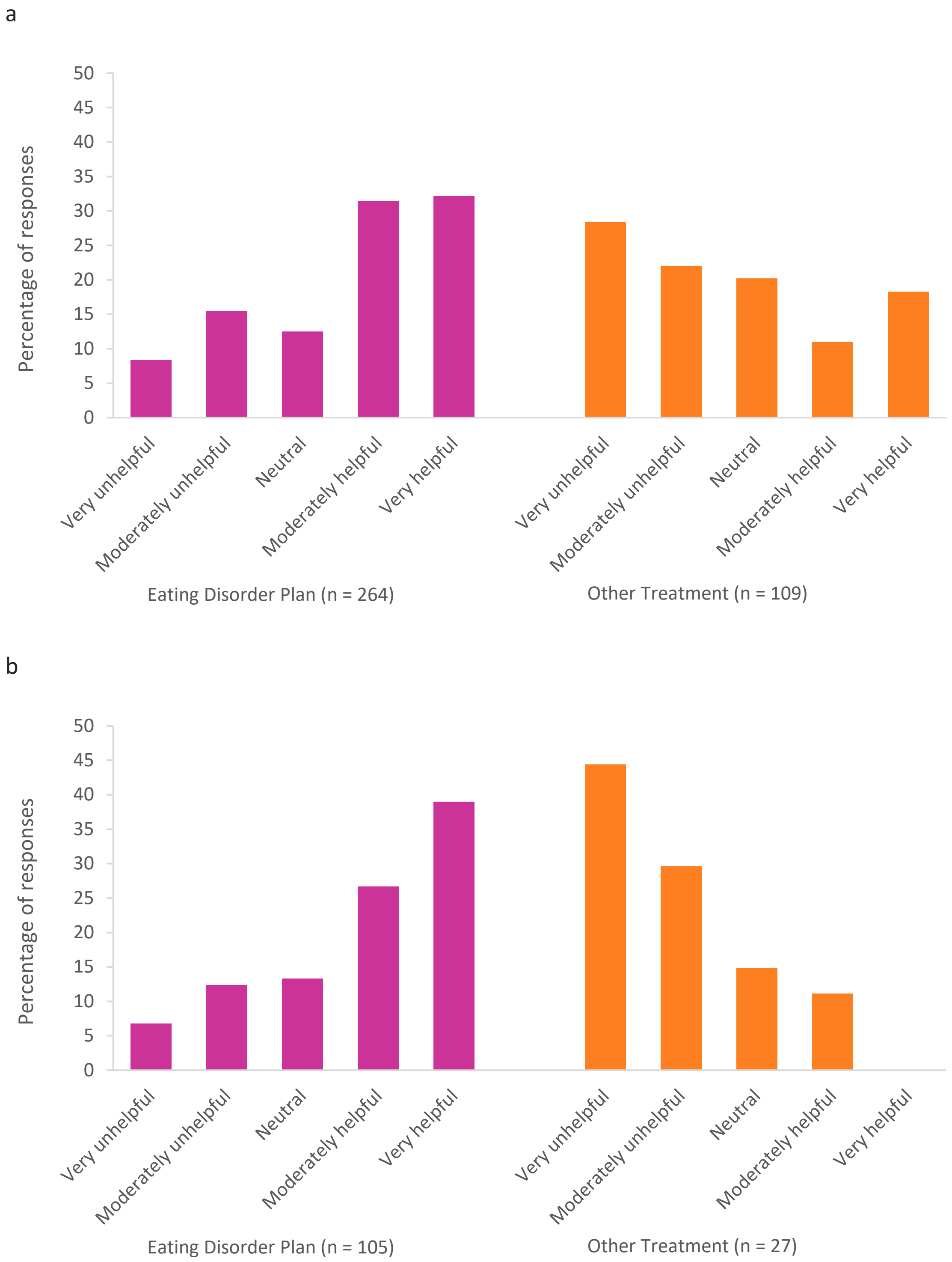


Figure 5.7. *Perceptions of helpfulness of the Eating Disorder Plan and of treatment via other means for reducing financial burden by (a) people who have received eating disorder treatment and (b) people with lived experience of caring for someone with an eating disorder*

5.4.3 Waiting times for services

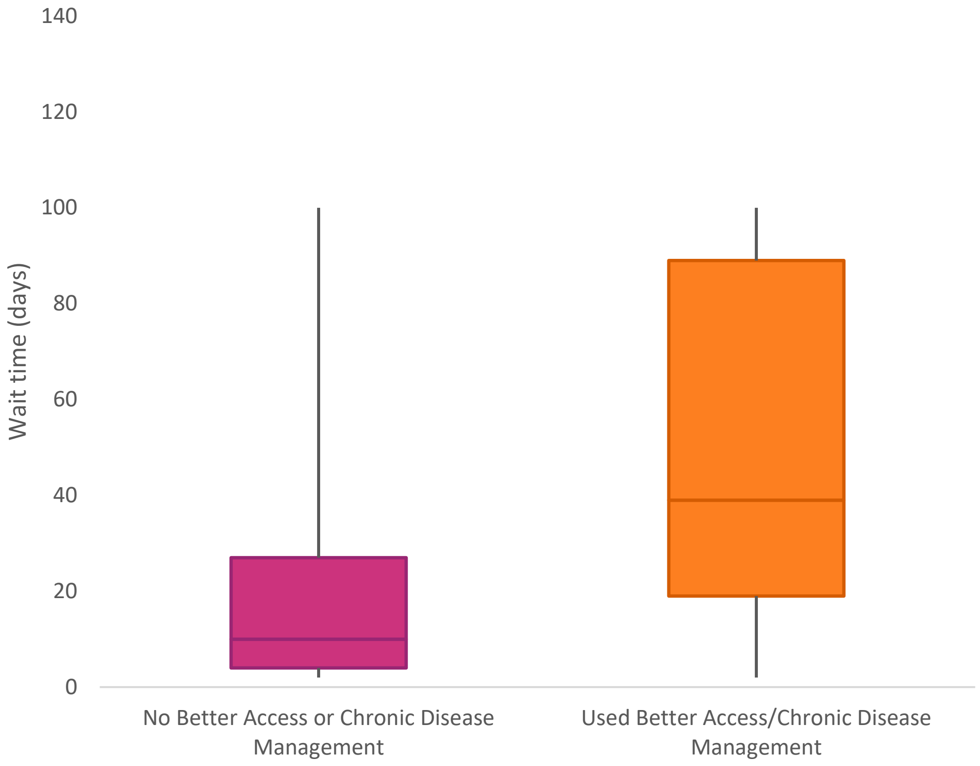
There was typically some wait time between receiving an Eating Disorder Plan and starting treatment. According to Services Australia national linkages data, among those who did access treatment, the average (mean) wait time between receiving a treatment plan and the first treatment service was 42.6 days. However, the median wait time was 15 days, and the inter-quartile range 6 – 41 days, indicating the mean is inflated by outliers with very long wait times. Ten per cent of those who received treatment waited 100 days or longer for their first treatment service.

We examined whether these long wait times for eating disorder treatment services could be explained by service users accessing services through a different treatment plan, such as Better Access or a chronic disease management plan. Of people with an Eating Disorder Plan who accessed treatments, 24.2% had used services under a Better Access Mental Health Treatment Plan and 5.7% had used services under a chronic disease management plan after receiving their Eating Disorder Plan. People who did not access services through either Better Access or a chronic disease management plan had average wait times for treatment of 27.5 days, with a median wait time of 10 days and inter-quartile range of 4 – 27 days. Those who used services under another initiative (Better Access or chronic disease management plan) had longer wait times for eating disorder specific services through the Eating Disorders MBS items (see Figure 5.8). For these people, the average wait time was 82.6 days, the median was 39 days, and the inter-quartile range was 19 – 89 days. This indicates that for some users, the wait time to receive treatment was artificially inflated while they used their allowed services through a pre-existing plan before moving on to eating disorder-specific services.

Although these data indicate that the wait time for treatment services is on average reasonable, for the 25% of people who receive an Eating Disorder Plan and wait more than 27 days to receive treatment via the plan, there is a concern that this time lapse does not allow for a timely response and may be detrimental to outcomes. Given the risk of poorer outcomes (symptom exacerbation and greater likelihood of treatment dropout) for people who have delayed treatment, this could be a substantial impact at individual and population levels.

Views on wait times from people with lived experience of an eating disorder in our Medicare and community surveys corresponded with the wait times observed in the national linkage data. In the Medicare survey, about one third (36.6%) indicated waiting too long to receive their first psychological treatment session through the Eating Disorder Plan (agree 23.9%; strongly agree 12.7%) and a slightly lower proportion (19.4%) reported waiting too long for their first dietetic appointment (agree 15.2%; strongly agree 4.1%). Similarly, responses from the community survey indicated that about one in ten people who had received psychological treatment and dietetic services through an Eating Disorder Plan felt they had to wait *much too long* to receive these sessions (14.1% and 11.4%, respectively). The importance of reducing wait times is emphasised in Chapter 7 (see recommendations #14, 16,18-23).

Responses of health professionals in the community survey demonstrate variable availability for provision of psychological treatment and dietetic health services. A small proportion of mental health professionals (22.2%) had immediate availability whereas about half of dietitians (56.6%) had immediate availability. Similar proportions of mental health (13.5%) and dietetic professionals (13.2%) had stopped taking on new referrals. Of those who had a wait list for new referrals (psychological treatment providers 59.3%; dietetic health service providers 30.3%), wait list times varied with about 80% of psychological treatment providers having a wait list of up to 3 months (less than 1 month 8.3%; 1 month 20.8%; 2 months 25.0%; 3 months 25.0%; > 3 months 20.9%) and about 80% of dietetic service providers having a wait list of up to 2 months (less than one month 30.4%; 1 month 30.4%; 2 months 21.7%; 3 months 4.3%; > 3 months 13.0%).



Note. The figure displays the range of wait times. The lower vertical lines show the lowest 25% of wait times starting from the minimum wait. The upper vertical lines show the highest 25% of waiting times through to the maximum wait time. The boxes represent the middle 50% of wait times with the midline being the median wait time.

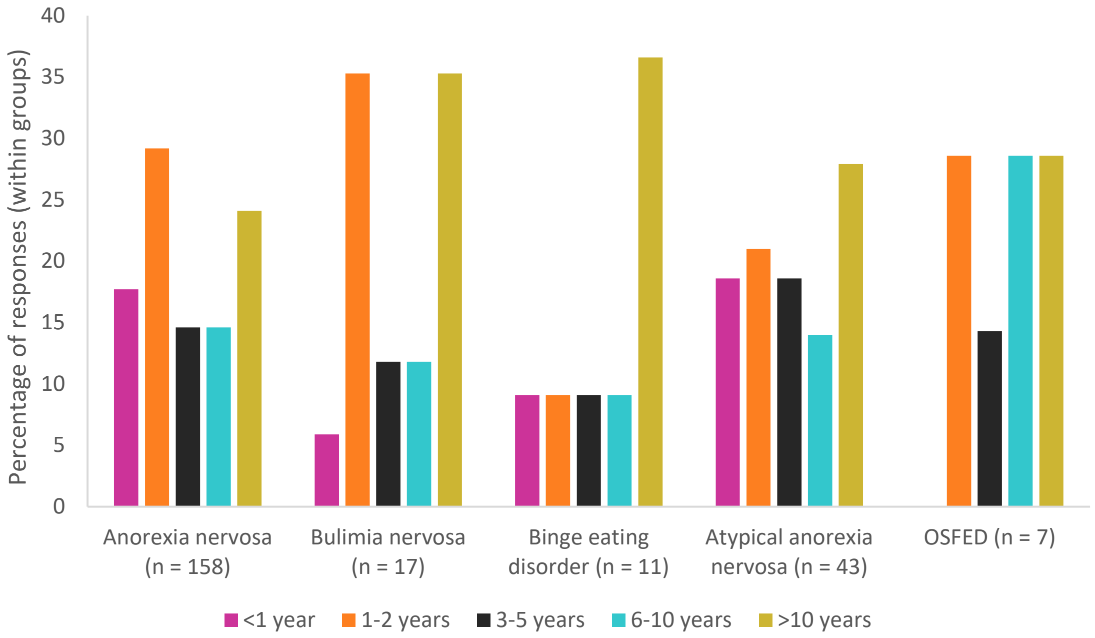
Figure 5.8. *Wait time in days from plan preparation to receipt of any treatment according to overlapping or non-overlapping use of Eating Disorder Plans with Mental Health Treatment Plans or chronic disease management services*

Qualitative interview data provided further context for understanding treatment delays and consequent frustrations. People with a lived experience of caring for someone with an eating disorder reported finding the process for getting and implementing the Eating Disorder Plan confusing and frustrating. This frustration was expressed in relation to the perceived lack of knowledge and experience of GPs regarding both the Eating Disorder Plan in general and knowledge of local health professionals to provide referrals to. There was a general feeling that this leaves those people with a lived experience of caring for someone with an eating disorder unsure of how to understand and navigate the Eating Disorder Plan, with significant time required to address these barriers. Further, the location of appropriate healthcare professionals, and difficulties in securing appointments – particularly where long waiting lists were experienced– increased frustration with significant back and forth required between the person with lived experience of an eating disorder or those caring for the person with an eating disorder and health professionals. Concern was expressed by interviewees at the perceived danger this posed when the person with the eating disorder was experiencing a decline in health or was refusing treatment. Similarly, in the community survey, among respondents whose treatment had not progressed as planned, some people with lived experience of an eating disorder (37.2%) and half of those with lived experience of caring for someone with an eating disorder (50.0%) felt that waiting too long had made them feel discouraged about treatment.

5.4.4 Additional identified barriers and enablers to access and use

5.4.4.1 Perspectives of people with lived experience of an eating disorder and people with lived experience of caring for someone with an eating disorder

Our community survey and qualitative interviews asked about barriers and enablers to access. Long time lapses between eating disorder onset and treatment suggests that access barriers may exist. Many survey respondents (27.1%) reported having an eating disorder for more than 10 years prior to first receiving treatment through an Eating Disorder Plan, noting that this does not account for previous treatment through other means such as a Mental Health Treatment Plan. As shown in Figure 5.9, time between recognising eating disorder onset and receiving treatment through an Eating Disorder Plan varied according to diagnosis.



Note. Respondents with ARFID (n = 9), other (n = 1), or unsure (n = 7) diagnoses not included in the figure.

Figure 5.9. *Years having an eating disorder prior to receiving treatment through an Eating Disorder Plan reported by people with lived experience of an eating disorder in the community survey*

Regarding barriers to access to an Eating Disorder Plan, other than the plan not being available when people with lived eating disorder experience first needed treatment (51.5%), as noted above in Section 4.2, the most common reason for an Eating Disorder Plan not being accessed for treatment was people with eating disorder lived experience not knowing the plan was available (45.5%). A smaller proportion (20.1%) also reported that the health professional they saw at the time did not know an Eating Disorder Plan was available. These responses were mirrored by people with lived experience of caring for someone with an eating disorder. One third (33.3%) reported that an Eating Disorder Plan was not available when treatment was first needed, more than half were not aware of the availability of the plan (52.8%), and a smaller proportion reported that their health professional was not aware of the availability of the plan (16.7%).

Among a subsample of people with lived experience who had yet to seek help for their eating disorder symptoms (n = 31), personal reasons for not seeking treatment were prominent. These included thinking their eating concerns were not sufficiently serious to seek treatment, that they preferred to manage eating concerns on their own, that they were not ready for treatment, or feared stigma or discrimination from seeking treatment (see Table 5.2).

Additionally, several systemic issues impeded treatment seeking. One third to half of people identified that cost of treatment, lack of awareness of where to get treatment, and previous negative healthcare experiences were reasons they had not sought treatment for their eating disorder.

Table 5.2. *Reasons for not seeking eating disorder treatment*

Reason	Frequency	%
Did not think that their eating concerns were serious enough to require treatment	22	71.0
Preferred to manage eating concerns on their own	19	61.3
Not ready to seek treatment	18	58.1
Feared stigma or discrimination from seeking treatment	18	58.1
Could not afford to pay for treatment	15	48.4
Did not know where to go to get treatment	12	38.7
Had previous negative experiences in the health care system	11	35.5
Did not think that treatment would help	10	32.3
Did not know treatment was available for the type of problem they have	5	16.1
Waiting lists for access to treatment were too long	4	12.9
Only recently became aware of having an eating disorder	4	12.9
Preferred to use social supports	3	9.7
Other reason/s	2	6.5

Note. Multiple responses were permitted.

In qualitative interviews, people with lived experience of an eating disorder reported challenges in obtaining an Eating Disorder Plan. They also found it difficult to find mental health professionals and dietitians able to implement the plan. Mental health professionals and dietitians expressed similar concerns, worrying that the hurdles and challenges associated with the Eating Disorder Plan might prevent people with lived experience from receiving treatment.

Other factors were also evident that impacted people having ongoing access to treatment through an Eating Disorder Plan. People with lived experience of an eating disorder who stopped using an Eating Disorder Plan did so for various reasons. First, some reached a stage of their recovery journey where they had met their goals, their symptoms had improved, and they no longer needed services provided under an Eating Disorder Plan. Others said because their symptoms had improved, they no longer met the eligibility requirements. As a result, even if they still felt they needed further treatment, they did not qualify for a new treatment course under an Eating Disorder Plan. In relation to this point, most people in the interviews also expressed concerns about the lack of flexibility in an Eating Disorder Plan to adequately support people with lived experience of eating disorders in different stages of recovery.

At times, progress counterintuitively seemed to result in having to stop the plan or prevented access to further sessions, even while still being unwell. Participants felt this contributed to the widespread belief that people with an eating disorder must prove that they are ‘sick enough’ to benefit from adequate treatment.

Some people with lived experience who still met the eligibility requirements stopped services under an Eating Disorder Plan because they could not access appropriate services within their region, had competing financial demands, encountered lengthy waitlists, were not able to find a healthcare professional who was the right ‘fit’, or had hesitancy in completing the 20-session review. Regarding the 20-session review, in the community survey, about half of people with lived experience of an eating disorder (52.8%) and with lived experience of caring for someone with an eating disorder (43.9%) indicated that it was difficult to access or complete.

Similar reasons for not receiving the total number of psychological or dietetic sessions available via an Eating Disorder Plan were reflected in responses by people with lived experience of an eating disorder in the Medicare survey. Although many reported not needing further sessions because they felt better (psychological treatment cessation 27.2%; dietetic services cessation 22.8%), only a small portion who had received fewer than ten psychological sessions (9%) or fewer than 5 dietetic sessions (18%) reported having ceased sessions due to feeling better. Slightly more reported sessions being unhelpful (psychological 36.3%; dietetic 44.7%) as a reason for ceasing sessions and some did not like the manner or approach of their healthcare provider (psychological 23.7%; dietetic 21.5%). This latter reason was particularly prominent early in treatment; 43% respondents who had received fewer than 10 psychological sessions and 51% of respondents who had received fewer than 5 dietetic sessions endorsed not liking the manner or approach of their health professional as a reason for stopping treatment.

As noted in Section 5.4.2, treatment expense was a more prominent reason for stopping treatment from psychological (46.6%) than dietetic sessions (33.3%). Furthermore, for access to psychological sessions, one in ten (11.5%) respondents reported they did not continue treatment because they did not want to have another GP or specialist review to obtain additional sessions. Proportionally, this reason for stopping psychological treatment was more common for those who had received fewer than 10 sessions (21%) or 10 – 19 sessions (40%) than those who had received 20 – 29 sessions (13%), 30 – 39 sessions (8%), or 40 or more sessions (6%). Similarly, in the community survey, about one in ten people with lived experience of an eating disorder (9.8%) and people with lived experience of caring for someone with an eating disorder (12.5%) indicated they could not get a review at the right time to access further sessions.

5.4.4.2 Perspectives of health professionals on system and service barriers

Barriers related to implementing the Eating Disorders MBS items from the perspective of healthcare professionals were also explored in the community survey. These included the ease or difficulty with which health professionals completed the required components of an Eating Disorder Plan, and the perceived adequacy of remuneration and time taken for these activities.

Preparing and managing an Eating Disorder Plan

Although more than half of health professionals engaged in preparing Eating Disorder Plans and coordinating treatment reported selecting appropriate providers of psychological treatment (51.5%) and dietetic services (63.2%) to be relatively easy, other difficulties were reported. Some level of difficulty finding health professionals who were available to provide psychological sessions in a timely manner was reported by 88.3% of respondents. Difficulty finding a dietitian for timely provision of dietetic services was reported to a somewhat lower extent (66.2%). These difficulties may have impacted initial and ongoing access to care for people with eating disorders.

In relation to ongoing access, most medical practitioners reported it was difficult (29.9%) or very difficult (55.2%) to select an appropriate psychiatrist or paediatrician to conduct the 20-session review, and even more difficult to find a provider with availability to conduct a timely review (14.9% difficult; 80.6% very difficult.

In terms of remuneration for preparing an Eating Disorder Plan, most health professional respondents to the community survey said the fee was not sufficient with 68.6% reporting the fee was much less than required and 24.3% reporting that it was somewhat less than required. Only 7.1% of respondents indicated the fee was about right, with only 4.4% of GPs being in this category.

We explored the tasks required to be completed in preparing the plan in terms of the impact of the task and the time for completion on perceptions that the schedule fee was too low. A high proportion of medical practitioners (78.5%) reported that providing education about eating disorders made a large contribution to the schedule fee being too low. The remaining 21.5% indicated a moderate contribution. Providing an opinion on diagnosis and providing treatment options and recommendations (moderate 46.2% and 47.7%; large 53.8% and 49.2%, respectively) also contributed to perceptions that the fee was inappropriate. Providing a copy of the plan to the person with the eating disorder and where appropriate a person providing care was reported as contributing somewhat less to the fee being perceived as too low (no contribution 47.7%; moderate contribution 36.9%; large contribution 15.4%). Given that most medical practitioners reported being confident in completing the tasks required to prepare Eating Disorder Plans (see Section 5.3.1), these views about the impact of the tasks appear to be driven by the time taken to complete the tasks, rather than difficulty with doing so.

Psychological treatment providers: Obtaining reviews

Health professionals who provided psychological treatment were asked to indicate the ease or difficulty they experienced in obtaining GP and psychiatrist/paediatrician reviews. At least some difficulty was experienced by respondents in obtaining timely 10-session (41.5%), 20-session (42.8%)

and 30-session (40.0%) reviews by GPs. Similar to the responses of medical practitioners who prepared plans, greater difficulty was reported in accessing a psychiatrist or paediatrician with appropriate knowledge skills and experience (difficult 24.6%; very difficult 68.1%) and in finding a timely review at 20-sessions by a psychiatrist or paediatrician (difficult 27.5%; very difficult 66.7%). Moderate to strong negative effects of delays in accessing timely reviews were reported by 79.7% of respondents.

Perceptions of available time and remuneration for psychological treatment and dietetic services

For psychological treatment provided by allied health professionals, most (89.2%) reported treatment session length of 50-minutes, rather than shorter sessions. Similarly, psychological treatment provided by GPs was typically delivered in sessions of at least 40 minutes (62.5%), although more than one third of GPs used 30-40 minute sessions. Dietetic services are provided in sessions of at least 20 minutes.

Session length was reported as being too short to conduct assessments by 83.8% of psychological treatment providers and by 97.6% of dietetic service providers. Session length was considered appropriate for delivering treatment by most (76.8%) providers of psychological treatment. In contrast, 96.3% of providers of dietetic services reported session length to be too short for delivering nutrition intervention.

In relation to the remuneration for providing psychological treatment through the Eating Disorders MBS items, the majority of respondents indicated that the fee was not sufficient, with 63.1% reporting that the fee was much less than required, and 21.4% reporting that it was somewhat less than required. No psychological treatment providers indicated the fee was more than required and 15.5% indicated the fee was about right. A higher proportion of dietitians indicated the remuneration for dietetic services was not sufficient, with 85.2% reporting the fee was much less than required, and 7.4% reporting it was somewhat less than required. The remainder indicated the fee was about right (4.9%) or somewhat more than required (2.5%).

The tasks needing to be completed to provide psychological treatment and dietetic services were explored in terms of the impact of the task and the associated time for completion on perceptions that the schedule fee was too low. A high proportion of psychological treatment providers (75.7%) and dietetic providers (96.0%) reported that conducting the initial consultation or assessment contributed to a moderate or large extent to the schedule fee being too low. Ongoing treatment and dietetic sessions were also reported to contribute to a moderate or large extent to the perceived inadequacy of the schedule fee by most psychological treatment (78.8%) and dietetic providers (89.4%). Other tasks, including follow-up and preparing reports after initial consultation, contact with family or other supports, and communication with the multidisciplinary care team were reported by fewer respondents to contribute to a moderate or large degree to the schedule fee being too low (psychological treatment providers 55.9%, 39.7%, and 60.6%, respectively; dietetic service providers 73.0%, 61.3%, and 64.5%, respectively).

Perceptions of time required and remuneration for GP and psychiatrist/paediatrician reviews

GPs indicated the sessions they conduct for the first (10-session), second (20-session), and fourth (30 session) reviews took on average more than half an hour to complete (M = 39.2 minutes, SD = 14.97). Review sessions conducted by psychiatrists/paediatricians for the third (20-session specialist) review were reported to take on average a little over one hour to complete (M = 62.5 minutes, SD = 17.5). Note that the number of psychiatrist and paediatrician responses to the community survey was low.

Regarding the schedule fee for providing reviews, most GPs said the fee was too low for the required tasks and time, with 70.8% reporting the fee was much less than required, and 22.9% reporting the fee was somewhat less than required. Psychiatrists conducting the third review sessions had varying views on the adequacy of the schedule fee with 40% reporting it to be much less than required, 40% reporting it to be about right, and 20% reporting it to be somewhat more than was required.

5.4.4.3 Perceptions of eligibility criteria for Eating Disorder Plan access

Respondents to the community survey were asked their views on the eligibility criteria for an Eating Disorder Plan and whether each criterion impact access to these services for people who need treatment. As shown in Table 5.3, criteria specifically addressing anorexia nervosa (diagnosis) or related symptoms (clinically underweight) were viewed as too restrictive and preventing access to an Eating Disorder Plan for people who need it. Similar assessments were made for the hospitalisation criterion and the need to meet multiple criteria for people with diagnoses other than anorexia nervosa. The presence of serious comorbid conditions that impact functions and risk of medical complications had the strongest endorsement as providing appropriate access matched to need. Interestingly, all groups of respondents were relatively consistent in their views of the criteria, although people with lived experience of caring for someone with an eating disorder were less sure in their assessments of the criteria.

None of the criteria were viewed as being too open and allowing access to the plan by more people than need it (that view was endorsed by less than 5% of respondents).

Table 5.3. *Views on Eating Disorder Plan eligibility criteria from health professionals, people with lived experience of an eating disorder, and people with lived experience of caring for someone with an eating disorder*

	Health professionals % (n)	People with lived experience of an eating disorder % (n)	People with caring lived experience % (n)
Diagnosis of anorexia nervosa			
Too restrictive and prevents access to those who need it	51.8 (103)	63.7 (270)	40.1 (55)
Provides appropriate access matched to need	42.2 (84)	22.6 (96)	32.8 (45)
Too open and allows more people access than need it	2.0 (4)	1.7 (7)	1.5 (2)
Unsure	4.0 (8)	10.2 (51)	25.5 (35)

	Health professionals % (n)	People with lived experience of an eating disorder % (n)	People with caring lived experience % (n)
Criteria A: A high score on the Eating Disorder Examination-Questionnaire (standard pencil-and-paper questionnaire about eating disorder symptoms)			
Too restrictive and prevents access to those who need it	36.7 (69)	26.5 (105)	36.5 (46)
Provides appropriate access matched to need	57.4 (108)	58.6 (232)	30.2 (38)
Too open and allows more people access than need it	2.1 (4)	2.3 (9)	0.0 (0)
Unsure	3.7 (7)	12.6 (50)	33.3 (42)
Criteria B: Rapid weight loss or frequent (at least 3 times per week) binge eating or inappropriate compensatory behaviours (e.g., vomiting, laxatives, fasting, excessive exercise)			
Too restrictive and prevents access to those who need it	46.8 (87)	48.2 (190)	36.7 (47)
Provides appropriate access matched to need	46.8 (87)	43.7 (172)	35.9 (46)
Too open and allows more people access than need it	2.7 (5)	1.0 (4)	1.6 (2)
Unsure	3.8 (7)	5.6 (28)	25.8 (33)
Criteria C: Clinically underweight with body weight less than 85% of expected weight where weight loss is directly attributable to the eating disorder			
Too restrictive and prevents access to those who need it	72.6 (135)	77.0 (304)	47.6 (60)
Provides appropriate access matched to need	22.0 (41)	14.2 (56)	27.8 (35)
Too open and allows more people access than need it	1.1 (2)	2.0 (8)	2.4 (3)
Unsure	4.3 (8)	6.8 (27)	22.2 (28)
Criteria D: Current or high risk of medical complications due to eating disorder behaviours and symptoms			
Too restrictive and prevents access to those who need it	34.9 (65)	41.4 (163)	34.1 (43)
Provides appropriate access matched to need	57.0 (106)	51.8 (204)	44.4 (56)
Too open and allows more people access than need it	1.6 (3)	1.0 (4)	1.6 (2)
Unsure	6.5 (12)	5.8 (23)	19.8 (25)
Criteria E: Presence of other serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status with impacts on function			
Too restrictive and prevents access to those who need it	22.9 (43)	24.1 (95)	28.3 (36)
Provides appropriate access matched to need	71.3 (134)	61.3 (242)	44.9 (57)
Too open and allows more people access than need it	1.6 (3)	4.6 (18)	2.4 (3)

	Health professionals % (n)	People with lived experience of an eating disorder % (n)	People with caring lived experience % (n)
Unsure	4.3 (8)	10.1 (40)	24.4 (31)
Criteria F: The person has been admitted to a hospital for an eating disorder in the previous 12 months			
Too restrictive and prevents access to those who need it	51.6 (97)	59.5 (235)	40.2 (51)
Provides appropriate access matched to need	42.0 (79)	31.1 (123)	33.1 (42)
Too open and allows more people access than need it	1.1 (2)	1.0 (4)	2.4 (3)
Unsure	5.3 (10)	8.4 (33)	24.4 (31)
Criteria G: Inadequate treatment response to evidence-based eating disorder treatment over the past six months despite active and consistent participation			
Too restrictive and prevents access to those who need it	39.9 (75)	39.3 (154)	33.9 (42)
Provides appropriate access matched to need	50.0 (94)	45.9 (180)	32.3 (40)
Too open and allows more people access than need it	1.1 (2)	1.3 (5)	1.6 (2)
Unsure	9.0 (17)	13.5 (53)	32.3 (40)
The need to meet both A and B above and at least 2 of the criteria presented in C to G to be eligible for the Eating Disorder Treatment and Management Plan			
Too restrictive and prevents access to those who need it	70.3 (130)	66.5 (262)	54.4 (68)
Provides appropriate access matched to need	22.7 (42)	19.0 (75)	14.4 (18)
Too open and allows more people access than need it	1.1 (2)	2.0 (8)	3.2 (4)
Unsure	5.9 (11)	12.4 (49)	28.0 (35)

5.5 Summary and Recommendations

The data from surveys and interviews suggest that many of the people accessing Eating Disorders MBS items have a diagnosis of anorexia nervosa. Probable over-representation of this group reflects GPs' confidence in assessing eligibility for anorexia nervosa – based on low weight status and reported dieting efforts. GPs reported less confidence in assessing eligibility for other symptom combinations and were more likely to recommend other treatment services in such cases (e.g., Better Access).

GP confidence, knowledge, and skill in establishing Eating Disorder Plans was variable and related to their experience in working with people experiencing an eating disorder.

Health professionals who self-described as meeting criteria for formal recognition of their qualifications, knowledge, and training through ANZAED's Eating Disorder Credential were significantly more confident in their ability to offer care to those with lived experience of an eating disorder than non-credentialed clinicians. These initiatives and other professional development opportunities are important for enhancing workforce competence and capacity, particularly considering evident deficiencies in tertiary curriculum that do not do enough to prepare future health professionals for working with people experiencing an eating disorder.

A range of barriers to treatment access were identified. Issues identified by people with lived experience of an eating disorder included:

- low awareness of availability of these services through MBS
- confusion about eligibility
- financial burden of treatment
- difficulties navigating health services, including long wait times for some people.

Cost considerations and general confusion about the need for review sessions were also key impediments to the uptake of the 20-session specialist review, as were difficulties finding appropriate providers for this review. The high level of difficulty finding a psychiatrist or paediatrician to conduct the 20-session review in a timely manner suggests a possible barrier to accessing ongoing treatment for people who require more than 20 sessions to help them with symptom remission and recovery.

From the perspective of people with a lived experience of caring for someone with an eating disorder, involvement in the treatment process was highly valued and well received where it was available. Some did report difficulty being granted this level of collaboration with health professionals though. People caring for someone with an eating disorder expressed the belief they were under-utilised, with greater capacity to assist with diagnosis and – through communication with health professionals – to help people they care for to navigate the healthcare system when seeking and receiving treatment. Health professionals reiterated the difficulties in finding suitable and available services for people with an Eating Disorder Plan, challenges in coordinating case reviews, and perceptions that significant and time-consuming work was required without commensurate remuneration.

There are also several important caveats to this assessment of treatment access. First, while health professionals, people with a lived experience of caring for someone with an eating disorder, and people with lived experience of an eating disorder noted that other services were recommended for people who had not met the eligibility for Eating Disorders MBS services, data collected by Services Australia do not identify when people are using these other MBS services for eating disorders. This makes it difficult to know the full extent of eating disorder treatment under MBS. The reasons for using an MBS item at point of service that links to service use data would help to more comprehensively document eating disorder treatment under the Medicare items. Second, as of July 1, 2023, there is provision in Medicare for health professionals to be remunerated for case reviews under the Mental Health Case Conferencing items. This is an important initiative in response to concerns raised by health professionals about the difficulties they have coordinating multidisciplinary case reviews. The extent to which this initiative will increase the uptake of case reviews in the Eating Disorders MBS items will require future evaluation. Based on our interview and survey data, it is likely that awareness-raising exercises and efforts to reduce out-of-pocket expenses will also be necessary to ensure case reviews are commonly taken up by people with lived experience of an eating disorder. These and other initiatives to strengthen access to treatment and review sessions under an Eating Disorder Plan are expanded upon in Chapter 7 (*policy recommendations*).

6

Objective 4: Improvement in Outcomes

Evaluation of the Eating Disorders
Medicare Benefits Schedule Items 2024

6 Objective 4: Improvement in Outcomes

Key Points

- There are encouraging findings showing Eating Disorders MBS items improve outcomes and facilitate recovery but there is insufficient and inconsistent data available, which hampers ongoing evaluation.
- Having access to enough treatment sessions contributes to positive outcomes because it provides time to work through concerns and develop therapeutic alliance (working relationship between the therapist and person with an eating disorder).
- Review sessions were seen as being generally valuable by about half of people with lived experience of an eating disorder and people who care for someone with an eating disorder but were thought less beneficial for their main purpose of reviewing treatment progress and considering new or different treatment approaches.
- Involving people caring for a person with an eating disorder in their treatment had positive outcomes for their ability to support that person.
- Workforce capacity in eating disorders has increased with the implementation of the Eating Disorders MBS items.

Overview

This chapter addresses Objective 4, primarily evaluating whether access to treatment through the Eating Disorders MBS items has improved outcomes for people with eating disorders. Secondary outcomes were also evaluated, including outcomes for people who care for someone with an eating disorder and changes in workforce capacity to deliver eating disorder services among health professionals.

Specifically, we evaluated:

(i) Outcomes from treatment for people with lived experience of eating disorders. These were considered from the perspectives of people experiencing eating disorders and having treatment, of people caring for someone having eating disorder treatment, and of health professionals engaged with providing treatment through the Eating Disorders MBS items. We evaluated whether specific evidence-based treatments and evidence-informed intervention techniques were used in services delivered under the Eating Disorders MBS items. We also evaluated the review sessions for aiding positive treatment outcomes.

(ii) Whether treatment reduced the need for help-seeking in the future. This broader view provides a perspective on the benefits of engaging with treatment through an Eating Disorder Plan.

(iii) Outcomes for people who care for a person with an eating disorder. Here we evaluated whether people who were engaged in, or adjacent to the treatment process of someone with an eating disorder also experienced a personal benefit that increased their capacity to provide care or enhance their own wellbeing.

(iv) Change in workforce capacity for providing eating disorder services coinciding with the implementation of the Eating Disorders MBS items and improvements in system level functionality from the perspective of health professionals.

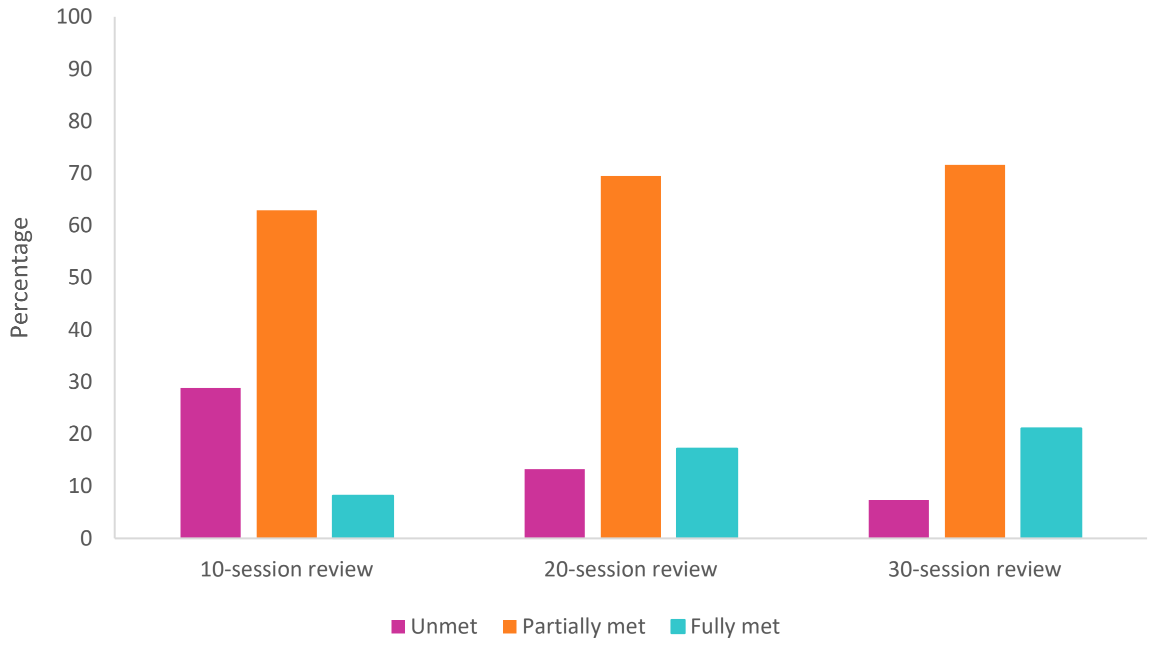
6.1 Outcomes for People with Eating Disorders: Eating Disorders MBS Item Use and Symptom Change

In this section we report clinical outcome data on the changes in symptoms and achievement of treatment goals from GP medical records. We also examine the subjective perceptions of change in symptoms and perceived helpfulness of an Eating Disorder Plan for recovery and related outcomes.

6.1.1 Clinical data on outcomes following treatment through an Eating Disorder Plan

By examining general practice case reviews, we aimed to find out if people who were given an Eating Disorder Plan met the individual treatment goals set at the beginning of the plan. From data extracted from GP medical records of people receiving treatment, there was a clear improvement in reaching goals over time. As shown in Figure 6.1, most people for whom data was available made progress in meeting their goals over the course of treatment. In particular, the proportion of people (for whom the goal outcome was known) who had unmet goals was significantly reduced from the first 10-session review, through to the second (20-session) and third (30-session) GP review. Correspondingly, the proportion of people having eating disorder treatment whose goals were fully met significantly increased over time.

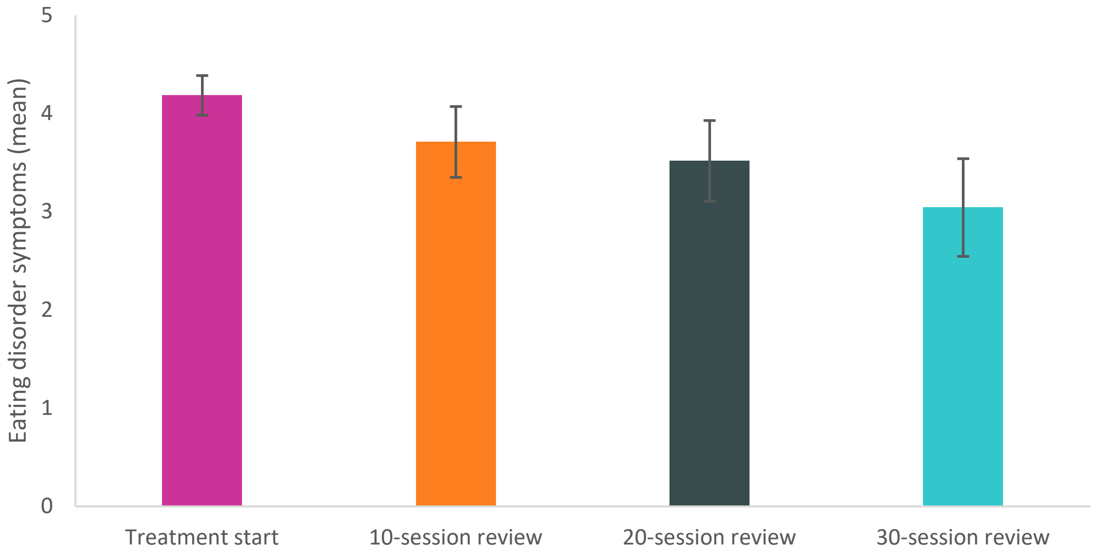
Although this increase was observed, the proportion of people receiving treatment who had fully met their goals at the 30-session review was somewhat low (21.1%), indicating the need for further treatment beyond 30 sessions. At the 30-session review, significantly fewer people with anorexia nervosa had met their goals compared to people with other eating disorders. There were no differences in goal attainment across socioeconomic groups at the 30-session review. Notably, early improvement recorded at the 10-session review was associated with a significantly greater likelihood of meeting goals at the 30-session review.



Note. At treatment start, 100% of goals were unmet. Review sessions refer to GP reviews only.

Figure 6.1. *Proportions of participants meeting their goals at the general practitioner Eating Disorder Plan reviews.*

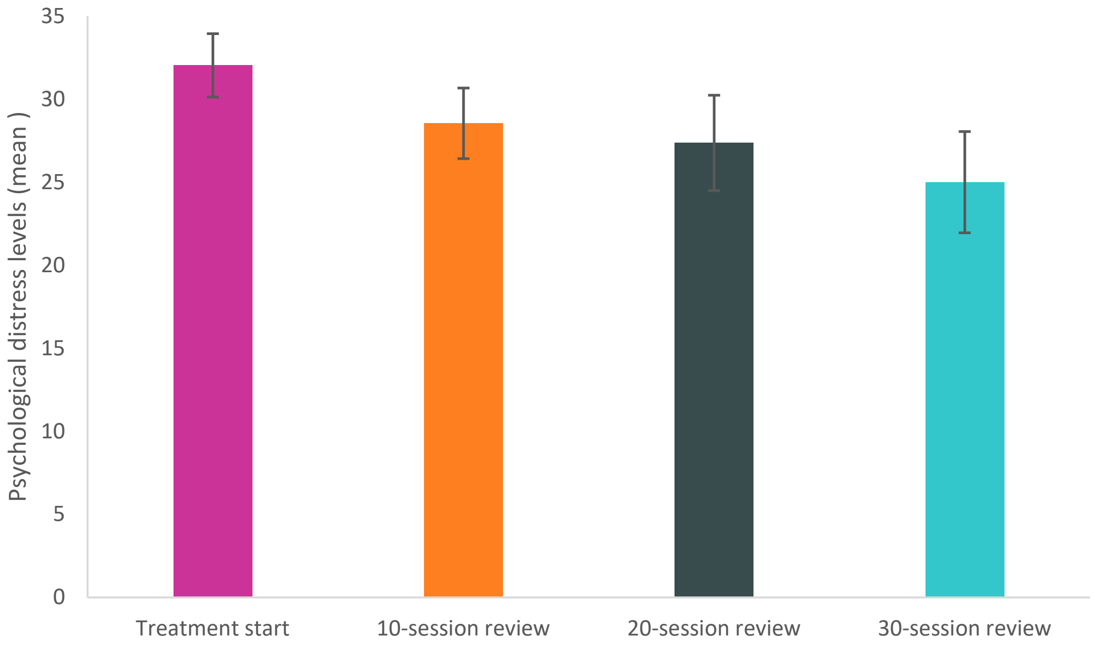
Objective data on changes in eating disorder symptoms and psychological distress from the general practice case reviews were also evaluated. As shown in Figure 6.2, significant improvements in eating disorder symptoms from the start of treatment to the 30-session review were observed. Symptoms decreased significantly between each time point except from baseline to the first review.



Note. Eating disorder symptom levels measured with the global score of the Eating Disorder Examination-Questionnaire; error bars are 95% confidence intervals.

Figure 6.2. *Eating disorder symptom levels for all diagnoses over time in general practice case reviews*

Similarly, significant improvements in general psychological distress symptoms were observed over the course of treatment (see Figure 6.3). Psychological distress decreased significantly between each time point except the 20- to 30- session review. The reduction in eating disorder and psychological distress symptoms did not differ between people diagnosed with anorexia nervosa or other eating disorders.

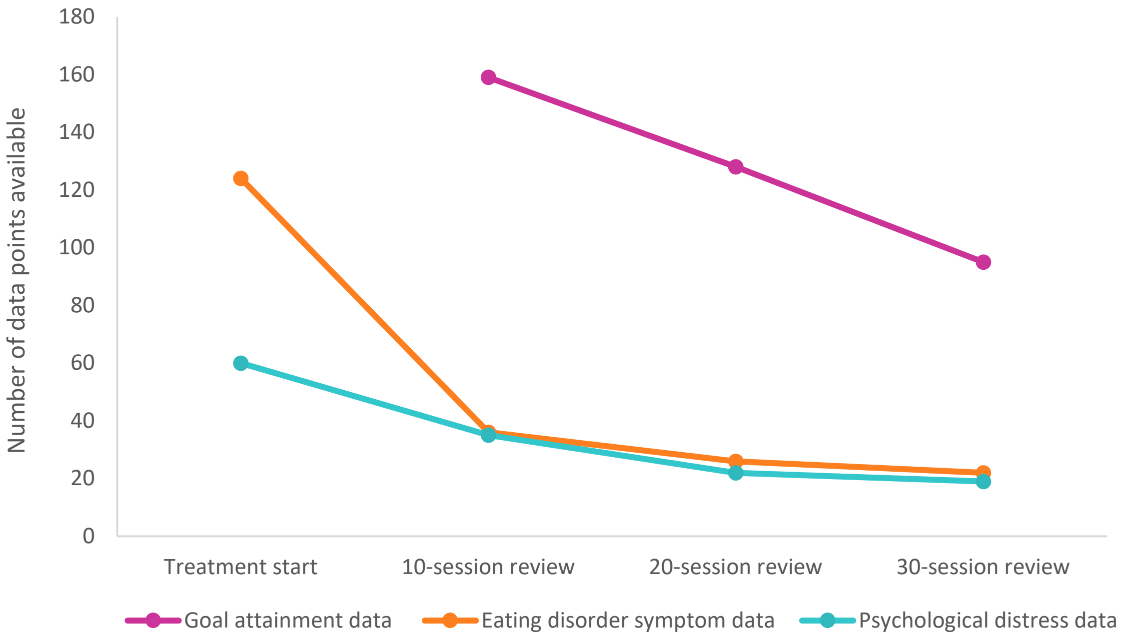


Note. Psychological distress symptom levels are measured with the Kessler-10 psychological distress scale; error bars are 95% confidence intervals.

Figure 6.3. *Psychological distress symptom levels for all diagnoses over time in general practice case reviews*

The general practice case review evaluation shows a consistent pattern of improvement over time across the three domains that were reviewed. From the start of treatment through to each review point, a higher proportion of treatment goals were met, and improvements in eating disorder symptoms and psychological distress observed. These changes reflect a steady reduction across each Eating Disorder Plan review and provides encouraging evidence for positive outcomes from engaging in treatment with an Eating Disorder Plan.

Notably, the data available on the eating disorder symptom and psychological distress measures was less than that available for evaluating goal attainment. From the 189 case files reviewed, little data existed for psychological distress and available data diminished over time (see Figure 6.4). This is likely due to many people completing or stopping treatment and not attending their GP for ongoing reviews. However, it is also likely that data were unavailable due to inconsistencies in recording of progress data.



Note. Data were not recorded for goals at treatment start.

Figure 6.4. *Availability of outcome data from general practice case reviews*

6.1.2 Perceptions of improvements in outcomes by people with eating disorders

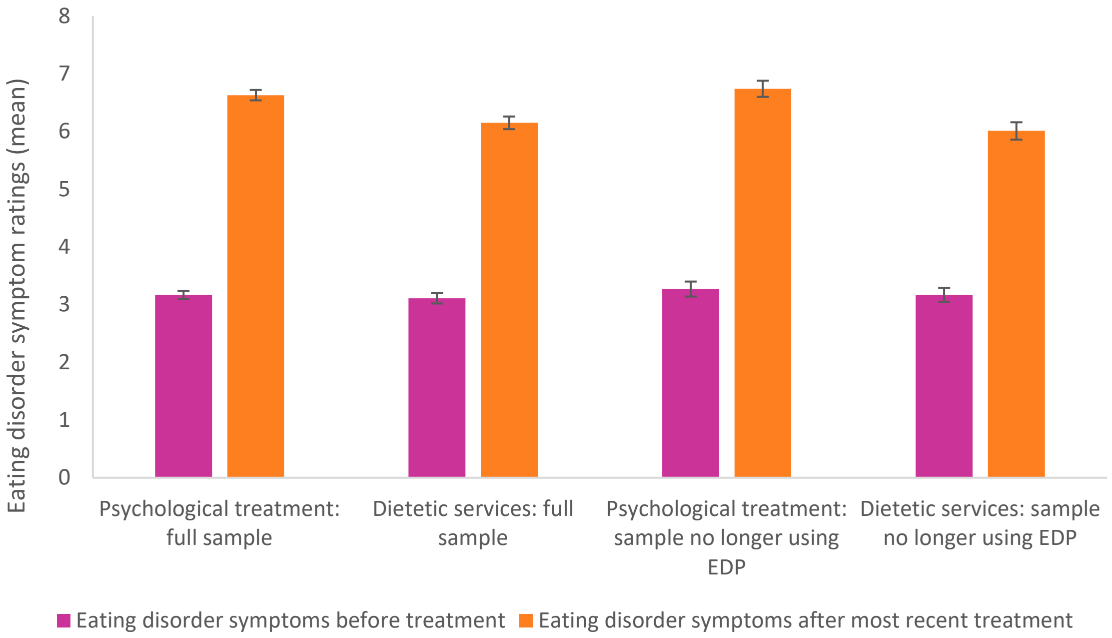
6.1.2.1 Reported symptom change and satisfaction with psychological treatment or dietetic services

People with lived experience of an eating disorder in the Medicare survey who were no longer in treatment reported their levels of eating disorder symptoms prior to starting and after their most recent psychological and/or dietetic sessions (on a scale from 1 = worst symptoms to 10 = best symptoms). For both psychological treatment and dietetic intervention, eating disorder symptoms were significantly worse prior to receiving services under an Eating Disorder Plan than after the most recent session. Differences in self-report symptoms between the two time points were significant and large among those who were no longer in treatment and also in the full sample of Medicare respondents, including those still receiving treatment (see Figure 6.5). Among those no longer receiving sessions through the Eating Disorder Plan, greater improvement in eating disorder symptoms following psychological treatment was significantly related to receiving a higher number of psychological treatment sessions. Similarly, greater improvement in eating disorder symptoms following dietetic intervention was significantly related to receiving a higher number of dietetic health sessions and to receiving a greater number of psychological treatment sessions.

Receiving psychological treatment sessions via telehealth was significantly related to symptom improvement reported for psychological treatment. People who received some or all of their psychological treatment sessions via telehealth were more likely to have improvement in symptoms relative to those who had no treatment sessions via telehealth. Receiving dietetic sessions via telehealth was not related to symptom improvement following dietetic health services.

Importantly, most people with lived experience of an eating disorder who experienced improved symptoms attributed their symptom change to the sessions they received through an Eating Disorder Plan. Of the Medicare survey respondents who experienced symptom improvement, almost all

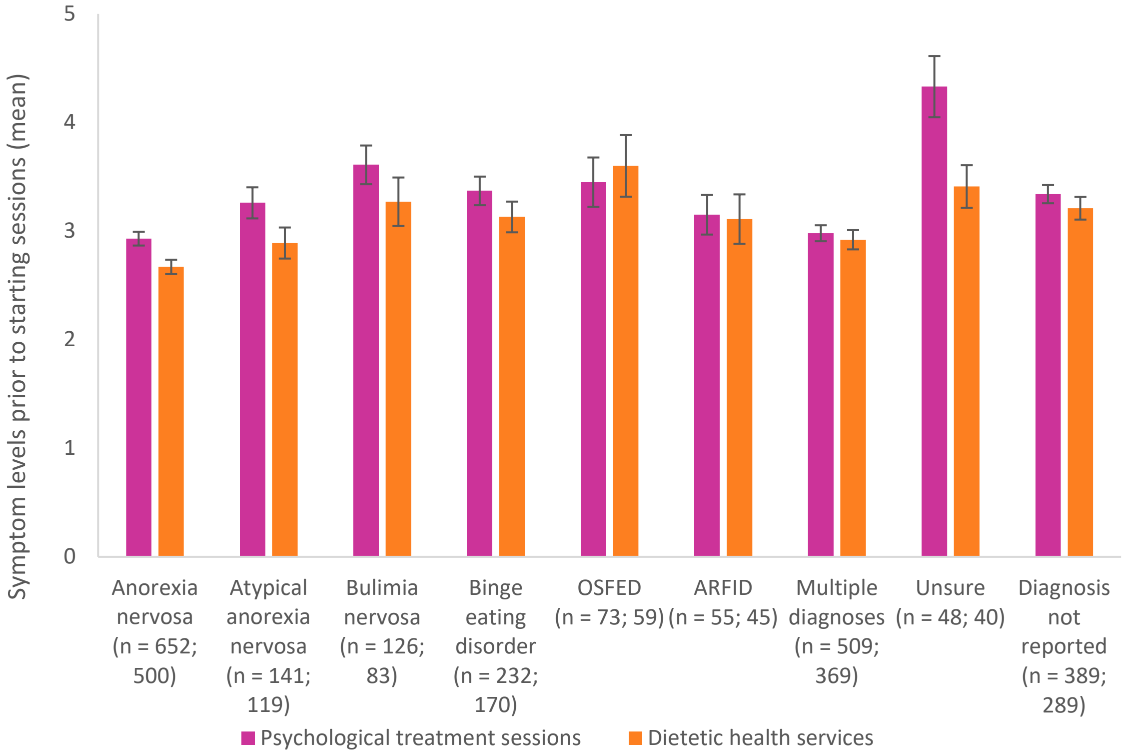
(91.9%) viewed their psychological treatment as responsible for the improvement (entirely responsible 28.4%; partially responsible 63.5%). Similarly, 84.8% of people viewed their dietetic sessions as responsible for the improvement (entirely responsible 17.1%; partially responsible 67.7%). There was little variation in these views between people with diagnoses of different eating disorders.



Note. Symptoms rated from 1 = worst possible to 10 = best possible by people who received psychological treatment or dietetic sessions; error bars are 95% confidence intervals; EDP = Eating Disorder Plan.

Figure 6.5. *Eating disorder symptoms prior to starting psychological treatment and dietetic sessions and after the most recent session reported by people with lived experience of an eating disorder in the Medicare survey*

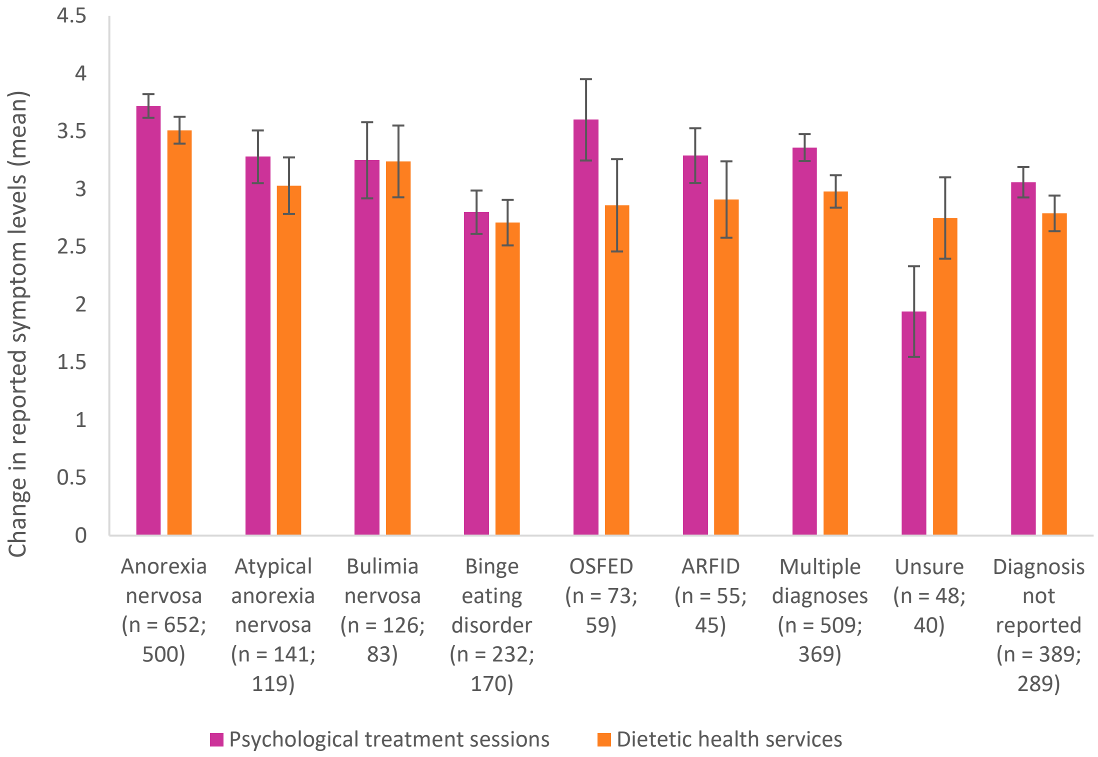
We also explored self-reported symptom levels among people with different eating disorder diagnoses. As shown in Figure 6.6, of those who received psychological treatment, people with anorexia nervosa reported significantly worse symptom levels than people with bulimia nervosa, binge eating disorder, those unsure about their diagnosis, and those who reported not having an eating disorder diagnosis. People with multiple diagnoses also reported significantly worse symptoms than people with bulimia nervosa. People who were unsure of their diagnosis had significantly better self-reported symptom levels than people with all other diagnoses except for bulimia nervosa and other specified feeding or eating disorder (excluding atypical anorexia nervosa). Prior to dietetic sessions, people with anorexia nervosa had significantly worse self-reported eating disorder symptoms than people with other specified feeding or eating disorder and people who were unsure of their diagnosis.



Note. Symptoms rated from 1 = worst possible to 10 = best possible by people who received psychological treatment (n = 2,235) or dietetic sessions (n = 1,685); error bars are 95% confidence intervals; sample sizes are for people who received psychological treatment or dietetic services.

Figure 6.6. *Eating disorder symptoms prior to starting psychological treatment and dietetic sessions reported by people with lived experience of an eating disorder in the Medicare survey*

On average, improvement in symptom levels was reported in the range of a change of about 2.5 to 4 points (possible range -9 to 9) across most diagnostic groups, except for people who were unsure about their diagnosis (see Figure 6.7). Change in symptom levels over time for those who received psychological treatment was significantly greater among people with anorexia nervosa than people with binge eating disorder, those who were unsure of their diagnosis, and those who reported not having an eating disorder diagnosis. People who were unsure of their diagnosis had significantly better self-reported symptom levels than people with other specified feeding or eating disorder and those with multiple diagnoses. Change in symptom levels over time for those who received dietetic sessions was significantly greater among people with anorexia nervosa than people with binge eating disorder and those who reported not having an eating disorder diagnosis.



Note. Change in symptoms is the difference in self-reported symptoms from prior to treatment to after the most recent psychological treatment (n = 2,235) or dietetic health session (n = 1685); higher scores reflect greater improvement; error bars are 95% confidence intervals; sample sizes are for people who received psychological treatment or dietetic services.

Figure 6.7. *Change in eating disorder symptoms levels from the start to most recent session reported by people with lived experience of an eating disorder in the Medicare survey according to eating disorder diagnosis*

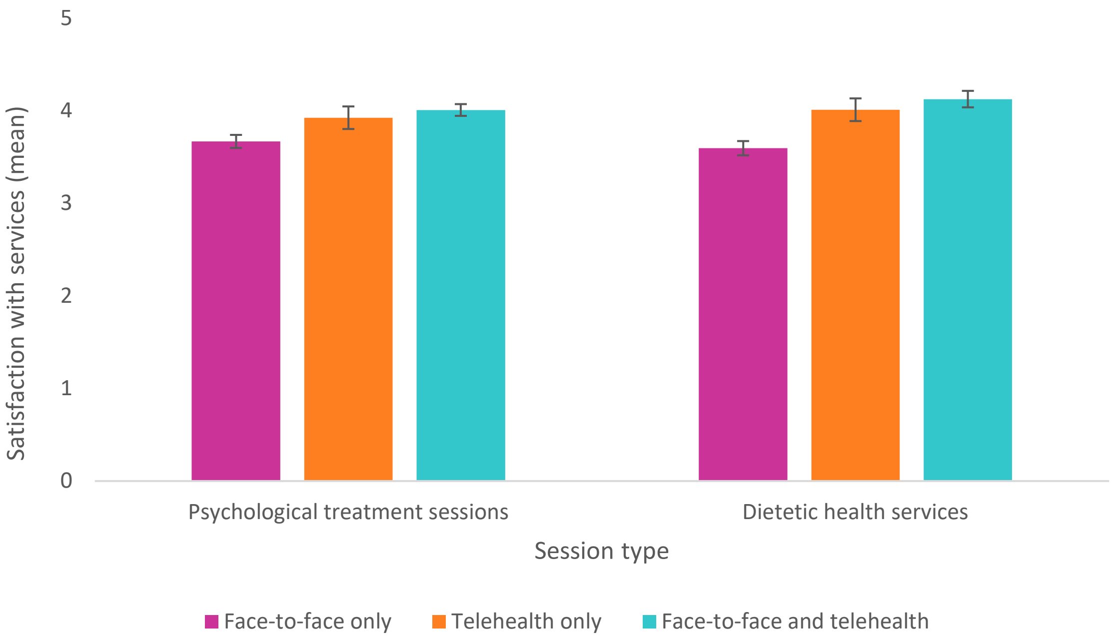
Reported satisfaction with psychological treatment and dietetic sessions among respondents to the Medicare survey align with views on services received via an Eating Disorder Plan being responsible for symptom change as described above. Most people with lived experience of an eating disorder were satisfied with their psychological treatment (satisfied 40.6%; very satisfied 30.7%) and with their dietetic sessions (satisfied 35.2%; very satisfied 32.9%).

Satisfaction with both psychological treatment and dietetic services was significantly higher when a greater number of sessions had been received. For example, among people who reported being satisfied with their psychological treatment, less than ten percent (9.6%) were those who had received fewer than 10 psychological treatment sessions. Similarly, of people who reported being satisfied with their dietetic care only 15.0% were those who had received fewer than 5 dietetic health services.

Respondents to the Medicare survey indicated whether they received their psychological treatment and dietetic health sessions in face-to-face in-person settings, via telehealth, or a combination. We explored if delivery setting was related to reported satisfaction levels. About half of services were delivered only in face-to-face in-person settings (psychological treatment 46.3%; dietetic services

54.1%), a small proportion were telehealth only (psychological 11.7%; dietetic 17.4%), and a substantial proportion were combined delivery (psychological 42.0%; dietetic 28.5%).

People with lived experience of an eating disorder who received sessions both in-person and via telehealth, or via telehealth only, reported significantly higher satisfaction than those who received sessions only in face-to-face in-person settings. As shown in Figure 6.8, the differences in satisfaction between type of delivery were small for both psychological treatment and dietetic health services.



Note. Error bars are 95% confidence intervals.

Figure 6.8. *Satisfaction with psychological and dietetic health services according to type of delivery of service among people with lived experience of an eating disorder in the Medicare survey*

6.1.2.2 Reported helpfulness of an Eating Disorder Plan

Responses to the community survey by people with lived eating disorder experience indicated that most found treatment under an Eating Disorder Plan to be helpful (moderately or very; 77.5%), with 68.1% indicating an Eating Disorder Plan helped aid their recovery. People who received a greater number of psychological treatment sessions and a greater number of dietetic health sessions reported higher perceived helpfulness of the Eating Disorder Plan for their recovery.

In addition, treatment with an Eating Disorder Plan was found to be helpful for non-eating disorder-related outcomes, although to a lesser extent than for aiding recovery. For instance, the proportion of respondents rating treatment through an Eating Disorder Plan as helpful for reducing other difficulties such as those related to work, education, or social areas was 47.9%. More than a third of respondents found treatment helpful for reducing use of other health services (40.7%) and for reducing reliance on family or other supports (43.4%).

Different parts of the services offered through an Eating Disorder Plan contributed to the overall helpfulness ratings, as shown in Figure 6.9. Psychological treatment, and dietetic sessions to a lesser extent, were rated more strongly than review sessions by GPs, and in turn by psychiatrists or paediatricians. The latter review sessions received the lowest ratings for helpfulness, where fewer than half of people with lived experience of eating disorders (44.0%) found reviews by psychiatrists or paediatricians to be helpful (moderately or very). This may in part be due to therapeutic factors. These are the factors that influence therapeutic interactions. Review sessions with psychiatrists or paediatricians are typically a one-off session where the person with an eating disorder does not have an ongoing therapeutic relationship with that health professional, in contrast to regular sessions with their psychological treatment or dietetic services provider. Indeed, ratings of helpfulness of receiving empathic care were lowest for care at the psychiatrist/paediatrician review (M = 3.38, SD = 1.38; scale from 1 = very unhelpful to 5 = very helpful) compared with care at the GP review (M = 3.97, SD = 1.19), in dietetic sessions (M = 4.27, SD = 1.06) and in psychological treatment (M = 4.36, SD = 1.07).

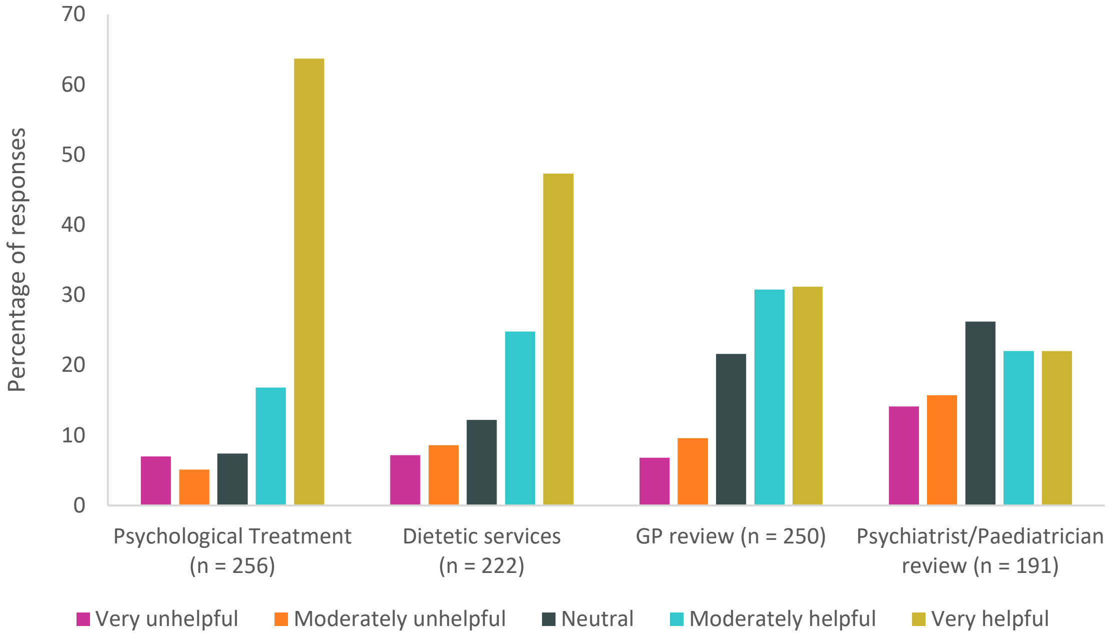
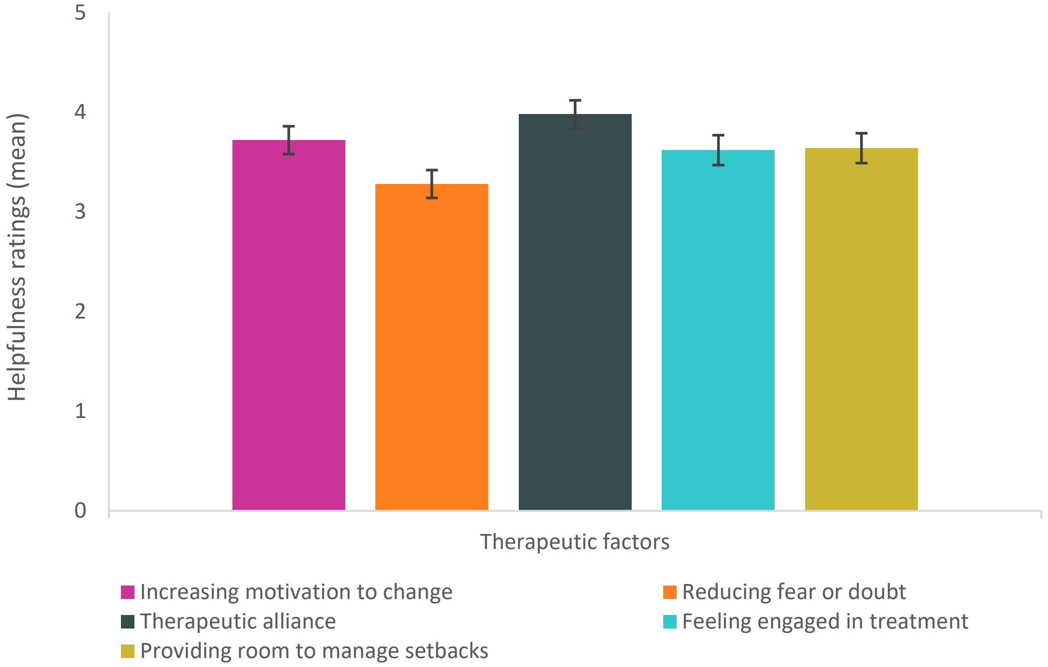


Figure 6.9. *Perceptions of helpfulness of components of an Eating Disorder Plan by people with lived experience of eating disorders in the community survey*

People with eating disorders were also asked about the helpfulness of treatment through an Eating Disorder Plan for other treatment-relevant issues. These ratings give insights into therapeutic or system-related factors that may have contributed to reducing symptoms and positive outcomes. Therapeutic factors reflect the processes occurring within treatment sessions that influence therapeutic interactions and may impact overall symptom change and recovery. System factors are those that reflect the way the 'system' of an Eating Disorder Plan works to provide treatment for eating disorders and may impact use of and perceived appropriateness of treatment. In relation to therapeutic factors, as shown in Figure 6.10, treatment through an Eating Disorder Plan was rated most highly by people in the community survey as being helpful for therapeutic alliance, that is, connecting with the healthcare provider, and for increasing motivation for change, and less highly for reducing fear or doubts about treatment. In the Medicare survey, most people with lived experience of an eating disorder agreed that psychological treatment sessions (agreed or strongly agreed 76.0%) and dietetic sessions (agreed or strongly agreed 72.7%) had equipped them with strategies to address the issues they were facing.



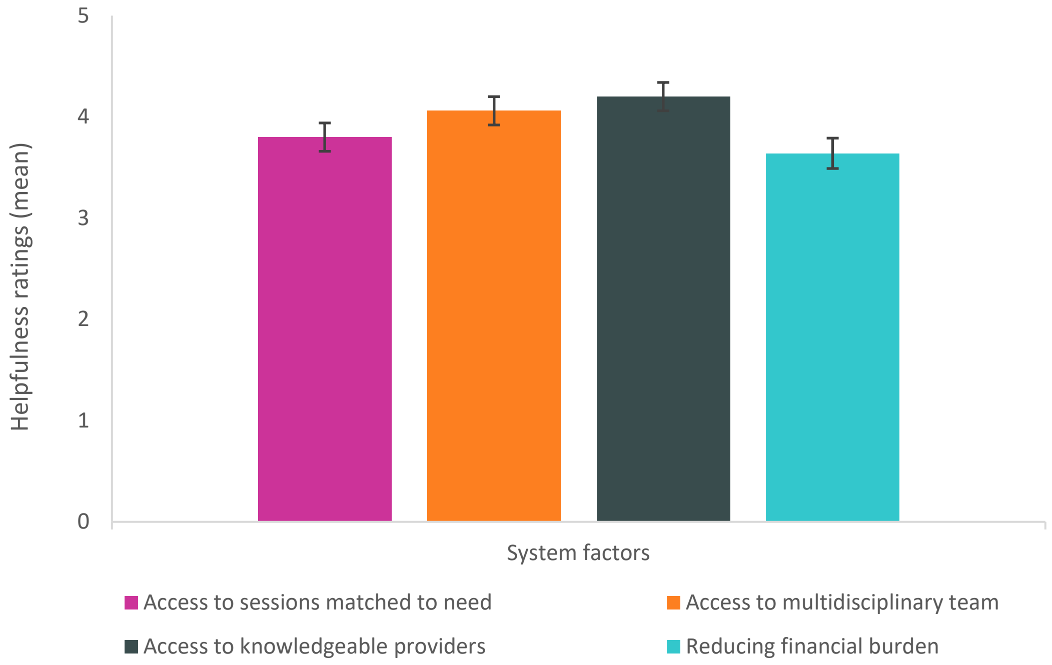
Note. Helpfulness rated from 1 = very unhelpful to 5 = very helpful; error bars are 95% confidence intervals.

Figure 6.10. *Helpfulness ratings of therapeutic factors by people with lived experience of eating disorders in the community survey*

In relation to system factors, in the community survey, treatment through an Eating Disorder Plan was rated highly by people with lived experience of eating disorders for providing access to health professionals who had a good understanding of eating disorders (see Figure 6.11). It was rated less highly for reducing the financial burden for treatment (note however, perceived financial benefits of the Eating Disorders MBS items relative to other treatment pathways; section 5.4.2). Greater perceived helpfulness of the Eating Disorder Plan for eating disorder recovery was strongly related to perceptions of helpfulness of the plan in providing access to health professionals with a good understanding of eating disorder and to a multidisciplinary team.

High ratings for an Eating Disorder Plan being helpful for providing access to a suitable number of sessions to match need were also reported. Adding to this, greater perceived helpfulness of the Eating Disorder Plan for providing access to the right number of sessions matched to need was strongly associated with perceiving the Eating Disorder Plan as being more helpful for recovery from an eating disorder.

These ratings correspond with views about the appropriate number of sessions received among respondents to the Medicare survey who were no longer in treatment. About half of people who received 20 or more psychological treatment sessions (49.6%) or 10 or more dietetic health sessions (56.7%) indicated that the number of sessions they received was ‘just right’ for them. In contrast, less than a fifth of people who received fewer than 10 psychological treatment sessions (18.0%) or fewer than 5 dietetic sessions (14.7%) indicated the number of sessions they received was ‘just right’ for them. Overall, less than a tenth of respondents (8.1%) indicated that any number of sessions they received was too many.



Note. Helpfulness rated from 1 = very unhelpful to 5 = very helpful; error bars are 95% confidence intervals.

Figure 6.11. *Helpfulness ratings of system-related factors by people with lived experience of eating disorders in the community survey*

Several insights from interviews with people who had received treatment for an eating disorder aligned with findings from the community survey and provided insights as to elements of an Eating Disorder Plan that may contribute to positive outcomes. People with lived experience confirmed in interviews that an Eating Disorder Plan allowed for increased frequency of services, upheld consistency, and promoted the perception that recovery is possible. Access to more frequent sessions meant there was less pressure placed on each session, treatment could be client-paced and personalised, therapeutic relationships could be more successfully developed, and treatment could be more in-depth and comprehensive, resulting in more positive treatment outcomes.

Comparisons of experiences from different treatment pathways

Further insights into the helpfulness of an Eating Disorder Plan were sought by comparing views of community survey respondents on the quality of care received through different treatment pathways. People with eating disorders who had received treatment via a Mental Health Treatment Plan prior to receiving treatment on an Eating Disorder Plan were asked to compare their experiences. Figure 6.12 shows that people with lived experience of an eating disorder overwhelmingly rated the quality of care as higher when received through an Eating Disorder Plan compared with a Mental Health Treatment Plan.

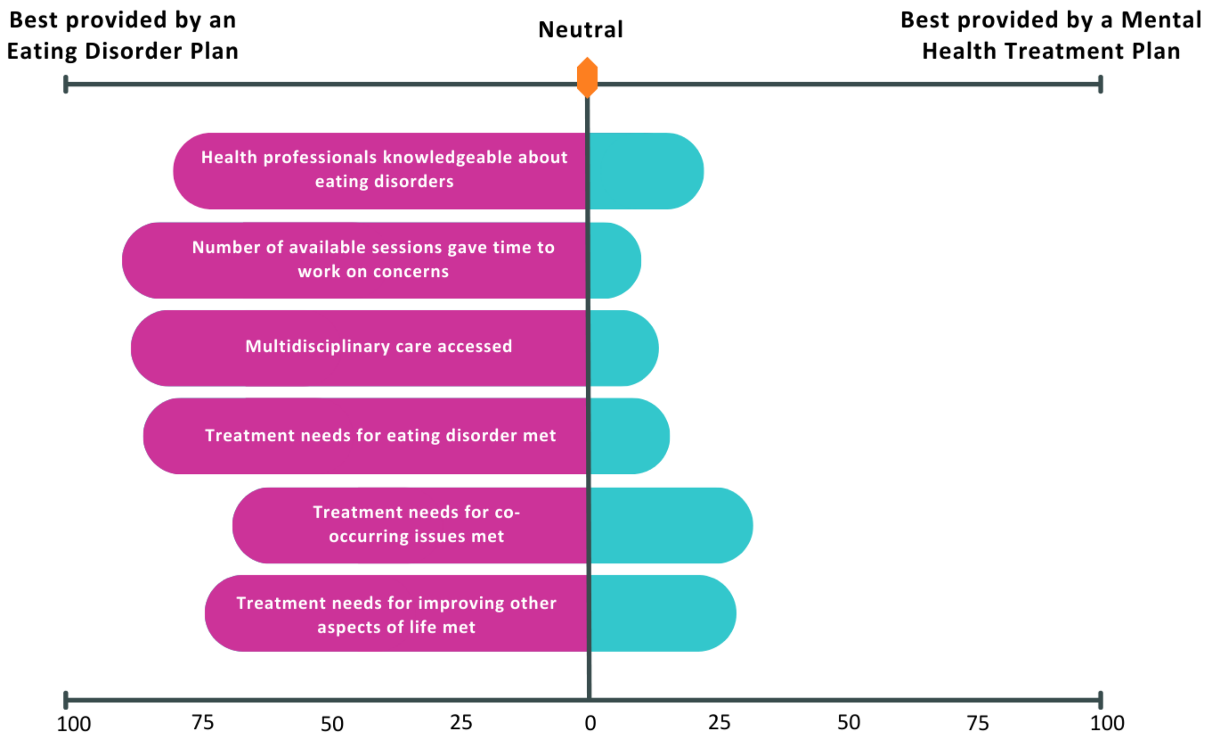
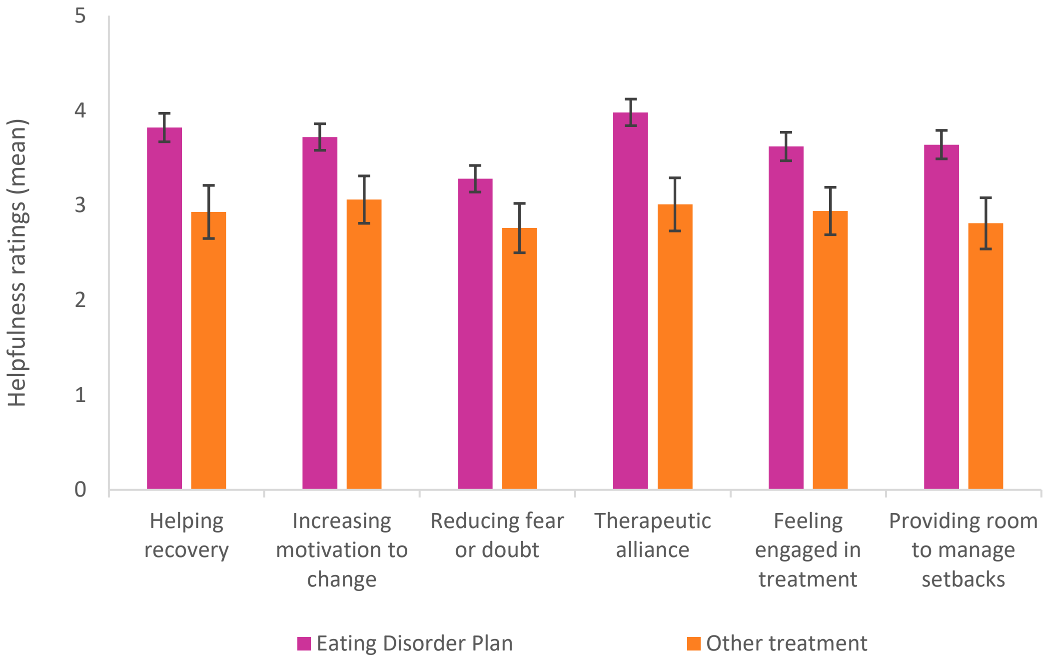


Figure 6.12. *Views of people with lived experience of an eating disorder on quality of care for treatment accessed via an Eating Disorder Plan compared with a Mental Health Treatment Plan*

This was particularly pronounced for the perception that an Eating Disorder Plan provided enough sessions to work through concerns and gave access to a multidisciplinary care team where 93.2% and 91.8%, respectively, indicated that their needs were best met through an Eating Disorder Plan relative to a Mental Health Treatment Plan. Further to this, only 4.1% of respondents indicated that their eating disorder treatment needs were best provided through a Mental Health Treatment Plan rather than an Eating Disorder Plan.

We note that these views are from people with lived experience of an eating disorder and people with lived experience of caring for someone with an eating disorder (noted below) where treatment was first received through a Mental Health Treatment Plan and then progressed to an Eating Disorder Plan. It does not capture responses from people who had successful treatment through a Mental Health Treatment Plan and did not require further treatment via an additional pathway.

In addition, from the community survey, ratings of helpfulness of treatment by people who received treatment via an Eating Disorder Plan were compared to ratings of helpfulness by a different group of people who had received treatment for their eating disorder via other means, such as public services or private health insurance. People who received treatment via an Eating Disorder Plan rated helpfulness of treatment for aiding recovery and helpfulness of therapeutic factors that may contribute to positive outcomes significantly higher than people who received treatment via other means (see Figure 6.13).

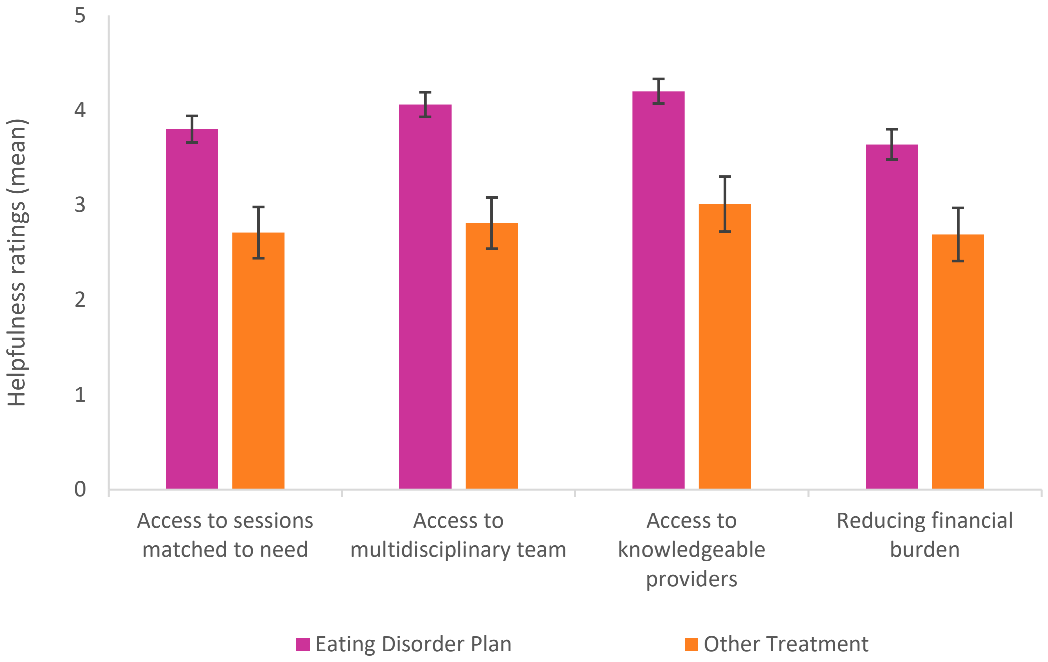


Note. Helpfulness rated from 1 = very unhelpful to 5 = very helpful; error bars are 95% confidence intervals.

Figure 6.13. *Helpfulness ratings of therapeutic factors for treatment received via an Eating Disorder Plan or via other means by people with lived experience of eating disorders in the community survey*

Similarly, ratings of system-related factors were also significantly higher among people who received eating disorders treatment with an Eating Disorder Plan than people who received other treatment, as shown in Figure 6.14.

Differences in ratings of helpfulness by people caring for someone receiving eating disorder treatment also followed the pattern observed amongst people with lived experience of an eating disorder favouring treatment via an Eating Disorder Plan compared with treatment via other means for both therapeutic and systemic factors (see Chapter 6, Technical Report for detail). It is noted that these comparisons do not account for other factors that may have affected perceptions of treatment, such as eating disorder diagnosis, severity of symptoms or duration of time that the person had an untreated eating disorder.



Note. Helpfulness rated from 1 = very unhelpful to 5 = very helpful; error bars are 95% confidence intervals

Figure 6.14. *Helpfulness ratings of system-related factors for treatment received via an Eating Disorder Plan or via other means by people with lived experience of an eating disorder in the community survey*

6.1.3 Perceptions of improvements in outcomes for people with eating disorders by people with lived experience of caring for someone with an eating disorder

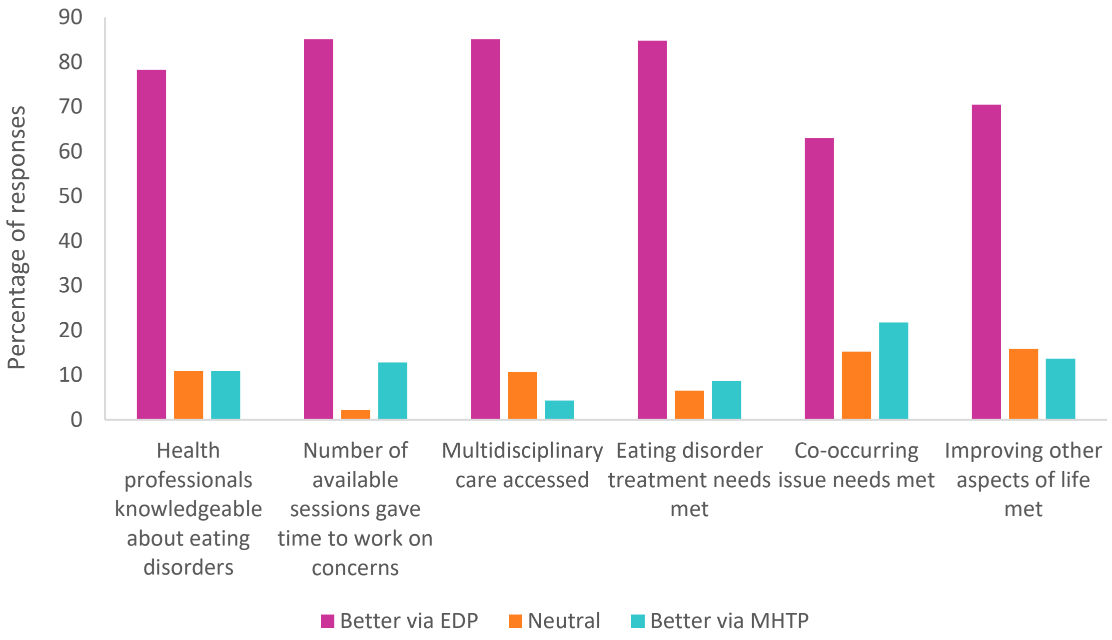
People who have a lived experience of caring for someone with an eating disorder were asked in the community survey to provide their views on the helpfulness of treatment received through an Eating Disorder Plan for the person they care for. Like the ratings by people with lived experience of an eating disorder, carers also rated treatment as favourable. Most rated treatment received through an Eating Disorder Plan as helpful (moderately or very) overall (78.9%) and for helping with eating disorder recovery (75.2%). Regarding other relevant outcomes, the helpfulness of treatment through the Eating Disorders Plan was less strongly endorsed. Only 37.7% of people with lived experience of caring for someone with an eating disorder viewed the treatment as having been helpful in reducing use of other health services. Approximately half (57.4%) perceived treatment as being helpful in reducing other difficulties (such as work, education, or social difficulties) and 44.0% rated treatment as having been helpful for increasing independence from other supports.

In terms of access to treatment, an Eating Disorder Plan was perceived by people who care for someone with an eating disorder to be helpful for several therapeutic factors. The plan was rated as helpful (moderately to very) by most respondents for increasing motivation to change (66.7%), therapeutic alliance (70.7%), being engaged in treatment (64.4%), and having room to manage setbacks (65.1%).

However, fewer people who care for someone with an eating disorder (50.0%) considered treatment with an Eating Disorder Plan to be helpful for reducing fear or doubt about treatment for the person receiving treatment. This result was similar to the lower rating this aspect received from people with lived experience of an eating disorder in the community survey.

Treatment through an Eating Disorder Plan was perceived to be helpful (moderately to very) in relation to system-related factors by most people caring for someone with an eating disorder. These included providing access to the right number of sessions for level of need (72.9%), providing access to a multi-disciplinary team (74.3%), and providing access to health professionals with a good understanding of eating disorders (75.2%). Reducing the financial burden was less strongly endorsed as being helpful (67.6%).

Although some aspects of an Eating Disorder Plan were less highly endorsed than others by people with lived experience of caring for someone with an eating disorder, comparison with other treatment initiatives suggests carers perceive that high quality care is delivered via an Eating Disorder Plan. People with lived experience of caring for someone with an eating disorder were strongly in favour of an Eating Disorder Plan providing better quality of care than a Mental Health Treatment Plan. As shown in Figure 6.15, these perceptions were strongest for eating disorder-related aspects of care and slightly less strong, but still favoured an Eating Disorder Plan for aspects of care related to co-occurring issues (such as symptoms of anxiety or depression) or other aspects of life such as the need to improve broader functioning.



Note. *EDP = Eating Disorder Plan; MHTP = Mental Health Treatment Plan*

Figure 6.15. *Views of people with lived experience of caring for someone with an eating disorder on quality of care for treatment accessed via an Eating Disorder Plan compared with a Mental Health Treatment Plan*

6.1.4 Health professionals' perceptions of improvements in outcomes for people with eating disorders

Among health professional respondents to the community survey, most said an Eating Disorder Plan was helpful (moderately or very) for people with eating disorders in facilitating recovery from their eating disorder (76.4%). This perception was consistent among different types of health professionals, although dietitians (82.2%) and psychologists, social workers, and occupational therapists (79.7%) gave higher ratings for the plan being helpful in facilitating recovery than GPs and other medical practitioners (67.2%).

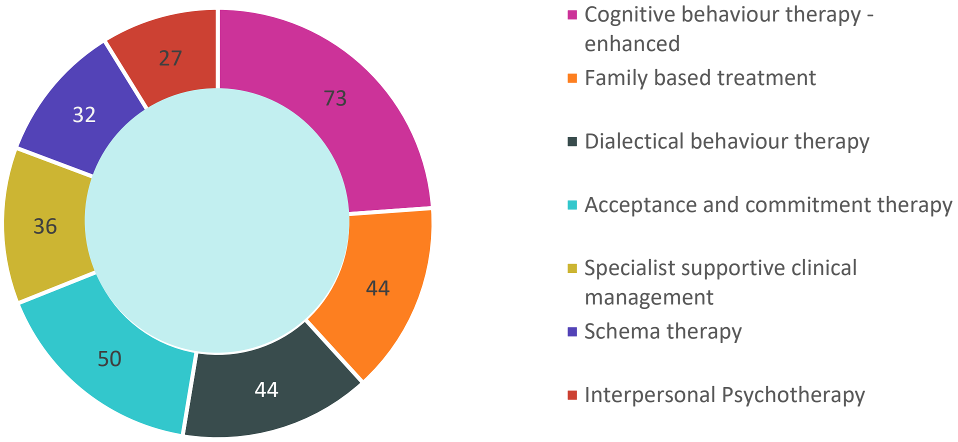
Insights into the potential reasons that treatment of eating disorders with the Eating Disorders MBS items may facilitate recovery were sought from health professionals. An Eating Disorder Plan was endorsed strongly as being helpful (moderately to very) for providing an appropriate number of treatment sessions to meet the needs of people with eating disorders (82.1%). Consistent with this view, in qualitative interviews mental health clinicians noted that the increased treatment frequency that could result from availability of a higher number of sessions better aligned with evidence-based guidelines and treatment approaches. Importantly, mental health clinicians and dietitians reported that while the introduction of the Eating Disorders MBS items increased access to treatment, it was the severity of the eating disorder symptoms that mostly influenced treatment outcomes. From the community survey, a little over half of health professionals reported that an Eating Disorder Plan was helpful (moderately or very) for increasing client engagement with treatment (61.8%), increasing motivation for treatment (57.2%), and facilitating good therapeutic alliance (58.5%). An Eating Disorder Plan was less strongly endorsed as helping to reduce fear and doubt about treatment (39.2%).

6.1.5 Therapeutic approaches used with Eating Disorders MBS items

The approaches taken by health professionals in providing psychological treatment and dietetic services were explored through surveys and interviews. Among health professionals in our community survey, the most common treatment models used by those who provide psychological treatment services and the most common dietetic-specific practices used by those who provide dietetic services are displayed in Figure 6.16 and Figure 6.17.

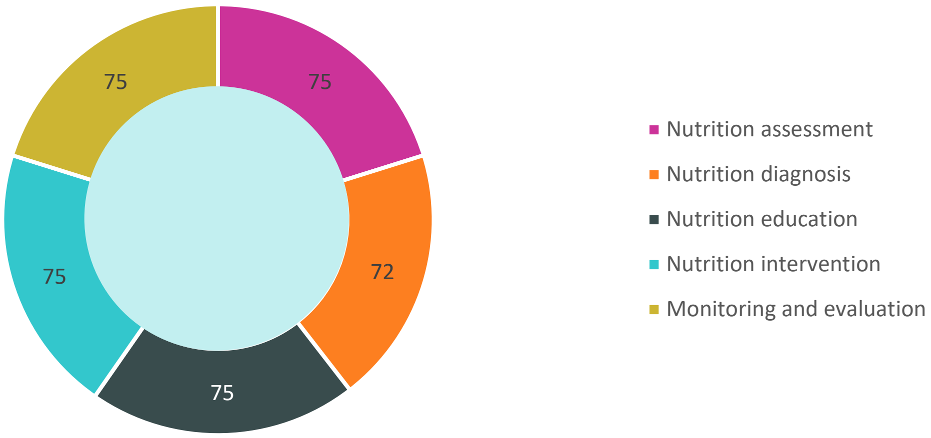
These psychological treatment approaches are consistent with recommended services under the Eating Disorders MSB items, and most have strong support in scientific literature for efficacy, acceptability, and tolerability, and appear in clinical guidelines documents (see summary of Study 8; Chapter 8, Technical Report). Dialectical behaviour therapy and acceptance and commitment therapy are possible exceptions, where the evidence base is much smaller, though existing results are encouraging.

Interview data were generally consistent with community survey findings, reinforcing that healthcare professionals providing psychological treatment were typically using evidence-based treatments including cognitive behaviour therapy-enhanced (CBT-E), Maudsley Model of Anorexia Treatment in Adults, and specialist supportive clinical management for eating disorders. In addition, many clinicians also reported incorporating client-centred and trauma informed approaches in their care. Some noted they also used interventions that are not on the approved Eating Disorders MBS items



Note. Numbers in the figure represent the number of health professionals who used the treatment model; respondents could select more than one option. Models used with lower frequency (Maudsley Model of Anorexia Treatment in Adults (n = 19), adolescent-focused therapy for eating disorders (n = 14), cognitive behaviour therapy – guided self-help (n = 12), and focal psychodynamic therapy for eating disorders (n = 6)) are not displayed.

Figure 6.16. *Frequently used eating disorder treatment models by health professional providers of psychological treatment (n = 81)*



Note. Numbers in graph are number of health professionals who used the treatment model; respondents could select more than one option.

Figure 6.17. *Frequently used dietetic-specific practices by health professional providers of dietetic services (n = 76)*

intervention list, including motivational interviewing and acceptance and commitment therapy. Most mental health clinicians agreed that the guidelines for treatment models specified in the Eating Disorders MBS items reflected current evidence-based treatment but they – and people with an eating disorder – reported frustrations with the limitations of the specific interventions allowed.

Many felt this was not reflective of emerging evidence about eating disorders interventions (for example, temperament-based therapy with supports) and noted a lack of flexibility in Eating Disorders MBS items-supported service provision. Furthermore, the interventions included in the Eating Disorders Plan were perceived to favour people with anorexia over those with other eating disorder presentations.

Dietetic-specific interventions were used by almost all (94.7% – 98.7%) community survey respondents who provide dietetic services. In interviews, dietitians were positive about the flexibility allowed for in providing nutrition interventions through the Eating Disorders MBS items, with the only requirement being that their dietetic services were evidence-informed. Dietitians reported providing nutritional counselling and meal planning based on client-centred and trauma informed approaches.

6.1.5.1 Multidisciplinary and coordinated care

The best-practice stepped care model for delivering services under the Eating Disorder Plan expect that a multidisciplinary approach with coordinated care between health care providers will be implemented. Under this framework, frequent communication and the potential use of case conferencing is intended to support a shared care plan to facilitate positive outcomes from treatment for people with an eating disorder (see the Australian Department of Health and Aged Care [25] explanatory notes for more information on the stepped care approach).

Despite this intention for frequent communication and coordinated care, health professionals in our community survey did not strongly endorse that the Eating Disorders MBS items supported coordinated multidisciplinary treatment or communication between treating team members. Less than half (43.8%) indicated that an Eating Disorder Plan supported coordinated, well-functioning multidisciplinary treatment (moderately or very much so). Furthermore, less than one-third (29.6%) indicated that an Eating Disorder Plan facilitated communication (moderately or very much so) between health professionals involved in providing care under the plan. Medical professionals tended to view Eating Disorder Plans as better at supporting multidisciplinary treatment than dietitians and psychologists, occupational therapists, and social workers. Similarly, as discussed in Section 4.5, health professionals participating in interviews expressed concerns regarding the significant volume of unpaid work necessary to facilitate coordinated care effectively.

With MBS items to support case conferencing only being introduced on 1 July 2023, it is unsurprising some health professional respondents in the community survey (28%) were not aware these items existed. Of those who were aware of the new case conferencing items, about half perceived that they would at least moderately improve health professionals' ability to provide well-functioning multidisciplinary treatment (49.0%) and communication within the multidisciplinary team (49.3%) under use of the Eating Disorder Plan. Interview responses from health professionals did not strongly endorse the case conferencing items as likely to improve care coordination. This concern was particularly emphasised in relation to communication between dietitians and psychological treatment providers, given that the existing criteria states that case conferences must be organised and coordinated by a GP or other medical practitioner, with no item being available for communication solely between these two professional groups. Additionally, during interviews, mental health clinicians and dietitians also conveyed challenges in establishing communication, particularly with GPs, and encountered difficulties scheduling care team meetings due to busy and conflicting schedules. This meant that crucial lines of communication were often hindered, impeding collaboration between dietitians, mental health professionals and GPs.

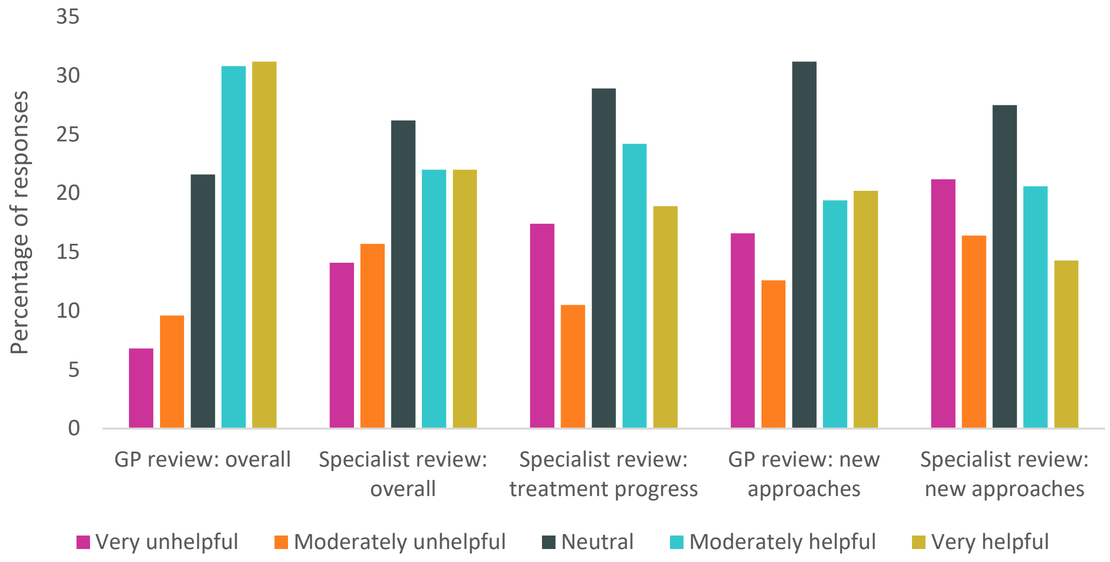
6.1.5.2 Review sessions

Reviews conducted within an Eating Disorder Plan have a key place in supporting positive treatment outcomes and facilitating ongoing access to psychological treatment. As described in Section 1.5, all reviews are conducted to monitor treatment progress and permit additional treatment services according to need and are intended to i) review the effectiveness of treatment to date, and ii) modify the plan (where necessary) with the intention of improving outcomes (see the Australian Department of Health and Aged Care [18] explanatory notes for Eating Disorder Plan reviews). This is supported by treatment guidelines that recommend reviews where an absence of progress is observed (see Technical Report, Chapter 8).

Overall, GP review sessions accessed through an Eating Disorder Plan were perceived as being helpful (moderately or very) by people with lived experience of eating disorders (62.0%) and by people who care for someone with an eating disorder (73.0%) in the community survey. Ratings were lower for perceptions of the overall helpfulness of psychiatrist/paediatrician review sessions by people with an eating disorder (44.0%), but at somewhat similar levels by people who care for someone with an eating disorder (62.5%).

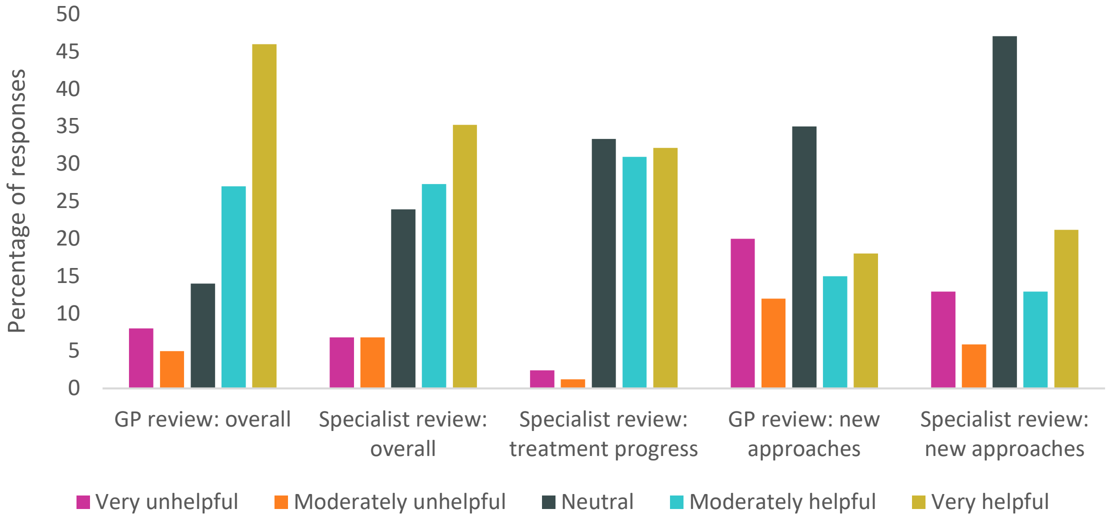
People with lived experience of eating disorders and people who care for someone with an eating disorder indicated their views in the community survey about the helpfulness of the psychiatrist/ paediatrician review sessions for reviewing treatment progress. About half found the sessions to be helpful (moderately or very) for this purpose (people with eating disorders 43.1%; people with lived experience of caring for someone with an eating disorder 63.1%). In contrast, as shown in Figures 6.18 and 6.19, reviews by GPs and psychiatrists/paediatricians were not strongly endorsed as being helpful for considering new or different approaches to treatment. Only 39.4% of people with eating disorders rated GP reviews as being helpful for considering new approaches and 34.9% rated psychiatrist/paediatrician reviews as helpful for this purpose. Similarly, one-third of people who care for someone with an eating disorder rated reviews by GPs (33.0%) or psychiatrists/paediatricians (34.1%) as helpful for considering new approaches. Further to this, some health professionals and those with lived experience of an eating disorder expressed reservations in interviews about the 20-session specialist review, specifically citing the requirement to consult a psychiatrist as a deterrent to continuing services.

Frustration was expressed with the associated expense, extended wait times, and challenges in finding available psychiatrists to complete what was viewed as an unnecessary, confusing, and stressful exercise.



Note. Specialist refers to psychiatrist/paediatrician review.

Figure 6.18 *Ratings of helpfulness of GP and psychiatrist/paediatrician reviews by people with lived experience of an eating disorder*



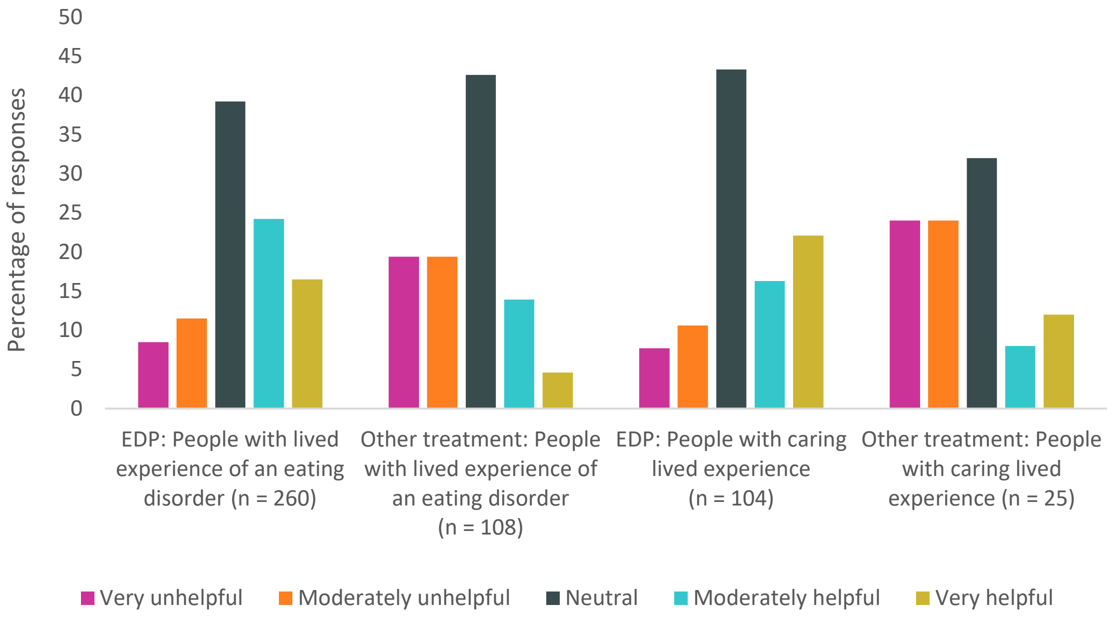
Note. Specialist review refers to the 20-session psychiatrist or paediatrician review.

Figure 6.19 *Ratings of helpfulness of GP and psychiatrist/paediatrician reviews by people who care for someone with an eating disorder*

Ratings by GPs, and psychiatrists and paediatricians who conduct reviews were slightly more positive regarding helpfulness of reviews for considering new or different treatment approaches. More than half of respondents (57.4%) perceived reviews as being helpful for this purpose. However, views on the best timing for reviews were varied. Many of the health professionals who conducted review sessions (56.6%) indicated that reviews at 10-session intervals were appropriate with some GPs (27.1%) also agreeing that an earlier review was frequently necessary. Many GPs (50.0%) also indicated that a specialist review (by a psychiatrist or paediatrician) was not necessary under the plan for most patients. Conversely, no psychiatrists or paediatricians held this view. In addition, all psychiatrists and paediatricians agreed with the notion that only a specialist review (by a psychiatrist or paediatrician) at 20 sessions was necessary.

6.2 Eating Disorders MBS Item Use and Subsequent Healthcare Utilisation

Responses to the community survey support that use of Eating Disorder Plans may contribute to positive outcomes for people with lived experience of eating disorders by affecting subsequent healthcare use. People with lived experience of an eating disorder and people who care for someone with an eating disorder who received treatment via an Eating Disorder Plan perceived their treatment to be significantly more helpful for reducing their use of other health services than people who received treatment or cared for someone who received treatment via other means. As shown in Figure 6.20, a pattern was observed where for Eating Disorder Plans, the proportion of respondents rating treatment as helpful for reducing use of other health services was greater than the proportion finding this element unhelpful. In contrast, the observed pattern was in the opposite direction for perceptions of treatment received by other means. The proportion of respondents rating the treatment as unhelpful for reducing use of other health services was greater than those rating this aspect as helpful.



Note. EDP = Eating Disorder Plan

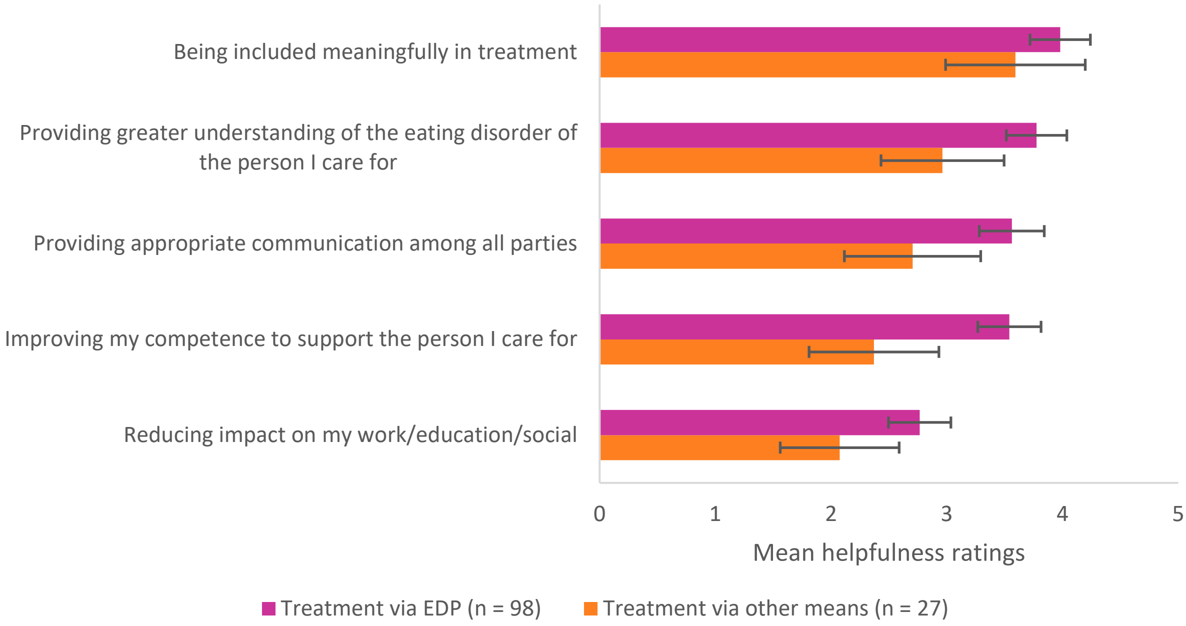
Figure 6.20. *Perceptions of helpfulness of treatment for reducing use of other health services by people with lived experience of an eating disorder and people with lived experience of caring for someone with an eating disorder*

In addition, the number of psychological treatment services received was significantly related to views that an Eating Disorder Plan was helpful for reducing use of other health services. For both people with a lived experience of an eating disorder ($r = .14$, $p = .023$) and people with a lived experience of caring for someone with an eating disorder ($r = .35$, $p < .001$), having a higher number of psychological treatment sessions was associated with perceiving the treatment as more helpful for reducing use of other health services. The number of dietetic sessions received was not associated with perceptions of helpfulness for reducing use of other health services for either people with lived experience of an eating disorder or people who care for someone with an eating disorder.

6.3 Outcomes for People who Care for a Person with an Eating Disorder

Outcomes from implementing the Eating Disorders MBS items may also be considered in terms of the impact on people who care for someone receiving treatment for an eating disorder. From the community survey, several outcomes were compared for circumstances where treatment for the person with an eating disorder was supported through an Eating Disorder Plan or through other means, such as public services or private health insurance.

As shown in Figure 6.21, people with lived experience of caring for someone with an eating disorder reported the helpfulness of being meaningfully included in treatment at approximately equivalent levels for either treatment pathway. For helpfulness of several other outcomes, treatment received through an Eating Disorder Plan was rated as significantly more helpful than treatment received through other means. This was notable for treatment-relevant factors: having greater understanding of their loved one's eating disorder and improved competence in supporting the person they care for. It is noted that neither pathway was rated highly for reducing the impact of caring for a person with an eating disorder on personal domains for people with lived experience of caring for someone with an eating disorder. These domains being their own work, education, or social/relationships. However, an Eating Disorder Plan pathway was still rated as significantly more helpful than treatment received by other means for this outcome, suggesting the need for individual support for personal well-being as addressed in Section 4.3. These ratings of helpfulness by carers in the community survey suggest important positive outcomes from access to the Eating Disorders MBS items for those supporting a loved one through eating disorder treatment that may additionally have flow-on benefits to the person receiving eating disorder treatment.



Note. EDP = Eating Disorder Plan. Helpfulness rated from 1 = very unhelpful to 5 = very helpful; error bars are 95% confidence intervals.

Figure 6.21. *Ratings by people with lived experience of caring for someone with an eating disorder of helpfulness for outcomes from treatment supported by the Eating Disorders MBS items or other means*

6.4 Workforce Capacity for Implementation of Eating Disorders MBS Items

6.4.1 Provision of services

The national linkage data study shows that for the period from November 2019 to end of December 2022, there were 5,146 providers of psychological treatment services and 1,343 providers of dietetic health services under the Eating Disorders MBS initiative. On average, providers delivered 64.2 psychological sessions (median = 18, IQR = 6-53) and 108 dietetic sessions (median = 19, IQR = 5-72) in total during this period. Figures 6.22 (psychological treatments) and 6.23 (dietetic health services) show that there is significant skew in the distribution of service provision such that a large number of providers deliver few sessions and a very small number of providers deliver a high number of sessions.

Providers were classified into 5 categories based on the total number of psychological treatment sessions they had delivered: 10 or fewer, between 11 and 20, 21 to 149 services, 150 to 279 services, and 280 or more services. For each of these categories of service providers, Figure 6.22 shows the percent of providers in each group and in the corresponding colour the percent of overall psychological sessions that were delivered by that group. Almost half of all psychological sessions (46.4%) are delivered by the smallest group of providers which comprises just 5.1% of psychological treatment providers. At the other end of the distribution, Figure 6.22 shows that providers who delivered 10 or fewer psychological sessions in total since the introduction of the Eating Disorders MBS items, comprise 38.1% of all providers in the initiative but they delivered less than three percent of total psychological sessions (2.8%). The disparity in experience and familiarity of providers with the Eating Disorders MBS items initiative means that more than half of all providers of psychological treatment (54.4%) delivered 20 or fewer sessions in total and only 6.7% of all sessions while the top 10% of providers who delivered 150 services or more, accounted for 62.2% of all provided sessions.

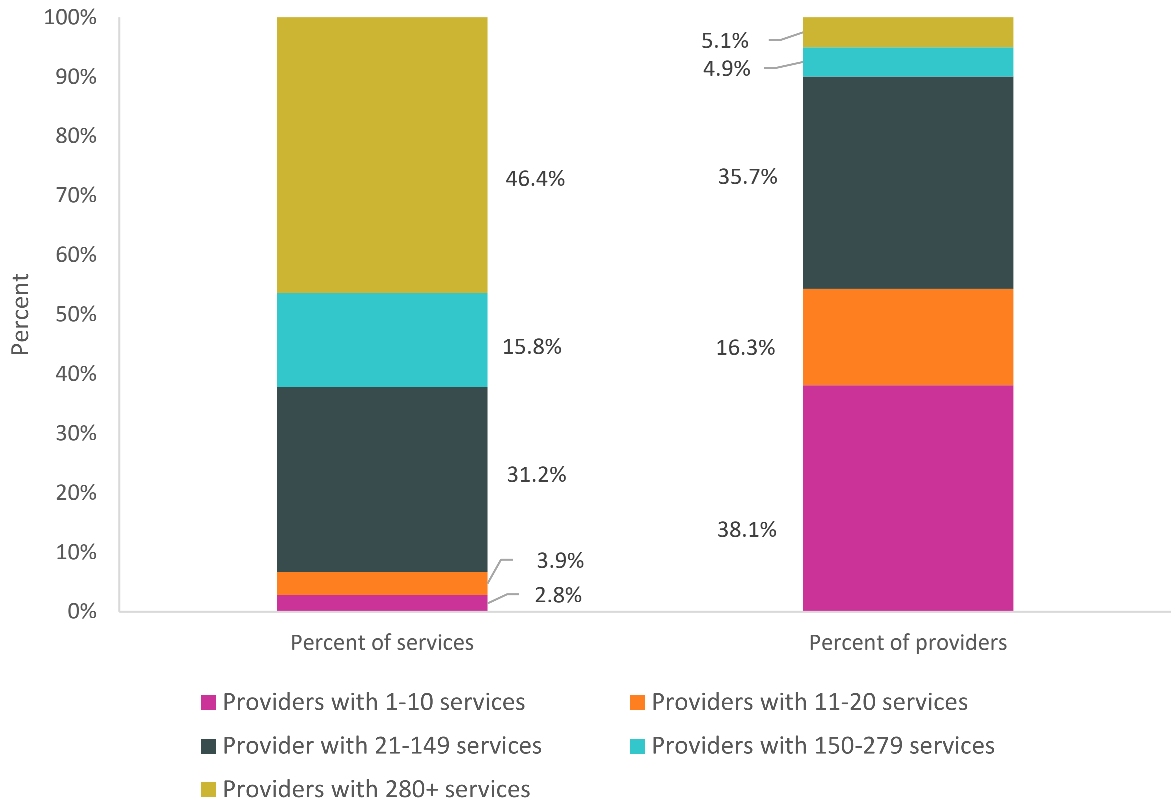


Figure 6.22. *Distribution of psychological treatment services across providers*

Dietetic health service provision also showed a skew in the number of sessions delivered by providers. This disparity is shown in Figure 6.23. Again, we categorised providers into 5 groups based on the number of sessions delivered. Similar to what was found for the psychological treatment service providers, just 5 percent of dietetic service providers delivered almost half (47.7%) of all dietetic health sessions. In contrast, 39.9% of providers delivered only 1.6% of overall dietetic health sessions. Collectively, these findings suggest the bulk of treatment sessions are delivered by a small number of providers, with many more providers infrequently providing services via the Eating Disorder Plan. This inequity in service distribution could account for differences in confidence in delivering services, as articulated in interview and survey data.

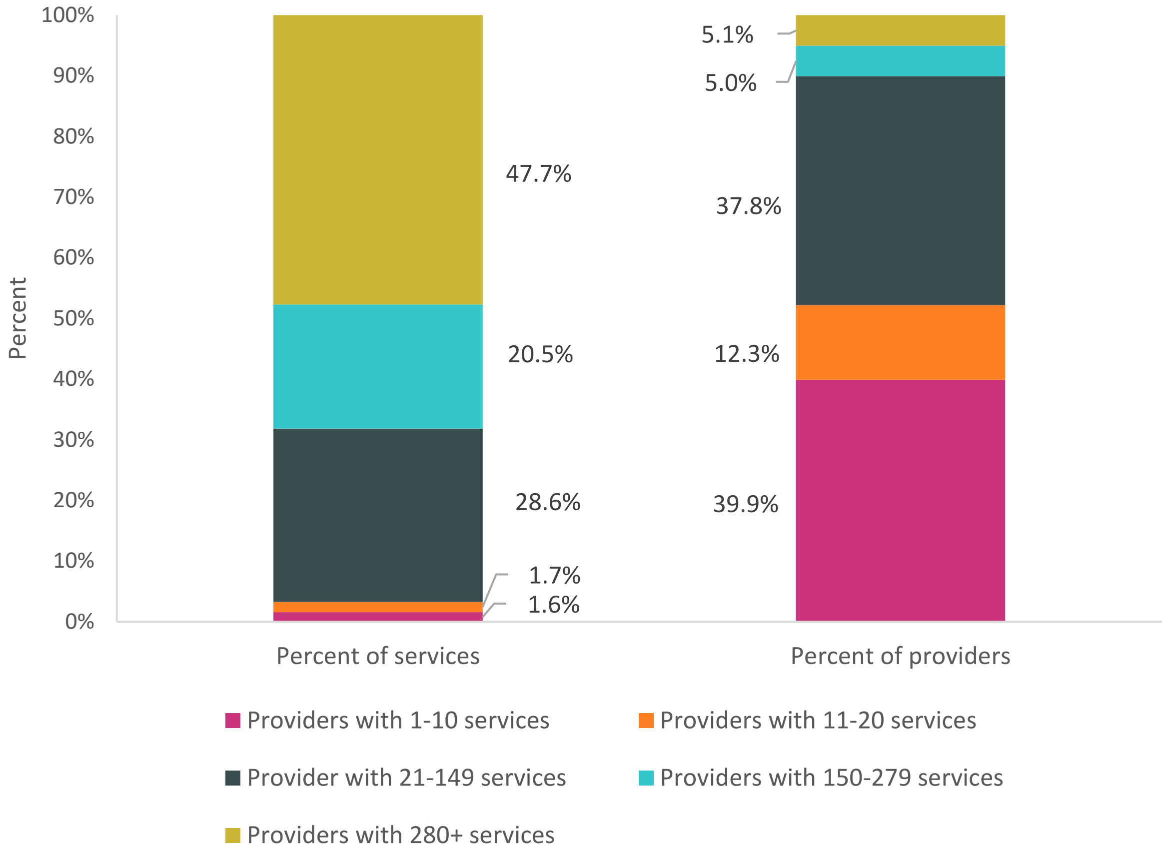
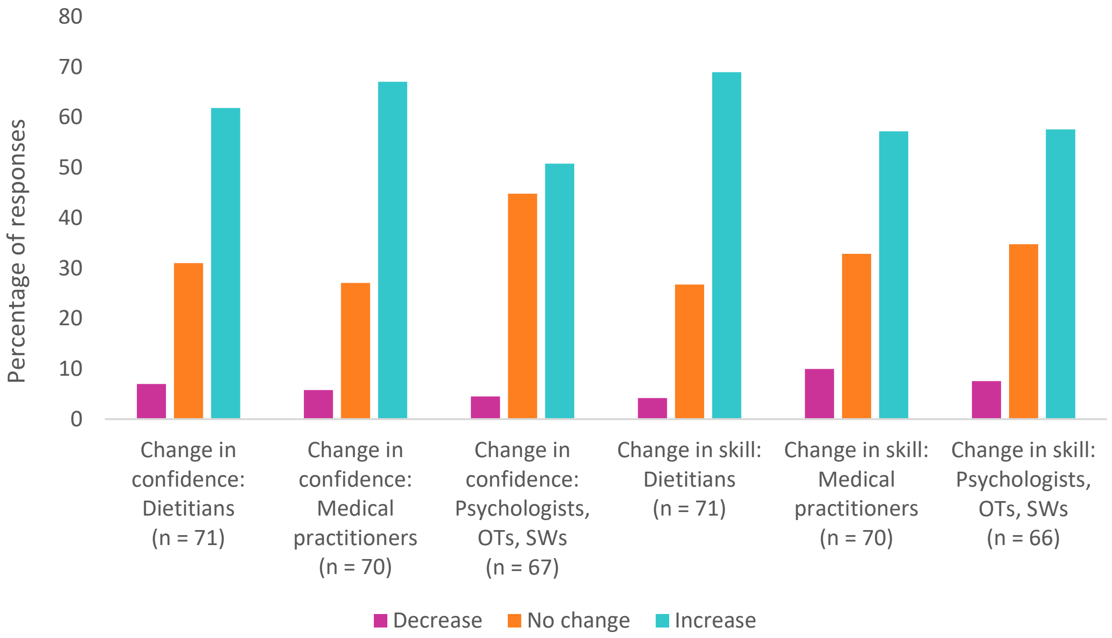


Figure 6.23. *Distribution of dietetic health services across providers*

6.4.2 Confidence, skill, and capacity to provide eating disorder services

Most health professionals responding to the community survey indicated they had experienced a small (38.0%; 36.2%) or large (22.1%; 25.1%) increase in confidence and skills, respectively, to work with people with eating disorders over the period the Eating Disorder Plan has been available. Very few health professionals reported a decrease in confidence (5.8%) or skills (7.1%) over this time.

As shown in Figure 6.24, a higher proportion of dietitians and GPs or other medical practitioners than psychologists, occupational therapists, and social workers reported any increase in confidence. More dietitians reported increased skills to work with people with eating disorders than other health professionals.



Note. OT = occupational therapist, SW = social worker.

Figure 6.24. *Perceived change in confidence and skill by health professionals in the community survey*

Although these are self-reported reflections of change over time, the findings suggest an increase in workforce capacity to treat eating disorders since the Eating Disorder Plan has been available. It may be that the focus on, or awareness of, an eating disorder-specific pathway for treatment has resulted in greater exposure to and engagement with eating disorders treatment, contributing to increased workforce capacity. This suggests an additional positive outcome of Eating Disorder Plans beyond the planned outcomes for people receiving eating disorder treatment and people who provide care and support. Additionally, other activities in the sector, such as the ANZAED Eating Disorder Credential and freely available online training for GPs and mental health professionals (e.g., NEDC's Core Skills eLearning), may have also supported health professional development over this period.

Although health professionals reported an increase in their personal capacity relating to confidence and skills to provide services for eating disorders, systemic capacity may limit the benefits of this increase. For example, as noted in Section 5.4.3, among health professionals providing psychological treatment, more than half had a wait list for new clients and only a quarter of providers had immediate availability to take on new clients. This lack of availability may have contributed to few health professional respondents to the community survey indicating a preference to increase their eating disorder caseload. Notably, dietitians reported more availability to take on new clients and a higher preference to take on a small caseload increase. In conjunction with their self-perceived increase in confidence and skill, this may represent an opportunity to increase workforce capacity. It could provide an alternative option for intervention to assist in tackling the difficulty reported by GPs in finding appropriate mental health professionals to provide psychological treatment in a timely manner (see Sections 5.4.4.1 and 5.4.4.2).

However, dietitians who were willing to increase their caseloads were significantly less experienced in working with people with eating disorders than those who did not want to take on a greater eating disorder caseload. This suggests other strategies are also required to ensure maintenance of experience in the dietitian workforce.

6.5 Summary and Recommendations

The available evidence suggests that access to treatment through an Eating Disorder Plan is associated with positive outcomes for people with eating disorders. Objective data from clinical case reviews revealed improvements in eating disorder symptoms and psychological distress and increased attainment of goals over the course of treatment. Reflections of people who had received treatment supported these findings. People with lived experience of an eating disorder felt an Eating Disorder Plan contributed to their recovery from an eating disorder. They attributed this to the plan providing enough sessions through which motivation to change was enhanced, therapeutic alliance could be successfully developed, and consistent, in-depth, and comprehensive treatment could be client-paced and personalised.

Views from people who care for someone with an eating disorder and from health professionals also supported perceptions of positive outcomes from treatment with an Eating Disorder Plan. Perceptions of helpfulness were higher among health professionals involved in direct eating disorder care, that is mental health and dietetic health professionals, whereas GPs and psychiatrists and paediatricians who provide management and review of care endorsed the helpfulness of an Eating Disorder Plan slightly less strongly for facilitating eating disorder recovery.

Although findings on outcomes are encouraging, lack of readily accessible, consistent, high quality objective data significantly impedes evaluation of the effectiveness of this initiative. An agreed upon system for collecting, recording, and sharing consistent progress and outcomes data within multidisciplinary teams is required to enable ongoing evaluation of the effectiveness of the Eating Disorders MBS items. Such a system would enhance the benefit of review sessions in facilitating consistent assessments of progress and indicate when the need to adopt new approaches has arisen as well as supporting health professionals' self-reflection of outcomes from their clinical practice in eating disorders, facilitating improvement in practice.

Regarding the different services available within the Eating Disorders MBS items, treatments and interventions delivered were found to be consistent with the permitted approaches and with guidelines for psychological treatment and dietetic intervention. Mental health professionals predominantly used evidence-based treatment models to provide psychological treatment.

These treatment models have received scientific support for their efficacy. Dietitians predominantly used interventions that are indicated in guidelines for nutrition intervention. Consequently, treatment under this initiative has a higher likelihood of achieving positive outcomes for people with eating disorders.

Explicit evidence for the benefits of review sessions was lacking from our evaluation studies, raising questions as to whether people with eating disorders receive the intended benefit from the reviews. It is noted that some treatment guidelines specifically state that reviews should occur when there is no progress so alternative intervention options can be considered. Despite the desired benefit, people with lived experience of an eating disorder did not perceive reviews to be helpful for that purpose and, for some, the review was perceived as confusing and a burden to obtain, rather than a useful exercise (see Section 5.3.2). The slight disconnect between ratings of health professionals and ratings of people with lived experience and caring experience about the benefits of reviews suggests that treatment needs for some people are being missed. This is particularly the case for people who may not achieve early progress in their treatment and may be most in need for modification of the approach to their eating disorder treatment. In addition, mixed views about the best timing for the reviews was noted by health professionals who provide this service. Considering this, it is unsurprising that the timing of reviews was perceived by other stakeholders to be arbitrary (see Section 5.3.2). There is a need for greater clarity around the purpose of and best timing to deliver the intended outcomes of reviews.

The higher number of psychological treatment sessions available through the Eating Disorders MBS items appears to be integral to positive outcomes as noted above and is consistent with the treatment dose required in evidence-based treatment. As such, the availability of 40 psychological treatment sessions should be maintained. However, the value of review sessions required to open access to each course of psychological treatment was not evident from the responses of people with eating disorder lived experience who have participated in the reviews. This suggests that modifications to the operation of reviews, including the best time for reviews within the course of treatment, is required to reap their full potential. Given i) the requirement within the Eating Disorders MBS items and desire from people with an eating disorder and people caring for someone with an eating disorder that review sessions be conducted by health professionals with sufficient knowledge, skill, and experience in providing eating disorder treatment (Section 5.3.2), and ii) the potential complexity of determining new directions for treatment when progress is impaired, consideration as to who is best placed to contribute to the review is needed. With the recent introduction of MBS case conferencing items, greater involvement in reviews by the multidisciplinary team may be better supported. Promoting awareness of these items among health professionals who use the Eating Disorders MBS items may also result in greater uptake.

Additional positive outcomes from an Eating Disorder Plan were observed for people with a lived experience of caring for someone with an eating disorder and for increasing capacity among health professionals to work with people with eating disorders. These secondary outcomes point to broader benefits from the initiative. Enhancing understanding and competence of people with lived experience of caring for someone with an eating disorder to support them through treatment and increasing confidence and skills of health professionals will ultimately positively impact people with lived experience of eating disorders. The observation of these broader benefits also suggests that conditions that deliver these benefits should be maintained.

Regarding involving people who care for a person with an eating disorder in eating disorder care, provision should be made for funding sessions where the person caring for someone who has an Eating Disorder Plan can access independent sessions – where appropriate and part of the overall integrated care plan – to support their understanding, skills, and competence in contributing to the recovery of the person with an eating disorder.

The secondary benefits identified for health professionals could be built upon in several ways. First, further improvement in capacity to work with eating disorders among currently practising health professionals should be sought through multiple avenues, including training, supervision, and increased exposure to treating eating disorders. The need for this is evident through the skewed distribution of service delivery, with almost half of all services being delivered by around 5% of providers for the ED MBS scheme, and a large number of providers infrequently offering services. Second, identifying opportunities that presently exist regarding current availability in the system for providing eating disorders treatment, and taking advantage of these opportunities is necessary to increase access to support. This is especially important for people with lived experience of eating disorders who experience a lag between time of diagnosis and beginning of treatment. Availability and willingness of dietitians to take on additional eating disorder work presents one such opportunity but should be considered cautiously so as not to focus the workforce among those less experienced in working with eating disorders. Third, greater promotion and subsequent awareness of the availability of the new case conferencing items for people with an Eating Disorder Plan may contribute to improved functioning of and communication between multidisciplinary teams for providing treatment under an Eating Disorder Plan.

7

Objective 5: Recommendations to Inform the Ongoing Success of the Eating Disorders MBS Items

7 Objective 5: Recommendations to Inform the Ongoing Success of the Eating Disorders MBS Items

7.1 Overview

In proposing eating disorder-specific MBS items, the Eating Disorders Medicare Benefits Schedule Review Taskforce sought to deliver affordable and universal access to best-practice health services to provide value for both individuals (e.g., services appropriate to the needs of the person with an eating disorder) and the Australian Government (e.g., value for the overall health system).

The Eating Disorders MBS items initiative is small compared to the Better Access initiative through which Mental Health Treatment Plans are provided and this eating disorder specific initiative has been operating for a relatively short time (with much of that time period including COVID-19 disruptions). As such, limited data are available on usage of services in linked data sets. Nonetheless, this evaluation unambiguously found agreement among health professionals, people with lived experience of an eating disorder, and those caring for someone with an eating disorder that the Eating Disorders MBS items are a substantial improvement on previously available Medicare supported services for eating disorder treatment. Availability of a suitable number of treatment services and access to knowledgeable providers within a multidisciplinary team were perceived positively and as contributing to improved outcomes. Wait times were found to be generally (though not always) acceptable, improvements in symptoms were observed and attributed to treatment received through an Eating Disorder Plan, and multi-disciplinary teams and care coordination that includes carers were also found to be very helpful. As a result, a decrease in the use of Better Access or chronic disease management services was observed after receiving an Eating Disorder Plan.

Even so, findings from our evaluation highlight areas in need of refinement to maximise the potential benefits of the Eating Disorders MBS items. Known barriers to treatment access for people living with an eating disorder persist. Key impediments to continuity of treatment include lengthy wait-times, usefulness, and costs associated with 20-session reviews. Similarly, under-dosing of treatment is apparent, with less than 4% of people receiving 40 psychological treatment sessions and 20 dietetic health services in a 12-month period.

Understanding the system is important, as indicated by our finding that prior use of Better Access or chronic disease management services was associated with greater likelihood of using psychological and dietetic services once an Eating Disorder Plan was created. We identified barriers that impeded uptake and ongoing use, including lack of awareness of the items, eligibility confusion, and confusion about the purpose of reviews, so rather than seeing them as a way of maximising treatment usefulness, they were perceived as a way of punishing either too much or not enough progress.

We also identified gaps in workforce capacity and capability. While eligibility assessments and preparation of Eating Disorder Plans were distributed across many GPs, their ability to formulate diagnoses and treatment goals varied. The experience and familiarity of service providers with the Eating Disorders MBS items initiative was more uneven, with over half of all psychological and dietetic providers delivering fewer than twenty treatment sessions (in total), while 5% of providers accounted for provision of almost half of all treatment sessions delivered since the start of the initiative. This inequity is a risk to sustainability and equity of access. Further, it is evident that knowledge, experience, and confidence in delivering eating disorder treatment is highly variable.

Providers with limited experience may lack detailed knowledge of the program, and the large number of providers delivering only a handful of services may compromise consistency of services. Existing eating disorder (ANZAED) clinician credentialing is well subscribed, and linked to enhanced health professional confidence and knowledge. Credentialing may thus be an important accelerator of good clinical practice that serves to enhance workforce capability and consistency of experience.

Reliance on psychiatrists (or paediatricians) for a 20-session review remains a considerable risk given the low number of registered psychiatrists in Australia [26], their uneven distribution across the country, variable expertise in eating disorders, and the high out-of-pocket costs associated with their services [27].

Health professionals raised concerns about the amount of time required to provide adequate services at all stages of an Eating Disorder Plan (plan preparation, treatment, and review). The recent introduction of case conferencing items is a positive addition to remunerate these multi-disciplinary teams, but other solutions are needed to further redress the imbalance between time commitment and quality of care, and to facilitate timely commencement of services. Solutions to achieve more streamlined plan preparation and commencement of treatment for people living with an eating disorder include:

- task shifting to reduce workload on health professionals to enable higher caseload and more distributed delivery of services across the full workforce with capability and capacity to deliver Eating Disorders MBS items.
- providing easy-to-use templates for eligibility assessment and reviews of progress to help expedite initial on-boarding aspects of an Eating Disorder Plan and provide helpful cues to guide health professionals who may be less experienced in treatment of people experiencing an eating disorder
- integrating single-session interventions while treatment seeking people are on waitlists to facilitate more timely assessment.

Our evaluation identifies a range of solutions to enhance delivery and impact of the Eating Disorders MBS items. While each of these may be expected to positively impact a specific aspect of service, it is in combination that these proposed changes are likely to yield greatest impact in terms of enhanced system efficiency and efficacy.

This chapter organises recommendations according to key barriers and enablers at pivotal stages along the Eating Disorder Plan treatment journey, from initiation of services, treatment, and treatment review. Figure 7.1 summarises the barriers and potential enablers at different stages of service delivery. We also propose possible linkages, services, and partnerships that could complement the Eating Disorders MBS items, but currently sit outside of this initiative.

Each recommendation in this chapter is informed by multiple sources that are included in the preamble to each recommendation: i) initial recommendations from Butterfly Foundation [28] and the Medicare Benefits Schedule Review Taskforce: Report from the Eating Disorders Working Group [29] ii) data collected over the course of this project, and iii) emerging evidence from the broader relevant scientific literature arising since introduction of the Eating Disorders MBS items. Each recommendation identifies opportunities to enhance the usefulness of the Eating Disorders MBS items for people experiencing eating disorders, those who care for them, and health professionals, and offers value for the health system.

EATING DISORDERS MBS USER JOURNEY

Enablers ⊕ **Barriers** ⊗

Initiation of service

First contact is with a GP who is sufficiently knowledgeable about eating disorders, including: screening tools; assessment (medical risk, eligibility for Eating Disorder Plan); knowledge of local treatment pathways.

Provision of evidence-based contact while people are waiting for treatment to commence, including detailed psychological assessment.

Care co-ordination.

Belief that an eating issue is not severe enough to warrant intervention.

An unhelpful first contact with a health professional.

Time required by the GP to conduct eligibility assessment and complete an Eating Disorder Plan.

Lower socio-economic status, younger people and those living in rural and remote areas.

Timely provision of treatment after initial detection.

Treatment

The way in which evidence-based therapies are conducted can make them more effective.

Families recognised as part of treatment team and provided with sufficient support.

Greater emphasis placed on ongoing role of supervision.

Increasing use of dietetic sessions.

Recommended eating disorder therapies updated as evidence emerges and reflected in approved training.

Large out of pocket expenses.

Lack of incentive for experienced ED practitioners to become/remain credentialled.

Some of the recommended ED therapies lack accessible treatment manuals.

Review

Multidisciplinary case conferences.

Use of sessional progress indicators.

Using early progress to inform changes to the treatment approach.

Purpose of reviews unclear.

Specialist reviewer narrowly defined (experienced clinicians excluded from this role).

Specialist reviews hard to access.

Specialist reviews not always necessary.

Figure 7.1. *Facilitators and barriers along the eating disorder treatment journey*

7.2 Recommendations Framework

The remainder of this chapter presents the recommendations derived from our evaluation of the Eating Disorders MBS items. Although these recommendations are presented in accordance with stages along the Eating Disorder Plan treatment journey as described above, we also emphasise that a holistic view of the scheme and the interconnections between all elements is required to provide appropriate understanding of the intent and expected benefits of the recommendations.

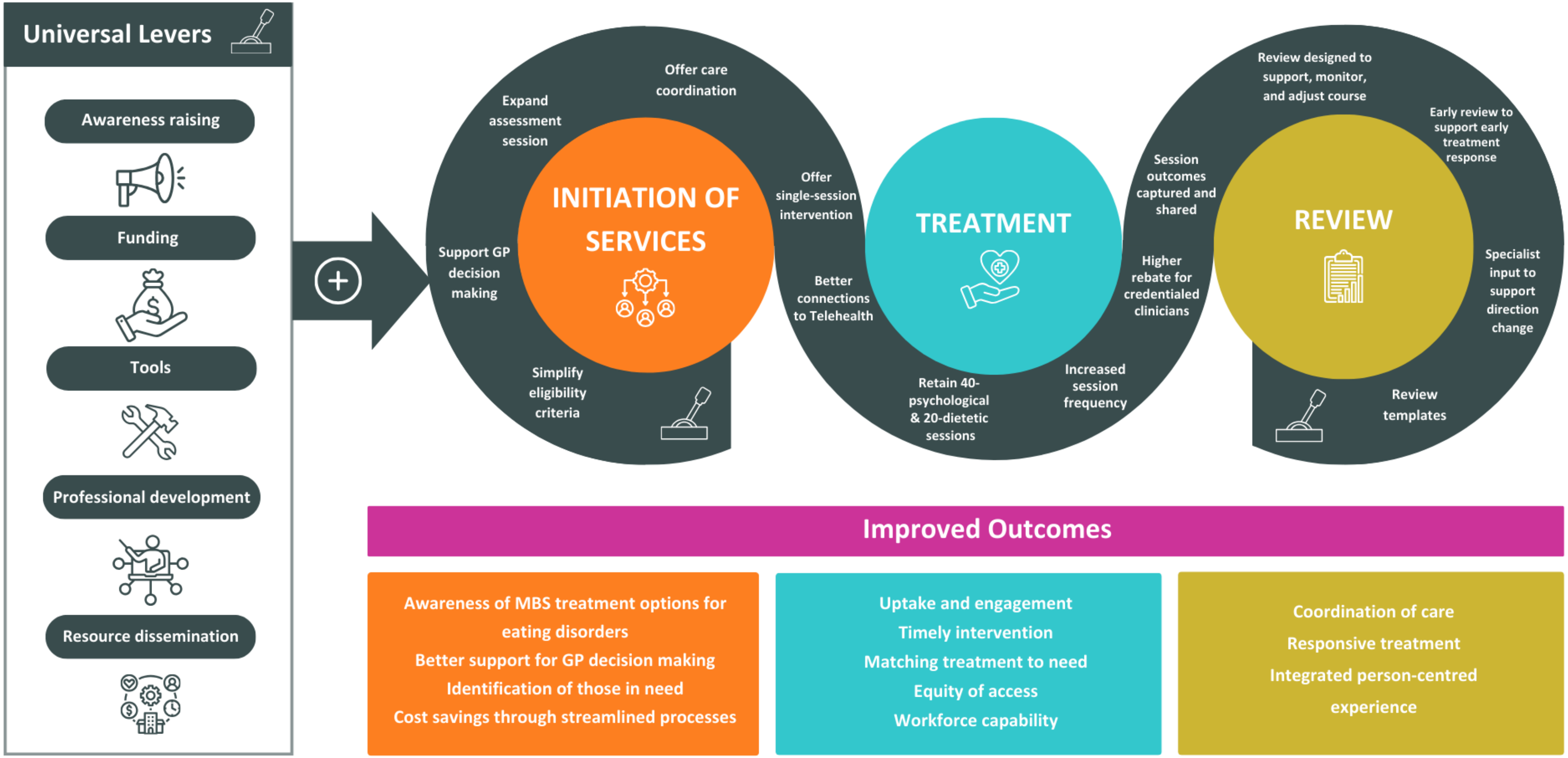
In this regard, it is important to recognise the original intent of the Eating Disorders MBS items as envisaged in the report of the Eating Disorders Working Group from the MBS Review Taskforce. This was for a stepped care model of delivery of treatment for people with eating disorders across the spectrum of severity of presentation, with intensity of treatment tailored to level of need. It was proposed that individuals experiencing an eating disorder who are deemed to be at higher risk would have immediate access to up to 40 sessions of psychological treatment and 20 sessions of dietetic intervention. In contrast, those individuals not meeting the high-risk profile would receive an initial course of 10 sessions of psychological treatment and 5 sessions of dietetic intervention and would 'step-up' to higher levels of treatment as required and indicated following review at regular points during treatment.

Although the initial rollout of the Eating Disorders MBS items was restricted to only the 'high risk' pathway, several elements that were intended to apply across lower levels of need were applied at the higher intensity level of treatment delivery. These are provision of psychological treatment in 10-session courses which may contribute to treatment under-dosing and access to further courses of treatment being permitted only through the review processes. These settings have created challenges. In particular, reviews are seen as punitive, performing only a limited gatekeeping function, and their potential benefits for monitoring progress, altering the course of treatment, and improving outcomes have not been realised.

In response to these challenges, it is important that the delivery of services under an Eating Disorder Plan be reframed so that i) the initial referral for eating disorder treatment be for up to 40 psychological treatment sessions and up to 20 dietetic health services, and ii) review sessions are conducted with the clear purpose of monitoring progress and making adjustments when treatment is not meeting the needs of the person with an eating disorder. Specialist advice may be called on to assist the treating team in reviews of progress and treatment direction, but this is to be done in a way that will not impede ongoing engagement with an Eating Disorder Plan. Reviews are still to be conducted at 10-session intervals, but the reframing will remove perceptions of them having a gatekeeping function and will reinforce the benefits reviews can bring.

Overall, proposed recommendations will enhance the user journey and provide better experience across all points of connection with the Eating Disorders MBS items scheme. Key policy recommendations, levers of action, and expected improved outcomes from implementation of the recommendations derived in this evaluation are shown in Figure 7.2. A full list of all recommendations is presented in Appendix 12.

Policy Recommendations



Universal Levers

- Awareness raising
- Funding
- Tools
- Professional development
- Resource dissemination

INITIATION OF SERVICES

Expand assessment session

Offer care coordination

Offer single-session intervention

Support GP decision making

Simplify eligibility criteria

TREATMENT

Better connections to Telehealth

Retain 40-psychological & 20-dietetic sessions

Increased session frequency

Higher rebate for credentialed clinicians

REVIEW

Session outcomes captured and shared

Review designed to support, monitor, and adjust course

Early review to support early treatment response

Specialist input to support direction change

Review templates

Improved Outcomes

Awareness of MBS treatment options for eating disorders
Better support for GP decision making
Identification of those in need
Cost savings through streamlined processes

Uptake and engagement
Timely intervention
Matching treatment to need
Equity of access
Workforce capability

Coordination of care
Responsive treatment
Integrated person-centred experience

Figure 7.2. *Key policy recommendations, levers of action, and expected improved outcomes across the Eating Disorders MBS items initiative*

7.3 Initiation of Services

7.3.1 Early identification by the GP

Previous recommendations

- Screening for eating disorders using an evidence-based tool is recommended [28].
- Missed opportunities for timely identification were identified as a priority for improvement [29].

Findings from the evaluation project

Only 20% of people living with an eating disorder had uptake of Eating Disorders MBS items (page 45). This may, in part, indicate under-detection or under-servicing at the first point of contact with the GP, with lack of awareness about the Eating Disorders MBS items on the part of health professionals cited as a reason for not receiving an Eating Disorder Plan by people experiencing an eating disorder and people who care for someone with an eating disorder (pages 59-60). Psychological treatment and dietetic service providers reported often needing to inform GPs about how and when to initiate and complete an Eating Disorder Plan (pages 62-63). This is complicated by a probable lack of assertive reporting by people living with an eating disorder who do not go on to receive treatment via the Eating Disorders MBS items, 71% of whom did not think their eating concerns were serious enough to require treatment (page 85). These findings suggest that extra support is required for GPs to detect eating disorders and to instigate an Eating Disorder Plan where appropriate.

Emerging evidence

- One-third of people with an eating disorder in the community had symptoms serious enough to be detected by health professionals [30].
- The strongest reason people with an eating disorder do not seek help is they believe the problem is not severe enough [31,32].
- Health professionals also struggle to identify and distinguish among eating disorder presentations, and this adversely impacts referrals and treatment formulation [33].
- Providing GPs with online screening tools and information about availability of referral pathways in conjunction with training and/or support triples eating disorder referrals [34].
- Parents of a young person with an eating disorder report the strongest facilitator to accessing help for their teenage child with an eating disorder was a first contact that involved a health professional with sufficient knowledge of eating disorders [35].
- Duration of untreated illness was longer when relatives of people with anorexia nervosa rated that primary care practitioners (i.e., general practitioners) trivialised patients' difficulties [36].

Recommendations: Early Identification by the GP

1. All GPs should be equipped with an online validated screening tool:
    a. The screening tool should be the Screen for Disordered Eating [37] which is more sensitive than other tools for detecting any eating disorder in people.
    b. The Screen for Disordered Eating should be provided in an online format that can be automatically scored.
    c. Primary Health Networks (PHNs) operate an online portal (HealthPathways) that provides GPs with access to comprehensive evidence-based assessment. Currently the tool provided through this portal is the SCOFF Questionnaire. This should be replaced with the Screen for Disordered Eating.
2. GPs should be offered training and support to enhance awareness of eating disorder symptoms and treatment options, including when eating is not mentioned by the patient as a problem, but mental health is considered an issue [38]. To support this recommendation:
    a. PHNs, which currently provide a training and events function for GPs, should routinely offer training and support to use and interpret a screening tool for eating disorders and distribute unambiguous, brief documentation to raise awareness of the availability, eligibility, and associated treatment options of an Eating Disorder Plan.
    b. Training and support options should also include offerings like the NEDC Eating Disorder Core Skills: eLearning for GPs, which already exist and are intended to enhance the ability to recognise eligibility for different diagnoses and eating disorder presentations.

7.3.2 GP assessment of eligibility

Previous recommendations

- Access to eating disorder treatment through the Eating Disorders Medicare Benefits items be made available specifically to higher risk pathways as a pragmatic “first step” towards a stepped care model for eating disorder treatment [29].

Findings from the evaluation project

Twenty-five percent of GPs reported difficulty in assessing eligibility for an Eating Disorder Plan overall, while 40% reported difficulty in assessing eligibility for people who did not fit the criteria for anorexia nervosa (page 74). GPs also noted that the average time required in consultation sessions to gather the required information to identify eligibility was time-consuming (M = 53.6 minutes, SD = 17.9), and exceeded that allocated for their Medicare rebate (page 62). These findings suggest the need to simplify the eligibility criteria and process to make these assessments more accurate, easier to conduct, and less time-consuming for the GP. This will also ensure GPs do not default to an overly restrictive application of the eligibility criteria.

Emerging evidence

None.

Recommendations: GP Assessment of Eligibility

3. Simplify the process for determining eligibility by GPs by establishing two pathways as shown in Figure 7.3:
   a. Path A for people with anorexia nervosa – determination of eligibility according to a GP-generated diagnosis of anorexia nervosa
   b. Path B for people with bulimia nervosa, binge eating disorder, or other specified feeding or eating disorder – determination of eligibility according to presence of eating disorder symptoms and presence of clinical indicators specified below in (4a) and shown in Figure 7.3.

Path A would retain the existing pathway for eligibility for people with anorexia nervosa. Path B would retain the existing pathway for eligibility for people with other eligible eating disorder diagnoses with simplification by removing the need for a GP-generated eating disorder diagnosis for non-anorexia nervosa eating disorders.

4. Update determination of eligibility for an Eating Disorder Plan for Path B. To be specified as:
   a. An Eating Disorder Examination Questionnaire global score ≥ 3, **and** the condition is characterised by rapid weight loss, *or* frequent binge eating, *or* inappropriate compensatory behaviour occurring 3 or more times per week, **and** two of the following indicators are present: (1) current or high risk of medical complications due to eating disorder behaviours and symptoms, (2) serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status and function, (3) admission to a hospital for an eating disorder in the previous 12 months, and (4) inadequate treatment response to evidence-based eating disorder treatment over the past 6 months despite active and consistent participation.
   b. The criterion regarding weight status (i.e., clinically underweight with a body weight less than 85% of expected weight where weight loss is directly attributable to the eating disorder) to be removed given this is encompassed in the assessment of a diagnosis of anorexia nervosa for people meeting eligibility criteria for the Path A, and is not applicable for any eating disorder diagnosis criteria for Path B. See Figure 7.3.
   c. The GP does not make a diagnosis at the time of determining eligibility for an Eating Disorder Plan given its redundancy with information provided in (a). A schematic for this process is shown in Appendix 4.

Recommendations: GP Assessment of Eligibility

5. Modify the online Eating Disorder Examination-Questionnaire (provided by InsideOut Institute) to automatically provide the global eating disorder examination - questionnaire score, and the weekly frequency of objective binge eating and inappropriate compensatory behaviours, thus expediting GP assessment of eligibility.

6. Change the link to the eating disorder examination provided in the Australian Government Medicare Benefits Scheme Quick Reference Guide - which currently references the lengthy eating disorder examination interview - to the InsideOut Institute link for the eating disorder examination questionnaire provided in recommendation #5.

7. As per recommendation #2, use existing structures and organisations to support the provision, use and interpretation of online materials required to assess eligibility for Eating Disorders MBS items.

<table>
<tr><th>Path A</th><th></th><th colspan="4">Path B</th></tr>
<tr><td rowspan="5">A person who has a clinical diagnosis of anorexia nervosa (determined by the GP)</td><td rowspan="5">OR</td><td colspan="4">A person who has eating disorder symptoms but diagnostic criteria for anorexia nervosa are not met (as determined by the GP)
The person has a clinical diagnosis of bulimia nervosa, binge eating disorder or other specified feeding or eating disorder (OSFED) but this does not need to be identified by the GP in order to determine eligibility for an Eating Disorder Plan.</td></tr>
<tr><td colspan="4">AND both:</td></tr>
<tr><td colspan="2">The person's Global Eating Disorder Examination Questionnaire score is 3 or higher.</td><td colspan="2">The person's condition is characterised by rapid weight loss, <i>or</i> frequent binge eating, <i>or</i> inappropriate compensatory behaviour as manifested by 3 or more occurrences per week.</td></tr>
<tr><td colspan="4">AND at least two of:</td></tr>
<tr><td>The person has a current or high risk of medical complications due to eating disorder behaviours and symptoms.</td><td>The person has serious comorbid medical or psychological conditions that significantly impact their medical or psychological health status with impacts on function.</td><td>The person has been admitted to hospital for an eating disorder in the previous 12 months.</td><td>The person has had an inadequate treatment response to evidence-based eating disorder treatment over the past 6 months despite active and consistent participation.</td></tr>
</table>

Figure 7.3. *Recommended eligibility criteria and process for determining eligibility for an Eating Disorder Plan*

7.3.3 Development of the treatment plan and referral to treatment providers

Previous recommendations

None.

Findings from the evaluation project

Almost 70% of our survey respondents reported not using the Eating Disorders MBS items due to lack of awareness of these items by themselves or their health professional (pages 59-60). GPs reported that assessment of eligibility for an Eating Disorder Plan and writing the plan took a mean of 87 minutes, over twice the maximum indicated time (page 62). Mental health clinicians and dietitians reported in the qualitative interviews that they often had to inform GPs about what to include in the plan for it to be actioned (pages 62-63). Most also reported that session length for psychological (84%) or dietetic (98%) services was too short to conduct a sufficiently thorough assessment that could meaningfully inform treatment needs and goals (page 88).

People caring for someone with an eating disorder described the process of obtaining an Eating Disorder Plan as frustrating; they were unsure where appropriate healthcare professionals were located, and they experienced difficulties in securing appointments (page 83). GPs also indicated that finding appropriate psychological and dietetic providers for timely referral was difficult (page 87). Of all the people issued with an Eating Disorder Plan, 33% did not take up any treatment (page 46). People who were male, or Indigenous Australians, or with lower income, or who lived in rural and regional areas, or who spoke a language other than English at home were less likely to transition from preparation of the plan to treatment sessions (page 48). Both direct (out-of-pocket) and indirect costs (e.g., transport, loss of income) associated with treatment were cited as reasons for receiving fewer than the available number of sessions by people living with an eating disorder (page 79).

These findings suggest the following barriers and enablers need to be addressed: helping people with experiencing an eating disorder and those who care for them become more aware of Eating Disorder Plans; task shifting appropriately supported assessment and goal setting to the mental health professional; and tackling financial barriers, service availability, and care navigation problems that impact conversion of plans into treatment.

Emerging evidence

- Care co-ordination (or navigation) was integral to the success of a model that increased the likelihood that screening by the GP translates to successful treatment engagement [34].
- Multi-disciplinary case co-ordination meetings have been shown to help keep people in therapy for an eating disorder and significantly improve the effectiveness of therapy [39].
- Telehealth options for treatment delivery has the potential to increase access to eating disorder treatment due to geographic isolation [40].

Recommendations: Treatment Plan Development and Referral

Assessment and treatment initiation

8. Helpful unambiguous summaries of the Eating Disorders MBS items initiative suitable for people experiencing an eating disorder and people who care for someone with an eating disorder are hard to locate. A short overview should be co-designed and made available across relevant websites. The Eating Disorders Victoria online information provides the most useful foundation for this summary, and we have provided an integrated version of this summary with additional relevant information in Appendix 5, informed by knowledge gaps identified in this review.
9. Create an Eating Disorders MBS item number (90-min session total) – or expand provisions within current Eating Disorders MBS psychological treatment items – for those providers eligible to deliver psychological treatment, so they can conduct a **60-minute** assessment that generates: i) a diagnosis; ii) treatment goals; and iii) clear specification of treatment to be used, with an additional **30 minutes** for completing a written plan that is sent to the GP. An example of this plan is provided in Appendix 6. This plan should be used over the duration of treatment by the psychological treatment provider to record progress against the stated goals and is suitable for use in review sessions.
10. Further modifications should be made to the newly revised online GP Eating Disorders Plan provided by the InsideOut Institute in line with recommendations from this report related to eligibility criteria enhancements, task shifting, reframing the course of treatment, and clarity of purpose of review sessions including:
    a. in the 'establish access to EDP' section: i) remove all diagnoses except for anorexia nervosa; (ii) add 'Type I diabetes - underdosing insulin' to the list of compensatory behaviours; and (iii) remove 'clinically underweight' from the clinical indicators.
    b. in the 'treatment recommendations under EDP' section: i) the psychological treatment referral to indicate that up to 40 sessions are available over 12 months; ii) the psychiatric/paediatric review should be titled 'specialist review' with a link to health professionals credentialed in eating disorder treatment; (iii) the goals and psychological treatments be removed with a note reminding the GP that these (along with a diagnosis where the eating disorder is not anorexia nervosa) will be generated by the provider of psychological treatment and communicated to the GP; (iv) add 'care co-ordination required (yes/no)' and 'referred to' as a new section; (v) 'build my treatment team' should be revised to read: 'if no care co-ordination, build my treatment team' and a link provided to https://connected.anzaed.org.au/.

An example of the modified GP Eating Disorder Plan template is provided in Appendix 7. Appendix 8 shows the required flow of reports between members of the multidisciplinary team at points of plan preparation, assessment, treatment, and review.

Recommendations: Treatment Plan Development and Referral

11. Promote the online GP Eating Disorders Plan provided by the InsideOut Institute widely to GPs via the resource library offered by PHNs.

Care navigation and case coordination to facilitate receipt of treatment services

12. PHNs should be required to provide regularly updated and accessible (local and telehealth) referral pathway information to GPs and care co-ordinators in line with their central role related to coordinating care and connecting services so people receive 'the right care, in the right place, at the right time', with mental health a priority area.
13. Provision and funding of eating disorders care co-ordination beyond GP assessment and plan preparation should be available for those who need it. For example, this may be required particularly by people with lower uptake of treatment after receiving an Eating Disorder Plan, including those who are male, or Indigenous Australians, or with lower income, or who live in rural and regional areas, or who speak a language other than English at home. Australian Government funding to PHNs for a care co-ordinator role is one possible model that should be investigated. This role has been shown to be successful in the Sunshine Coast Eating Disorders Access Trial and is currently being evaluated by the federally funded National Eating Disorders Collaboration 'Right Care Right Place: Eating disorder care in my community' project.

14. We note that although case coordination items have been available since July 2023, these do not provide for attendance by a mental health professional and dietitian without attendance by a medical practitioner and the conference having been organised by a medical practitioner. Relevant MBS items should be expanded in scope to allow for allied health (dietitians and mental health) clinicians to organise the case conference with attendance by the organising clinician and a GP (and attendance by other multidisciplinary team members where appropriate); these arrangements will maximise the ability of these meetings to retain the person with an eating disorder in therapy and improve effectiveness of therapy.

Addressing financial and geographic barriers in order to increase treatment access

15. Financial burden is indicated as a barrier as lower income predicts a lower likelihood of pursuing treatment once an Eating Disorder Plan is issued. In line with recommendations from the Grattan Institute report on reducing out-of-pocket healthcare payments, state and territory governments should expand outpatient services to reduce wait times and the Australian Government should fund bulk-billed healthcare services in private clinics. This should be especially focused on parts of Australia with lower socioeconomic status.

16. In addition, levers to encourage weekly therapy sessions should be considered, given clear evidence in mental health research that slower frequency substantially slows the recovery process such that more sessions are ultimately required [41]. Weekly sessions

Recommendations: Treatment Plan Development and Referral

would ultimately reduce consumer and government costs per person treated and could free up more treatment sessions to reduce wait-times and the associated risk of treatment drop-out.

17. Promote telehealth as a viable option for treatment, as this may also help with workforce capacity issues in rural and regional areas, and reduce indirect out-of-pocket costs, such as transport and travel time. Telehealth also offers greater flexibility due to extended hours of availability across time zones, which may in turn be less disruptive to other commitments. Promotion could be achieved by the care coordinators suggesting telehealth where indicated (see recommendation # 23) and PHNs providing up to date referral pathways to GPs as per recommendation #12

7.4 Treatment

7.4.1 Timely intervention after initiation of the treatment plan

Previous recommendations

- Timely intervention should be prioritised to reduce risk of further exacerbation of symptoms. People who are waiting to access eating disorder specific psychological treatment, and those who are not yet ready to engage in this treatment may benefit from a short course of psychotherapy (e.g., motivational interviewing, psychoeducation), nutritional counselling and medical monitoring [42].

Findings from the evaluation project

Of those receiving an Eating Disorder Plan, one-third did not proceed to receipt of treatment (page 46). While concerns about out-of-pocket costs and difficulties navigating disparate healthcare services to find suitable practitioners have been discussed above, wait times for treatment access were also identified as a barrier to treatment by both people experiencing an eating disorder and those who care for them. One-quarter of people waited longer than a month for an initial session (page 82). Mental health professionals who provided psychological treatment services indicated they had eventual availability for new eating disorder clients, but few had immediate availability (22%) and most had a waitlist (59%), while 57% of those who provide dietetic treatment services had immediate availability (pages 82-83). A little under half of dietitians from the community survey either had a waitlist (30.3%) or had stopped taking on clients (13.5%; pages 82-83). Telehealth has been proposed as a means to help overcome geographic limits to service availability (especially in regional and remote areas). Encouragingly, people living with an eating disorder who received treatment sessions both in-person and via telehealth or via telehealth only reported significantly higher satisfaction with their psychological or dietetic sessions than those who received sessions only in face-to-face settings (page 102). These findings suggest several approaches to providing timely intervention, including providing immediate assessment and psychoeducation before treatment starts and strategic use of dietetic services.

Emerging evidence

- Longer time waiting for eating disorder treatment is associated with lower likelihood of treatment commencing [43]. Similarly, a longer duration between referral and start of psychological treatment predicts drop-out from treatment [44].
- Use of assessment and single session interventions (SSI) while people are on the waitlist for eating disorder treatment means that they are three times more likely to complete treatment than when no initial single session intervention was received [45,46].

Recommendations: Timely Intervention

18. In circumstances where a wait time of more than four weeks is anticipated, with an attendant risk of symptom exacerbation, risk of drop-out from treatment, and reduced motivation for treatment, it is recommended that as soon as practicable after the mental health professional has accepted the referral, they provide a 90-minute eating disorders single session intervention as described below* [45].
    In this circumstance, the GP should be clearly informed by the mental health professional that the treatment-seeking person is not yet in treatment and that the GP is required to monitor the person with the eating disorder.

    This session does not count towards the 40 psychological treatment sessions available within a 12-month period.

    When treatment with the mental health professional starts after the waiting period, assessment (as per recommendation #8) should be re-conducted to ensure that diagnosis and goals are current and up-to-date information for inclusion in the Eating Disorder Plan is provided to the GP.

19. Introduce a 90-minute single-session intervention (assessment and psychoeducation) service. This could be achieved through introduction of a new Eating Disorders MBS item.
    a. To incentivise uptake by providers of this single-session intervention, a higher rebate is recommended for this service (i.e., greater than application of a simple multiplier reflecting the longer duration of session from a standard 40 or 50 minute psychological treatment session) as it requires significant reorganisation of waitlist management processes and change to usual assessment procedures

20. Offer training on the single-session intervention either through existing or newly established organisations.

21. Make an online assessment protocol and evidence-based SSI materials available through the websites of suitable organisations such as NEDC, InsideOut Institute, ANZAED, and the Centre for Clinical Interventions.

22. Develop a best approach protocol for dietitians to use while people are on the waitlist for psychological intervention as well as a best approach protocol by dietitians while

Recommendations: Timely Intervention

people are on the waitlist for dietetic services. To ensure this work is completed in a timely fashion, a competitive funded call would be beneficial.

23. Systematic evaluation should build on emerging evidence gained during COVID-19 restrictions which suggest that telehealth is suitable for the treatment of eating disorders [47]. This further evaluation needs to determine the most appropriate mix of telehealth and face-to-face service delivery in order to ensure safety and efficacy. Such evaluations should also establish whether telehealth is more suitable at specific stages of treatment, and for specific eating disorder diagnoses. Until that time, medical monitoring should be conducted in person on a regular basis as determined by the multidisciplinary treating team, e.g., at appropriate timepoints such as review sessions.

*A single session intervention can be conducted by a mental health professional with a person experiencing an eating disorder and with people who care for them present if appropriate. This session takes a hope-inducing stance and comprises a collaborative and individualised assessment, provision of a diagnosis, psychoeducation about physical and psychosocial consequences of an eating disorder, understanding of the factors maintaining the disorder, and psychoeducational resources about immediate strategies to try. This program was successfully offered in 2022 by the Butterfly ‘In the Wings’ program.

7.4.2 Eligible practitioners and workforce capacity

Previous recommendations

- Expansion of eligible practitioners who can administer evidence-based treatment of eating disorders – minimum 12 hours of professional training in eating disorders [28].
- Establish a credentialing process to ensure there is a sufficient skilled workforce available to provide eating disorder treatment and use the credentials to determine eligibility [of practitioners] to provide eating disorder services under the recommended Eating Disorders MBS items [29].

Findings from the evaluation project

The helpfulness of sessions was rated significantly higher by people who had access to knowledgeable providers through an Eating Disorder Plan relative to other treatment options such as Better Access (pages 105-106). Variability amongst health professionals in self-perceived confidence, knowledge, and skill to work with eating disorders was evident (page 74), although those who were Credentialed Eating Disorder Clinicians had significantly higher self-rated confidence, knowledge, and skill than non-credentialed health professionals (pages 76-77). Credentialing is an important avenue for enhancing workforce capacity and capability. However, expert clinician evidence suggested there was low incentive for experienced eating disorder practitioners to seek or retain the credential, given costs involved, time commitment required, and the fact they are already established in the field. Such sentiment among senior clinicians suggests that, in the future, the cohort of Credentialed Eating Disorder Clinicians could be at risk of skewing towards those with less experience.

Data show a strong skew in experience of psychological treatment and dietetic health service providers engaged in provision of services in the Eating Disorders MBS items initiative. Half of all providers have delivered in total less than one full course of psychological treatment (54.4% delivered 20 or fewer sessions) or dietetic intervention (52.2% delivered 20 or fewer sessions). At the other end of the continuum, a very small number of providers, fewer than 5%, provided approximately half of all sessions (both psychological and dietetic sessions) delivered across the lifetime of the initiative (pages 117-119). This represents a risk to sustainability of service delivery and workforce capacity for which solutions are required to attract and maintain engagement by providers.

Sessions by health professionals who provided dietetic treatment services steadily increased with up to 50% of services received in 2022 from 37% in 2020; 14% of people with an eating disorder saw only a dietitian through an Eating Disorder Plan (pages 44; 46). People with a lived experience of an eating disorder who received services from a dietitian were satisfied with (68%; page 101) and attributed symptom improvement to their dietetic sessions (85%; pages 98-99). However, dissatisfaction with the manner or approach of the health professional was a clear reason for early cessation of treatment for those who ceased treatment prior to receiving 10 sessions of psychological treatment (43%) or prior to receiving 5 dietetic health services (51%; page 86), highlighting the importance of knowledgeable and experienced health professionals early in the treatment experience. These findings suggest that financial incentives should be provided to Credentialed Eating Disorder Clinicians and that expanding the expertise of dietitians to work with people experiencing eating disorders either in a multidisciplinary team or independently would increase workforce capacity. As well as increasing capacity generally, providing incentives to broaden the skilled workforce can decrease wait times.

Emerging evidence

- Therapeutic proficiency is significantly enhanced when training is supplemented with supervision, resulting in trainee therapists performing as well as more experienced therapists [48,49].
- While the evidence is not strong enough for treatment guidelines to recommend nutritional counselling as the sole treatment for people with anorexia nervosa [50], and consistent guidelines are not yet available for dietetic roles in a multidisciplinary team [51], the inclusion of dietetic sessions is valued by consumers [52], and increases retention in treatment [39].

Recommendations: Workforce capacity

24. Offer a higher rate of rebate for Eating Disorders MBS items to Credentialed Eating Disorder Clinicians than the rate of rebate available to non-credentialed health professionals for provision of psychological treatment and dietetic health services. This higher rebate might also include communication of phasing out, over time (e.g., over a 5-year period) of eligibility of non-credentialed healthcare providers to provide services under these MBS items. This incentive structure, coupled with signal of eventual requirement of all healthcare providers being suitably credentialed, would help to expand the current pool of Credentialed Eating Disorder Clinicians and thereby facilitate capacity building of an effective workforce across all disciplines. It offers a *sustainable* approach to increase workforce capacity while not causing accessibility issues.

25. The Australian Government should continue funding support of supervision of Credentialed Eating Disorder Clinicians.

26. Enact a competitive funded call to develop and test treatment guidelines for dietitians supporting people experiencing an eating disorder.

7.4.3 Treatment session delivery and approved evidence-based psychological therapies

Previous recommendations

- The following treatments are approved for use under the Eating Disorders MBS items (Medicare Eating Disorder Task Force Report, 2018):
    - Family based treatment for eating disorders [53] (including whole family, parent based therapy, parent only or separated therapy**)**
    - Adolescent focused therapy for eating disorders [54]
    - Cognitive behavioural therapy (CBT) for eating disorders (CBT-ED)
    - CBT-anorexia nervosa (AN) (CBT-AN)
    - CBT for bulimia nervosa (BN) and binge-eating disorder (BED) (CBT-BN and CBT-BED)
    - Specialist supportive clinical management (SSCM) for eating disorders
    - Maudsley Model of Anorexia Treatment in Adults (MANTRA) [55]
    - Interpersonal therapy (IPT) for BN, BED [56]
    - Dialectical behavioural therapy (DBT) for BN, BED [57,58]
    - Focal psychodynamic therapy for eating disorders.

Findings from the evaluation project

The need for access to up to 40 psychological treatment sessions and up to 20 dietetic treatment sessions was evident throughout the evaluation findings. A higher number of sessions received was associated with greater satisfaction with treatment (page 101), higher perceived helpfulness of treatment for eating disorder recovery (page 102), and greater improvement in eating disorder symptoms (page 98). A higher number of available sessions allowed for increased frequency of services which was perceived as therapeutically valuable (page 105) and available number of sessions was attributed as providing room to manage setbacks (pages 104; 108). An Eating Disorder Plan was viewed as superior to a Mental Health Treatment Plan for providing enough sessions to address needs (page 106).

Eating disorder symptoms, psychological distress, and goal attainment improved progressively over treatment sessions, indicating that early cessation of treatment would impede progress (pages 95-97). Fully met goals at 30 sessions was somewhat low (21.1%), and at the 30-session review, significantly fewer people with anorexia nervosa had met their goals compared to people with other eating disorders, indicating the need for further treatment beyond 30 sessions (page 95). Furthermore, of people who ceased psychological treatment because they felt better, only 9% had received ten or fewer psychological treatment sessions and of those who ceased dietetic sessions because they felt better, only 18% had received 5 or fewer dietetic sessions (page 86).

However, the data suggest that psychological treatment sessions are not conducted per protocol, with an average of 14 sessions in 12 months (page 46) rather than weekly sessions. This could be due to therapist capacity, financial restrictions (pages 47-48; 50; 79-80; 82-83), avoidance of 10- or 20-session reviews by pausing psychological treatment sessions and initiating a new plan to enable continuation of treatment sessions in the next 12-month period (pages 46-48; 70; 86), or some people with lived experience of an eating disorder who no longer met eligibility for the Eating Disorders Plan after reviews being transitioned to a Mental Health Treatment Plan instead (roughly one-quarter transitioned to Better Access after receiving eating disorder services in a 12-month period; page 57). The pattern of cessation prior to review was strikingly demonstrated in the national linkage data study (see Figure 3.6, pages 47-48).

In general, the evidence suggested high uptake of evidence-based treatments. Among health professionals who provided psychological treatment services, the most commonly provided treatment model was CBT- Enhanced (CBT-E), followed by acceptance and commitment therapy (not currently approved as a treatment), family-based treatment (FBT) and dialectic behavioural therapy (DBT; pages 110-111). The most common dietetic-specific practice that health professionals who provided dietetic treatment services use with eating disorder patients (>96% of those surveyed) was nutrition assessment, education, intervention, and monitoring (pages 111-112). Most mental health clinicians agreed that the guidelines for treatment models specified in the Eating Disorders MBS items reflected current evidence-based treatment but they and people with an eating disorder reported frustrations with the limitations of the specific interventions allowed (pages 110-111). Collectively, these findings strongly support ongoing provision of services (40 psychological treatment sessions, 20 dietetic services), but some further refinements to maintain quality assurance and increase effectiveness of sessions would be helpful.

Emerging evidence

- Where evidence exists for psychological treatment, current guidelines indicate that for adults, up to 40 sessions are recommended (see Chapter 8 in appendices to the Technical Report).
- How therapies are delivered makes an impact on effectiveness. The frequency of sessions is an impactful component in delivering more efficient psychotherapy; 50% of people receiving weekly psychotherapy sessions for mixed mental health needs reach reliable change in approximately 6 weeks, while those with fortnightly sessions require 21 weeks of treatment

[41]. A small significant effect of progress feedback (sessional measurement shared with the client in session) exists for symptom reduction and has a small favourable effect on dropout rates [59].

- Evidence across studies indicates specific effective treatments for eating disorders that is broadly consistent with the listed treatments approved for use under the Eating Disorders MBS items [60].
- Consumer choice with respect to therapy can improve outcomes [61], for example, family-based treatment is more effective where families can choose whether to have conjoint or separated forms [62].
- Dialectical behaviour therapy has a growing evidence base, though clinical guidelines continue to recommend this as a secondary treatment, particularly in the context of mental health issues characterised by emotion dysregulation [63].

Recommendations: Treatment Delivery and Approved Therapies

27. Retain access to up to 40 psychological sessions and 20 dietetic sessions with further refinements to enhance clinical effectiveness and reduce likelihood of under-dosing (see recommendations #10; 28-30; 37-41).

28. Psychological treatment sessions should be delivered at a frequency of one session per week, where possible, to optimise outcomes.

29. Explore strategies to increase the frequency of sessions, such as:
    a. updating the NEDC Training Framework so that approved training modules include information on the importance of weekly sessions (compared with lower frequency delivery) to produce change and the need to document sessional progress.
    b. communicating the importance of session frequency for treatment outcomes across multiple forums, e.g., ANZAED webinars, NEDC newsletters, InsideOut web resources.

As per recommendation #24, increasing workforce capacity will provide greater availability for more regular session delivery.

30. Data should be collected at each session on any changes to eating behaviours and body image to optimise outcomes and enhance the benefit of review sessions and feedback about sessional progress should be provided to the person receiving treatment. The process should include:
    a. using the short ED15 questionnaire [64]
    b. providing data on progress from responses to the ED15 questionnaire to the GP or specialist ahead of review sessions (see recommendations #38-41)

Recommendations: Treatment Delivery and Approved Therapies

c. making an excel spreadsheet available on multiple platforms, such as NEDC, ANZAED, and InsideOut websites (a schematic of an Excel spreadsheet document that can be used to score and graph results is shown in Appendix 9).

31. Recommended 'first line' treatments should only be included if they:

    a. are recommended by treatment guidelines and/or meta-analytic evidence as a potential stand-alone therapy* *and*

    b. a comprehensive treatment manual or workbook is available to support implementation and dissemination and training.

*Note: In line with appropriate use of individualised treatment, first line treatments could be augmented when progress towards identified goals is not satisfactory (see Section 7.5). This refers to use of a specific intervention or technique as a supplement to the first line treatment to improve effectiveness.

32. Make changes, based on the accumulated evidence, to the acceptable treatments approved for use by practitioners with the Eating Disorders MBS items as follows:

    a. Family based treatment for eating disorders (including whole family, parent-based therapy, parent only or separated therapy): no changes to initial listing.

    b. Adolescent focused therapy (AFT) - specified for anorexia nervosa: previously listed as Adolescent Focused Therapy for eating disorders.

    c. Cognitive behavioural therapy-enhanced (CBT-E) [65]; previously listed as CBT-anorexia nervosa; CBT for bulimia nervosa and binge-eating disorder.

    d. Specialist Supportive Clinical Management (SSCM) [66] – specified for anorexia nervosa; previously listed as Specialist Supportive Clinical Management for eating disorders.

    e. Maudsley Model of Anorexia Treatment in Adults (MANTRA); no changes to initial listing.

    f. Interpersonal Therapy (IPT) – specified for bulimia nervosa; binge eating disorder; no changes to initial listing.

    g. Focal psychodynamic therapy – specified for anorexia nervosa only; previously listed as focal psychodynamic therapy for eating disorders which is not indicated [67].

Note. Dialectical behavioural therapy (DBT) for bulimia nervosa and for binge eating disorder was previously listed as an acceptable treatment. Based on available evidence and existing clinical guidelines, we recommend it currently only be used to augment the first line therapies for emotion regulation difficulties and not as a standalone treatment for eating disorders.

Recommendations: Treatment Delivery and Approved Therapies

33. Regular review and updating of the approved acceptable treatments under the Eating Disorders MBS items to be scheduled within existing mechanisms (MBS Review Advisory Committee and Medical Services Advisory Committee). Reviews are required to respond to emerging evidence of efficacy (following National Health and Medical Research Council [NHMRC] Level 1 evidence standards). This will enable expansion of the approved treatments as the evidence base changes, and consideration of inclusion of other eating disorders e.g., avoidant restrictive food intake disorder (ARFID), when sufficient evidence for the effectiveness and safety of treatments are available - at present only 2 published evaluation studies exist but a further 7 studies are listed in ClinicalTrials.gov, which may make new recommendations possible in around 3 years.

    a. The Department of Health and Aged Care to promote at regular intervals (e.g., annually) to the eating disorder sector the processes required to request a review via the MBS Review Advisory Committee and Medical Services Advisory Committee. This will facilitate submission of the most up to date evidence for emerging treatments for consideration for inclusion in the Eating Disorders MBS items initiative.

7.4.4 Involvement of Carers of People Living with an Eating Disorder

Previous recommendations

- Families are recognised as part of the treatment team; provision for education, counselling support and separate eating disorder therapy sessions are needed for people with lived experience of caring for someone with an eating disorder who is undergoing treatment [28].
- Limitations of current Medicare funding include lack of funding of item numbers for support of people with lived experience of caring for someone with an eating disorder, including respite care, peer support, education, and counselling [29].

Findings from the evaluation project

Positive outcomes from access to the Eating Disorders MBS items for those supporting someone through eating disorder treatment were indicated by ratings of helpfulness in the community survey (page 116). However, some expressed frustration about difficulties in gaining access to sessions, especially once the person they care for was over 18 years of age. Access was seen to be particularly critical in the assessment phase of an Eating Disorder Plan. Additionally, most people who care for a person with an eating disorder believe that it is necessary for carers to access sessions without the person with an eating disorder to better understand the experience of the eating disorder (93%) and to get personal support for needs related to their carer role (96%; pages 61, 72). The Better Access Mental Health Treatment Plan was commonly used to receive support for personal needs (page 61). These findings suggest there should be additional MBS items included that enable further support for people who are caring for someone with an eating disorder. There should also be methods to enhance awareness for these carers about the avenues for support that are available.

Emerging evidence

- Treatment guidelines (e.g., SIGN [68]) recommend formal support be offered to people who care for a person with an eating disorder.
- Distress, burden and expressed emotion of people with lived experience of caring for someone with an eating disorder can be reduced by a variety of psychoeducational interventions, and these changes are sustainable over time [69].
- Slow progress in a child's weight gain (for children receiving treatment for anorexia nervosa) can be substantially improved when parents are given four sessions of intensive coaching [62,70].

Recommendations: Involvement of Carers

34. Make directed, carer-related, eating disorder-specific psychological services available for people caring for someone receiving eating disorder treatment under an Eating Disorder Plan to support them in their carer roles. This support, explicitly linked to the Eating Disorder Plan of the person receiving eating disorder treatment, could be made available through existing services (Better Access, Medicare Mental Health Centres, etc.). This is intended to support people with lived experience of caring for someone with an eating disorder to:

    a. engage in separated family-based therapy

    b. develop appropriate management skills for the eating disorder, as well as self-care skill

    c. participate in family coaching where this might improve progress for the person receiving treatment for an eating disorder.

Note. It is critical that this carer support be connected to an Eating Disorder Plan of the person living with an eating disorder to reinforce the importance of carer involvement in eating disorder treatment, and to facilitate ongoing evaluation of the full scope of treatment received under Eating Disorders MBS items (also see recommendation #43).

35. Develop strategies to raise awareness for people with lived experience of caring for someone with an eating disorder about the importance of looking after themselves as a carer and pathways to receive this support. Strategies could include:

    a. adding a section in the GP Eating Disorder Plan to indicate the importance of accessing support and detail where this support can be accessed, e.g., eating disorder support organisations, carer support organisations, Mental Health Treatment Plan

    b. promoting sources of support for people with lived experience of caring for someone with an eating disorder provided by carer support organisations.

36. Implement actions that will assist people with a lived experience of supporting a person with an eating disorder be more involved in their treatment, in line with requirements for integrated care, including:

Recommendations: Involvement of Carers

a. the need for people with lived experience of caring for someone with an eating disorder to be included in treatment to be more prominent in the Medicare Benefits Schedule Online explanatory notes

b. introductory training having an additional module on integrating people with lived experience of caring for someone with an eating disorder in treatment/intervention.

7.5 Reviews

Previous recommendations

- The core team is GP, psychologist, and dietitian, with frequent communication to coordinate treatment goals, review progress and support transition to alternative treatment as presentation of this dynamic illness changes [28].
- GPs should be the focal point, providing frequent monitoring of progress and medical condition [29].
- Given complexities of eating disorders and potential for rapid escalation in symptoms or risk, it is advisable that the core team have access to an eating disorder specialist or psychiatrist to assist with case review [28].
- Assigning initial assessment to a psychiatrist or paediatrician is likely to create a bottleneck to access [29].
- Case conference items to be expanded to include dietitians and eating disorder clinicians and may include a designated care coordinator [29].

Findings from the evaluation project

Progressing past 10 session review

Approximately 50% of people who received psychological treatment completed at least 10 psychological sessions (page 46), but only 32% of people receiving treatment with an Eating Disorder Plan received a review after their initial 10 sessions (page 46). Peaks in cessation prior to review were observed for 10, 20, and 30 sessions (pages 47-48), suggesting many individuals did not get the opportunity to evaluate progress with healthcare providers, nor the opportunity to adjust course to enhance outcomes if needed. This missed opportunity may also provide a marker of later treatment prognosis, exemplified by findings that early improvement recorded at the first 10-session review was associated with a significantly greater likelihood of meeting goals at the 30-session review (page 95).

20-session review

The specialist review at 20 sessions was discussed by all participants and its relevance was questioned. For some people experiencing an eating disorder, the significant financial cost, lengthy wait times and inability to find a psychiatrist able to complete the review meant that the review could not be completed, and further services were unable to be provided (page 70). Finding a provider who was available to conduct a timely review was seen to be difficult by 96% of GPs (page 87). Accessing the specialist review session was also reported to be difficult by about half of people with lived experience of an eating disorder (53%) and with lived experience of caring for someone with an eating disorder (44%; page 86). Not wanting a review was the most common reported reason for ceasing treatment for those who had received between 10-19 psychological treatment sessions (40%; page 86) and may account for peaks in drop-out observed around the 20-session review milestone (pages 47-48). For health professionals, people experiencing an eating disorder, and people with lived experience of caring for someone with an eating disorder, it was important that health professionals who provide reviews have the appropriate knowledge, skills, and experience to provide eating disorder treatment, and not simply an available psychiatrist or paediatrician (page 75).

These findings suggest that the 10-session review can be very useful for adjusting the direction of therapy if progress is not being made, and that reviews with external clinicians need to be significantly modified to provide less of a barrier to progress at the 20-session mark.

Emerging evidence

- The most robust predictor of outcome at both end of treatment and follow-up in eating disorders is not baseline measures but greater symptom reduction early during treatment (first 4 to 8 sessions) – across age groups, disorders and therapeutic modalities [71,72].
- Most other predictors, including severity of eating disorder symptoms, are ‘consistently unrelated’ to outcome [73].
- Where some meaningful change has not occurred, review and some change in direction (e.g., augmentation, a different therapeutic approach, more intensive treatment options) is recommended as it improves outcomes [74].
- Treatment completion for an eating disorder was predicted by uptake of ≥ 3 dietetic sessions, and ≥ 2 team case conferences, the latter also predicting better outcome [39].

Recommendations: Reviews

37. Clarify the purpose and therapeutic value of reviews to shift perceptions of reviews as punitive or performing a purely gatekeeping function.
    a. Reinforce the original intent of review sessions through the reframing as a means to support people experiencing an eating disorder by providing an opportunity to assess progress from both their own and their health professional team’s perspectives and, where necessary, modify the therapeutic/intervention approach to ensure best outcomes.
    b. Ensure consistent use of the reframed messaging about purpose of reviews across all public-facing materials about the Eating Disorders MBS items, including MBS explanatory notes, and in initial assessment, treatment, and review sessions by healthcare providers when explaining the review process.
38. With this framing and purpose in mind, implementing reviews should focus on evaluating symptom change and personal recovery and the need for augmenting or

Recommendations: Reviews

changing direction in treatment. Consequently, the first 10-session review is more critical than later reviews because early change is critical for treatment outcomes. To this end, the review process for the 10-session review should be revised so:

   a. in the case of satisfactory progress towards initial goals as indicated by the treating clinician, the 10-session review is conducted by the GP, with input from the treating mental health clinician and where relevant, dietitian; alternatively,
   b. in the case of slow/no progress towards initial goals as indicated by the treating clinician, a case conference is conducted at the 10-session mark, organised by the GP, or treating clinician as per recommendation #14, with members of the multidisciplinary team present to agree on a clear strategy for the forthcoming treatment sessions to enhance likelihood of positive outcomes.

39. Conduct the 20-session review as follows:
   a. in the case of satisfactory progress towards goals as indicated by the treating clinician, the 20-session review is conducted by the GP, with input from the treating mental health clinician and where relevant, dietitian; alternatively,
   b. in the case of slow/no progress toward goals at the 20-session mark, as indicated by the treating clinician, specialist advice/review is sought in a case conference organised by the GP, with members of the multidisciplinary team and the specialist present to agree on a clear strategy for the following treatment sessions to enhance likelihood of positive outcomes
   c. the specialist should be a practitioner experienced in working with eating disorders rather than a particular profession.

   An outline of the steps and provisions are required for putting this specialist process in place is as follows: 1) determination of the criteria and thresholds required to indicate a sufficient degree of experience in working with eating disorders to denote specialist status, 2) infrastructure and processes to objectively review and determine which health professionals meet criteria, 3) identification of the specialist within the MBS/Services Australia system, and 4) publicly available information to identify specialists to allow multidisciplinary teams to seek their involvement in review sessions.

   The details of this process, particularly deciding on criteria for eligibility to provide the specialist review, should be established in greater detail through sector consultation.

40. Conduct the 30-session review as per recommendation #38 for 10-session reviews.

Note. Appendix 10 shows a schematic of the treatment and review process under the Eating Disorder Plan demonstrating inclusions of recommendations #9, #18, and 38-40

Recommendations: Reviews

41. Inform all reviews with data from a short sessional measure of treatment response and progress (as per recommendation #30), including measuring body mass index (for people with anorexia nervosa only).

Note. Appendix 6 provides a review report template for the treating clinician to share with the GP and members of the multidisciplinary team prior to review sessions.

42. Modify the InsideOut Institute review template (https://insideoutinstitute.org.au/resource-library/gp-care-plan-review-template) to facilitate appropriate documentation of progress and outcomes of all reviews, to include recording:
    a. the current psychological treatment and dietetic services intervention approaches used in sessions and comments on progress from the treating clinician
    b. quantitative data on change in eating disorder behaviours, rather than just the absolute level of behaviours
    c. identified reasons for satisfactory or unsatisfactory progress toward goals
    d. actions from the treating team, including recommendations for augmentation or changes in therapy that should proceed directly from the identified reasons for progress that have been shared with the person experiencing an eating disorder.

Note. We have also provided an updated review template for the GP to facilitate this proposed change in approach (Appendix 7).

7.6 Integration with Complementary Services, Mechanisms, and Partnerships

Previous recommendations

- Stepped care approach for treatment of eating disorders, whereby intensity and type of treatment is dictated by stage of illness, symptom severity and comorbidities [29]
- Prioritise delivery of proposed Eating Disorders MBS items to those individuals with most severe eating disorder symptoms and comorbidities, but with evaluation after 3 years to ensure fit-for-purpose and evaluate extending to those living with an eating disorder who are not initially eligible for these items [29]

Findings from the evaluation project

People with lived experience of an eating disorder who were granted access to the Eating Disorders MBS items rated their experience of this scheme as much more beneficial than other services they had received for their eating disorder symptom treatment (e.g., Better Access; pages 105-106). Our evaluation also shows that Better Access was used by many people with lived experience of an eating disorder prior and subsequent to Eating Disorders MBS item use (pages 56-58), and – in cases where eligibility was uncertain or ruled out – instead of the Eating Disorders MBS items (page 60).

Even so, we note that MBS items for Better Access do not identify the psychological condition for which treatment is sought, and any information collected during psychological treatment about diagnosis, symptom severity, treatment progress, and treatment strategies deployed are not linked in PLIDA (formerly MADIP) or other data sources that would provide data linkage-based analysis of efficacy of treatment.

Without more detailed and integrated data collection, it is difficult to determine whether combinations of existing services (e.g., Better Access plus Eating Disorders MBS items) sufficiently form the full stepped care plan envisaged for eating disorder treatment, or whether other complementary services are needed to fill remaining gaps in treatment. We acknowledge that the stepped care model also includes prevention, however, prevention is out of scope of services provided through MBS. It is also unclear whether the sorts of psychological treatments received by people with a lived experience of an eating disorder via Better Access and other schemes are well-matched to symptom severity profiles, and evidence-informed, since strict provisions on eligible treatments (as per Eating Disorders MBS items) are not developed for these more general (non-eating disorder specific) schemes.

Emerging evidence

- Lower intensity treatment options, such as 10-session cognitive behaviour therapy for eating disorder treatment (CBT-T) and guided self-help, can be beneficial for individuals with less severe symptom presentations [75]
- Availability of a manual [76] and extensive website resources support implementation and dissemination of CBT-T; similarly, web resources with manuals and training are available for guided self-help for eating disorder treatment
- Efforts to enhance data linkage capacity across states and territories in Australia are underway.

Recommendations: Integration

43. Enhance data collection and linkage through PLIDA to enable formal evaluation of the full scope of MBS eating disorder treatment, including:
    a. linking MBS item numbers for eating disorder treatments (whether Better Access, chronic disease management or Eating Disorders MBS items) to eating disorder diagnosis and symptom severity data
    b. identifying treatment approaches received
    c. charting treatment progress, as per recommendation #30.
44. Evaluate which MBS services (including and beyond Eating Disorders MBS items) are associated with positive outcomes for different eating disorder presentations including level of complexity and severity of eating disorder symptoms; such information could inform appropriate treatment matching as per the stepped care model.
45. Promote awareness of evidence-informed treatment options aligned with lower intensity treatment needs in the stepped care model for eating disorder treatment, by:

Recommendations: Integration

   a. developing a brief summary document outlining treatment options for eating disorders across varying levels of risk for those who do not meet the criteria for Eating Disorders MBS items to raise awareness of these options
   b. prioritising CBT-T and guided self-help as treatment approaches that are i) aligned with lower intensity needs, ii) have a strong evidence-base, and iii) have available manuals and workbooks and extensive website support (though mechanisms are needed to update recommendations based on emerging evidence (as per recommendation #33))

46. Provide training and support in delivery of CBT-T and guided self-help, including through:
    a. promoting and making existing materials and web resources readily available through PHNs, with particular targeted focus on promotion to GPs of guided self-help to enhance uptake
    b. providing training to mental health professionals in delivering CBT-T to enhance uptake.

Appendix 11 provides mapping of recommendations in this and other sections aligned with key evaluation questions specifically about policy recommendations. These policy recommendations are with regard to complementary services and partnerships, gaps in data and evidence, and policies and programs to better support access to the Eating Disorders MBS Items and improve usage and outcomes.

8

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Evaluation of the Eating Disorders
Medicare Benefits Schedule Items 2024

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9

Appendices

Evaluation of the Eating Disorders
Medicare Benefits Schedule Items 2024

Appendix 1. List of Eating Disorder Medicare Benefit Schedule Items

Program phase	Item Type	Provider	Item Number	Delivery Mode
Original	Preparation of Plan (EDTMP)	General Practitioners (w/o MH skills training)	90250	Face to face
Original	Preparation of Plan (EDTMP)	General Practitioners (w/o MH skills training)	90251	Face to face
Original	Preparation of Plan (EDTMP)	General Practitioners (w/ MH skills training)	90252	Face to face
Original	Preparation of Plan (EDTMP)	General Practitioners (w/ MH skills training)	90253	Face to face
Original	Preparation of Plan (EDTMP)	Other Medical Practitioners (w/o MH skills training)	90254	Face to face
Original	Preparation of Plan (EDTMP)	Other Medical Practitioners (w/o MH skills training)	90255	Face to face
Original	Preparation of Plan (EDTMP)	Other Medical Practitioners (w/ MH skills training)	90256	Face to face
Original	Preparation of Plan (EDTMP)	Other Medical Practitioners (w/ MH skills training)	90257	Face to face
Original	Preparation of Plan (EDTMP)	Consultant Psychiatrists	90260	Face to face
Original	Preparation of Plan (EDTMP)	Consultant Paediatricians	90261	Face to face
Original - removed	Preparation of Plan (EDTMP)	Consultant Psychiatrists	90262	Telehealth
Original - removed	Preparation of Plan (EDTMP)	Consultant Paediatricians	90263	Telehealth
COVID-19	Preparation of Plan (EDTMP)	General Practitioners (w/o MH skills training)	92146	Telehealth
COVID-19	Preparation of Plan (EDTMP)	General Practitioners (w/o MH skills training)	92147	Telehealth
COVID-19	Preparation of Plan (EDTMP)	General Practitioners (w/ MH skills training)	92148	Telehealth
COVID-19	Preparation of Plan (EDTMP)	General Practitioners (w/ MH skills training)	92149	Telehealth
COVID-19	Preparation of Plan (EDTMP)	Other Medical Practitioners (w/o MH skills training)	92150	Telehealth
COVID-19	Preparation of Plan (EDTMP)	Other Medical Practitioners (w/o MH skills training)	92151	Telehealth
COVID-19	Preparation of Plan (EDTMP)	Other Medical Practitioner (w/ MH skills training)	92152	Telehealth
COVID-19	Preparation of Plan (EDTMP)	Other Medical Practitioners (w/ MH skills training)	92153	Telehealth
COVID-19	Preparation of Plan (EDTMP)	Consultant Psychiatrists	92162	Telehealth
COVID-19	Preparation of Plan (EDTMP)	Consultant Paediatricians	92163	Telehealth
COVID-19 - removed	Preparation of Plan (EDTMP)	General Practitioners (w/o MH skills training)	92154	Phone
COVID-19 - removed	Preparation of Plan (EDTMP)	General Practitioners (w/o MH skills training)	92155	Phone
COVID-19 - removed	Preparation of Plan (EDTMP)	General Practitioners (w/ MH skills training)	92156	Phone

Program phase	Item Type	Provider	Item Number	Delivery Mode
COVID-19 - removed	Preparation of Plan (EDTMP)	General Practitioners (w/ MH skills training)	92157	Phone
COVID-19 - removed	Preparation of Plan (EDTMP)	Other Medical Practitioners (w/o MH skills training)	92158	Phone
COVID-19 - removed	Preparation of Plan (EDTMP)	Other Medical Practitioners (w/o MH skills training)	92159	Phone
COVID-19 - removed	Preparation of Plan (EDTMP)	Other Medical Practitioners (w/ MH skills training)	92160	Phone
COVID-19 - removed	Preparation of Plan (EDTMP)	Other Medical Practitioners (w/ MH skills training)	92161	Phone
COVID-19 - removed	Preparation of Plan (EDTMP)	Consultant Psychiatrists	92166	Phone
COVID-19 - removed	Preparation of Plan (EDTMP)	Consultant Paediatricians	92167	Phone
Original	Psychological treatment service	Clinical Psychologists	82352	Face to face
Original	Psychological treatment service	Clinical Psychologists	82354	Face to face
Original	Psychological treatment service	Clinical Psychologists	82355	Face to face
Original	Psychological treatment service	Clinical Psychologists	82356	Telehealth
Original	Psychological treatment service	Clinical Psychologists	82357	Face to face
Original	Psychological treatment service	Psychologists	82360	Face to face
Original	Psychological treatment service	Psychologists	82362	Face to face
Original	Psychological treatment service	Psychologists	82363	Face to face
Original	Psychological treatment service	Psychologists	82365	Face to face
Original	Psychological treatment service	Occupational Therapists	82368	Face to face
Original	Psychological treatment service	Occupational Therapists	82370	Face to face
Original	Psychological treatment service	Occupational Therapists	82371	Face to face
Original	Psychological treatment service	Occupational Therapists	82373	Face to face
Original	Psychological treatment service	Social Worker	82376	Face to face
Original	Psychological treatment service	Social Worker	82378	Face to face
Original	Psychological treatment service	Social Worker	82379	Face to face
Original	Psychological treatment service	Social Worker	82381	Face to face
Original	Psychological treatment service	General Practitioners	90271	Face to face
Original	Psychological treatment service	General Practitioners	90272	Face to face

Program phase	Item Type	Provider	Item Number	Delivery Mode
Original	Psychological treatment service	General Practitioners	90273	Face to face
Original	Psychological treatment service	General Practitioners	90274	Face to face
Original	Psychological treatment service	Other Medical Practitioners	90275	Face to face
Original	Psychological treatment service	Other Medical Practitioners	90276	Face to face
Original	Psychological treatment service	Other Medical Practitioners	90277	Face to face
Original	Psychological treatment service	Other Medical Practitioners	90278	Face to face
Original - removed	Psychological treatment service	Clinical Psychologists	82353	Telehealth
Original - removed	Psychological treatment service	Psychologists	82361	Telehealth
Original - removed	Psychological treatment service	Psychologists	82364	Telehealth
Original - removed	Psychological treatment service	Occupational Therapists	82369	Telehealth
Original - removed	Psychological treatment service	Occupational Therapists	82372	Telehealth
Original - removed	Psychological treatment service	Social Worker	82377	Telehealth
Original - removed	Psychological treatment service	Social Worker	82380	Telehealth
Original - removed	Psychological treatment service	General Practitioners	90279	Telehealth
Original - removed	Psychological treatment service	General Practitioners	90280	Telehealth
Original - removed	Psychological treatment service	Other Medical Practitioners	90281	Telehealth
Original - removed	Psychological treatment service	Other Medical Practitioners	90282	Telehealth
COVID-19	Psychological treatment service	General Practitioners	92182	Telehealth
COVID-19	Psychological treatment service	General Practitioners	92184	Telehealth
COVID-19	Psychological treatment service	Other Medical Practitioners	92186	Telehealth
COVID-19	Psychological treatment service	Other Medical Practitioners	92188	Telehealth
COVID-19	Psychological treatment service	General Practitioners	92194	Phone
COVID-19	Psychological treatment service	General Practitioners	92196	Phone
COVID-19	Psychological treatment service	Other Medical Practitioners	92198	Phone
COVID-19	Psychological treatment service	Other Medical Practitioners	92200	Phone
COVID-19	Psychological treatment service	Clinical Psychologists	93076	Telehealth

Program phase	Item Type	Provider	Item Number	Delivery Mode
COVID-19	Psychological treatment service	Clinical Psychologists	93079	Telehealth
COVID-19	Psychological treatment service	Psychologists	93084	Telehealth
COVID-19	Psychological treatment service	Psychologists	93087	Telehealth
COVID-19	Psychological treatment service	Occupational Therapists	93092	Telehealth
COVID-19	Psychological treatment service	Occupational Therapists	93095	Telehealth
COVID-19	Psychological treatment service	Social Worker	93100	Telehealth
COVID-19	Psychological treatment service	Social Worker	93103	Telehealth
COVID-19	Psychological treatment service	Clinical Psychologists	93110	Phone
COVID-19	Psychological treatment service	Clinical Psychologists	93113	Phone
COVID-19	Psychological treatment service	Psychologists	93118	Phone
COVID-19	Psychological treatment service	Psychologists	93121	Phone
COVID-19	Psychological treatment service	Occupational Therapists	93126	Phone
COVID-19	Psychological treatment service	Occupational Therapists	93129	Phone
COVID-19	Psychological treatment service	Social Worker	93134	Phone
COVID-19	Psychological treatment service	Social Worker	93137	Phone
Original	Psychological (group) treatment service	Clinical Psychologists	82358	Face to face
Original	Psychological (group) treatment service	Clinical Psychologists	82359	Telehealth
Original	Psychological (group) treatment service	Psychologists	82366	Face to face
Original	Psychological (group) treatment service	Psychologists	82367	Telehealth
Original	Psychological (group) treatment service	Occupational Therapists	82374	Face to face
Original	Psychological (group) treatment service	Occupational Therapists	82375	Telehealth
Original	Psychological (group) treatment service	Social Worker	82382	Face to face
Original	Psychological (group) treatment service	Social Worker	82383	Telehealth
Original	Dietetic health service	Dietitians	82350	Face to face
Original	Dietetic health service	Dietitians	82351	Telehealth
COVID-19	Dietetic health service	Dietitians	93074	Telehealth

Program phase	Item Type	Provider	Item Number	Delivery Mode
COVID-19	Dietetic health service	Dietitians	93108	Phone
Original	Review of progress	General Practitioners	90264	Face to face
Original	Review of progress	Other Medical Practitioners	90265	Face to face
Original	Review of progress	Consultant Psychiatrists	90266	Face to face
Original	Review of progress	Consultant Paediatricians	90267	Face to face
Original - removed	Review of progress	Consultant Psychiatrists	90268	Telehealth
Original - removed	Review of progress	Consultant Paediatricians	90269	Telehealth
COVID-19	Review of progress	General Practitioners	92170	Telehealth
COVID-19	Review of progress	Other Medical Practitioners	92171	Telehealth
COVID-19	Review of progress	Consultant Psychiatrists	92172	Telehealth
COVID-19	Review of progress	Consultant Paediatricians	92173	Telehealth
COVID-19	Review of progress	General Practitioners	92176	Phone
COVID-19	Review of progress	Other Medical Practitioners	92177	Phone
COVID-19 - removed	Review of progress	Consultant Psychiatrists	92178	Phone
COVID-19 - removed	Review of progress	Consultant Paediatricians	92179	Phone

Notes.

EDTMP = Eating Disorder Treatment and Management Plan

w/ MH skills training = with mental health skills training; w/o MH skills training = without mental health skills training;

Appendix 2. Changes to Eating Disorder Medicare Benefit Schedule Items

Table A2.1. *Summary of changes to Eating Disorders MBS items, up to 30 June 2023*[a]

Start date	End date	Description
Initial Rollout		
01 Nov 2019	NA	64 new MBS items were introduced to support a model of best practice evidence-based care for patients with anorexia nervosa and other eligible patients with eating disorders: • 12 items (90250-90257 and 90260-90263) for GPs, medical practitioners, consultant psychiatrists and paediatricians for preparation of eating disorders treatment and management plans. • 6 items (90264-90269) for GPs, medical practitioners, consultant psychiatrists and paediatricians for review of eating disorders treatment and management plans. • 12 items (90271-90282) for GPs and medical practitioners for provision of psychological treatment services. • 2 items (82350-82351) for Dietitians for provision of eating disorders dietetic health services. • 32 items (82352-82383) for Clinical Psychologists and Psychologists, Occupational Therapists and Social Workers for provision of eating disorder psychological treatment services.
01 Nov 2019	31 Dec 2021	Telehealth items for consultant psychiatrists and consultant paediatricians for preparation and review of eating disorder treatment and management plan (90262, 90263, 90268, 90269) were discontinued. Services covered by these items can continued to be claimed under items 92162, 92172 as described below for telehealth items introduced for COVID-19.
01 Nov 2019	28 Feb 2023	The removal of several telehealth items to consolidate eating disorder and mental health telehealth services and remove duplication of equivalent services. • Telehealth items for Clinical Psychologists and Psychologists, Occupational Therapists and Social Workers for provision of eating disorder psychological treatment services (82353, 82356, 82361, 82364, 82369, 82372, 82377, 82380) were discontinued. Patients will continue to have access to telehealth services for eating disorder psychological treatment and mental health services under equivalent items (see below for telehealth items introduced for COVID-19). • Telehealth items for GPs and medical practitioners for provision of psychological treatment services (90279, 90280, 90281, 90282) were discontinued. Patients will continue to have access to telehealth services for eating disorder psychological treatment and mental health services under items 92182, 92184, 92186 and 92188 (see below for telehealth items introduced for COVID-19). • Telehealth item for Dietitians for provision of eating disorders dietetic health services (82351) was discontinued. Patients will continue to have access to eating disorders dietetic health services under

Start date	End date	Description
		equivalent items (see below for telehealth items introduced for COVID-19).
COVID-19 Additions		
30 Mar 2020	NA	Temporary MBS telehealth items were made available to help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers. New telehealth and phone items introduced that replicate existing face-to-face treatment, consultation, plan and review item services. No requirements regarding location of consumer. • 20 items (92146-92163 and 92166-92167) for GPs, medical practitioners, consultant psychiatrists and paediatricians for preparation of eating disorders treatment and management plans. • 8 items (92170-92173, 92176-92177, 92178-92179) for GPs, medical practitioners, consultant psychiatrists and paediatricians for review of eating disorders treatment and management plans. • 8 items (92182, 92184, 92186, 92188, 92194, 92196, 92198, 92200) for GPs and medical practitioners for provision of psychological treatment services. • 16 items (93076, 93079, 93084, 93087, 93092, 93095, 93100, 93103, 93110, 93113, 93118, 93121, 93126, 93129, 93134, 93137) for Clinical Psychologists and Psychologists, Occupational Therapists and Social Workers for provision of eating disorder psychological treatment services. • 2 items (93074, 93108) for Dietitians for provision of eating disorders dietetic health services
30 Mar 2020	30 Jun 2021	Phone items for GPs and medical practitioners for preparation of eating disorders treatment and management plans (92154-92161) were discontinued. These services continue to be available for face-to-face consultation or telehealth via videoconferencing.
30 Mar 2020	31 Dec 2021	Phone items for consultant psychiatrists and consultant paediatricians for preparation of eating disorders treatment and management plans (92166, 92167, 92178, 92179) were discontinued. These services continue to be available for face-to-face consultation or telehealth via videoconferencing.

Note. [a] Changes in this table describe the addition or retirement of Eating Disorders MBS item numbers. NA, not applicable; GP, general practitioner. EDP, eating disorder treatment and management plan.

Table A2.2. *Summary of the Mental Health Case Conferencing items initiative*

Start date	End date	Description
01 Jul 2023	NA	21 new MBS items were introduced to improve access to and facilitate multidisciplinary, collaborative, and coordinated mental healthcare. These items enable eligible health providers to organise and coordinate or participate in case conferences to discuss a patient's mental health care, including for patients with an active eating disorder treatment and management plan. • 9 time-tiered items for GPs, OMPs, and consultant physicians in their speciality of psychiatry or paediatrics to organise and coordinate a multidisciplinary case conference (930, 933, 935, 969, 971, 972, 946, 948 and 959). • 9 time-tiered items for GPs, OMPs, and consultant physicians in their speciality of psychiatry or paediatrics to participate in a multidisciplinary case conference (937, 943, 945, 973, 975, 986, 961, 962 and 964). • 3 new time-tiered items for eligible clinical psychologists, psychologists, social workers, occupational therapists and dietitians to participate in a multidisciplinary case conference (80176, 80177 and 80178).

Note. GP, general practitioner. OMP, other medical practitioners.

Appendix 3. Key Evaluation Questions for Objectives 1 – 5

Objective 1. Examine Utilisation of the Eating Disorders MBS items
1.1. What is the overall and item specific uptake of the Eating Disorder MBS Items?
1.2. How many sessions are being accessed under Eating Disorders Treatment and Management Plans?
1.3. Are patients having recurring Eating Disorders Treatment and Management Plans generated?
1.5. What explanations are there for ceasing Eating Disorders Treatment and Management Plan?
1.6. For what clinical diagnosis are people receiving treatment?
1.7. Are there any specific barriers to access for people in Priority Populations including First Nations people?
2.4. To what extent have the Eating Disorders MBS Items reached their intended population?
4.4. What is clinician feedback on the Eating Disorder MBS Items?
5.1. What is the primary carer's experience of the Eating Disorder MBS Items?
5.2. How do different carer relationships (e.g., parent, partner, child) impact the use of Eating Disorder MBS Items?
5.4. Are carers accessing treatment sessions under an Eating Disorders Treatment and Management Plan without the patient present?
5.5. How did the out-of-pocket cost of treatment and waitlist impact access to treatment?
6.1. How effectively do the items meet the needs of consumers?
6.2. How did the out of pocket cost of treatment and wait times impact access to treatment?

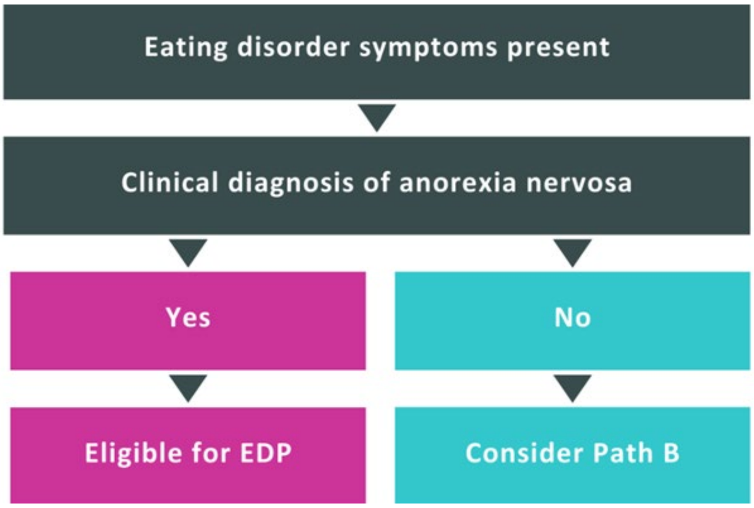
Objective 2: Examine the Relationship between the Eating Disorders Treatment and Management Plan and Other Related MBS items
1.4. How many people have both an Eating Disorders Treatment and Management Plan and a Mental Health Treatment Plan? 3.1. What other support mechanisms, partnerships and linkages to existing initiatives would complement the Eating Disorder MBS Items? 3.2. Is there appropriate consistency with similar MBS items (such as the Mental Health Treatment and Chronic Disease Management Plans)? 3.3. To what extent do the Eating Disorders MBS Items align with other key Commonwealth policies and programs including, but not limited to, the National Mental Health and Suicide Prevention Plan, programs funded under the National Disability Insurance Scheme (NDIS) and the Better Access scheme? 4.3. Are clinicians aware of, and confident with using, the Eating Disorders MBS Items appropriately? 4.4. What is clinician feedback on the Eating Disorder MBS Items? 5.3. How often are carers accessing a Mental Health Treatment Plan to receive additional support in their role as a carer for a person with an Eating Disorder? 6.1. How effectively do the items meet the needs of consumers?

Objective 3: Consider whether the Eating Disorders MBS items have improved access to treatment services
1.6. For what clinical diagnosis are people receiving treatment?
1.7. Are there any specific barriers to access for people in Priority Populations including First Nations people?
2.1. Have the Eating Disorders MBS Items improved access to treatment services?
2.4. To what extent have the Eating Disorders MBS Items reached their intended population?
4.1. Which therapy techniques are being used by health professionals in the treatment of eating disorders under an Eating Disorders Treatment and Management Plan?
4.2. What role/s are GPs playing in supporting and/or treating a person with an Eating Disorders Treatment and Management Plan?
4.3. Are clinicians aware of, and confident with using, the Eating Disorders MBS Items appropriately?
4.4. What is clinician feedback on the Eating Disorders MBS Items?
5.1. What is the primary carer's experience of the Eating Disorders MBS Items?
5.2. How do different carer relationships (e.g., parent, partner, child) impact the use of Eating Disorder MBS Items?
5.5. How did the out of pocket cost of treatment and waitlist impact access to treatment? (carer perspective)
6.2. How did the out of pocket cost of treatment and wait times impact access to treatment? (consumer perspective)
6.1. How effectively do the items meet the needs of consumers?

Objective 4: Determine if the Eating Disorders MBS items improve patient outcomes
1.5. What explanations are there for ceasing Eating Disorders Treatment and Management Plan?
2.2. How effective have the Eating Disorders MBS Items been in achieving positive treatment outcomes?
2.3. Do the Eating Disorders MBS Items reflect contemporary evidence-based treatment guidelines? In particular, what is the benefit of the specialist review at 20 sessions in achieving positive treatment outcomes?
4.1. Which therapy techniques are being used by health professionals in the treatment of eating disorders under an Eating Disorders Treatment and Management Plan?
4.2. What role/s are GPs playing in supporting and/or treating a person with an Eating Disorders Treatment and Management Plan?
4.4. What is clinician feedback on the Eating Disorder MBS Items?
5.2. How do different carer relationships (e.g., parent, partner, child) impact the use of Eating Disorder MBS Items?
5.4. Are carers accessing treatment sessions under an Eating Disorders Treatment and Management Plan without the patient present?
6.1. How effectively do the items meet the needs of consumers?

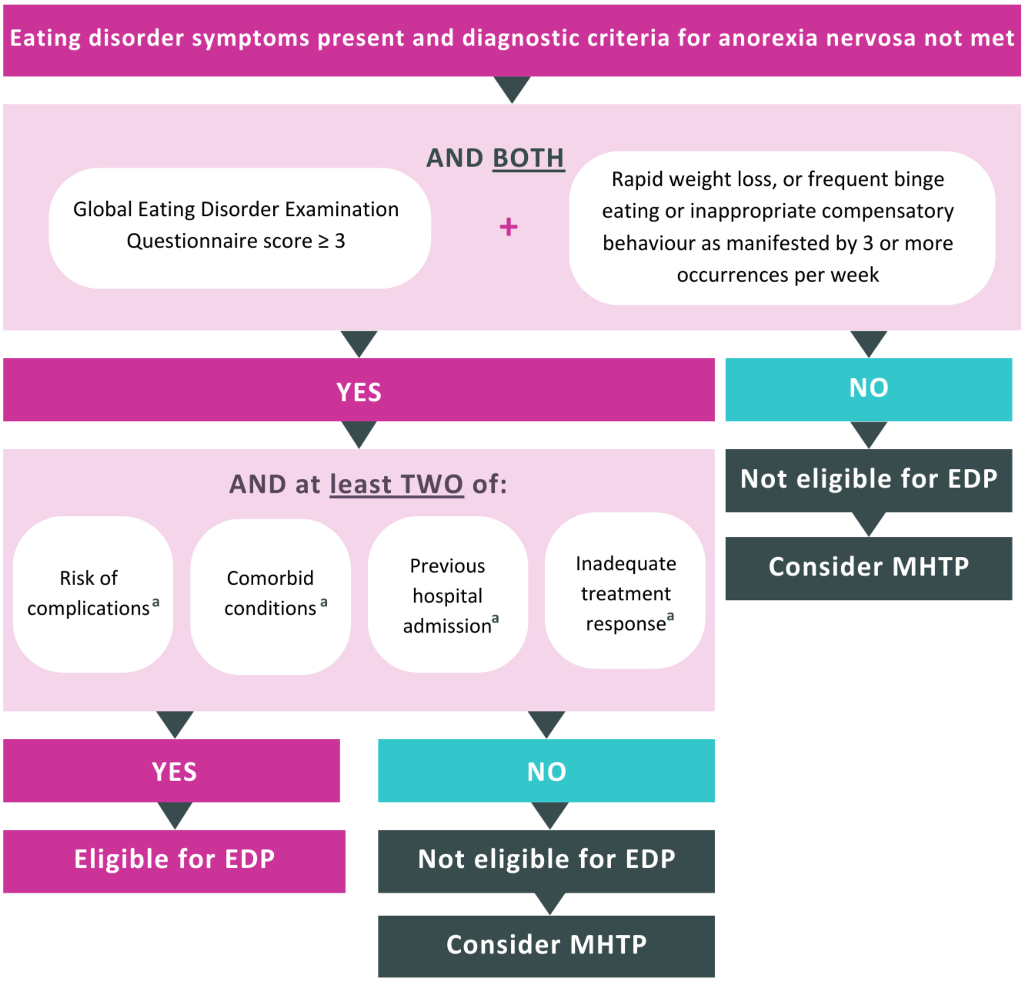
Objective 5: Develop Recommendations to Inform Ongoing Success of the Eating Disorder MBS Items
7.1. What are the existing gaps in data and evidence that could be collected in the future to better inform the use and effectiveness of the Eating Disorder MBS Items?
7.2. Drawing on these findings, should there be any changes to the delivery model and/or functions of the Eating Disorders MBS Items to improve outcomes for people with an eating disorder and their families/carers?
7.3. Drawing on these findings, what policies or programs are needed to better support access to the Eating Disorders MBS Items and improve usage and outcomes?

Appendix 4. Process for GPs to determine Eating Disorder Plan eligibility under Path A and B



Note. EDP refers to Eating Disorder Plan

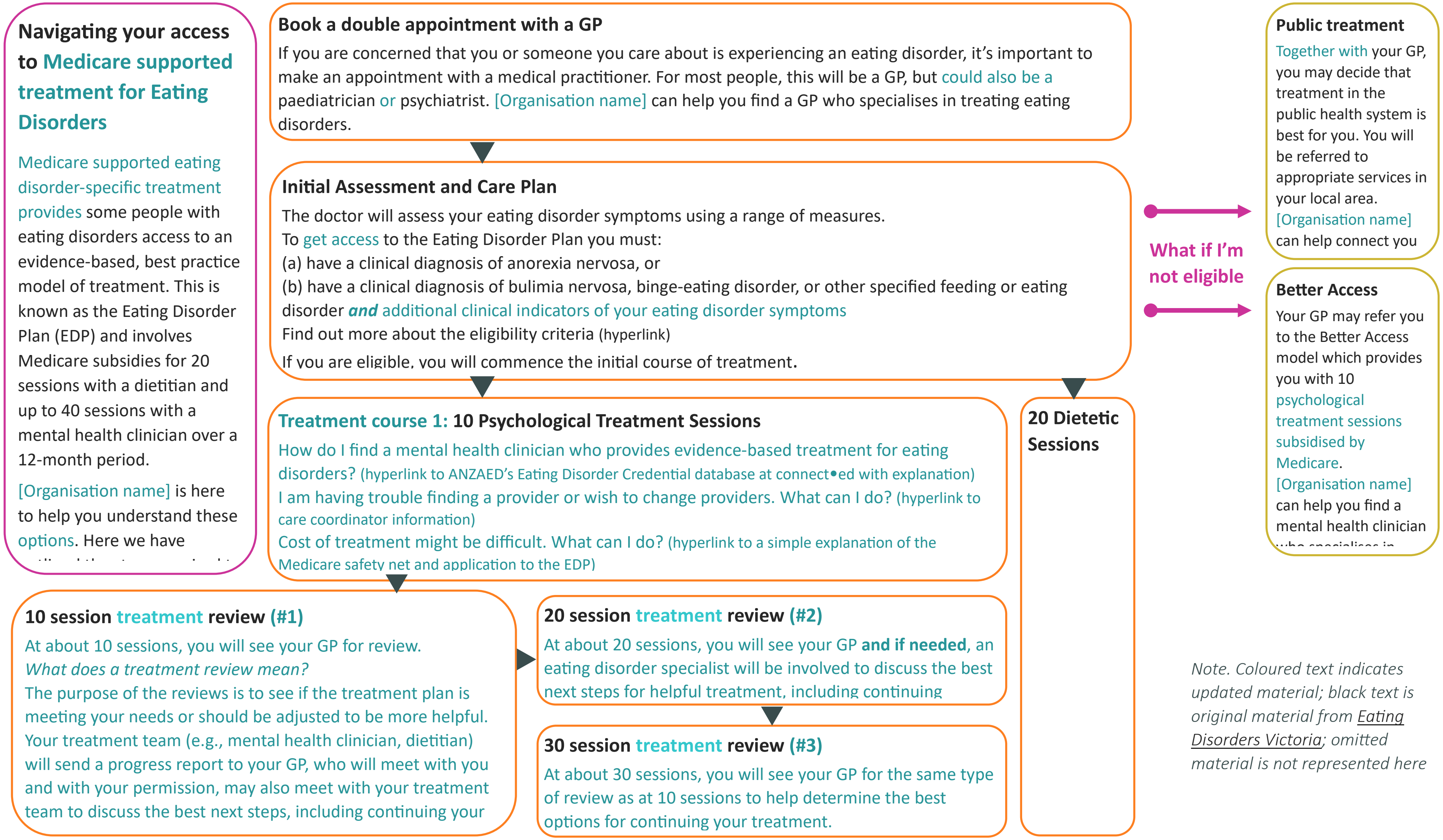
Figure A4.1. *Schematic of recommended process for determining eligibility via Path A*



Note [a] criteria abbreviated, for full description see Figure 7.3; EDP refers to Eating Disorder Plan; MHTP refers to Mental Health Treatment Plan

Figure A4.2. *Schematic of recommended process for determining eligibility via Path B*

Appendix 5. Suggested updates to available summary material from Eating Disorders Victoria on navigating an Eating Disorder Plan



Navigating your access to Medicare supported treatment for Eating Disorders

Medicare supported eating disorder-specific treatment provides some people with eating disorders access to an evidence-based, best practice model of treatment. This is known as the Eating Disorder Plan (EDP) and involves Medicare subsidies for 20 sessions with a dietitian and up to 40 sessions with a mental health clinician over a 12-month period.

[Organisation name] is here to help you understand these options. Here we have

Book a double appointment with a GP

If you are concerned that you or someone you care about is experiencing an eating disorder, it's important to make an appointment with a medical practitioner. For most people, this will be a GP, but could also be a paediatrician or psychiatrist. [Organisation name] can help you find a GP who specialises in treating eating disorders.

Initial Assessment and Care Plan

The doctor will assess your eating disorder symptoms using a range of measures.
To get access to the Eating Disorder Plan you must:
(a) have a clinical diagnosis of anorexia nervosa, or
(b) have a clinical diagnosis of bulimia nervosa, binge-eating disorder, or other specified feeding or eating disorder ***and*** additional clinical indicators of your eating disorder symptoms
Find out more about the eligibility criteria (hyperlink)
If you are eligible, you will commence the initial course of treatment.

What if I'm not eligible

Public treatment

Together with your GP, you may decide that treatment in the public health system is best for you. You will be referred to appropriate services in your local area. [Organisation name] can help connect you

Better Access

Your GP may refer you to the Better Access model which provides you with 10 psychological treatment sessions subsidised by Medicare. [Organisation name] can help you find a mental health clinician

Treatment course 1: 10 Psychological Treatment Sessions

How do I find a mental health clinician who provides evidence-based treatment for eating disorders? (hyperlink to ANZAED's Eating Disorder Credential database at connect•ed with explanation)
I am having trouble finding a provider or wish to change providers. What can I do? (hyperlink to care coordinator information)
Cost of treatment might be difficult. What can I do? (hyperlink to a simple explanation of the Medicare safety net and application to the EDP)

20 Dietetic Sessions

10 session treatment review (#1)

At about 10 sessions, you will see your GP for review.
What does a treatment review mean?
The purpose of the reviews is to see if the treatment plan is meeting your needs or should be adjusted to be more helpful. Your treatment team (e.g., mental health clinician, dietitian) will send a progress report to your GP, who will meet with you and with your permission, may also meet with your treatment team to discuss the best next steps, including continuing your

20 session treatment review (#2)

At about 20 sessions, you will see your GP **and if needed**, an eating disorder specialist will be involved to discuss the best next steps for helpful treatment, including continuing

30 session treatment review (#3)

At about 30 sessions, you will see your GP for the same type of review as at 10 sessions to help determine the best options for continuing your treatment.

Note. Coloured text indicates updated material; black text is original material from Eating Disorders Victoria; omitted material is not represented here

Appendix 6. Mental health professional assessment and review template

Eating Disorder Plan: MENTAL HEALTH PRACTITIONER ASSESSMENT REPORT TEMPLATE

To:

Date:

Dear Dr   cc treating team (e.g., Dietitian)

RE: DOB:

Thank you for referring this patient with an Eating Disorder Care Plan (EDP). I have now assessed this patient as follows:

Diagnosis	(Tick if provisional ☐)		
Baseline measures	BMI (if AN)		
	ED15 (mean cognitive score*) **lower is better*	/6	
	ED15 (behavioural measures)	Binge	times/week
		Vomit	times/week
		Laxative use	days/week
		Restricted eating	days/week
		Driven exercise	days/week
Treatment approach (Eating Disorder Plan approved first line therapies)	☐Family based treatment (FBT) for eating disorders ☐Adolescent focused therapy (AFT) - for anorexia nervosa ☐Cognitive behavioural therapy-enhanced (CBT-E) ☐Specialist Supportive Clinical Management (SSCM) – for anorexia nervosa ☐Maudsley Model of Anorexia Treatment in Adults (MANTRA) ☐Interpersonal Therapy (IPT) – for bulimia nervosa; binge eating disorder ☐Focal psychodynamic therapy –for anorexia nervosa *Note. Dialectical behavioural therapy (DBT) for bulimia nervosa and for binge eating disorder was previously listed as an acceptable treatment. Based on available evidence and existing clinical guidelines, we recommend it only be used as therapy augmentation for emotion regulation difficulties that interfere with treatment and not as a standalone treatment for eating disorders.*		
Goals Sessions 1-10 (for symptom change and personal recovery)			
Other comments			

A progress report will be forwarded at or nearing sessions 10, 20, and 30 as relevant, as per the next section of this form.

Yours sincerely,

Name: Date:

Phone: Email:

Eating Disorder Plan: MENTAL HEALTH PRACTITIONER REVIEW (PROGRESS REPORT) TEMPLATE

To:

Date:

Dear Dr cc treating team (e.g., Dietitian)

RE: DOB:

Thank you for referring this patient with an Eating Disorder Care Plan. We have now completed / are approaching completion of:

☐10 ☐20 ☐30 ☐40 sessions

Progress by session (*this can be linked to a spreadsheet that collates and plots progress for report)*

Session	Date	BMI *If AN*	ED15 Cognitions Mean score *Lower = better*	ED15 behavioural measures (weekly frequency)				
				Binge	Vomit	Laxative use	Restricted eating	Driven exercise
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Progress summary

☐ Treatment complete ☐ Satisfactory progress towards goals ☐ Slow/no progress towards goals; case conference requested
Comments on progress towards goals (symptom reduction and personal recovery)
Goals (symptom reduction and personal recovery) for next phase of treatment

Yours sincerely

Name: Date:

Phone: Email:

Appendix 7. GP Eating Disorder Plan and Review template (modified from InsideOut Institute)

To :

Address:

Date:

Dear

RE: DOB:

Please find below an Eating Disorder Care Plan (EDP) prepared for this patient with details of their condition. The information in this referral is for the first course of psychological treatment (sessions 1-10) of which there are a maximum of 40 sessions in a 12-month period, and sessions 1-20 for dietetic care. After the first course of psychological treatment, I will review progress or if necessary, with case conference will discuss and endorse strategies for forthcoming sessions of psychological treatment (session 11-20). Many thanks for your care and for your ongoing collaboration and communication.

Yours sincerely,

Name:

Date:

GP EATING DISORDER PLAN (EDP)

Item No : 90250 – 90257 MBS Quick Reference

GP DETAILS			
GP Name Provider No.		Practice Name & Address	
Practice Phone		Practice Fax	
GP Health Identifier			
GP Email			

PATIENT DETAILS			
First Name (as on Medicare)		Last Name	
Preferred Name		Marital Status	
Date of Birth		Age	
Gender Identity	As identified in software: Current identity ☐ Male ☐ Female ☐ Non-binary/Gender fluid ☐ Different Identity		
Address			
Phone (h)			
Cultural Identity		Aboriginal or Torres Strait Islander	☐ Yes ☐ No
First Language	Interpreter needed ☐ Yes ☐ No		
Family / Support Person Details (Consider involving support person in session if appropriate) InsideOut resources for carers Butterfly resources for carers NEDC resources for carers	Name: Relationship to Patient: Pt consent to contact given ☐ Yes ☐ No Ph: ☐ Very well supported ☐ Well supported ☐ Somewhat supported ☐ Not supported Any information not to be shared with support person :		
Relevant Current Medications			

ESTABLISH ACCESS TO EDP (If not appropriate consider using a MHCP or GPMP)	
Eating Disorder Diagnosis (DSM-V) InsideOut GP HUB & diagnostic guides	☐ Anorexia nervosa (AN) (if yes, eligibility for EDP confirmed) ☐ Eating disorder symptoms present but not AN (determine EDE-Q global score, eating disorder behaviours, and clinical indictors below)
EDE-Q Global Score InsideOut EDE-Q online with scoring	☐ EDE-Q Score: ☐ Score greater than or equal to 3 to access EDP, below 3 consider Better Access to Mental Health Plans
Eating Disorder Behaviours (At least one needed to access EDP and rebates)	**Eating disorder behaviours:** ☐ Rapid weight loss ☐ Binge eating (frequency >=3 times per week) ☐ Compensatory Behaviour (frequency >=3 times per week) Type of compensatory behaviours (if relevant): ☐ Purging ☐ Excessive exercise ☐ Laxative abuse ☐ Restriction/Fasting ☐ Type I diabetes - underdosing insulin ☐ N/A Frequency of behaviour: ☐ N/A ☐ Daily ☐ Weekly ☐ Monthly
Clinical Indicators (at least 2 to access EDP and rebates)	Clinical Indicators: ☐ Current or high risk of medical complications due to ED ☐ Serious comorbid psychological/medical conditions impacting function ☐ Hospital admission for an ED in past 12mths ☐ Suboptimal response to evidence-based treatment over past 6mths despite participation ☐ N/A

MENTAL HEALTH ASSESSMENT & HISTORY	
Previous Specialist Mental Health Care	
Social & Family History	
Personal History Childhood, education, relationship history, previous stressors, protective factors	
Results of Mental State Examination Detail findings Royal Children's Hospital Melbourne Mental State Examination Guide	Appearance: General behaviour: Speech: Mood: Affect: Thought: Perceptions: Cognition: Insight:
Risk Assessment Note any identified risks Blackdog Institute resources	Identified risk: ☐ Suicidal ideation ☐ Suicidal intent ☐ Current plan ☐ Medical risk ☐ None

MENTAL HEALTH ASSESSMENT & HISTORY

	Other:
	Plan for managing risk: ☐ Mental Health Line ☐ After hours GP service ☐ Family monitoring ☐ GP monitoring Other

MEDICAL REVIEW

Examination As indicated	Physical examination done: ☐ N/A ☐ Height, weight, BMI (adults) BMI percentile (children) ☐ Pulse & blood pressure, with postural measurements ☐ Temperature ☐ Assessment of breathing & breath (e.g. ketosis) ☐ Examination of periphery for circulation and oedema ☐ Assessment of skin colour (e.g. anaemia, hypercarotenaemia, cyanosis) ☐ Hydration state (e.g. moisture of mucosal membranes, tissue turgor) ☐ Examination of head & neck (e.g. parotid swelling, dental enamel erosion, gingivitis, conjunctival injection) ☐ Examination of skin, hair & nails (e.g. dry skin, brittle nails, lanugo, dorsal finger callouses (Russell's sign) ☐ Sit up or squat test (i.e. test of muscle power) Investigations done: ☐ FBC ☐ EUC/LFT/CMP/BSL ☐ Urinalysis ☐ Electrocardiography ☐ Iron studies, B12, folate ☐ E/P, LH/FSH, if appropriate TSH/Prl ☐ Bone densitometry – relevant after 9-12mths of disease or of amenorrhoea & as baseline in adolescents (recommendation is for 2yrly scans thereafter while DEXA scans are abnormal)
Observations	
Psychological / medical comorbidities	
Medical complications	
Protective factors	
Emergency care / relapse prevention	

TREATMENT RECOMMENDATIONS UNDER EDP

Psychological treatment services (EDPT) (up to 40 sessions in 12 months) Psychological treatment provider to provide progress reports prior to or at sessions 10, 20, and 30	**Dietetic services** (up to 20 in 12 months) Dietitian to provide letter of treatment to GP at EDP completion (if progress satisfactory) or participate in case conference (if no/slow progress)	**Specialist review (at 20-sessions)** If necessary, where no or slow progress: Engagement of eating disorder specialist (Credentialed Eating Disorder Clinician) for advice/review in case conference with multidisciplinary treatment team to review progress and determine clear strategy for forthcoming sessions Health professionals credentialed in eating disorder treatment
Referred to: Phone: Note: Goals and treatment approach will be generated by the provider of the psychological treatment and communicated to the GP (along with a diagnosis where the eating disorder is not anorexia nervosa)	Referred to: Phone:	Specialist: Phone: Other team member Profession: Name: Phone:

InsideOut treatment services database
ANZAED Credentialed Eating Disorder Clinician database

Care co-ordination required: ☐ Yes ☐ No Referred to:

Family/supports engaged to participate in treatment: ☐ Yes ☐ No

GP Management - Frequency of review

☐ Weekly ☐ Monthly ☐ As indicated :

Actions for patient to take: ☐ If no care co-ordination, build my treatment team (https://connected.anzaed.org.au/)

☐ Use of the Healthy Mind Platter ☐ Read through RAVES approach ☐ Engage family/Friends
☐ Limit my exercise to set amount ☐ Attend all appointments with dietitian/psychologist ☐ Use Plate by Plate
Other actions identified by patient:

Patient education given: ☐ Yes ☐ No Specify :

Copy of EDP offered to patient : ☐ Yes ☐ No Specify :

GP REVIEW REQUIREMENTS

Mental health: Prior or at sessions 10, 20 & 30 of psychological treatment & at EDP completion. In the case of no/slow progress, participate in case conference.
Dietetics: At EDP completion
Note: Specialist Review
Required for 20-session review in the case of no/slow progress. Consider engaging early in course of treatment.

RECORD OF PATIENT CONSENT

I , (patient name - please print clearly)
agree to information about my mental and medical health to be shared between the GP and the health professionals to whom I am referred, either via correspondence, verbal communication, or case conferences to assist in the management of my health care.

Signature (patient) _____________________________ Date ___________________

I (GP) have discussed the proposed referral(s) with the patient and am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these.

GP Signature ____________________________ GP Name _____________________________ Date ____________________

Note. Pink highlight represents added content.

To :

Address:

Date:

Dear

RE: DOB:

Please find below an Eating Disorder Care Plan (EDP) Review prepared for this patient with details of their condition. The information in this referral is for the next phase of psychological treatment (sessions ___________). Many thanks for your care and for your ongoing collaboration and communication.

Yours sincerely,

Name:

Date:

GP EATING DISORDER PLAN REVIEW (EDP)

Item No : 90264 MBS Quick Reference

GP DETAILS

GP Name Provider No.		Practice Name & Address	
Practice Phone		Practice Fax	
GP Health Identifier			
GP Email			

PATIENT DETAILS

First Name (as on Medicare)		Last Name	
Preferred Name		Marital Status	
Date of Birth		Age	
Gender Identity	As identified in software: Current identity ☐ Male ☐ Female ☐ Non-binary/Gender fluid ☐ Different Identity		
Address			
Phone (h)			
Cultural Identity		Aboriginal or Torres Strait Islander	☐ Yes ☐ No
First Language	Interpreter needed ☐ Yes ☐ No		
Family / Support Person Details (Consider involving support person in session if appropriate) InsideOut resources for carers Butterfly resources for carers NEDC resources for carers	Name: Relationship to Patient: Pt consent to contact given ☐ Yes ☐ No Ph: ☐ Very well supported ☐ Well supported ☐ Somewhat supported ☐ Not supported Any information not to be shared with support person :		
Relevant Current Medications			

GP Review	
GP Review time point:	☐ After session 10 ☐ After session 20 ☐ After session 30
Review type	☐ GP review ☐ Case conference (where slow/no progress)
Progress towards goals As indicated in mental health practitioner progress report	☐ Satisfactory progress towards goals ☐ Slow/no progress towards goals[a] Comments on progress from treating clinicians: ____________________* [a]Identified reason for slow/no progress towards goals: ____________________ Psychological treatment approach used: ____________________* Dietetic services intervention approach used: ____________________* *Or, insert/link to mental health practitioner progress report
Quantitative data on change in eating disorder behaviours	Change in eating disorder cognitions (ED15 mean score) from first to most recent sessions: ____________________* Change in weekly eating disorder behaviours (ED15): ____________________* *Or, insert/link to mental health practitioner progress report
Eating Disorder Behaviours (At least one needed to access EDP and rebates)	**Continuing eating disorder behaviours:** ☐ Restriction ☐ Weight loss ☐ Body image concerns ☐ Binge eating ☐ Rumination ☐ Pica Other: **Behaviour Frequency:** ☐ Daily ☐ Weekly ☐ Monthly **Restriction type** (if relevant): ☐ Skipping meals ☐ Fasting ☐ Fad diets ☐ Avoiding food groups Other: **Compensatory behaviours** (if relevant): ☐ Purging ☐ Excessive exercise ☐ Laxative abuse ☐ Type I diabetes - underdosing insulin Other: Frequency of behaviour: ☐ Daily ☐ Weekly ☐ Monthly
Risk Assessment Note any identified risks Blackdog Institute resources	Identified risk: ☐ Suicidal ideation ☐ Suicidal intent ☐ Current plan ☐ Medical risk ☐ None Other:
	Plan for managing risk: ☐ Mental Health Line ☐ After hours GP service ☐ Family monitoring ☐ GP monitoring Other
Observations	

REVIEW TREATMENT RECOMMENDATIONS UNDER EDP

Psychological treatment services (EDPT) (Up to 40 sessions in 12 months) Psychological treatment provider to provide progress reports prior to or at sessions 10, 20, and 30	**Dietetic services** (up to 20 sessions in 12 months) Dietitian to provide letter of treatment to GP at EDP completion (if progress satisfactory) or participate in case conference (if no/slow progress)	**Specialist review (at 20-sessions)** If necessary, where no or slow progress: Engagement of eating disorder specialist (Credentialed Eating Disorder Clinician) for advice/review in case conference with multidisciplinary treatment team to review progress and determine clear strategy for forthcoming sessions Health professionals credentialed in eating disorder treatment
Referred to: Phone: Progress review/comments: ________________* *Or, insert/link to mental health practitioner progress report	Referred to: Phone: Progress review/comments: ___________	Specialist: Phone: Other team member Profession: Name: Phone:

InsideOut treatment services database
ANZAED Credentialed Eating Disorder Clinician database

Emergency Care/Relapse Prevention:
InsideOut GP Hub – Management supports

GP management - frequency of review/monitoring

☐ Weekly ☐ Monthly ☐ As indicated :

Actions the treating team needs to make (recommendations for):

☐ Augmentation of therapy ☐ Change therapy ☐ More intensive therapy

Other

Actions for patient to take:

☐ Use of the Healthy Mind Platter ☐ Read through RAVES approach ☐ Engage family/Friends
☐ Limit my exercise to set amount ☐ Attend all appointments with dietitian/psychologist ☐ Use Plate by Plate
Other actions identified by patient:

Continuation of next phase of EDP treatment	☐ Yes ☐ No
Copy of EDP Review offered to patient	☐ Yes ☐ No
Physical examination conducted	☐ Yes ☐ No

EATING DISORDERS PATIENT PHYSICAL ASSESSMENT

Suggested minimal physical assessment	Height, weight, body mass index (BMI; adults with anorexia nervosa), BMI percentile for age (children) Pulse and blood pressure, with postural movements Temperature
Any significant findings/comments	

RECORD OF PATIENT CONSENT

I , (patient name - please print clearly)

agree to information about my mental and medical health to be shared between the GP and the health professionals to whom I am referred, either via correspondence, verbal communication, or case conferences to assist in the management of my health care.

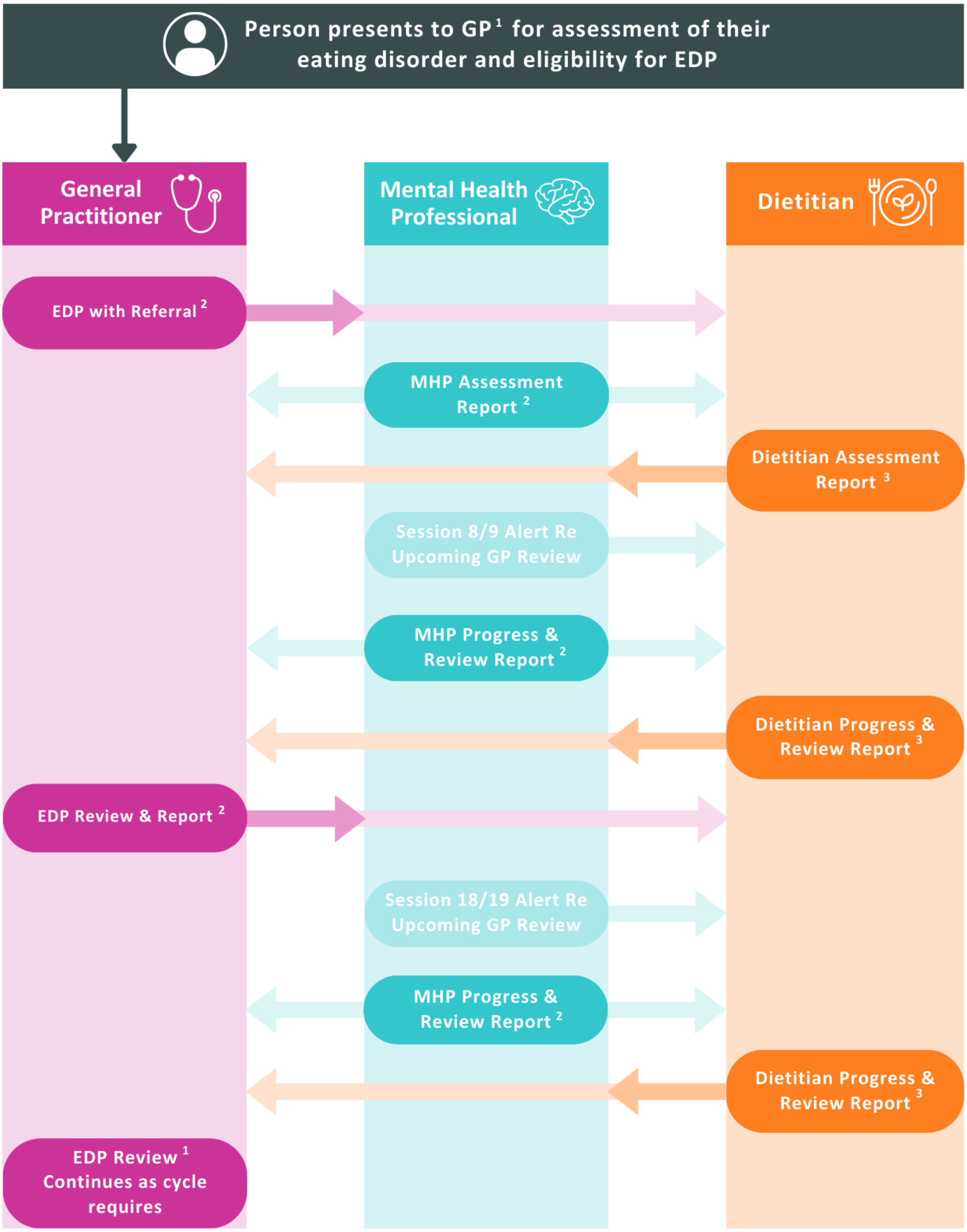
Signature (patient) ____________________________ Date ___________________

I (GP) have discussed the proposed continuation or change to the treatment plan with the patient and am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these.

GP Signature ___________________________ GP Name ____________________________ Date ____________________

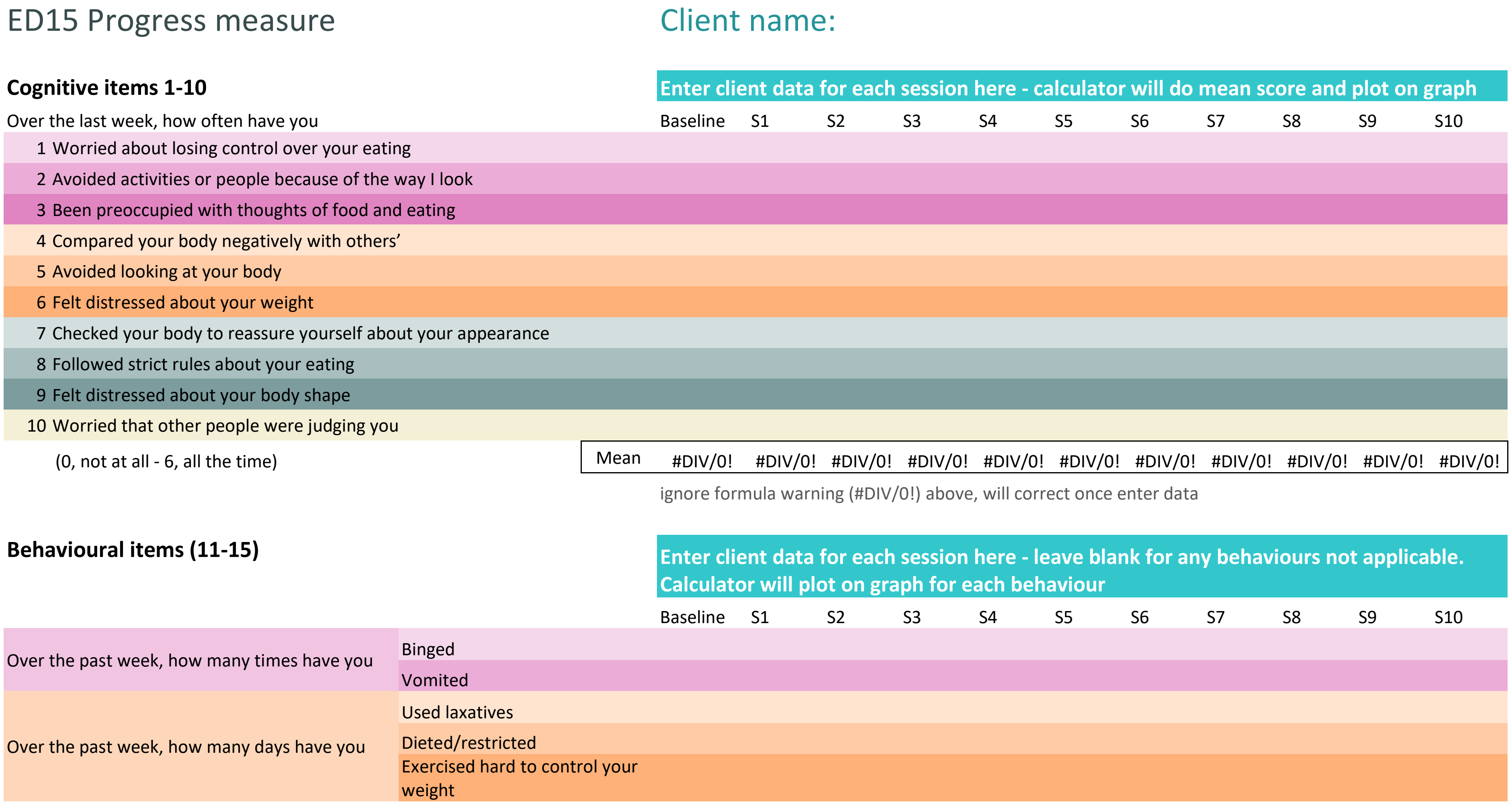
Note. Pink highlight represents added content.

Appendix 8. Timing and flow of information between multidisciplinary team members at initiation of services, assessment, and review



Note. [1] *people with a lived experience of an eating disorder typically present to a GP for preparation of an Eating Disorder Plan, but may also present to a psychiatrist, paediatrician, or other medical practitioner;* [2] *reports are to be completed using recommended templates (see Appendices 7 and 8);* [3] *templates to be developed.*

Appendix 9. Schematic of spreadsheet for scoring and graphing sessional measurement of treatment response and progress



ED15 Progress measure

Client name:

Cognitive items 1-10

Enter client data for each session here - calculator will do mean score and plot on graph

Over the last week, how often have you		Baseline	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10
1 Worried about losing control over your eating												
2 Avoided activities or people because of the way I look												
3 Been preoccupied with thoughts of food and eating												
4 Compared your body negatively with others'												
5 Avoided looking at your body												
6 Felt distressed about your weight												
7 Checked your body to reassure yourself about your appearance												
8 Followed strict rules about your eating												
9 Felt distressed about your body shape												
10 Worried that other people were judging you												
(0, not at all - 6, all the time)	Mean	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

ignore formula warning (#DIV/0!) above, will correct once enter data

Behavioural items (11-15)

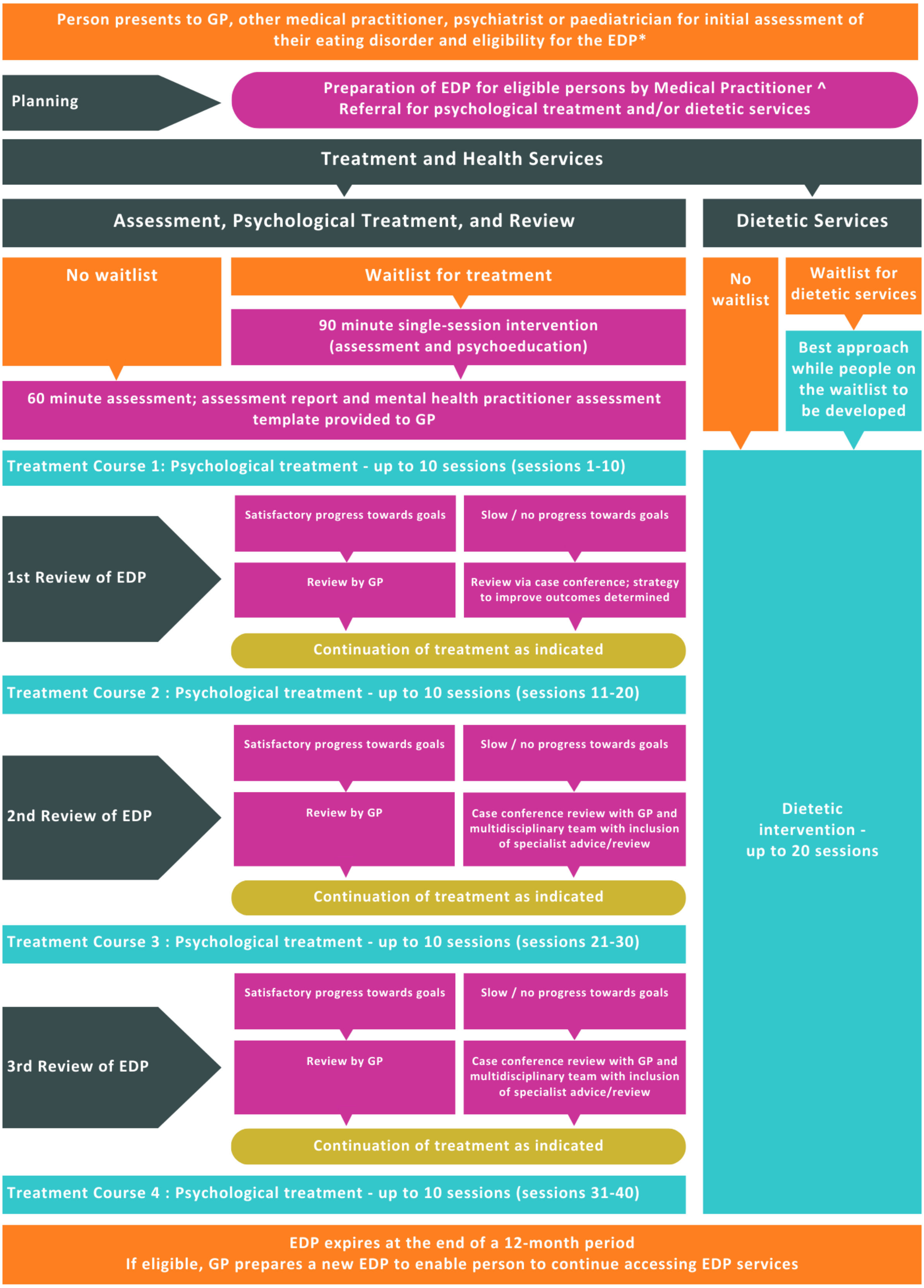
Enter client data for each session here - leave blank for any behaviours not applicable. Calculator will plot on graph for each behaviour

		Baseline	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10
Over the past week, how many times have you	Binged											
	Vomited											
Over the past week, how many days have you	Used laxatives											
	Dieted/restricted											
	Exercised hard to control your weight											

Figure A9.1. *Schematic of a spreadsheet to enter and score sessional progress using the ED15*

Figure A9.2. *Example progress graphs of cognitive and behavioural symptoms created from data entered into spreadsheet (mock data)*

Appendix 10. Treatment and review process under the Eating Disorder Plan incorporating recommendations



Appendix 11. Recommendations for relevant key evaluation questions

This section provides mapping of recommendations against policy related key evaluation questions. We note that there is some overlap in mapping as some recommendations are relevant for several key evaluation questions. Indicated recommendations can be found in full in Chapter 7.

KEQ 3.1. What other support mechanisms, partnerships and linkages to existing initiatives would complement the Eating Disorder MBS Items?

Recommendations #1, #2, #5, #7, #8, #10, #21, #25, #29, #33, #35, #36, #45, and #46 address this key evaluation question.

KEQ 7.1. What are the existing gaps in data and evidence that could be collected in the future to better inform the use and effectiveness of the Eating Disorder MBS Items?

Recommendations #30, #35, #41, #43, and #44, address this key evaluation question.

KEQ 7.2. Drawing on these findings, should there be any changes to the delivery model and/or functions of the Eating Disorders MBS Items to improve outcomes for people with an eating disorder and their families/carers?

Recommendations #3, #4, #9, #13, #14, #18, #19, #24, #27, #28, #31, #32, #34, #35, #36, #37, #38, #39, and #40 address this key evaluation question.

KEQ 7.3. Drawing on these findings, what policies or programs are needed to better support access to the Eating Disorders MBS Items and improve usage and outcomes?

Recommendations #2, #12, #15, #22, #25, #26, and #33 address this key evaluation question.

Appendix 12. List of recommendations in full

Initiation of Service

Early identification by the GP

1. All GPs should be equipped with an online validated screening tool:
    a. The screening tool should be the Screen for Disordered Eating [37] which is more sensitive than other tools for detecting any eating disorder in people.
    b. The Screen for Disordered Eating should be provided in an online format that can be automatically scored.
    c. Primary Health Networks (PHNs) operate an online portal (HealthPathways) that provides GPs with access to comprehensive evidence-based assessment. Currently the tool provided through this portal is the SCOFF Questionnaire. This should be replaced with the Screen for Disordered Eating.
2. GPs should be offered training and support to enhance awareness of eating disorder symptoms and treatment options, including when eating is not mentioned by the patient as a problem, but mental health is considered an issue [38]. To support this recommendation:
    a. PHNs, which currently provide a training and events function for GPs, should routinely offer training and support to use and interpret a screening tool for eating disorders and distribute unambiguous, brief documentation to raise awareness of the availability, eligibility, and associated treatment options of an Eating Disorder Plan.
    b. Training and support options should also include offerings like the NEDC Eating Disorder Core Skills: eLearning for GPs, which already exist and are intended to enhance the ability to recognise eligibility for different diagnoses and eating disorder presentations.

GP assessment of eligibility

3. Simplify the process for determining eligibility by GPs by establishing two pathways as shown in Figure 7.3:
    a. Path A for people with anorexia nervosa – determination of eligibility according to a GP-generated diagnosis of anorexia nervosa
    b. Path B for people with bulimia nervosa, binge eating disorder, or other specified feeding or eating disorder – determination of eligibility according to presence of eating disorder symptoms and presence of clinical indicators specified below in (4a) and shown in Figure 7.3.

Path A would retain the existing pathway for eligibility for people with anorexia nervosa. Path B would retain the existing pathway for eligibility for people with other eligible eating disorder diagnoses with simplification by removing the need for a GP-generated eating disorder diagnosis for non-anorexia nervosa eating disorders.

4. Update determination of eligibility for an Eating Disorder Plan for Path B. To be specified as:

   a. An Eating Disorder Examination Questionnaire global score ≥ 3, **and** the condition is characterised by rapid weight loss, or frequent binge eating, or inappropriate compensatory behaviour occurring 3 or more times per week, **and** two of the following indicators are present: (1) current or high risk of medical complications due to eating disorder behaviours and symptoms, (2) serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status and function, (3) admission to a hospital for an eating disorder in the previous 12 months, (4) inadequate treatment response to evidence-based eating disorder treatment over the past 6 months despite active and consistent participation.

   b. The criterion regarding weight status (i.e., clinically underweight with a body weight less than 85% of expected weight where weight loss is directly attributable to the eating disorder) to be removed given this is encompassed in the assessment of a diagnosis of anorexia nervosa for people meeting eligibility criteria for the Path A, and is not applicable for any eating disorder diagnosis criteria for Path B. See Figure 7.3.

   c. The GP does not make a diagnosis at the time of determining eligibility for an Eating Disorder Plan given its redundancy with information provided in (a). A schematic for this process is shown in Appendix 4.

5. Modify the online Eating Disorder Examination-Questionnaire (provided by InsideOut Institute) to not only automatically provide the global eating disorder examination - questionnaire score, but also the weekly frequency of objective binge eating and inappropriate compensatory behaviours, so the assessment of eligibility by the GP can be expedited.

6. Change the link to the eating disorder examination provided in the Australian Government Medicare Benefits Scheme Quick Reference Guide - which currently references the lengthy eating disorder examination interview - to the InsideOut Institute link for the eating disorder examination questionnaire provided in recommendation #5.

7. As per recommendation #2, use existing structures and organisations to support the provision, use and interpretation of online materials required to assess eligibility for Eating Disorders MBS items.

Development of the treatment plan and referral to treatment providers

Assessment and treatment initiation

8. Helpful unambiguous summaries of the Eating Disorders MBS items initiative suitable for people experiencing an eating disorder and people who care for someone with an eating disorder are hard to locate. A short overview should be co-designed and made available across relevant websites. The Eating Disorders Victoria online information provides the most useful foundation for this summary, and we have provided an integrated version of this summary with additional relevant information in Appendix 5, informed by knowledge gaps identified in this review.

9. Create an Eating Disorders MBS item number (90-min session total) – or expand provisions within current Eating Disorders MBS psychological treatment items – for those providers

eligible to deliver psychological treatment, so they can conduct a **60-minute** assessment that generates: i) a diagnosis; ii) treatment goals; and iii) clear specification of treatment to be used, with an additional **30 minutes** for completing a written plan that is sent to the GP. An example of this plan is provided in Appendix 6. This plan should be used over the duration of treatment by the psychological treatment provider to record progress against the stated goals and is suitable for use in review sessions.

10. Further modifications should be made to the newly revised online GP Eating Disorders Plan provided by the InsideOut Institute in line with recommendations from this report related to eligibility criteria enhancements, task shifting, reframing the course of treatment, and clarity of purpose of review sessions including:
    a. in the 'establish access to EDP' section: i) remove all diagnoses except for anorexia nervosa; (ii) add 'Type I diabetes - underdosing insulin' to the list of compensatory behaviours; and (iii) remove 'clinically underweight' from the clinical indicators.
    b. in the 'treatment recommendations under EDP' section: i) the psychological treatment referral to indicate that up to 40 sessions are available over 12 months; ii) the psychiatric/paediatric review should be titled 'specialist review' with a link to health professionals credentialed in eating disorder treatment; (iii) the goals and psychological treatments be removed with a note reminding the GP that these (along with a diagnosis where the eating disorder is not anorexia nervosa) will be generated by the provider of psychological treatment and communicated to the GP; (iv) add 'care co-ordination required (yes/no)' and 'referred to' as a new section; (v) 'build my treatment team' should be revised to read: 'if no care co-ordination, build my treatment team' and a link provided to https://connected.anzaed.org.au/.

An example of the modified GP Eating Disorder Plan template is provided in Appendix 7. Appendix 8 shows the required flow of reports between members of the multidisciplinary team at points of plan preparation, assessment, treatment, and review.

11. Promote the online GP Eating Disorders Plan provided by the InsideOut Institute widely to GPs via the resource library offered by PHNs.

Care navigation and case coordination to facilitate receipt of treatment services

12. PHNs should be required to provide regularly updated and accessible (local and telehealth) referral pathway information to GPs and care co-ordinators in line with their central role related to coordinating care and connecting services so people receive the 'right care, in the right place, at the right time', with mental health a priority area.

13. Provision and funding of eating disorders care co-ordination beyond GP assessment and plan preparation should be available for those who need it. For example, this may be required particularly by people with lower uptake of treatment after receiving an Eating Disorder Plan, including those who are male, or Indigenous Australians, or with lower income, or who live in rural and regional areas, or who speak a language other than English at home. Australian Government funding to PHNs for a care co-ordinator role is one possible model that should be investigated. This role has been shown to be successful in the Sunshine Coast

Eating Disorders Access Trial and is currently being evaluated by the federally funded National Eating Disorders Collaboration 'Right Care Right Place: Eating disorder care in my community' project.

14. We note that although case coordination items have been available since July 2023, these do not provide for attendance by a mental health professional and dietitian without attendance by a medical practitioner and the conference having been organised by a medical practitioner. Relevant MBS items should be expanded in scope to allow for allied health (dietitians and mental health) clinicians to organise the case conference with attendance by the organising clinician and a GP (and attendance by other multidisciplinary team members where appropriate); these arrangements will maximise the ability of these meetings to retain the person with an eating disorder in therapy and improve effectiveness of therapy.

Addressing financial and geographic barriers in order to increase treatment access

15. Financial burden is indicated as a barrier as lower income predicts a lower likelihood of pursuing treatment once an Eating Disorder Plan is issued. In line with recommendations from the Grattan Institute report on reducing out-of-pocket healthcare payments, state and territory governments should expand outpatient services to reduce wait times and the Australian Government should fund bulk-billed healthcare services in private clinics. This should be especially focused on parts of Australia with lower socioeconomic status.

16. In addition, levers to encourage weekly therapy sessions should be considered, given clear evidence in mental health research that slower frequency substantially slows the recovery process such that more sessions are ultimately required [41]. Weekly sessions would ultimately reduce consumer and government costs per person treated and could free up more treatment sessions to reduce wait-times and the associated risk of treatment drop-out.

17. Promote telehealth as a viable option for treatment, as this may also help with workforce capacity issues in rural and regional areas, and reduce indirect out-of-pocket costs, such as transport and travel time. Telehealth also offers greater flexibility due to extended hours of availability across time zones, which may in turn be less disruptive to other commitments. Promotion could be achieved by the care coordinators suggesting telehealth where indicated (see recommendation # 23) and PHNs providing up to date referral pathways to GPs as per recommendation #12

Treatment

Timely intervention after initiation of the treatment plan

18. In circumstances where a wait time of more than four weeks is anticipated, with an attendant risk of symptom exacerbation, risk of drop-out from treatment, and reduced motivation for treatment, it is recommended that as soon as practicable after the mental health professional has accepted the referral, they provide a 90-minute eating disorders single session intervention as described below* [45].

In this circumstance, the GP should be clearly informed by the mental health professional that the treatment-seeking person is not yet in treatment and that the GP is required to monitor the person with the eating disorder.

This session does not count towards the 40 psychological treatment sessions available within a 12-month period.

When treatment with the mental health professional starts after the waiting period, assessment (as per recommendation #8) should be reconducted to ensure that diagnosis and goals are current and up-to-date information for inclusion in the Eating Disorder Plan is provided to the GP.

19. Introduce a 90-minute single-session intervention (assessment and psychoeducation) service. This could be achieved through introduction of a new Eating Disorders MBS item.
    a. To incentivise uptake by providers of this single-session intervention, a higher rebate is recommended for this service (i.e., greater than application of a simple multiplier reflecting the longer duration of session from a standard 40 or 50 minute psychological treatment session) as it requires significant reorganisation of wait list management processes and change to usual assessment procedures

20. Offer training on the single-session intervention either through existing or newly established organisations.

21. Make an online assessment protocol and evidence-based SSI materials available through the websites of suitable organisations such as NEDC, InsideOut Institute, ANZAED, and the Centre for Clinical Interventions.

22. Develop a best approach protocol for dietitians to use while people are on the waitlist for psychological intervention as well as a best approach protocol by dietitians while people are on the waitlist for dietetic services. To ensure this work is completed in a timely fashion, a competitive funded call would be beneficial.

23. Systematic evaluation should build on emerging evidence gained during COVID-19 restrictions which suggest that telehealth is suitable for the treatment of eating disorders [47]. This further evaluation needs to determine the most appropriate mix of telehealth and face-to-face service delivery in order to ensure safety and efficacy. Such evaluations should also establish whether telehealth is more suitable at specific stages of treatment, and for specific eating disorder diagnoses. Until that time, medical monitoring should be conducted in person on a regular basis as determined by the multidisciplinary treating team, e.g., at appropriate timepoints such as review sessions.

*A single session intervention can be conducted by a mental health professional with a person experiencing an eating disorder and with people who care for them present if appropriate. This session takes a hope-inducing stance and comprises a collaborative and individualised assessment, provision of a diagnosis, psychoeducation about physical and psychosocial consequences of an eating disorder, understanding of the factors maintaining the disorder, and psychoeducational resources about immediate strategies to try. This program was successfully offered in 2022 by the Butterfly 'In the Wings' program.

Eligible practitioners and workforce capacity

24. Offer a higher rate of rebate for Eating Disorders MBS items to Credentialed Eating Disorder Clinicians than the rate of rebate available to non-credentialed health professionals for provision of psychological treatment and dietetic health services. This higher rebate might also include communication of phasing out, over time (e.g., over a 5 year period) of eligibility of non-credentialed healthcare providers to provide services under these MBS items. This incentive structure, coupled with signal of eventual requirement of all healthcare providers being suitably credentialed, would help to expand the current pool of Credentialed Eating Disorder Clinicians and thereby facilitate capacity building of an effective workforce across all disciplines. It offers a *sustainable* approach to increase workforce capacity while not causing accessibility issues.

25. The Australian Government should continue funding support of supervision of Credentialed Eating Disorder Clinicians.

26. Enact a competitive funded call to develop and test treatment guidelines for dietitians supporting people experiencing an eating disorder.

Treatment session delivery and approved evidence-based psychological therapies

27. Retain access to up to 40 psychological sessions and 20 dietetic sessions with further refinements to enhance clinical effectiveness and reduce likelihood of under-dosing (see recommendations #10; 28-30; 37-41).

28. Psychological treatment sessions should be delivered at a frequency of one session per week, where possible, to optimise outcomes.

29. Explore strategies to increase the frequency of sessions, such as:

    a. updating the NEDC Training Framework so that approved training modules include information on the importance of weekly sessions (compared with lower frequency delivery) to produce change and the need to document sessional progress.

    b. communicating the importance of session frequency for treatment outcomes across multiple forums, e.g., ANZAED webinars, NEDC newsletters, InsideOut web resources.

As per recommendation #24, increasing workforce capacity will provide greater availability for more regular session delivery.

30. Data should be collected at each session on any changes to eating behaviours and body image to optimise outcomes and enhance the benefit of review sessions and feedback about sessional progress should be provided to the person receiving treatment. The process should include:

    a. using the short ED15 questionnaire [64]

    b. providing data on progress from responses to the ED15 questionnaire to the GP or specialist ahead of review sessions (see recommendations #38-41)

    c. making an excel spreadsheet available on multiple platforms, such as NEDC, ANZAED, and InsideOut websites (a schematic of an Excel spreadsheet document that can be used to score and graph results is shown in Appendix 9).

31. Recommended ‘first line’ treatments should only be included if they:

    a. are recommended by treatment guidelines and/or meta-analytic evidence as a potential stand-alone therapy* *and*

    b. a comprehensive treatment manual or workbook is available to support implementation and dissemination and training.

*Note: In line with appropriate use of individualised treatment, first line treatments could be augmented when progress towards identified goals is not satisfactory (see Section 7.5). This refers to use of a specific intervention or technique as a supplement to the first line treatment to improve effectiveness.

32. Make changes, based on the accumulated evidence, to the acceptable treatments approved for use by practitioners with the Eating Disorders MBS items as follows:

    a. Family based treatment for eating disorders (including whole family, parent-based therapy, parent only or separated therapy): no changes to initial listing.

    b. Adolescent focused therapy (AFT) - specified for anorexia nervosa: previously listed as Adolescent Focused Therapy for eating disorders.

    c. Cognitive behavioural therapy-enhanced (CBT-E) [65]; previously listed as CBT-anorexia nervosa; CBT for bulimia nervosa and binge-eating disorder.

    d. Specialist Supportive Clinical Management (SSCM) [66] – specified for anorexia nervosa; previously listed as Specialist Supportive Clinical Management for eating disorders.

    e. Maudsley Model of Anorexia Treatment in Adults (MANTRA); no changes to initial listing.

    f. Interpersonal Therapy (IPT) – specified for bulimia nervosa; binge eating disorder; no changes to initial listing.

    g. Focal psychodynamic therapy – specified for anorexia nervosa only; previously listed as focal psychodynamic therapy for eating disorders which is not indicated [67].

Note. Dialectical behavioural therapy (DBT) for bulimia nervosa and for binge eating disorder was previously listed as an acceptable treatment. Based on available evidence and existing clinical guidelines, we recommend it currently only be used to augment the first line therapies for emotion regulation difficulties and not as a standalone treatment for eating disorders.

33. Regular review and updating of the approved acceptable treatments under the Eating Disorders MBS items to be scheduled within existing mechanisms (MBS Review Advisory Committee and Medical Services Advisory Committee). Reviews are required to respond to emerging evidence of efficacy (following National Health and Medical Research Council [NHMRC] Level 1 evidence standards). This will enable expansion of the approved treatments as the evidence base changes, and consideration of inclusion of other eating disorders e.g., avoidant restrictive food intake disorder (ARFID), when sufficient evidence for the effectiveness and safety of treatments are available - at present only 2 published evaluation studies exist but a further 7 studies are listed in ClinicalTrials.gov, which may make new recommendations possible in around 3 years.
    a. The Department of Health and Aged Care to promote at regular intervals (e.g., annually) to the eating disorder sector the processes required to request a review via the MBS Review Advisory Committee and Medical Services Advisory Committee. This will facilitate submission of the most up to date evidence for emerging treatments for consideration for inclusion in the Eating Disorders MBS items initiative.

Involvement of Carers of People Living with an Eating Disorder

34. Make directed, carer-related, eating disorder-specific psychological services available for people caring for someone receiving eating disorder treatment under an Eating Disorder Plan to support them in their carer roles. This support, explicitly linked to the Eating Disorder Plan of the person receiving eating disorder treatment, could be made available through existing services (Better Access, Medicare Mental Health Centres, etc.). This is intended to support people with lived experience of caring for someone with an eating disorder to:
    a. engage in separated family-based therapy
    b. develop appropriate management skills for the eating disorder, as well as self-care skill
    c. participate in family coaching where this might improve progress for the person receiving treatment for an eating disorder.

Note. It is critical that this carer support be connected to an Eating Disorder Plan of the person living with an eating disorder to reinforce the importance of carer involvement in eating disorder treatment, and to facilitate ongoing evaluation of the full scope of treatment received under Eating Disorders MBS items (also see recommendation #43).

35. Develop strategies to raise awareness for people with lived experience of caring for someone with an eating disorder about the importance of looking after themselves as a carer and pathways to receive this support. Strategies could include:

   a. adding a section in the GP Eating Disorder Plan to indicate the importance of accessing support and detail where this support can be accessed, e.g., eating disorder support organisations, carer support organisations, Mental Health Treatment Plan
   b. promoting sources of support for people with lived experience of caring for someone with an eating disorder provided by carer support organisations.

36. Implement actions that will assist people with a lived experience of supporting a person with an eating disorder be more involved in their treatment, in line with requirements for integrated care, including:
    a. the need for people with lived experience of caring for someone with an eating disorder to be included in treatment to be more prominent in the Medicare Benefits Schedule Online explanatory notes
    b. introductory training having an additional module on integrating people with lived experience of caring for someone with an eating disorder in treatment/intervention.

Reviews

37. Clarify the purpose and therapeutic value of reviews to shift perceptions of reviews as punitive or performing a purely gatekeeping function.
    a. Reinforce the original intent of review sessions through the reframing as a means to support people experiencing an eating disorder by providing an opportunity to assess progress from both their own and their health professional team's perspectives and, where necessary, modify the therapeutic/intervention approach to ensure best outcomes.
    b. Ensure consistent use of the reframed messaging about purpose of reviews across all public-facing materials about the Eating Disorders MBS items, including MBS explanatory notes, and in initial assessment, treatment, and review sessions by healthcare providers when explaining the review process.

38. With this framing and purpose in mind, implementing reviews should focus on evaluating symptom change and personal recovery and the need for augmenting or changing direction in treatment. Consequently, the first 10-session review is more critical than later reviews because early change is critical for treatment outcomes. To this end, the review process for the 10-session review should be revised so:
    a. in the case of satisfactory progress towards initial goals as indicated by the treating clinician, the 10-session review is conducted by the GP, with input from the treating mental health clinician and where relevant, dietitian; alternatively,
    b. in the case of slow/no progress towards initial goals as indicated by the treating clinician, a case conference is conducted at the 10-session mark, organised by the GP, or treating clinician as per recommendation #14, with members of the multidisciplinary team present to agree on a clear strategy for the forthcoming treatment sessions to enhance likelihood of positive outcomes.

39. Conduct the 20-session review as follows:
    a. in the case of satisfactory progress towards goals as indicated by the treating clinician, the 20-session review is conducted by the GP, with input from the treating mental health clinician and where relevant, dietitian; alternatively,
    b. in the case of slow/no progress toward goals at the 20-session mark, as indicated by the treating clinician, specialist advice/review is sought in a case conference organised by the GP, with members of the multidisciplinary team and the specialist present to agree on a clear strategy for the following treatment sessions to enhance likelihood of positive outcomes
    c. the specialist should be a practitioner experienced in working with eating disorders rather than a particular profession.

    An outline of the steps and provisions are required for putting this specialist process in place is as follows: 1) determination of the criteria and thresholds required to indicate a sufficient degree of experience in working with eating disorders to denote specialist status, 2) infrastructure and processes to objectively review and determine which health professionals meet criteria, 3) identification of the specialist within the MBS/Services Australia system, and 4) publicly available information to identify specialists to allow multidisciplinary teams to seek their involvement in review sessions.

    The details of this process, particularly deciding on criteria for eligibility to provide the specialist review, should be established in greater detail through sector consultation.

40. Conduct the 30-session review as per recommendation #38 for 10-session reviews

Note. Appendix 10 shows a schematic of the treatment and review process under the Eating Disorder Plan demonstrating inclusions of recommendations #9, #18, and 38-40

41. Inform all reviews with data from a short sessional measure of treatment response and progress (as per recommendation #30), including measuring body mass index (for people with anorexia nervosa only).

Note. Appendix 6 provides a review report template for the treating clinician to share with the GP and members of the multidisciplinary team prior to review sessions

42. Modify the InsideOut Institute review template (https://insideoutinstitute.org.au/resource-library/gp-care-plan-review-template) to facilitate appropriate documentation of progress and outcomes of all reviews, to include recording:
    a. the current psychological treatment and dietetic services intervention approaches used in sessions and comments on progress from the treating clinician
    b. quantitative data on change in eating disorder behaviours, rather than just the absolute level of behaviours
    c. identified reasons for satisfactory or unsatisfactory progress toward goals

   d. actions from the treating team, including recommendations for augmentation or changes in therapy that should proceed directly from the identified reasons for progress that have been shared with the person experiencing an eating disorder.

Note. We have also provided an updated review template for the GP to facilitate this proposed change in approach (Appendix 7).

Integration with Complementary Services, Mechanisms, and Partnerships

43. Enhance data collection and linkage through PLIDA to enable formal evaluation of the full scope of MBS eating disorder treatment, including:
    a. linking MBS item numbers for eating disorder treatments (whether Better Access, chronic disease management or Eating Disorders MBS items) to eating disorder diagnosis and symptom severity data
    b. identifying treatment approaches received
    c. charting treatment progress, as per recommendation #30.
44. Evaluate which MBS services (including and beyond Eating Disorders MBS items) are associated with positive outcomes for different eating disorder presentations including level of complexity and severity of eating disorder symptoms; such information could inform appropriate treatment matching as per the stepped care model.
45. Promote awareness of evidence-informed treatment options aligned with lower intensity treatment needs in the stepped care model for eating disorder treatment, by:
    a. developing a brief summary document outlining treatment options for eating disorders across varying levels of risk for those who do not meet the criteria for Eating Disorders MBS items to raise awareness of these options
    b. prioritising CBT-T and guided self-help as treatment approaches that are i) aligned with lower intensity needs, ii) have a strong evidence-base, and iii) have available manuals and workbooks and extensive website support (though mechanisms are needed to update recommendations based on emerging evidence (as per recommendation #33))
46. Provide training and support in delivery of CBT-T and guided self-help, including through:
    a. promoting and making existing materials and web resources readily available through PHNs, with particular targeted focus on promotion to GPs of guided self-help to enhance uptake
    b. providing training to mental health professionals in delivering CBT-T to enhance uptake.