



Medicare Benefits Schedule Review Taskforce

Report from the Eating Disorders Working Group

2018



Important note

The views and recommendations in this report have been endorsed by the MBS Review Taskforce following consultation with stakeholders.

This report has now been forwarded to the Government for consideration.

The Taskforce welcomes ongoing feedback on this or any MBS Review report via:

mbsreviews@health.gov.au



Table of contents

| | |
|--|-----------|
| 1. Executive summary | 6 |
| 1.1 Key recommendations | 9 |
| 1.2 Consumer impact | 12 |
| 2. About the Medicare Benefits Schedule (MBS) Review | 14 |
| 2.1 Medicare and the MBS..... | 14 |
| 2.1.1 What is Medicare? | 14 |
| 2.1.2 What is the MBS?..... | 14 |
| 2.2 What is the MBS Review Taskforce?..... | 14 |
| 2.2.1 What are the goals of the Taskforce?..... | 14 |
| 3. About the Eating Disorders Working Group..... | 16 |
| 3.1 Eating Disorders Working Group members | 16 |
| 3.2 Conflicts of interest..... | 18 |
| 3.3 Areas of responsibility of the Eating Disorders Working Group | 18 |
| 3.4 Summary of the Working Group’s review approach | 20 |
| 4. Eating Disorders in Australia | 22 |
| 5. Recommendations | 25 |
| 5.1 Finding 1: Current Medicare-funded services and the MBS infrastructure do not support the clinical guidelines of best practice care, as delivered by an experienced practitioner | 29 |
| 5.1.1 Background | 29 |
| 5.1.2 Supporting general practitioners as the main primary healthcare provider | 30 |
| 5.1.3 Access to the evidence-care for people with eating disorders through the MBS..... | 30 |
| 5.1.4 Encouraging a comprehensive stepped model of care for the treatment for patients with eating disorders | 32 |
| 5.1.5 Comprehensive stepped care is patient centric care | 33 |
| 5.1.6 Psychological therapy as part of a comprehensive stepped model of care . | 34 |
| 5.1.7 Nutritional intervention as part of a comprehensive stepped model of care | 36 |
| 5.1.8 Access to services to support patients through relapse..... | 37 |
| 5.1.9 Action required to align the MBS arrangements with evidence based care | 37 |
| Recommendation 1.1..... | 39 |
| Recommendation 1.2..... | 39 |
| Recommendation 1.3..... | 42 |
| Recommendation 1.4..... | 42 |



| | |
|---|-----------|
| 5.2 Finding 2: There is a lack of service integration between primary, secondary and tertiary health care in developing care plans and effectively communicating with patients and their families | 43 |
| 5.1.10 Background | 43 |
| 5.1.11 Delivery through a multidisciplinary team | 43 |
| 5.1.12 MDT's delivering stepped care and MDT care plans | 44 |
| 5.1.13 Case conferencing..... | 45 |
| Recommendation 2.1..... | 46 |
| 5.2.6 Family integration..... | 46 |
| Recommendation 2.2..... | 48 |
| 5.2.7 Further support for families and carers..... | 48 |
| 5.2.8 Other changes to strengthen the MBS arrangements for the treatment and management of patients with eating disorders | 49 |
| Recommendation 2.3..... | 49 |
| 5.3 Finding 3: Limited access to clinicians who are experts in eating disorders is an impediment to supporting timely diagnosis, intervention and the treatment of eating disorders | 50 |
| 5.3.1 Background | 50 |
| 5.3.2 Supporting the timely identification and intervention of eating disorders.. | 51 |
| 5.3.3 Enabling a skilled workforce to identify eating disorders..... | 51 |
| Recommendation 3.1..... | 52 |
| 5.3.4 Training to support clinicians in the treatment of eating disorders..... | 52 |
| Recommendation 3.2..... | 54 |
| 5.3.7 The need for credentialing of appropriately trained clinicians | 54 |
| Recommendation 3.3..... | 55 |
| 5.3.8 Utilising the PHN Network to deliver educational programs | 55 |
| Recommendation 3.4..... | 55 |
| Glossary..... | 57 |
| References..... | 60 |
| Appendix A: Further information on the Taskforce's approach to the MBS Review | 64 |
| Appendix B: MBS items that relate to the treatment of patients with eating disorders | 67 |
| Appendix C: Appropriately trained health practitioners able to provide eating disorders specific treatment | 69 |
| Appendix D: Referrals to other Clinical Committees | 70 |
| Memorandum to the Allied Health Reference Group..... | 70 |
| Memorandum to the General Practice and Primary Care Clinical Committee..... | 73 |
| Memorandum to the Mental Health Reference Group | 75 |
| Memorandum to the Principles and Rules Committee..... | 78 |



Appendix E: Summary for consumers 80

List of tables

Table 1: Eating Disorders Working Group members..... 16



1. Executive summary

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is undertaking a program of work that considers how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice to improve health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health (the Minister) that will allow the MBS to deliver on each of these four key goals:

- Affordable and universal access
- Best practice health services
- Value for the individual patient
- Value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by clinical committees and working groups.

The Eating Disorders Working Group (the Working Group) was established in late 2017 in response to a request from the Minister for Health for the Taskforce to investigate Medicare funding for the treatment needs of Australians with eating disorders. The Working Group was asked to:

- Assess whether the current MBS approaches adequately assist with the treatment needs of people with eating disorders;
- Consider whether new approaches to these illnesses would be appropriate; and
- Advise on how MBS funded treatment options can be better aligned with national standards for the safe and integrated treatment of people with eating disorders and meeting best practice standards.

The Working Group reviewed all aspects of treatment, including the physical, psychological, behavioural, nutritional, occupational and social needs of the patient. The Working Group determined that the recommendations should be guided by the following five core principles:

- The need to fund effective services that are informed by evidence from research, consensus expert opinion and the experience of the Working Group;
- Services should be delivered by a skilled health workforce with the requisite knowledge and experience to identify, assess and contribute to the treatment of eating disorders;
- Services should be accessible when and where they are needed, and should also support the prevention, identification, timely intervention as well as treatment of eating disorders;



- There is a need to support collaborative systems that enable integrated team care between medical, nursing, allied health and mental health professionals, and integration across primary, secondary and tertiary treatment; and
- There is a need to support families and carers as they are integral members of the treatment team.

These principles were based upon an evidence review conducted by the Working Group, their clinical expertise and lived experience. In addressing the five principles the Working Group believe the recommendations and rationale in this report effectively address the concerns of the Minister, whilst also putting forward a comprehensive, coordinated approach for the treatment of Australians with eating disorders, delivered through the MBS.

The Working Group acknowledges that the current MBS items and infrastructure adequately meet the treatment needs of most patients with subclinical presentations of disordered eating and some patients whose condition was detected in the initial stages of the disorder. For these patients, the Better Access initiative provides a good foundation for treatment.

The Working Group were of the opinion that the needs of all patients with eating disorders would be better served through the MBS by facilitating greater access to psychological and dietetic services. The evidence supports an expansion of the MBS arrangements to provide for a comprehensive stepped model of care. A comprehensive stepped model would provide care tailored to the patients' needs different levels of intensity, starting at 10 psychological services and 5 dietetic services which would incrementally 'step up' to maximum of 40 psychological services and 20 dietetic services if required. The Working Group acknowledges that this is a very significant reform to the MBS arrangements, which may not be able to be implemented at this time.

It is recognised there is a need to take a pragmatic approach to such an expansion of the MBS arrangements and a phased approach may be appropriate. As such, the Working Group recommends that a comprehensive stepped model of care be trialled within the MBS for those patients for whom the service deficit under the current MBS arrangements is the greatest – that is those patients with anorexia nervosa and those patients with bulimia nervosa, binge-eating disorder and other specified feeding and eating disorders who have not responded to treatment at a lower level of intensity, who have complex needs and are assessed as 'high-risk' of serious medical and psychological complications. This cohort has been identified as a group considered as most at-risk due to the likelihood of repeat hospitalisation, disease chronicity and potential mortality. This would allow the delivery of evidence based care for these patients and provide a platform to demonstrate that such a model of care can operate within the MBS.



The Working Group also concluded that there are other non-MBS related changes that need to be made to improve the timely identification of eating disorders and support the delivery of high quality care. These include the provision of further information and education for GPs, dissemination of evidenced based information and clinical pathways for eating disorders, the establishment of a credentialing system specific to practitioners providing care in the field of eating disorders and encouraging the development and/or expansion of eating disorder specific training by professional organisations and relevant training bodies.

It is acknowledged that addressing the burden of eating disorders on individuals, families and carers of patients with eating disorders and on the health system will require a comprehensive multifaceted approach and that the MBS may not provide all the solutions, but the MBS is part of the solution.



1.1 Key recommendations

Recommendation 1.1: The Working Group is of the view that there is an evidence base that supports stepped care, including comprehensive care for appropriate patients, for *all patients with eating disorders*.

Under a comprehensive stepped model, the evidence shows that all patients with a diagnosed eating disorder should get access to up to 20 psychological sessions in total per year and 10 dietetic sessions in total per year, depending on their needs. Under this model, patients requiring more intensive treatment would be eligible to receive up to 40 psychological sessions in total and 20 dietetic sessions in total per year, depending on their needs.

The Working Group views that the expansion of MBS arrangements for all patients with eating disorders is necessary and should be implemented as soon as practical after the implementation of the new items outlined in recommendation 1.2.

Recommendation 1.2: The Working Group recommends the introduction of a new suite of items to provide a comprehensive stepped model of care for:

- all patients with anorexia nervosa; and
- patients with bulimia nervosa, binge-eating disorder and other specified feeding or eating disorders who have complex needs, have not responded to treatment at a lower level of intensity and are assessed as ‘high-risk’ of serious medical and psychological complications.

The new items would provide for:

- the development and review of a treatment and management plan by a medical practitioner (such as a GP).
- This item would trigger eligibility for a comprehensive model of care, consisting of an initial and more intensive course of psychological and dietetic treatment depending of the patient’s needs.

Initial course of treatment

- Triggered by the development of a treatment and management plan by a medical practitioner (GP):
 - an initial course of up to 20 psychological sessions; and
 - an initial course of up to 10 dietetic sessions.



- The GP will assess the patient throughout the treatment process, but should assess whether the patient should progress beyond 10 psychological sessions and 5 dietetic sessions by conducting a review consultation (with a New Item Number) before or around 9 or 10 sessions completion mark, to approve and trigger another course of 10 psychological sessions and 5 dietetic services (up to 20 psychological sessions and up to 10 dietetic sessions). This review item will involve a full medical and psychological history, a full physical examination and ordering and reviewing relevant investigations.
- The mental health professional involved in the patients treatment will be required to formally report back to the practitioner before or around the 9 to 10 services completion mark to certify the patient's diagnosis and confirm that the patient requires a further course (an additional 10 psychological sessions) of treatment.

More intensive treatment

If the patient has not responded to treatment at a lower intensity, upon formal review and assessment of the patient by a psychiatrist or paediatrician, the patient would be eligible for:

- an additional course of up to 20 psychological sessions (40 sessions in total per year) ; and
- an additional course of up to 10 dietetic sessions (20 sessions in total per year).

GP reviews

It is expected that as the central care provider, the GP will review the patient throughout the treatment process, performing the necessary medical assessments, including ordering and reviewing the required tests, and assessing the patient's response to treatment.

Reports back to the GP from the mental health professional and dietitian

It will be a requirement that the mental health professional and dietitian delivering care to the patient provide written reports back to the managing GP after each set of services (that is, after each set of 10 psychological services and 5 dietetic services).

Recommendation 1.3: The Working Group recommends that the impact and operation of the new items should be reviewed as soon as practical (within three years) after introduction of the new items. The Review should assess whether the items are operating as intended for all parties (the Government, practitioners and patients) and should assess the viability of expanding the MBS arrangements to provide for a comprehensive stepped care models to all patients with a diagnosed eating disorder.



Recommendation 1.4: The Working Group recommends the services referred to in recommendation 1.2 be allowed to be provided via telehealth (under the same eligibility requirements that exist for other MBS services) in order to increase access to services for patients in rural and remote areas.

Recommendation 2.1: The Working Group requests that the Allied Health Reference Group investigate and consider expanding access to provide multidisciplinary team (MDT) case conference MBS items 735, 739, 743 and to item 729 (contribution to a MDT care plan prepared by another practitioner) to allied health professionals who are trained in the treatment of eating disorders.¹ This would enable these practitioners to be remunerated for their involvement in MDT care plan development and case conferences.

Recommendation 2.2: Allow appropriately trained practitioners to provide family-based therapy (FBT) under the items for focussed psychological strategy services and any new psychological services provided under the new MBS items (to which recommendation 1.2 refers). FBT should be delivered in line with the evidence base in this area. FBT services will count towards the patient's allocation of psychological services provided through the new MBS items.

Recommendation 2.3: The Working Group identified a number of other changes that could be made to MBS items to support the delivery of care for patients with eating disorders. The Working Group requests that the Clinical Committees responsible for these items consider the identified issues in the course of the Committees' work. Appendix D: Referral to other Clinical Committees provides the full referrals made to these Committees.

Recommendation 3.1: Further support and education should be provided to GPs about locally available specialist services for patients with eating disorders, and their families.

Recommendation 3.2: Professional associations and other relevant training organisations should develop and/or extend specific training, education and clinical guidance for working with people who have eating disorders. This training should be included in undergraduate and post graduate university health programs, continuing

¹ The term allied health professional is used refers to dietitians and accredited mental health professionals including GPs who have completed accredited mental health training, psychologists, mental health nurses, social workers, occupational therapists, counsellors and psychotherapists. Appendix C: Appropriately trained health practitioners able to provide eating disorders specific treatment provides a comprehensive list of the allied health and mental health professionals to which the Working Group believes should provide services to patients referred for treatment under the new MBS items.



professional development programs for disciplines involved in the diagnosis, treatment and management of patients with eating disorders, and in particular, any health professionals providing services under the new MBS items.

Recommendation 3.3: A credentialing process should be established, specific to practitioners who diagnose and provide specialist treatment to patients with eating disorders. Once established, these credentials should be used to determine practitioner eligibility to provide eating disorder services under the new MBS items that are recommended within this report.

Recommendation 3.4: The Department of Health to write to the 31 Primary Health Networks (PHNs) on behalf of the Working Group to increase awareness about evidence-based clinical pathways for the treatment of people with eating disorders, and to provide an example clinical pathway which could be adapted and implemented for use in their local area.

1.2 Consumer impact

The new MBS items recommended by the Working Group will enable patients with anorexia nervosa and patients with other eating disorders who have complex care needs to access evidence-based care through the MBS. The new items will fund the development and review of a treatment and management plan for these patients who will then be eligible to access an increased number of psychological and dietetic services than currently available. This will align MBS funding with current best practice care and allow these patients to access a greater number of Medicare funded psychological and dietetic sessions at a subsidised cost. Evidence indicates that this higher level of treatment services is correlated with a reduced rate of repeat hospitalisation and improved health outcomes. Allowing the proposed new services to be provided via telehealth will increase patient access to services, particularly for patients in rural and remote areas where the number of practitioners with experience in providing treatment to patients with eating disorders is limited.

The promotion and dissemination of guidance and educational material on best-practice clinical care for patients with eating disorders will assist to upskill the health workforce and support the timely identification and treatment of patients with eating disorders. This will also improve practitioner confidence when providing care to this patient group. Evidence shows that intervening in the initial stages of the development of eating disorder provides the best chance of treatment success, leading to improvements in patient outcomes and efficiencies for the health system if patients are treated before deteriorating to a point where they require tertiary level care.



The establishment of training and educational materials, and with time, a credentialing process specific to eating disorders, will assist to ensure that there is a skilled workforce to provide care for patients with eating disorders. This will ensure that patients are provided with high quality care delivered by experienced practitioners and will assist in increasing the critical mass of practitioners who are able to correctly diagnose and meet the treatment needs of this patient group. It has been identified that availability of practitioners skilled diagnosing and in providing care to patients with eating disorders can impact on patient access to care.

The proposed changes to improve MBS funding for patients with eating disorders will have profound positive health and social impacts, as well as positive economic outcomes for patients, state governments and the Federal Government. Increased MBS funding will support improved health outcomes for patients and potentially reduce the frequency and duration of hospitalisations for these patients.



2. About the Medicare Benefits Schedule (MBS) Review

2.1 Medicare and the MBS

2.1.1 What is Medicare?

Medicare is Australia's universal health scheme that enables all Australian residents (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost.

Introduced in 1984, Medicare has three components:

- free public hospital services for public patients;
- subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS); and
- subsidised health professional services listed on the MBS.

2.1.2 What is the MBS?

The MBS is a listing of the health professional services subsidised by the Australian Government. There are more than 5,700 MBS items that provide benefits to patients for a comprehensive range of services, including consultations, diagnostic tests and operations.

2.2 What is the MBS Review Taskforce?

The government established the Taskforce as an advisory body to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also modernise the MBS by identifying any services that may be unnecessary, outdated or potentially unsafe. The Review is clinician-led, and there are no targets for savings attached to the Review.

2.2.1 What are the goals of the Taskforce?

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

- **Affordable and universal access**—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic, with some rural patients being particularly under-served.
- **Best practice health services**—one of the core objectives of the Review is to modernise the MBS, ensuring that individual items and their descriptors are



consistent with contemporary best practice and the evidence base when possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.

- **Value for the individual patient**—another core objective of the Review is to have an MBS that supports the delivery of services that are appropriate to the patient’s needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.
- **Value for the health system**—achieving the above elements of the vision will go a long way to achieving improved value for the overall health. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefits and are underused, particularly for patients who cannot readily or currently access those services.

Further information about the Taskforce’s approach to the MBS Review is detailed at Appendix A.



3. About the Eating Disorders Working Group

The Working Group was established in late 2017 to make recommendations to the Taskforce on the review of MBS items which relate to the treatment of patients with eating disorders based on rapid evidence review and clinical expertise.

3.1 *Eating Disorders Working Group members*

The Working Group consists of 14 members, whose names, positions/organisations and declared conflicts of interest are listed in Table 1.

Table 1: Eating Disorders Working Group members

| Name | Position/organisation | Declared conflict of interest |
|-------------------|---|--|
| Dr Lee Gruner | Chair; MBS Review Taskforce | None to declare |
| Dr Richard Newton | Psychiatrist; Medical Director, and Clinical Director for Body Imaging Eating Disorders Treatment and Recovery (BERRS), Butterfly Foundation Expert Advisory Group, Austin Medical Service, Melbourne; Clinical A/Prof of Psychiatry, University of Melbourne | None to declare |
| Prof Phillipa Hay | Psychiatrist; Chair of Mental Health, Western Sydney University, Director Eating Disorder Unit Wesley Hospital Ashfield, Consultant Psychiatrist Campbelltown Hospital SWSLDH, past-President of the Australian Academy for Eating Disorders; Past Member of the Scientific Committee of the International Academy for Eating Disorders | Deputy Chair, National Eating Disorders Collaboration; Expert Advisor, Butterfly Foundation, Advisor Shire Pharmaceuticals |
| Dr Sloane Madden | Psychiatrist; Coordinator and Director for Eating Disorder Service, Sydney Children's Hospital Network; past President of the Australian and NZ Academy of Eating Disorder | Expert Advisor, Butterfly Foundation |



| Name | Position/organisation | Declared conflict of interest |
|-------------------------|--|--|
| Prof Lyn Littlefield | Psychologist; Member of General Practice and Primary Care Clinical Committee | Executive Director, Australian Psychological Society |
| Dr Sarah Maguire | Psychologist; Director & NSW Statewide Eating Disorders Coordinator, InsideOut Institute for Eating Disorders | None to declare |
| Dr Catherine Andronis | General Practitioner; Private Practice, Access Health and Community, Victoria; medical psychotherapist, private practice | None to declare |
| Dr Leanne Barron | General Practitioner; General Practice, Queensland University of Technology Eating Disorder Clinic, Brisbane | None to declare |
| Ms Peta Marks | Credentialed Mental Health Nurse; Professional Development and National Project Manager, the Australian College of Mental Health Nurses | Professional Development and Project Manager, the Australian College of Mental Health Nurses |
| Dr Di Stow | Counsellor | None to declare |
| Ms Bronny Carroll | Consumer representative | Consumer consultant, InsideOut Institute for Eating Disorders |
| Ms Helen Maxwell-Wright | Consumer representative; Consumer Panel | None to declare |
| Mr Shane Jeffrey | Accredited Practising Dietitian Private Practice, Treasurer Australian and New Zealand Academy for Eating Disorders, Associate Lecturer School of Human Movement and Nutrition Sciences University of Queensland | None to declare |
| A/Prof Genevieve Pepin | Occupational Therapist; Associate Professor and discipline lead, Faculty of Health, Deakin University | None to declare |



3.2 Conflicts of interest

All members of the Taskforce, clinical committees and working groups are asked to declare any conflicts of interest at the start of their involvement and reminded to update their declarations periodically. A complete list of declared conflicts of interest can be viewed in Table 1 above.

It is noted that the majority of the committee members share a common conflict of interest in reviewing items that are a source of revenue for them (i.e. committee members claim the items under review). This conflict is inherent in a clinician-led process, and having been acknowledged by the committee and the Taskforce, it was agreed that this should not prevent a clinician from participating in the review.

3.3 Areas of responsibility of the Eating Disorders Working Group

The Working Group differs from other clinical committees established under the auspices of the MBS Review Taskforce in that the Working Group was not assigned responsibility over specific MBS items. The Working Group was tasked with assessing the overall existing MBS infrastructure and services as they relate to the treatment needs of patients with eating disorders. In making its recommendations, the Working Group considered 101 MBS items that are currently available to patients diagnosed with eating disorders. These items are presented in Appendix B.

There are no items that are exclusively used for the treatment of patients with eating disorders². It is therefore not possible to use Medicare data to isolate the number of services or the number of treatments used by patients with eating disorders.

Brief overview of items currently used for the treatment of patients with eating disorders

The *Better Access to Psychiatrists, Psychologists and GPs through the MBS Initiative* (Better Access Initiative) is available to patients with a diagnosed mental illness who would benefit from a planned approach to the management of their treatment needs. Patients are eligible for up to 10 allied mental health sessions and up to 10 group therapy sessions per calendar year.

Patients with an eating disorder need to visit their GP for diagnosis and for the preparation of a GP Mental Health Treatment Plan (or be directly referred by a

² Whilst there are no specific MBS items for the treatment and management of patients with eating disorders, MBS item 319 allows patients with AN and BN, among a number of other patient groups, to access up to 160 psychiatry services which are rebated at the higher rate.



psychiatrist from an eligible MBS service) in order to access Medicare mental health services under the Better Access Initiative.

From the 1st of November 2017, the expansion of the Better Access Initiative included new Medicare items- 80001, 80011, 80101, 80111, 80126, 80136, 80151 and 80161, to allow patients in rural and remote locations (Modified Monash Model areas 4-7) access to 7 of 10 consultations through video conferencing³.

Chronic Disease Management services

Patients assessed with chronic conditions or complex care needs that would benefit from a planned approach to the management of their treatment needs are eligible for up to five allied health sessions per calendar year. To be eligible for these services, the GP must prepare a GP management plan and team care arrangements plan.

The MBS defines a chronic disease medical condition as one that has been or is likely to be present for at least six months. A patient is considered to have complex care needs if they require ongoing care from a multidisciplinary team (MDT) consisting of their GP and at least two other health care providers.

Allied health professionals eligible to provide services under Medicare for patients with a chronic medical condition and complex care needs includes (but not limited to):

- Aboriginal and Torres Strait Islander health practitioners;
- Aboriginal health workers;
- Audiologists;
- Chiropractors;
- Diabetes educators;
- Exercise physiologists;
- Psychologists;
- Physiotherapists;
- Dietitians;
- Mental health nurses;
- Social workers;
- Occupational therapists;
- Osteopaths; and
- Speech pathologists.

³ Note that there are other eligibility requirements that need to be met in order to claim telehealth services through Medicare, including a minimum distance of 15km between the patient and the treating practitioner. For a full list of requirements refer to the MBS online website.



Consultant Psychiatrist services

A GP can refer those requiring more intensive treatment of their mental disorder to Medicare subsidised consultant psychiatrist services. Up to 50 sessions per year are rebated at the full rate (once 50 services have been provided the rebate level is reduced). Some patients with anorexia nervosa and bulimia nervosa are able to access up to 160 sessions per calendar year at the full rebate level. A psychiatrist may also prepare a psychiatric assessment and management plan. If indicated a psychiatrist can also directly refer the patient on to allied mental health services under the *Better Access Initiative*.

3.4 Summary of the Working Group's review approach

The Working Group completed a review across three working group meetings. During these meetings it developed the recommendations and rationales contained in this report, based on evidence and collective clinical experience.

The MBS items that relate to the treatment of patients with eating disorders are not exclusively for the use of patients with eating disorders. Accordingly, Medicare utilisation data was of limited use to the Working Group for the review.

The Review therefore drew on data, clinical treatment protocols and models of care presented in the relevant literature and clinical guidelines. This includes those developed by the Butterfly Foundation and the Royal Australian and New Zealand College of Psychiatrists. Guidelines and literature were sourced from medical journals and professional societies. The models of care compared to the existing MBS arrangements.

The Working Group also considered submissions from a range of relevant stakeholders, including the Australian College of Mental Health Nurses, Australian Psychological Society, Psychotherapy and Counselling Federation of Australia and the Butterfly Foundation. The submissions identified a range of issues including:

- The cap placed on the number of sessions available for mental health treatment and nutritional therapy;
- The limitations placed on who can deliver services under the current MBS mental health items;
- Restrictions placed on the type of sessions provided by mental health nurses and other allied and mental health professionals;
- The need to support integrated team care and MDTs; and



- The financial burden on patients and families and the impact on their treatment outcomes.



4. Eating Disorders in Australia

Eating disorders are a group of serious and complex bio-psychosocial disorders that range in severity from moderately-severe through to critical and life threatening. All diagnoses are associated with significant physical complications and nutritional issues⁴. If not treated appropriately and in a timely manner, eating disorders take a long course with long term, serious implications for the individual's health and for health care costs.

Eating disorders are complex mental illnesses differentiated through two subtypes; the self-induced restriction of food intake relative to energy requirements, and binge eating or the purging of food. These actions are characterised through a relatively similar psychopathology centralising around an intense fear of gaining weight or becoming fat, and a disturbance in the way one perceives their body weight or shape.

Anorexia nervosa (AN) involves the self-restriction of food intake, characterised by rapid weight loss and low body weight and is a chronic illness with an average duration of seven years.

Bulimia Nervosa (BN) is characterised by recurrent binge-eating episodes, which trigger frequent weight compensatory behaviours such as self-induced vomiting, fasting, overexercising and/or the misuse of laxatives, enemas or diuretics. The repeated cycle of bingeing and purging can become compulsive and uncontrollable over time.

Binge Eating Disorder (BED) is characterised by frequently eating excessive amounts of food considered to be much more than a standard person would consume under similar conditions. BED is not the same as overeating, as it is recurrent and more serious. A person with BED often suffers from feeling of intense guilt, shame and self-hatred and will often compensate for binging through fasts and repetitive diets.

Other specified feeding and eating disorders (OSFED) refer to disorders characterised by feeding or eating behaviours that cause clinically significant distress and impairment in areas of functioning, but do not meet the full criteria for any of the other feeding and eating disorders. For example, a person with atypical AN meets all other diagnostic criteria, except despite significant weight loss, the individual's weight is within or above the normal range.

⁴ Hay, P., Chinn, D., Forbes, D., Madden, S., Newton, R., Sugenor, L., Touyz, S. and Ward, W. (2014). Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Treatment of Eating Disorders, *Australian and New Zealand Journal of Psychiatry*, Vol 48(11) pp. 1 – 62.



Changing face of the illness

The number of people in Australia with an eating disorder is estimated to be 913,986 at any given time. Of these people, 47 per cent have BED, 12 per cent have BN, three per cent have AN and 38 per cent experience OSFED. The classic face of eating disorders has changed considerably since foundational research into the illnesses begun,⁵ no longer are eating disorders the ‘preserve of females, the wealthy or westerners’⁶ rather, they afflict a range of diverse population sub-groups including men, women, boys and girls. This is due to the pervasive nature of eating disorders and the wide range of socio-cultural, biological and psychological factors that contribute to the prevalence of the illness. Evidence suggests approximately 50 per cent to 74 per cent of patients will achieve full recovery over 5 to 10 years, while between 20 per cent - 30 per cent will experience an enduring illness and between 9 per cent - 14 per cent will die.⁷ With that said, the Working Group emphasise that eating disorders are treatable. There is significant evidence for effective intervention models and treatments, if provided in the initial stages of the illness.

The Australian Government’s response

There has been an increased awareness of eating disorders from various programs targeting both clinicians and consumers. As a result, consumers are better informed and have access to information and resources that provides guidance on treatment and referral options. This has been fuelled by increased funding through the Australian health system to improve services in the treatment of eating disorders. To date, the government has funded several initiatives including the Butterfly Foundation’s National Eating Disorders Hope helpline and funding for the National Eating Disorders Collaboration (NEDC) to help develop a nationally consistent approach to the prevention and management of eating disorders.

More recently, in June 2013, the Minister for Health announced that the Australian Government was investing \$3.2 million to fund a pilot project to improve the treatment and care of people with eating disorders. Through this project, the Butterfly Foundation will engage with local doctors on the Sunshine Coast, undertaking a six-month education and awareness program on eating disorders. The national pilot will support over 240

⁵Hay, P et al., op cit., p. 3

⁶ibid., p. 3

⁷ Fairweather – Schmidt, K., and Wade, T. D. (2014). DSM – 5 Eating Disorders and Other Specified Eating and Feeding Disorders: Is There a Meaningful Differentiation?, *International Journal of Eating Disorders*, Vol 47(5) pp.525 – 535.



patients, trialling new ways to support people with eating disorders, which will ultimately inform future support for patients around Australia.⁸ Under this trial, patients are able to access best practice support. This means patients, following diagnosis and referral by a GP, can access up to 40 sessions for psychological sessions which can be used for family based therapy (FBT), Cognitive Based Therapies (CBT) and allied mental health professional services. It is expected that this will support a reduction in hospitalisation, increase likelihood of recovery and reduce the risk of chronicity.

⁸ The Australian Government Department of Health (2018). *\$3.2 million to improve care for people with eating disorders [online]*. Available at: <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2018-hunt072.htm> [Accessed 10 Aug 2018]



5. Recommendations

The recommendations from the Working Group were guided by the philosophy that public funds should be directed towards:

- Effective services that are informed by evidence from research, consensus expert opinion and the experience of clinicians; that is, the requirement for the right type of treatment for the right duration;
- Delivery of services by a skilled health workforce with the requisite knowledge and experience to identify, assess and contribute to the treatment of eating disorders;
- Services that are accessible when and where they are needed;
- Services that include prevention, identification, timely intervention and treatment;
- Collaborative systems that enable integrated team care between medical, nursing, allied health and mental health professionals and integration across primary, secondary and tertiary programs; and
- Support and intervention with families and carers as they are integral members of the treatment team.

The Working Group discussed areas in which they could have the biggest impact. It was agreed that no single response could address all the issues in the area of eating disorders and that a comprehensive, multi-faceted staged approach is required, involving both MBS and non-MBS solutions.

Identified priority areas include:

- Poor service integration; the lack of integration between primary, community, secondary and tertiary health care; including developing care plans, and effective communication mechanisms between care providers, families and patients.
- Current Medicare-funded services do not deliver treatment in line with the evidence-based treatment as recommended by experts. Limitations under the MBS include:
 - Inadequate number of MBS funded sessions to deliver evidenced-based psychological therapy;
 - Funding of family support item numbers is limited or, in some cases, is non-existent – such as respite care, peer support, education and counselling;



- MBS items do not adequately cover the pre-treatment phase – improvements are required for the assessment phase and planning to ensure engagement and development of treatment, and not just referral pathways;
- Patients cannot access services provided by many appropriately trained and qualified mental health providers via the MBS;
- Patients cannot access an appropriate number of services provided by dietitians and other allied health and mental health professionals via MBS funded sessions;
- MBS-supported management plans are not comprehensive enough for this group;
- Missed opportunities for timely identification and intervention; and
- Large out-of-pocket costs associated with treatment, resulting in an inability of patients to access care, especially for those in disadvantaged groups or living in rural, regional and remote areas.

The Working Group highlighted their key priorities and action list below.

Table 2: Working Group Priorities:

| Priority: | Action completed? |
|--|--|
| <p>More closely align the MBS arrangements with evidence based care models</p> | <p>✓ Highlight that the evidence base demonstrates that all patients with eating disorders should have access to up to 20 psychological and 10 dietetic services if required.</p> <p>✓ Recommend, that as a first step, a suite of new items be introduced for all patients with AN and patients with other eating disorders who have complex needs and have not responded to treatment at a lower level of intensity and are at high risk of serious medical and psychological complications. These new items should provide patients with access to up to a total of 40 psychological services and up to a total of 20 dietetic services per year.</p> |



| Priority: | Action completed? |
|---|---|
| | <p>✓ Recommend that MBS arrangements be expanded as soon as practical after the introduction of the new MBS items outlined above.</p> |
| <p>Funding an increased number of dietitian services under the MBS</p> | <p>✓ Recommend access to a higher number of dietetic services for all patients with eating disorders, but expand access to dietetic care to patients with AN and patients with other eating disorders who have complex needs and have not responded to treatment at a lower level of intensity and are at high risk of serious medical and psychological complications as a first step.</p> |
| <p>Investigate providing specific reimbursement for services provided by allied health professionals to contribute to multidisciplinary care plans and case conferencing through the MBS. *</p> | <p>✓ The matter of reimbursement of allied health and mental health professionals for MBS case conferencing and contributing to MDT care plans referred to the Allied Health Reference Group.</p> |
| <p>Funding for family and carer support.</p> | <p>✓ Highlight that there is a need for increased support for families and carers of patients with eating disorders.</p> <p>✓ Specify that family and carers should be involved in multidisciplinary team (MDT) treatment discussions where appropriate.</p> |
| <p>Support upskilling and further training for all MDT members to address shortages of expert and experienced practitioners in diagnosing and treating patients with eating disorders.</p> | <p>✓ Make non-MBS item recommendations that support the dissemination of clinical guidelines around treatment of people with eating disorders to all clinicians, and support the development/and or extension of specific training by professional bodies and relevant training</p> |



| Priority: | Action completed? |
|----------------------------|---|
| | organisations, relating to eating disorders which could be used for credentialing. |
| Funding for family therapy | <p>✓ Recommended that Family Based Therapy is made an appropriate intervention to be provided under the existing items for focussed psychological strategies (FPS) and any services provided through the new MBS items recommended in this report.</p> <p>✓ Highlight that there is a need for increased interventions with families and carers of patients with eating disorders.</p> <p>✓ Highlight that it would be beneficial for the MBS to fund providing services to family members and carers where the patient is not present.</p> |

*Note that allied health and mental health professionals employed by state services would not be eligible to claim MBS items for involvement in case conferences when acting in their capacity as a state employee.

The Working Group recognised the problem areas in the treatment of people with eating disorders that are outside the scope of the MBS Review, but nonetheless were viewed by members to be important and in need of being addressed. These include the:

- Stigma around having an eating disorder;
- Lack of affordable private services;
- Inadequate access to acute care and specialised intensive programs;
- Inadequate support those patients who are for borderline-medically stable;
- Lack of services in rural and remote locations;
- Lack of knowledge and skills in eating disorders across the workforce; and
- Lack of specialist support and intervention services for families and carers.



5.1 Finding 1: Current Medicare-funded services and the MBS infrastructure do not support the clinical guidelines of best practice care, as delivered by an experienced practitioner

5.1.1 Background

Current paths to treatment under the MBS are reliant upon a GP's assessment and identification of the eating disorder. Identification by the GP enables the patient to access treatment (depending on their health requirements) through the Better Access Initiative or CDM MBS Items and psychiatry consultations. Current treatments options may include:

- A GP chronic disease management (CDM) and team care plan which allows for:
 - Medicare rebates for up to five allied health services under the CDM Plan arrangements;
- A GP mental health plan which allows for:
 - Medicare rebates for up to ten mental health services per year by:
 - Clinical psychologists providing psychological therapies; or
 - Appropriately trained GPs or allied mental health professionals⁹ providing focused psychological strategy sessions; and
 - Medicare rebates for up to ten group therapy sessions.
- Treatment and management by a paediatrician or psychiatrist;
- Ongoing medical monitoring by a GP; and
- Multi-disciplinary team care review and reassessment through MBS case conferencing arrangements.¹⁰

⁹ Including psychologists, social workers and occupational therapists.

¹⁰ National Eating Disorders Collaboration. (2012). *An Integrated Response to Complexity National Eating Disorders Framework*, accessed 30 August 2018, <https://www.nedc.com.au/research-and-resources/show/an-integrated-response-to-complexity-national-eating-disorders-framework>.



5.1.2 Supporting general practitioners as the main primary healthcare provider

The Working Group reaffirmed that GPs should continue to be the initiators of treatment and remain a focal point throughout the patient's journey to recovery. The most common first point of contact for diagnosis and treatment are GPs.¹¹ A comprehensive assessment of the individual and their circumstances should be taken to baseline the diagnosis, along with any comorbid psychiatric or medical diagnosis, to accurately evaluate medical and psychiatric risks.

As the main primary health carer and the initiating health assessor,¹² GPs should incorporate best practice medical assessments to frequently monitor any changes in the overall physical health of the patient during the treatment and recovery process. This includes, when assessing whether a patient's nutritional health has been adequately restored (including monitoring of weight), monitoring other indicators of normal physiological functioning including; blood glucose levels, absence of hypotension and bradycardia, normal blood cell counts, whether bone marrow suppression has been reversed, return of menstruation and normal cognitive functioning. This should be done through regular physical examination, serum biochemistry, including a full blood examination, electrocardiogram, as well as routine bone mineral density scans if underweight for longer than six months, and mental status assessment.¹³ It is crucial that the GP remain involved the treatment of patients with eating disorders throughout the treatment process. The Working Group were of the strong view that GPs should be involved at every step of treatment, to provide ongoing and frequent monitoring of the patients progress and medical condition.

5.1.3 Access to the evidence-care for people with eating disorders through the MBS

The Working Group notes that the *Better Access Initiative* provides adequate coverage for people who experience subclinical presentations of disordered eating. The Working Group also noted that GPs are often effective treatment providers for these patients. The service provision available through the *Better Access Initiative* is beneficial for those patients for whom self-guided help with the support of a practitioner is appropriate.

¹¹ *ibid.*, p.37.

¹²The Australian Government Department of Health (2018). *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative* [online] Available at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/AD7820EAC9F90D90CA25817900186FB2/\\$File/Fact per cent20sheet per cent20- per cent20BA per cent20for per cent20patients.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/AD7820EAC9F90D90CA25817900186FB2/$File/Fact%20sheet%20-%20per%20BA%20for%20patients.pdf) [Accessed 9 Aug 2018].

¹³ Hay, P et al., *op cit.*, pp. 9-10



However, the Working Group concluded that there is considerable scope for changes to be made to the MBS arrangements to support the delivery of evidence based care to all patients with a diagnosed eating disorder – to provide the right treatment to the patient, at the earliest opportunity in the development of the illness and for treatment to respond to changes in the patients’ needs over time.

Access to evidence-based care under the MBS would deliver significant benefits, both in terms of patient outcomes, hospitalisations and downstream benefits for the health system. If patients suffering from eating disorders can access services in the initial stages of the lifecycle of their illness, the potential for recovery increases considerably.¹⁴ Whilst there is still a reasonable chance that the patient will relapse (relapse rate of 41 per cent within the first month, the highest risk period being at four to nine months after treatment),¹⁵ timely intervention reduces the likelihood of repeat hospitalisation and increases the possibility for the remission of symptoms.¹⁶

Hospitalisation is more likely to occur if access to evidence-based care is delayed and as a result, the patient then presents with complex or high-risk symptoms. Patients that present with complex or high-risk symptoms are usually experiencing disease chronicity and are at risk of premature mortality, displaying significant medical instability and psychiatric comorbidities. It is most likely that these patients have also failed to respond to eating disorder treatments at a lower intensity.

Patients with complex presentations with are likely to enter the hospital system during the first and then in subsequent years of treatment. This is due to a range of factors including illness trajectory, the ongoing cost of interventions and the ability of the patient to access and continue rehabilitative care.¹⁷ There are currently 0.3 per cent of eating disorders patients in Australia repeatedly transitioning between the hospital and community setting. Providing access to evidence based treatment in the community setting before the person’s conditions reaches this level of chronicity will deliver better outcomes for the patient and reduce costs for the health system.

¹⁴ National Eating Disorders Collaboration., op-cit., p.32

¹⁵ Carter J.C., Mercer,-Lynn K. B., Norwood, S.J., Bewell-Weiss, C.V., Crosby, R.D., Woodside, D. B., and Olmstead, M.P. (2012). A Prospective Study of Predictors of Relapse in Anorexia Nervosa; Implications for Relapse Prevention, *Australasian Psychiatry*, Vol 15 pp.390 – 395.

¹⁶ Stienhausen, H. (2009). Outcome of eating disorders, *Child and Adolescent Psychiatric Clinics of North America*, Vol 18(1), pp. 225 – 242.

¹⁷ National Eating Disorders Collaboration., op-cit., p.26



For example, a hospitalisation episode for a person with AN is likely to be an ongoing expense to the system and is estimated to cost second only to that of a cardiac artery bypass surgery in the private hospital sector in Australia.¹⁸

The Working Group therefore believes that the provisions under the *Better Access Initiative* are inadequate when treating patients with eating disorders, especially with the aim of treating patients in the community. Rather, the Working Group believe there is room to enhance the availability of mental health and dietetic services for people who experience eating disorders, linking currently available MBS services to evidence-based care, in alignment with comprehensive stepped care models for eating disorders.

5.1.4 Encouraging a comprehensive stepped model of care for the treatment for patients with eating disorders

The Working Group believe that to improve the recovery rates for patients diagnosed with an eating disorder, in addition to reducing the fiscal burden of hospitalisation, the introduction of a best practice care model is needed. A stepped model of care is an evidence-based treatment approach whereby a team of primary care professionals address the medical, dietetic, psychological and behavioural aspects of an eating disorder, with treatment increasing or decreasing in intensity depending on the individual patient's responses and needs.¹⁹ The Working Group considers a comprehensive stepped model of care the ideal treatment strategy for patients with an eating disorder. Stepped care has been central to the Australian Government's mental health reform agenda. Since 2016 it has provided the basis for Primary Health Networks (PHN)²⁰ to plan and commission mental health services in their region.²¹ A person with an eating disorder receiving treatment within a comprehensive stepped model of care will therefore have access to a full spectrum of treatment, at a tailored level of intensity.

Tailoring the intensity of treatment is achieved through skilled assessment. Once a GP has triggered a referral, an individual care plan can be developed in line with the patient's needs. This is dictated as required by the patient and their family, dependent upon their psychological, physical, nutritional, and functional needs. Importantly,

¹⁸ National Eating Disorders Collaboration., op-cit. p. 15

¹⁹ National Eating Disorders Collaboration., op-cit., p.45

²⁰ PHNs are independent non-for-profit organisations funded by the government that work to reorient and reform the primary health care systems within a geographic region.

²¹ Department of Health. (2018). *PHN Background*. [online] Available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background> [Accessed 30 August 2018]



parallel treatments, such as psychological, dietetic and medical care can occur.²² The ability to provide parallel care is a key reason that the National Framework for Eating Disorders (2012) and the Australian Guidelines for Eating Disorders (2014) identify a stepped suite of treatment options as best practice when treating eating disorder patients in the community²³.

Under a comprehensive stepped model of care for eating disorders, a patient would usually start treatment at a lower intensity, and ‘step-up’ to a high level of treatment if they do not respond to treatment at the lower intensity. Starting at the lowest level of intensity may be suitable for some patients with BN and BED who are diagnosed in the initial stages of development of their disorder. However, the evidence demonstrates that it is most effective for patients with a diagnosis of AN to immediately progress to the high levels of treatment as the medical complications of not accessing evidence based treatment could be life threatening²⁴.

Effective comprehensive ‘stepped care’ is dependent on frequent and ongoing monitoring of the person’s response to treatment. Factors to be considered for moving between levels of treatment include, but are not limited to, changes in:

- Dietary intake, nutritional health and weight gain or reduction;
- Physiological functioning, medical complications and comorbidities;
- Frequency of eating disorder behaviours;
- Levels of psychological distress, ongoing disordered thoughts and body image disturbance;
- Response to previous treatment;
- Chronicity of the illness; and
- Level of family and community support available²⁵.

5.1.5 Comprehensive stepped care is patient centric care

The best practice care model is fundamentally person and family centric, strengths based and tailored to meet the individual’s decision-making capability. This is because there is no standardised treatment plan for people with eating disorders, particularly

²² National Eating Disorders Collaboration., op-cit., pp.45 - 51

²³ Ibid., pp 45 - 51

²⁴ Wilson, G.T., Fairburn, C.C. Agras, W.S., Walsh, B.T. & Kraemer, H. (2002). Cognitive-behavioural therapy for bulimia nervosa: time course and mechanism for change. *Journal of Consulting and Clinical Psychology* 70, 267-274

²⁵ National Eating Disorders Collaboration (2017). *A guide to a stepped care approach for eating disorders in community integrated approaches to care.*



those with more chronic forms.²⁶ The National Framework (2012)²⁷ describes the person centric approach as a holistic perspective, contextually congruent with the patient, their family and their environment.²⁸

This translates to addressing the individual needs of patients with eating disorders, regarding treatment and support. The Working Group consider that the current MBS item framework is inflexible to the patient's needs and, due to the restrictions on the number of sessions funded, is too brief to have a lasting impact on patients' recovery process. This renders the current framework for treating people with eating disorders, antithetical to the patient centric model.²⁹

The Working Group is of the view that the best way to support patient centric care through the MBS is through a comprehensive stepped model of care. The following section examines the best practice care options required to support patients with eating disorders.

5.1.6 Psychological therapy as part of a comprehensive stepped model of care

Under the *Better Access Initiative*, patients diagnosed with an eating disorder are currently entitled to a Mental Health Care Plan and up to 10 individual mental health sessions and up to 10 group therapy sessions. The Working Group identified this as intervention as beneficial for patients with subclinical presentations of disordered eating, but inadequate for the delivery of evidence-based care for patients with eating disorders. Brief psychological treatments are generally not sufficient to achieve recovery from an eating disorder, let alone patients with complex needs, such as those with AN³⁰.

Additional psychological sessions are practical considering that pharmacological solutions, such as selective serotonin reuptake inhibitors (SSRI) antidepressants, are not a stand-alone intervention capable of addressing the long term nature of the illnesses. Pharmacological solutions must be combined with ongoing psychological intervention. This approach enables the treatment team to address all aspects of the illness, reducing the risk of chronicity.

²⁶ National Eating Disorders Collaboration., op-cit., pp.28 - 32

²⁷ Ibid., p. 28

²⁸ Law, M., Baptiste, S., and Mill, J. (1995). Client-Centred Practice: What does it Mean and Does it Make a Difference?, *The Canadian Journal of Occupational Therapy*, Vol 62(5) pp. 250 - 257.

²⁹ National Eating Disorders Collaboration., op-cit., pp.28 - 32

³⁰ Richard, M., Bauer, S., Kordy, H. (2005). Relapse in Anorexia and Bulimia Nervosa – a 2.5 Year Follow Up Study, *European Eating Disorder Review*, 12(3) pp. 180-190



In a best practice clinical care setting, the Working Group believe that effective and long-term treatment for patients with an eating disorder requires an increase in the psychological sessions that patients are entitled to under the MBS. The minimum course of treatment for patients in the initial stage of development of AN is around 20 to 25 sessions. Evidence shows that for those patients with AN who have been chronically underweight to achieve improved health outcomes, access to 40 fifty-minute sessions over a 40-week period is required. The provision of 40 sessions has shown to reduce the risk of relapse, the risk of chronicity and the need for future treatment^{31,32}. The median duration for treatment is one to two years. One recent trial examining the impact of three types of psychotherapy on weight gain, readmission, depression, anxiety, stress and clinical impairment showed that all three interventions lead to improvements in weight, clinical symptoms and readmission rates. A key feature of these therapies was the weekly delivery of care³³. Similarly, another trial found that delivery of between 40 to 50 sessions of psychotherapy over a 12 month period lead to weight gain and a decrease in eating disorder psychopathology³⁴.

For BN and BED, there is evidence to support that for people in the initial stages of illness, treatment could start at the lower level of intensity (including self-guided help and psychoeducation), with ongoing referral for more intensive psychological treatment³⁵. The minimum course of treatment which is supported by evidence is 20 sessions of cognitive-behavioural therapy (CBT). However, for patients who have not responded to treatment at a lower intensity or with a more persistent illness, longer courses of treatment are indicated.³⁶

³¹ Fairburn C. G., Cooper, Z., Doll, H.A., O'Connor, M.E, Bohn, K, Hawker, D.M, Wales, J.A. and Palmer, R. L. (2009). Transdiagnostic Cognitive Behavioral Therapy for Patients With Eating Disorders: A Two Site Trial With 60 Week Follow- Up, *The American Journal of Psychiatry* 166(3) pp 311 - 319

³² Carter, J.C., McFarlane, T.L., Bewell, C., Olmsted, M.P., Woodside, D.B., Kaplan, A.S., & Crosby, R.D. (2009). *Maintenance Treatment for Anorexia Nervosa: A Comparison of Cognitive Behavior Therapy*. Canada: University Health Network.

³³ Byrne, S., Wade, T., Hay, P., et al. (2017). A randomised controlled trial of three psychological treatments for anorexia nervosa. *Psychological Medicine*, 47. 2823-2833. doi:10.1017/S0033291717001

³⁴ Zipfel, S., Wild, B., Groß, G. et. al (2013). Focal psychodynamic therapy, cognitive behaviour therapy, and optimised treatment as usual in outpatients with anorexia nervosa (ANTOP study): randomised controlled trial. *The Lancet*, 383 (9912):127-37. doi: 10.1016/S0140-6736

³⁵ Mitchell, J.E., Agras, S., Crow, S., Halmi, K. Fairburn, C.G., Bryson, S. & Kraemar, H. (2011). Stepped care and cognitive-behavioural therapy for bulimia nervosa: randomised trial. *The British Journal of Psychiatry*, 198, 5, 391-397.

³⁶ Mitchell et al op cit



This type of intensive psychological support has also been modelled to demonstrate cost effective therapy. Measuring the cost of the therapy against Quality Adjusted Life Year (QALY – The amount of time an individual spends in a given health state is then multiplied by the health state preference value³⁷) against Disability Adjusted Life Year (DALY – the years of healthy life lost from death and illness³⁸), the cost of treatment represents value for money for the government.³⁹ The cost of treatment against QALY or DALY has been found to be in the same effective range as other specialised medical interventions. Primary analysis indicated that psychological services associated with supporting patients with AN averted an increase in DALY when compared to no intervention, resulting in the mean Incremental Cost Effective Ratio (ICER) of \$14,451 per DALY averted, rendering it a potentially optimal path for treatment.⁴⁰

5.1.7 Nutritional intervention as part of a comprehensive stepped model of care

The Working Group agree with the overwhelming evidence supporting patients with eating disorders being provided with access to an appropriate number of dietetic counselling services that facilitates and supports ongoing nutritional management. For patients whose illness has progressed, supporting refeeding of patients to a point where they are able to participate in psychological therapy is a critical first step. Dietetic care is vital to successful treatment as it supports the normalisation of eating patterns, the management of nutritional status, negotiation of nutritional goals, education and counselling, monitoring of food consumption and changing binge eating and purging behaviours.⁴¹

Under the current individual allied health services for CDM in the MBS, a patient with an eating disorder may only see a dietitian (and receive an MBS rebate) up to five times in a

³⁷ Health.gov.au. (2018). Department of Health | 5.2 Quality-Adjusted-Life-Years (QALYs). [online] Available at: <http://www.health.gov.au/internet/publications/publishing.nsf/Content/illicit-pubs-needle-return-1-rep-toc~illicit-pubs-needle-return-1-rep-5~illicit-pubs-needle-return-1-rep-5-2> [Accessed 14 Aug. 2018].

³⁸ Australian Institute of Health and Welfare. (2018). Burden of disease Overview - Australian Institute of Health and Welfare. [online] Available at: <https://www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/burden-of-disease/overview> [Accessed 14 Aug. 2018].

³⁹ Butterfly Foundation. (2018). *Paying the Price: The Economic and Social Impact of Eating Disorders in Australia*. [online] Available at: <https://thebutterflyfoundation.org.au/assets/Uploads/Butterfly-report-Paying-the-Price-Executive-Summary.pdf> [Accessed 14 Aug 2018]

⁴⁰ Le, Long Khanh-Dao, Barendregy, J.J, Sawyer, S.M., Paxton, S.J., and Mihalopoulos, C. (2017). The modelled cost effectiveness of cognitive dissonance for the prevention of anorexia nervosa and bulimia nervosa in adolescent girls in Australia, *International Journal of Eating Disorders*, Vol (50)7; pp. 834 - 841

⁴¹ Hay, P et al., op cit., pp.1-62



calendar year, providing they have a GP initiated chronic disease management plan. In addition to the sentiments of the Working Group, this has been identified by dietitians as entirely inadequate. Evidence recommends up to 20 sessions of dietetic care for high risk patients with complex presentations.⁴² This would allow for almost twice monthly nutritional therapy to occur over a twelve-month period, acknowledging the complexity of the disease, and potentially improving recovery rates and reducing hospital admissions.⁴³ The Working Group views that the inclusion of dietetic service is integral in a comprehensive stepped model of care for patients with eating disorders.

5.1.8 Access to services to support patients through relapse

Relapse is an expected part of the recovery process. The highest risk of relapse is in the 12 months after achieving remission through treatment. Access to relapse services is core to the treatment of eating disorders, and is essential to reduce chronicity and potential hospitalisation episodes. Frequent monitoring should occur for at least 18 months following treatment; this includes medical monitoring by the patient's GP, ongoing psychological sessions and further engagement with allied health services. Implementation of a relapse management plan should commence immediately after treatment, however, the Working Group believe that under current arrangements it is unlikely that the patient will be unable to continue treatment beyond the limited number of Medicare rebated sessions.

5.1.9 Action required to align the MBS arrangements with evidence based care

The Working Group acknowledges that the current MBS items and infrastructure adequately meet the treatment needs of most patients with subclinical presentations of disordered eating and some patients whose condition was detected in the initial stage of development. For these patients, the Better Access initiative provides a good foundation for treatment.

The Working Group were of the opinion that the needs of *all patients* with eating disorders would be better served through the MBS by facilitating greater access to psychological and dietetic services. The evidence demonstrates that a course of up to 20 psychological sessions and up to 10 dietetic sessions per year is effective in improving patient outcomes and improving the chance of remission of symptoms for patients requiring less intensive treatment. For patients requiring a more intensive level of treatment, such as patients with AN, the evidence demonstrates that patients should

⁴² Ibid pg 28

⁴³ Butterfly Foundation. (2018), op-cit., pp 1 -26



have access to up to 40 psychological services and up to 20 dietetic services per year. The MBS should be expanded to provide for a comprehensive stepped model which provides care tailored to the patients' needs at different levels of intensity; starting at 10 psychological services and 5 dietetic services which would incrementally 'step up' to maximum of 40 psychological services and 20 dietetic services if required.

The Working Group recommends that MBS arrangements be expanded to reflect the evidence based care models for all patients as soon as it is practical to do so. The Working Group acknowledges that this is a very significant reform to the MBS arrangements which needs to be considered carefully, but this kind of reform is necessary to meet the needs of patients with eating disorders being treated in the community. It is acknowledged that addressing the burden of eating disorders on individuals, families and carers of patients with eating disorders, and the health system, will require a comprehensive multifaceted approach and that the MBS may not provide all the solutions. The Working Group notes that the fee-for-service model of the MBS may not be the ideal solution for the delivery of services for some patients. It was noted that some patients can experience high out-of-pocket costs for MBS services which can create a barrier to accessing care. Whilst the MBS cannot provide all the solutions, it is part of the solution. Other possibilities which could be explored for providing an expanded range of care to patients with eating disorders include 'block funding' or funding specific eating disorder services.

The Working Group also notes that the broader review of MBS mental health items is examining the access and adequacy of care for all patients with mental illnesses across the severity continuum. It is acknowledged that the MBS should provide a comprehensive and consistent approach to the treatment of all mental illness, including eating disorders. However it should be noted that eating disorders are highly complex, serious mental illnesses which also have very significant physical and medical complications.

Whilst the Working Group recommends the full implementation of a comprehensive stepped model of care for all patients with eating disorders, it is acknowledged that in the current environment it may not be viable to do so. If a large scale expansion of the MBS arrangements is not possible, in the interim, the Working Group recommends that a comprehensive stepped model of care be trialled within the MBS for those patients for whom the service deficit under the current MBS arrangements is the greatest – that is all patients with AN and those patients with BN, BED and OSFED who have complex needs, have not responded to treatment at a lower level of intensity and are assessed as 'high-risk' of serious medical and psychological complications. This cohort has been



identified as a group considered as most at-risk due to the likelihood of repeat hospitalisation, disease chronicity and potential mortality. This prioritisation in no way diminishes the needs of patient groups with other eating disorders. This phased approach would allow the delivery of evidence based care for these patients and provide a platform to demonstrate that such a model of comprehensive stepped can operate within the MBS.

It was noted by some members that a pragmatic approach is required for the implementation of a comprehensive stepped care model as it is important to get the design and operation of such a model right. A more conservative approach would assist to mitigate the risk that such a scheme would need to be wound back in the future if it is not operating as intended.

Recommendation 1.1

The Working Group is of the view that there is an evidence base that supports stepped care, including comprehensive care for appropriate patients, for *all patients with eating disorders*.

Under a comprehensive stepped model, the evidence shows that all patients with a diagnosed eating disorder should get access to up to 20 psychological sessions in total per year and 10 dietetic sessions in total per year, depending on their needs. Under this model, patients requiring more intensive treatment would be eligible to receive up to 40 psychological sessions in total and 20 dietetic sessions in total per year, depending on their needs.

The Working Group views that the expansion of MBS arrangements for all patients with eating disorders is necessary and should be implemented as soon as practical after the implementation of the new items outlined in recommendation 1.2.

Recommendation 1.2

The Working Group recommends the introduction of a new suite of items to provide a comprehensive stepped model of care for:

- . all patients with anorexia nervosa; and
- . patients with bulimia nervosa, binge-eating disorder and other specified feeding or eating disorders who have complex needs, have not responded to treatment at a lower level of intensity and are assessed as 'high-risk' of serious medical and psychological complications.

The new items would provide for:



- . the development and review of a treatment and management plan by a medical practitioner (such as a GP).
- . this item would trigger eligibility for a comprehensive stepped model of care, consisting of an initial and more intensive course of psychological and dietetic treatment depending of the patient's needs.

Initial course of treatment

Triggered by the development of a treatment and management plan by a medical practitioner (GP):

- . an initial course of up to 20 psychological sessions; and
- . an initial course of up to 10 dietetic sessions.

The GP will assess the patient throughout the treatment process, but should assess whether the patient should progress beyond 10 psychological sessions and 5 dietetic sessions by conducting a review consultation (with a New Item Number) before or around 9 or 10 sessions completion mark, to approve and trigger another course of 10 psychological sessions and 5 dietetic services (up to 20 psychological sessions and up to 10 dietetic sessions). This review item will involve a full medical and psychological history, a full physical examination and ordering and reviewing relevant investigations.

The mental health professional involved in the patients treatment will be required to formally report back to the practitioner before or around the 9 to 10 services completion mark to certify the patient's diagnosis and confirm that the patient's requires a further course (an additional 10 psychological sessions) of treatment.

More intensive treatment

If the patient has not responded to treatment at a lower intensity, upon formal review and assessment of the patient by a psychiatrist or paediatrician, the patient would be eligible for:

- . an additional course of up to 20 psychological sessions (40 sessions in total per year) ; and
- . an additional course of up to 10 dietetic sessions (20 sessions in total per year).

GP reviews

It is expected that as the central care provider, the GP will review the patient throughout the treatment process, performing the necessary medical assessments, including ordering and reviewing the required tests, and assessing the patient's response to treatment.



Reports back to the GP from the mental health professional and dietitian

It will be a requirement that the mental health professional and dietitian delivering care to the patient provide written reports back to the managing GP after each set of services (that is, after each set of 10 psychological services and 5 dietetic services).

As GPs are central to the treatment and management of a patient with eating disorders, the Working Group suggests that the GP remain the initiator of care and actively involved throughout the treatment process. The Working Group discussed the appropriate gatekeeper and referral arrangements for the proposed new items at length. It was agreed that if it was a requirement that the patient be assessed and diagnosed by a psychiatrist or paediatrician before they can access care, it may create unintended barriers to patient access or a 'bottleneck' due to the limited number and geographical distribution of these specialists. It was also noted that there may be a conflict of interest in allowing those who would be providing the psychological care to assess initial eligibility for accessing services. It was agreed that the GP could initiate the access to the comprehensive stepped model, through the development of a treatment and management plan, which would provide eligibility for an initial course of up to 20 psychological services and up to 10 dietetic sessions. It was agreed that the GPs should review the patient frequently throughout the treatment process, to assess the patient's response to treatment and to perform the vital physical assessments and ongoing testing, but also to confirm that the initial course of treatment should continue beyond the first 10 psychological and five dietetic sessions. Written reports back to the GP will be required from the mental health professional and dietitian throughout the course of treatment, but particularly after each 'step' of 10 psychological services and 5 dietetic services.

Before a patient progresses to the 'next step' in the treatment model, that is, access to an additional 20 psychological and an additional 10 dietetic services (which would bring the total number to 40 psychological and 20 dietetic services), formal review by a psychiatrist or paediatrician will be required. The psychiatrist or paediatrician will reaffirm the patient's diagnosis, assess the patient's response to treatment and confirm that the patient should progress on to the intensive level of treatment. The rationale supporting the inclusion of a formal review by a specialist is to provide the reassurance that the correct diagnosis has been made and to enable the GP to receive specialist advice to support patient management. It is likely that a patient who would require this level of intensive treatment would already be accessing specialist care.



The Working Group were of the view that there are other aspects of the items' operation which should be considered to support the cost-effectiveness of the items. For example, the Working Group noted that there was a potential for large financial impacts on the Medicare safety net arrangements (as patients are generally charged large out-of-pocket costs for psychological services which would increase liability under the extended Medicare safety net (EMSN)). It was suggested that consideration be given to placing a lower EMSN benefit cap on the new items for psychological and dietetic services, for example, equal to double the schedule fee (rather than 300 per cent of the schedule fee which current applies to consultation items).

The Working Group recommends work should be carried out with all the professional groups involved in the delivery of care to patients with eating disorders, on the appropriate item descriptors, including the precise patient eligibility requirements, and explanatory notes which would operationalise the intent of the care model outlined in recommendation 1.2.

Recommendation 1.3

The Working Group recommends that the impact and operation of the new items should be reviewed as soon as practical (within three years) after introduction of the new items. The Review should assess whether the items are operating as intended for all parties (the Government, practitioners and patients) and should assess the viability of expanding the MBS arrangements to provide for a comprehensive stepped care models to all patients with a diagnosed eating disorder.

A review of the impact and operation of the new items referred to in recommendation 1.2 would allow for an assessment of the MBS as a delivery model for the comprehensive care model outlined in this report.

Recommendation 1.4

The Working Group recommends the services referred to in recommendation 1.2 be allowed to be provided via telehealth (under the same eligibility requirements that exist for other MBS services) in order to increase access to services for patients in rural and remote areas.



5.2 Finding 2: There is a lack of service integration between primary, secondary and tertiary health care in developing care plans and effectively communicating with patients and their families

5.2.1 Background

People with eating disorders also experience higher rates of other mental health issues, such as depression and anxiety, with reports of almost 97 per cent of people also having a comorbid condition.⁴⁴ As such, patients require targeted treatment, which is person centric and tailored to specifically address the nature of their eating disorder. The treatment of any underlying comorbid psychological issues should also occur in parallel.

The clinical treatment of an eating disorder requires a combination of medical, nutritional and psychological treatment.⁴⁵ Recovery from an eating disorder takes many years and may require several courses of treatment.⁴⁶ The timely identification of the illness and prompt intervention from a wide range of primary health professionals adequately trained to support the patient is paramount to reduce the severity, duration and the impact of eating disorders on the individual and more broadly on the community. This section discusses the other changes that could be made to existing MBS arrangements to strengthen service integration and MDT collaboration.

5.2.2 Delivery through a multidisciplinary team

The Working Group agrees with the overwhelming evidence that supports a multidisciplinary approach to ensure that patients diagnosed with eating disorders can access the combined medical, dietetic and psychological interventions. This is required to maximise the chances of a full recovery from an eating disorder, and also in the treatment of any comorbid conditions.⁴⁷ Whilst each patient's needs are individual, a typical range of services, required within the MDT, for someone with an eating disorder would include:

- Medical assessment care plan, monitoring and treatment as required from a psychiatrist;
- Ongoing regular medical monitoring and treatment from a general practitioner;

⁴⁴ Butterfly Foundation (2012). *Paying the price: the economic and social impact of eating disorders in Australia*.

⁴⁵ *ibid.*, pp 1 -26

⁴⁶ *ibid.*, pp 1 -26

⁴⁷ National Eating Disorders Collaboration., *op-cit.*, p. 86



- Psychological therapy – delivered on an individual or individual plus group basis;
- Nutritional counselling for nutritional rehabilitation;
- Selected functional therapies e.g. supportive meal therapy, occupational therapy, physiotherapy; and
- Family support and/or therapy.

A team comprising of medical, nursing, allied and mental health professionals are needed to target all factors that contribute to the development and maintenance of an eating disorder, such as the psychological, medical and behavioural aspects of the illness. In a survey run by the Butterfly Foundation, 97.7 per cent of respondents confirmed that they do treat patients as part of a care team. However, a major barrier to the ongoing management, treatment planning and care coordination was the lack of session rebates to support said activities. The limited number of allied health sessions available to patients with eating disorders means that the aforementioned activities are often forgone, especially once the patient begins paying full fee. This likely contributes to chronicity, incidence of relapse and poor outcomes.

A best practice, safe and effective treatment enables the MDT to plan and address all aspects of the illness; physical, behavioural, nutritional and psychological. The most effective approach to the treatment of people with eating disorders is a collaborative MDT approach which enables a broad range of primary, mental health and allied health services to work in partnership with each other and with the person and their family.⁴⁸ The minimum core team required in the treatment of a person with an eating disorder should consist of a medical practitioner (GP or a paediatrician), a mental health practitioner (e.g. clinical psychologist, registered psychologist, psychiatrist, mental health nurse) and a dietitian.⁴⁹ For patients requiring more intensive treatment, a consultant psychiatrist should also be considered within this minimum team.

5.2.3 MDT's delivering stepped care and MDT care plans

An evidence-based approach to treating eating disorders requires tailored treatment, delivered by a team of primary care professionals. Transitioning between services within the primary care team requires an effective 'continuum of care'. The utilisation of an MDT care plan encourages this by fostering a partnership approach to the treatment of people with eating disorders. When appropriate, the triggering GP will work with the

⁴⁸ Hay, P et al , op-cit., p.7

⁴⁹ *ibid.*, p. 7



patient, their family and other health support providers and practitioners to encourage a holistic approach to care planning and appointment scheduling. This means that physical, psychological and nutritional concerns are managed in relation to the eating disorder, whilst also treating any underlying comorbidity issues. These tailored care plans also allow the MDTs to assist patients meet health, occupational and social needs when access to treatment is managed through a designated care coordinator.⁵⁰ The Working Group notes that currently only GPs are remunerated through the MBS for contribution to MDT care plans and was of the view that enabling allied health and mental health professionals, including psychologists, dietitians and mental health nurses, to receive financial compensation for their involvement would support and enhance MDT collaboration within the private sector.

5.2.4 Case conferencing

Case conferencing is a key way that all professionals involved in the care of a patient can communicate and coordinate person-centred care. The safe treatment of an eating disorder is best provided by multiple disciplines and often multiple service agencies, with strong relationships and frequent communication required between the treatment providers to prevent deterioration in the physical and mental health of the patient. The current case conferencing items in the MBS are designed to be used by GPs and other medical practitioners to organise and coordinate, or to participate in, a meeting or discussion that ensures the patient's multidisciplinary care needs are met. To access the MBS item, the case conferencing team must include a GP and at least two other health or community care providers, one of whom can be another medical practitioner. Each team member should provide a different kind of care or service to the patient. A case conference can occur face-to-face, by phone or by video conference, or through a combination of these. The patient does not have to attend the case conference, though in some cases their presence may be appropriate. In addition, the patient's informal or family carer can be included as a formal member of the team but does not count towards the minimum of three service providers. Under the existing MBS requirements, the recommended frequency of occurrence for this item is not expected to exceed five case conferences in any 12-month period.

The minimum three care providers (including the GP) within the case conferencing team must be in communication with each other throughout the conference. For patients with an eating disorder a case conference team should consist of a GP, a paediatrician or a psychiatrist, and any of the following allied health or mental health practitioners; a

⁵⁰ Law, M et al., op-cit., pp.250 - 257.



psychologist, dietitian, mental health nurse, counsellor, psychotherapist or an occupational therapist, with appropriate further training and qualifications in the treatment of mental health and/or eating disorders.

The Working Group considers the inclusion of allied health/mental health professionals with specific training and credentialing in the area of eating disorders as a valuable addition to a team care arrangement, MDT or a case conference. The Working Group also considered it necessary that these allied health/mental professionals receive adequate financial compensation for their contribution to MDTs and case conferencing.

Recommendation 2.1

The Working Group requests that the Allied Health Reference Group investigate and consider expanding access to provide multidisciplinary case conference MBS items 735, 739, 743 and to item 729 (contribution to a MDT care plan prepared by another practitioner) to allied health and mental health professionals⁵¹ who are specialised in the treatment of eating disorders to enable these practitioners to be remunerated for their involvement in MDT care plan development and case conferences.

5.2.5 Family integration

Person centric care is family centric by definition.⁵² The family are usually an integral part of the decision-making process. The family can be involved in care options throughout the diagnosis and assessment, and are usually the support unit that help to bridge the gap between initial diagnosis and eating disorder specific treatment.⁵³ The level of involvement from the family is usually high, given that it will extend to psychological support, whilst also providing physical and economic support, as well as assistance with daily living and direct support with meals.

While therapy may be delivered at any time, patients with eating disorders require increased care during and immediately after meal times. This requires safety and skilled support from the family to enable the development of new, healthy eating behaviours.

⁵¹ The term allied health professional is used to refer to dietitians and accredited mental health professionals including general practitioners who have undertaken accredited mental health training, psychologists, mental health nurses, social workers, occupational therapists, counsellors and psychotherapists.

⁵² National Eating Disorders Collaboration. op. cit., p. 29

⁵³ Surgenor and Maguire, op. cit., p6.



Families that provide mealtime support are promoting therapeutic outcomes and need to be adequately equipped to take on this role.⁵⁴

The Working Group is of the strong view that families should be included, engaged, and educated by the treatment team as a key member, integral to the patient's outcome. Where possible, the families of patients with eating disorders should be supported and provided with skills, strategies, education and information to enable them to support the person with the illness. Care teams should plan treatment with the family structures and if family are not available for the patient, service providers should look to address this and implement an alternative support option.⁵⁵ There is some evidence to suggest that family therapy may be more effective than other treatments on reducing readmission rates and improved health outcomes at follow up^{56 57}.

Family integration can be further achieved through FBT. As noted in the previous section, psychotherapy is an important component of the treatment program and FBT is the best-established treatment for adolescent patients with eating disorders.⁵⁸ The positive efficacy results of FBT are due to its intensive community-based treatment and intervention with family dynamics, which was originally developed in the Maudsley hospital, London, and has come to be known as the 'Maudsely Method.'

FBT for adolescents is designed to mobilise parents in assisting their child reverse their state of starvation, aiming towards full remission.⁵⁹ Parents take an integral role delivering the treatment in the home environment supported by therapeutic supervision from MDT's. This treatment has three phases which occur over a period of 6-12 months and involves the entire family. FBT is recognised as a first line of treatment option for adolescents with an eating disorder. A course of FBT is 20 sessions and additional sessions may be needed. There are also clinical trials examining the use of FBT in young adults, with participation of partners and other carers, which has demonstrated some patient benefit.

⁵⁴ National Eating Disorders Collaboration. op. cit., p. 31

⁵⁵ *ibid.*, p. 22

⁵⁶ Fisher, C.A., Hetrick, S.E. and Rushford, N. (2010). Family therapy for anorexia nervosa. *The Cochrane Database of Systematic Reviews*, 4. CD004780. DOI: 10.1002/14651858.CD004780.pub2.

⁵⁷ Couturier, J., Kimber, M. and Szatmari, P. (2013) Efficacy of family-based treatment for adolescents with eating disorders: A systematic review and meta-analysis. *International Journal of Eating Disorders* 46: 3–11. doi: 10.1002/eat.22042.

⁵⁸ *ibid.*, p. 91

⁵⁹ Le Grange, D., Lock, J., Loeb, K., and Nicholls., D. (2009). Academy for Eating Disorders Position Paper: The Role of the Family in Eating Disorders, *Eating Disorders* Vol 43(1) pp. 1 -5



The Working Group noted that availability of MBS funded family group support and therapy when provided by a GP, although it was noted that the items are underutilised. In many cases it was thought that the GPs too busy to be able to provide these services. The Working Group noted that FBT is not listed in the explanatory notes for the *Better Access* items as an acceptable strategy to be provided under the focussed psychological services (FPS) items. The Working Group suggests allowing FBT to be delivered using the FPS items and under any services provided through the new MBS items for patients with eating disorders.

Recommendation 2.2

Allow appropriately trained practitioners to provide family-based therapy (FBT) under the items for focussed psychological strategy services and any new psychological services provided under the new MBS items (to which recommendation 1.2 refers). FBT should be delivered in line with the evidence base in this area. Family based therapy services will count towards the patient's allocation of psychological services provided through the new MBS items.

5.2.6 Further support for families and carers

The Working Group acknowledged the need for greater support and treatment for family members and carers of people with eating disorders. As highlighted in previous section, there is recognition of the importance of family members and carers being included in the core treatment team.

The stress and the pressure that can result from caring for a very ill family member can have great impacts on family members and carers' own physical, mental and emotional health. It was noted that family members and carers can currently access mental health services under the *Better Access Initiative* (if the family member meets the eligibility requirements for receiving services under these items, which includes being diagnosed with a mental illness). Mental health services provided under these items could assist family members and carers to manage these stressors, but perhaps the items may be underutilised for this purpose.

The Working Group were of the view that the support and treatment of families and carers is important aspect of providing holistic care and more should be done to increase the availability of existing MBS services to meet this need. Consideration should be given to how MBS arrangements could be strengthened to support the delivery of education and counselling services for family members and carers affected by caring for person with an eating disorder. Additionally, further information and education should be



provided to GPs about support services for families of patients with eating disorders (see Recommendation 3.1).

5.2.7 Other changes to strengthen the MBS arrangements for the treatment and management of patients with eating disorders

The Working Group discussed a number of other changes that could be made to MBS items to support the delivery of care for patients with eating disorders. These matters have been referred to other Clinical Committees reviewing these items. For example, the Working Group considers that there are a number of changes that could be made to the infrastructure around the *Better Access Initiative* items, to improve access to MBS funded psychological services and promote MDT collaboration and treatment. These changes include:

- ‘decoupling’ items for GP focussed psychological services from those provided by other mental health professionals (which would in effect increase the number of psychological services that could be provided to patients); and
- recognition of other groups of appropriately trained allied health practitioners (including mental health nurses) as eligible to provide services under the Better Access Initiative.

These issues and other structural issues with existing MBS services are outlined in Appendix D – referrals made to other Clinical Committees.

Recommendation 2.3

The Working Group identified a number of other changes that could be made to MBS items to support the delivery of care for patients with eating disorders. The Working Group requests that the Clinical Committees responsible for these items consider the identified issues in the course of the Committees’ work. Appendix D – referrals made to other Clinical Committees provides the full referrals made to these Committees.



5.3 Finding 3: Limited access to clinicians who are experts in eating disorders is an impediment to supporting timely diagnosis, intervention and the treatment of eating disorders

5.3.1 Background

The following section examines a series of non-MBS related changes that need to be made to support the timely identification of eating disorders. These are considered non-MBS items because they lend to systematic changes in practice as opposed to direct treatment through an MBS funded service provided by a clinician. This in no way lessens the priority of the changes that need to be made, rather shifting the focus of where changes should occur. Preceding sections of the report have focused directly on how the rebates are provided to patients when clinicians deliver services. This section looks at the delivery environment.

There are still very few services that are modelled specifically on the treatment of people with eating disorders. Those that do exist in Australia are primarily based in metropolitan areas, are specialist inpatient or day patient programs, and carry long waiting lists. Access to specialist community-based treatment either through the public system, or in primary care, is largely dependent on whether there are medical and mental health practitioners in the area with specific interest in the treatment of people with eating disorders. The NEDC (2012) recognises the importance of equity of access and entry for patients as a core principle required in the treatment of eating disorders. The requirements of regional and rural areas should be recognised specifically, and technological solutions for providing the treatment of eating disorders should be incorporated where appropriate. The Working Group also discussed how limited numbers of qualified health practitioners can impede patient access to appropriate treatment, particularly in rural and remote areas.

Primary healthcare practitioners are the entry point into the Australian health system. These include GPs, general practice nurses, nurse practitioners, community nurses, allied health professionals, mental health professionals, midwives, pharmacists, dentists and Aboriginal health professionals.⁶⁰ Of these, GPs are the most likely to be accessed with more than four out of five Australians (83 per cent) surveyed by the Australian Bureau of Statistics as consulting a GP in a single calendar year.⁶¹ GPs and the aforementioned primary health care practitioners focus on health promotion, prevention, acute

⁶⁰ Australian Bureau of Statistics (ABS) 2015. *Patient experiences in Australia: summary of findings 2014–15*. ABS Cat. No. 4839. Canberra: AIHW.

⁶¹ *ibid*



treatment, and the management of chronic conditions and, most importantly in relation to eating disorders, timely intervention.⁶²

5.3.2 Supporting the timely identification and intervention of eating disorders

The national standard for identification and intervention recommends that people get access to services as soon as they are needed: “early in the development of the illness, early in help seeking, and early in recurrent episodes of illness, with immediate access to treatment and support.”⁶³ GPs and other primary healthcare providers are a first line of defence in the treatment of eating disorders. This is contingent upon the extent to which a GP or any primary health care practitioner can recognise and respond to initial symptoms presented by the patient. For those patients with eating disorders who do seek help early, it may be necessary for them to see several GPs before receiving a correct diagnosis, with each delay likely to further influence the duration, severity and chronicity of the illness and prolong the outcomes of treatment.

Whilst it would be desirable to have a specialist eating disorder service in each PHN that can refer patients directly to psychiatrists, this is not currently possible given the number of practicing psychiatrists in Australia.⁶⁴ The intensive nature of the psychological services required to treat people with eating disorders, and the probable increase in referrals, would likely create a bottleneck, delaying the commencement of treatment. As previously noted, GPs are the most often accessed form of outpatient health service, but for specific risk groups, specialist health services may represent the first point of contact. For example, women presenting with eating disorder symptoms later in life may first interact with a gynaecologist or a midwife.

5.3.3 Enabling a skilled workforce to identify eating disorders

Under the current *Better Access Initiative*, GPs are the primary health care professional responsible for triggering the GP Mental Health Care plan and providing a referral to a specialist psychologist or psychiatrist. It is widely acknowledged that an effective system is founded on a skilled and supported workforce, and that all health professionals need to be effectively trained to raise awareness regarding the serious nature of eating disorders. For GPs this means developing the recognition of eating disorders as a foundational skill to improve rates of prevention and timely intervention.⁶⁵ This could be

⁶² *ibid*

⁶³ The Butterfly Foundation (2017). *National Agenda for Eating Disorders 2017 to 2022*. p.14

⁶⁴ *ibid*

⁶⁵ *Ibid.*, p.49



achieved through the Royal Australian College of General Practitioners' (RACGP) Quality Improvement and Continuing Professional Development (QI&CPD) Program, which supports GPs to maintain and improve their professional knowledge and skills in order to provide the best possible care for patients.⁶⁶

Being that eating disorders are a group of serious and complex bio-psychosocial disorders that range in severity, it is of paramount importance that the treating primary health care practitioner recognises how symptoms present.⁶⁷ A key feature of treating eating disorders under the current MBS framework assumes all health professionals have a high level of expertise in the area of eating disorders which would enable the practitioner to identify and diagnose the disorder and then refer the patient for appropriate evidence based care. However, there are a considerably limited number of mental health practitioners with an appropriate level of expertise in treating people with of eating disorders. Hudsons and Colleagues (2013) reported that a majority of people who were diagnosed with BN or BED had received treatment at some point in their lives for mental health issues, but that did not necessarily lead to specific treatment or recognition of the eating disorder.⁶⁸ The Working Group agrees with the evidence that the lack of suitably trained health professionals available to identify and/or provide support to patients with eating disorders has been identified as a barrier to effective treatment in Australia. This is compounded through the current workforce's capacity to work effectively with patients over time, and that the treatment of eating disorders is a consuming process that can only be learnt through professional development, clinical experience and eating disorder specific supervisor.⁶⁹

Recommendation 3.1

Further support and education should be provided to GPs about locally available specialist services for patients with eating disorders, and their families.

5.3.4 Training to support clinicians in the treatment of eating disorders

The Working Group believes that the minimum acceptable level of training per the National Workforce Competency Standards would support timely recognition and treatment. It is noted that the NEDC has been tasked with developing and disseminating

⁶⁶ The Royal Australian College of General Practitioners (RACGP) (2018). *RACGP – QI&CPD 2017-19 Program*. [online] The RACGP [Accessed 13 Aug 2018] Available at: <https://www.racgp.org.au/education/qicpd-program/>

⁶⁷ Hay, P et al., op cit., p.4

⁶⁸ National Eating Disorders Collaboration. op. cit., p.76

⁶⁹ *ibid.*, p.75



a consistent framework for competence for professionals involved in the identification, assessment and treatment of eating disorders.

This training should also include the development of attitudes and practices toward people presenting with eating disorder symptoms. GPs need to be skilled at interviewing the patient and their family to facilitate timely diagnosis, embody the attitudes and practices that support timely identification and intervention and recognise the ambivalence and fear that is prevalent in patients with eating disorders⁷⁰. It should also be noted that the NEDC also has numerous resources available to support practitioners, including a GP resource.

Further training could be made available by the RACGP as part of the QI&CPD program to GPs, and by the appropriate bodies governing the training requirements of the other primary and allied health and mental health professionals recommended by this report to be working within the eating disorders space.⁷¹

Recovery rates could be significantly improved by comparison with no treatment if more health professionals are trained in how to approach and work with the individual patient and are aware of their psychological framework; experiencing very low self-esteem and the need to develop feelings of safety, security and hope before they can actively engage in treatment.^{72 73}. Improving training for all health professionals could therefore increase the number of disorders diagnosed in a timely manner, referrals and decrease the overall number of eating disorder-related hospitalisations.⁷⁴

It is important to note that training alone is unlikely to be enough to maintain a long term skilled workforce. It is acknowledged that supervision provided by a practitioner that is experienced in the area of eating disorders is also a key component in assisting those new to the field to translate acquired knowledge to clinical confidence and practice. The resources to cover the cost of supervision are also a challenge in this area.

It was also suggested that the availability of funding to provide an evidence-based course of care influenced practitioner decisions to do further training in certain areas of practice. It is proposed that the expansion of MBS arrangements to support the delivery

⁷⁰ National Eating Disorders Collaboration. *op. cit.*, p.4

⁷¹ National Eating Disorders Collaboration (NEDC, 2012). Pg. 76

⁷² *ibid*

⁷³ *ibid*

⁷⁴ Hart, Jorm, Paxton, Kelly, and Kitchener, *op. cit.*, p. 354 - 384.



of evidence based care to patients with eating disorders will provide an incentive for more practitioners to complete advanced training in the area of eating disorders.

Recommendation 3.2

Professional associations and other relevant training organisations should develop and/or extend specific training, education and clinical guidance for working with people who have eating disorders. This training should be included in undergraduate and post graduate university health programs, continuing professional development programs for disciplines involved in the treatment and management of patients with eating disorders, and in particular, any health professionals providing services under the new MBS items.

5.3.7 The need for credentialing of appropriately trained clinicians

To ensure that this training is recognised, and that appropriately credentialed clinicians are diagnosing and treating patients with eating disorders, awarded credentials should be registered on an accreditation system for health professionals with expertise in eating disorders. This would ensure that correct diagnoses are given and high quality services are delivered by practitioners with the required knowledge and experience in eating disorders. As noted in Finding 1.2, the proposed MDT model is suggested to have a significant positive impact upon the patient's likelihood for recovery. This is reliant upon the MDT comprising of appropriately trained professionals, who can contribute to the development of a best care pathway for the patient in question. The Working Group acknowledges that there is an inadequate workforce trained in the treatment of eating disorders, primarily due to the limited number of clinicians with special interest in eating disorders; not only as a result of clinicians receiving inadequate training. It will be important that professional organisations be fully engaged in the process of establishing such a scheme.

An additional benefit of the establishment of a credentialing process would be the creation of a register of practitioners who are accredited to diagnose and provide specialised treatment to patients with eating disorders.

It is important that any credentialing process, which is intended to enhance the quality of care provided to care, does not adversely impact patient access to appropriate services, especially in the transition period to the establishment of such a procedure. Therefore, the Working Group recommends, that in the absence of such a credentialing process and until one is well established, it should be highlighted that there is a strong expectation that only practitioners with training and experience in providing care to



patients with eating disorders should provide services under the new MBS items and the referred psychological and dietetic services provided under the new MBS items.

Recommendation 3.3

A credentialing process should be established, specific to practitioners that diagnose and provide specialist treatment to patients with eating disorders. Once established, these credentials should be used to determine practitioner eligibility to provide eating disorder services under the new MBS item that is recommended within this report.⁷⁵

5.3.8 Utilising the PHN Network to deliver educational programs

The Working Group acknowledge that the Australian Government's mental health reforms included expanding the role of PHNs to lead mental health planning at a regional level. This planning would be done in partnership with State and Territory governments, non-government organisations and other related services and organisations.⁷⁶ The PHNs have also been provided with a flexible pool of funding to commission services that meet local needs, meaning the PHNs will have a key role in commissioning and facilitating the integration linkages between clinical and non-clinical services for people with eating disorders.

PHNs are ideally placed in the health system to facilitate information sharing regarding eating disorders and evidence based clinical pathways. It is noted that the NEDC has been commissioned to work with PHNs to raise awareness of eating disorders, to provide evidence-based information and education and training based on local needs. The Department should work with the NEDC to determine if there are any gaps in this area and how to best leverage the existing relationships that the NEDC has with PHNs in order to distribute an example of evidence based clinical pathway which is currently being utilised in one PHN area.

Recommendation 3.4

The Department of Health to write to the 31 Primary Health Networks (PHNs) on behalf of the Working Group to increase awareness about evidence-based clinical pathways for the treatment of people with eating disorders, and to provide an example clinical pathway which could be adapted and implemented for use in their local area.

⁷⁵ The practitioners should also have substantial training in mental health and accreditation by Australian Health Practitioner Regulation Agency (AHPRA) or their own profession organisation.

⁷⁶ Australian Government. (2015). *Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*.p.3





Glossary

| Term | Description |
|-----------------------------|--|
| Anorexia nervosa (AN) | Persistent restriction of energy intake leading to significantly low body weight, persistent behaviours that interfere with weight gain or the disturbance in the way one's body weight or shape is experienced. ⁷⁷ |
| Binge eating disorder (BED) | Recurrent episodes of binge eating in a discrete period of time, lack of control over eating during the episode and marked distress regarding binge eating; More subjective distress regarding the eating behaviour and commonly other co-occurring psychological problems. ⁷⁸ |
| Bulimia nervosa (BN) | Recurrent episodes of binge eating in a discrete period of time, lack of control over eating during the episode and recurrent inappropriate compensatory behaviour in order to prevent weight gain such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise. ⁷⁹ |
| CAGR | Compound annual growth rate or the average annual growth rate over a specified time period. |
| Change | When referring to an item, 'change' describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes; (ii) the consolidation of item numbers; and (iii) splitting item numbers (for example, splitting the current services provided across two or more items). |
| Delete | Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS. |

⁷⁷ Eating Disorders Victoria (2016). *Classifying eating disorders – DSM-5 [online]* Eating Disorders Victoria [Accessed 28 Aug 2018] Available at: <https://www.eatingdisorders.org.au/eating-disorders/what-is-an-eating-disorder/classifying-eating-disorders/dsm-5>

⁷⁸ Eating Disorders Victoria (2016)

⁷⁹ Eating Disorders Victoria (2016)



| | |
|------------------------------|--|
| Department, The | Australian Government Department of Health |
| DHS | Australian Government Department of Human Services |
| Eating disorder (ED) | An eating disorder is a serious mental illness, characterised by eating, exercise and body weight or shape becoming an unhealthy preoccupation of someone's life. ⁸⁰ |
| FY | Financial year |
| High-value care | Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs. |
| Inappropriate use / misuse | The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud. |
| Low-value care | Services that evidence suggests confer no or very little benefit to consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits. |
| MBS | Medicare Benefits Schedule |
| MBS item | An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits. |
| MBS service | The actual medical consultation, procedure or test to which the relevant MBS item refers. |
| Multidisciplinary team (MDT) | A multidisciplinary team involves a range of health professionals from one or more organisations, working together to deliver comprehensive patient care. ⁸¹ |
| Misuse (of MBS item) | The use of MBS services for purposes other than those intended. |

⁸⁰ Eating Disorders Victoria (2016)

⁸¹ NSW Health (2014). *Multidisciplinary Team Care* [online] NSW Government [Accessed 28 Aug 2018] Available at: <https://www.health.nsw.gov.au/healthone/Pages/Multidisciplinary-Team-Care.aspx>



| | |
|--------------------------------|--|
| | This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud. |
| MSAC | Medical Services Advisory Committee |
| New service | Describes when a new service has been recommended, with a new item number. In most circumstances, new services will need to go through the MSAC. It is worth noting that implementation of the recommendation may result in more or fewer item numbers than specifically stated. |
| No change or leave unchanged | Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (for example, references to other items, which may have changed as a result of the MBS Review or prior reviews). |
| Obsolete services / items | Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures. |
| PBS | Pharmaceutical Benefits Scheme |
| Services average annual growth | The average growth per year, over five years to 2014/15, in utilisation of services. Also known as the compound annual growth rate (CAGR). |
| SSU | Short Stay Unit |
| The Working Group | The Eating Disorders Working Group of the MBS Review |
| The Taskforce | The MBS Review Taskforce |
| Total benefits | Total benefits paid in 2014/15 unless otherwise specified. |



References

This contains references to sources and materials referenced in this report.

Australian Bureau of Statistics (ABS) 2015. *Patient experiences in Australia: summary of findings 2014–15*. ABS Cat. No. 4839. Canberra: AIHW

Australian Government. (2015). *Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*.p.3

Australian Institute of Health and Welfare. (2018). *Burden of disease Overview - Australian Institute of Health and Welfare*. [online] Available at: <https://www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/burden-of-disease/overview> [Accessed 14 Aug. 2018].

Butterfly Foundation. (2018). *Paying the Price: The Economic and Social Impact of Eating Disorders om Australia*. [online] Available at: <https://thebutterflyfoundation.org.au/assets/Uploads/Butterfly-report-Paying-the-Price-Executive-Summary.pdf> [Accessed 14 Aug 2018]

Byrne, S., Wade, T., Hay, P., et al. (2017). A randomised controlled trial of three psychological treatments for anorexia nervosa. *Psychological Medicine*, 47. 2823-2833. doi:10.1017/S0033291717001

Carter J.C., Mercer, Lynn K. B., Norwood, S.J., Bewell-Weiss, C.V., Crosby, R.D., Woodside, D. B., and Olmstead, M.P. (2012). A Prospective Study of Predictors of Relapse in Anorexia Nervosa; Implications for Relapse Prevention, *Australasian Psychiatry*, Vol 15 pp.390 – 395

Couturier, J., Kimber, M. and Szatmari, P.(2013) Efficacy of family-based treatment for adolescents with eating disorders: A systematic review and meta-analysis. *International Journal of Eating Disorders* 46: 3–11. doi: 10.1002/eat.22042.

Department of Health. (2018). *PHN Background*. [online] Available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background> [Accessed 30 August 2018]

Eatingdisorders.org.au. (2018). *Key Research & Statistics | Eating Disorders Victoria*. [online] Available at: <https://www.eatingdisorders.org.au/key-research-a-statistics> [Accessed 16 Aug. 2018].

Fairburn C. G., Cooper., Z., Doll, H.A., O'Connor, M.E, Bohn, K, Hawker, D.M, Wales, J.A. and Palemr, R. L. (2009). Transdiagnostic Cognitive Behavioral Therapy for



- Patients With Eating Disorders: A Two Site Trial With 60 Week Follow- Up, *The American Journal of Psychiatry* 166(3) pp 311 - 319
- Fairweather – Schmidt, K., and Wade, T. D. (2014). DSM – 5 Eating Disorders and Other Specified Eating and Feeding Disorders: Is There a Meaningful Differentiation?, *International Journal of Eating Disorders*, Vol 47(5) pp.525 – 535
- Fisher, C.A., Hetrick, S.E. and Rushford, N. (2010). Family therapy for anorexia nervosa. *The Cochrane Database of Systematic Reviews*, 4. CD004780. DOI: 10.1002/14651858.CD004780.pub2.
- Hay, P., Chinn, D., Forbes, D., Madden, S., Newton, R., Sugenor, L., Touyz, S. and Ward, W. (2014). Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Treatment of Eating Disorders, *Australian and New Zealand Journal of Psychiatry*, Vol 48(11) pp. 1 – 62.
- Hart, L. M., Jorm, A. F. , Paxton, S.J., Kelly, C. M and Kitchener, B. A. (2009) First Aid for Eating Disorders, *Eating disorders* , 17(5) pp. 357 – 384
- Hay, P. and Touyz, S. (2015). Treatment of Patients With Severe and Enduring Eating Disorders, *Current Opinion in Psychiatry* Vol 28(6) pp. 473 -477
- Health.gov.au. (2018). *Department of Health | 5.2 Quality-Adjusted-Life-Years (QALYs)*. [online] Available at: <http://www.health.gov.au/internet/publications/publishing.nsf/Content/illicit-pubs-needle-return-1-rep-toc~illicit-pubs-needle-return-1-rep-5~illicit-pubs-needle-return-1-rep-5-2> [Accessed 14 Aug. 2018].
- Law, M., Baptiste, S., and Mill, J. (1995). Client-Centred Practice: What does it Mean and Does it Make a Difference?, *The Canadian Journal of Occupational Therapy*, Vol 62(5) pp. 250 - 257.
- Le, Long Khanh-Dao, Barendregy, J.J, Sawyer, S.M., Paxton, S.J., and Mihalopoulos, C. (2017). The modelled cost effectiveness of cognitive dissonance for the prevention of anorexia nervosa and bulimia nervosa in adolescent girls in Australia, *International Journal of Eating Disorders*, Vol (50)7; pp. 834 – 841
- Le Grange, D., Lock, J., Loeb, K., and Nicholls., D. (2009). Academy for Eating Disorders Position Paper: The Role of the Family in Eating Disorders, *Eating Disorders* Vol 43(1) pp. 1 -5
- Machdo, P.P.P., Evaluation of the DSM-5 Severity Indicator for Anorexia Nervosa, *European Eating Disorders Review* Vol 25(3), pp. 221 – 223.



- National Eating Disorders Collaboration. (2012). *An Integrated Response to Complexity National Eating Disorders Framework*, accessed 30 August 2018, <https://www.nedc.com.au/research-and-resources/show/an-integrated-response-to-complexity-national-eating-disorders-framework>
- Richard, M., Bauer, S., Kordy, H. (2005). Relapse in Anorexia and Bulimia Nervosa – a 2.5 Year Follow Up Study, *European Eating Disorder Review*, 12(3) pp. 180-190
- Stienhausen, H. (2009). Outcome of eating disorders, *Child and Adolescent Psychiatric Clinics of North America*, Vol 18(1), pp. 225 – 242.
- Strober, M., Freeman, R., and Nirrekk, W., (1997)., The Long Term Course of Severe Anorexia Nervosa in Adolescents: Survival Analysis of Recovery, Relapse and Outcome Predictors Over 10- 15 Years in a Prospective Study, *International Journal of Eating Disorders*, 22(4) pp 339 -360
- Surgenor, L.J., and Maguire, S.(2013). Assessment of Anorexia Nervosa: An Overview of Universal Issues and Contextual Challenges, *Journal of Eating Disorders*. Vol1(1) pp.29
- Thaler, L., and Steiger, H. (2017). Eating Disorders and Epigenetics. In Delgado-Morales R. (eds) Neuroepigenomics in Aging and Disease. *Advances in Experimental Medicine and Biology*
- The Australian Government Department of Health (2018). *\$3.2 million to improve care for people with eating disorders [online]*. Available at: <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediareel-yr2018-hunt072.htm> [Accessed 10 Aug 2018]
- The Australian Government Department of Health (2018). *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative [online]* Available at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/AD7820EAC9F90D90CA25817900186FB2/\\$File/Fact per cent20sheet per cent20- per cent20BA per cent20for per cent20patients.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/AD7820EAC9F90D90CA25817900186FB2/$File/Fact%20per%20cent20sheet%20-%20BA%20for%20patients.pdf) [Accessed 9 Aug 2018].
- The Butterfly Foundation (2017). *National Agenda for Eating Disorders 2017 to 2022*. pg 14
- The Royal Australian College of General Practitioners (2018). *RACGP – QI&CPD 2017-19 Program*. [online] The RACGP [Accessed 13 Aug 2018] Available at: <https://www.racgp.org.au/education/qicpd-program/>



The Royal Australian College of General Practitioners (2018). *RACGP – Identifying eating disorders in general practice* [online] The RACGP [Accessed 13 Aug 2018]
Available at: <https://www.racgp.org.au/newsGP/Clinical/Identifying-eating-disorders-in-general-practice>

Zipfel, S., Wild, B., Groß, G. et. al (2013). Focal psychodynamic therapy, cognitive behaviour therapy, and optimised treatment as usual in outpatients with anorexia nervosa (ANTOP study): randomised controlled trial. *The Lancet*, 383 (9912):127-37. doi: 10.1016/S0140-6736



Appendix A: Further information on the Taskforce's approach to the MBS Review

The Taskforce is reviewing existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce's brief, there is considerable scope to review and provide advice on all aspects that would contribute to a modern, transparent and responsive system. This includes not only making recommendations about adding new items or services to the MBS, but also about an MBS structure that could better accommodate a changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach, and to seize this unique opportunity to recommend changes to modernise the MBS at all levels; from the clinical detail of individual items, to administrative rules and mechanisms, to structural whole-of-MBS issues. The Taskforce will also develop a mechanism for an ongoing review of the MBS once the current review has concluded.

As the MBS Review is clinician-led, the Taskforce decided that clinical committees should conduct the review of MBS items. The committees are broad-based in their membership, and members have been appointed in an individual capacity, rather than as representatives of any organisation.

The Taskforce asked the committees to review MBS items using a framework based on Professor Adam Elshaug's appropriate use criteria ⁽¹⁾. The framework consists of seven steps:

1. Develop an initial fact base for all items under consideration, drawing on the relevant data and literature.
2. Identify items that are obsolete, are of questionable clinical value[1], are misused[2] and/or pose a risk to patient safety. This step includes prioritising items as "priority 1", "priority 2", or "priority 3", using a prioritisation methodology (described in more detail below).
3. Identify any issues, develop hypotheses for recommendations and create a work plan (including establishing working groups, when required) to arrive at recommendations for each item.
4. Gather further data, clinical guidelines and relevant literature in order to make provisional recommendations and draft accompanying rationales, as per the work plan. This process begins with priority 1 items, continues with priority 2 items and concludes



with priority 3 items. This step also involves consultation with relevant stakeholders within the committee, working groups, and relevant colleagues or colleges. For those with complex needs, full appropriate use criteria were developed for the item's explanatory notes.

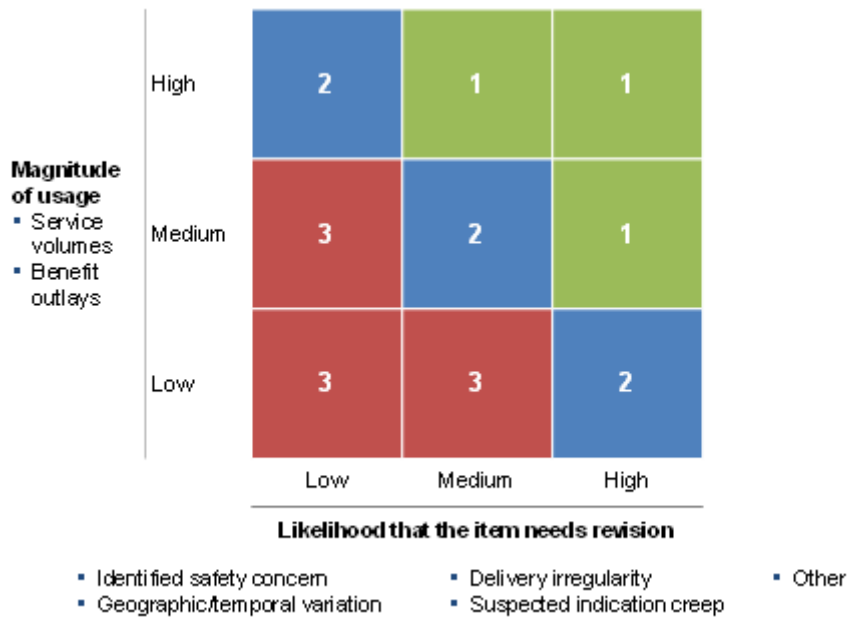
5. Review the provisional recommendations and the accompanying rationales, and gather further evidence as required.
6. Finalise the recommendations in preparation for broader stakeholder consultation.
7. Incorporate feedback gathered during stakeholder consultation and finalise the Review Report, which provides recommendations for the Taskforce.

All MBS items will be reviewed during the MBS Review. However, given the breadth of and timeframe for the Review, each clinical committee has to develop a work plan and assign priorities, keeping in mind the objectives of the Review. Committees use a robust prioritisation methodology to focus their attention and resources on the most important items requiring review. This was determined based on a combination of two standard metrics, derived from the appropriate use criteria:

- Service volume.
- The likelihood that the item needed to be revised, determined by indicators such as identified safety concerns, geographic or temporal variation, delivery irregularity, the potential misuse of indications or other concerns raised by the clinical committee (such as inappropriate co-claiming).



Figure 1: Prioritisation matrix



For each item, these two metrics were ranked high, medium or low. These rankings were then combined to generate a priority ranking ranging from one to three (where priority 1 items are the highest priority and priority 3 items are the lowest priority for review), using a prioritisation matrix (Figure 1). Clinical committees use this priority ranking to organise their review of item numbers and apportion the amount of time spent on each item.

[1] The use of an intervention that evidence suggests confers no or very little benefit on patients; or where the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of the intervention do not provide proportional added benefits.

[2] The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.



Appendix B: MBS items that relate to the treatment of patients with eating disorders

| MBS Category | MBS Group | MBS item/s |
|--|---|--|
| Category 1 – Professional Attendances | Group A6 – Group Therapy | Items 170-172 – supervision of family group therapy by a GP |
| | Group A8- Consultant Psychiatrist attendance | 291, 293, 359 - Referred patient assessment and management plan 296, 297, 299 and 361 - Initial consultation for new patients 342, 344, 346 - Group psychotherapy 288 - Video conferencing 300-319 - In consulting rooms 320-328 - In hospital 330-338 - Other locations 348-352 - Interview with non-patient 353-370 - Telepsychiatry |
| | Group A15- GP Management Plans, Team Multidisciplinary Care Plans | 855-866 – Multidisciplinary Case conferencing – participation by psychiatrist |
| | Group A20- GP Mental Health Treatment | 2700-2717 - GP Mental Health Plans 2721-2727 - GP Mental Health Treatment |
| Category 8 – Miscellaneous Services | Group M3-Allied Health Services | 10954 - Dietetics services for chronic condition 10956 - Mental health service for chronic condition 10958 - Occupational therapy services for chronic condition 10968 - Psychology health service |
| | Group M6- Psychological Therapy Services | 80000-80021 - Clinical psychologist |



| MBS Category | MBS Group | MBS item/s |
|---------------------|---|--|
| | Group M7- Focussed Psychological Strategies (Allied Mental Health) | 80100-80121 - Registered psychologist 80125-80146 - Occupational therapist 80150-80171 - Social worker |
| | Group M14- Nurse Practitioner | 82200-82225 – nurse practitioner attendance |



Appendix C: Appropriately trained health practitioners able to provide eating disorders specific treatment

The Working Group believes that the following allied health and mental health professionals (with further training, credentialing and experience in the treatment of eating disorders) should be able to administer evidence-based treatments to patients with a diagnosis of an eating disorder:

- GPs who have completed accredited mental health training
- Psychologists
- Social workers
- Occupational therapists
- Counsellors
- Psychotherapists
- Dietitians
- Mental health nurses

The Working Group also believe that these practitioners should have substantial training in mental health and accreditation by AHPRA or their own profession.



Appendix D: Referrals to other Clinical Committees

Memorandum to the Allied Health Reference Group

14th August 2018

Dear Allied Health Reference Group,

In September 2017 the Medicare Benefits Schedule Review Taskforce (the Taskforce) established the Eating Disorders Working Group (EDWG). The Taskforce was requested by the Minister to investigate current treatment options for those suffering with eating disorders.

The EDWG have investigated current approaches to the treatment of people with eating disorders as funded by the Medicare Benefits Schedule (MBS), examining whether they are adequate. The EDWG also reviewed new approaches to improving treatment pathways.

The EDWG's investigation is framed through the following lenses:

- △ The goal of the Taskforce is to ensure that the MBS funds 'affordable and universal access [to] best practice health services'. MBS funding should represent both 'value for the individual patient [and] value for the community'.
- △ It is widely accepted that treatment services for people with eating disorders are fragmented and difficult to locate. This can be exacerbated by the patient's geographical location in relation to treatment services, and item restrictions. These two factors can potentially limit access.
- △ Of all psychiatric disorders, eating disorders have one of the highest impacts on health-related quality of life. Eating disorders affect about 1 in 20 Australians, with an increasing prevalence in both women and men, with Anorexia nervosa (AN) and bulimia nervosa (BN) often associated with high rates of hospitalisation, premature death and suicide. The Australian Government has therefore flagged eating disorders as a priority.

Following the completion of the investigation, a report is expected to be provided to the Minister by the end of 2018.

The EDWG will be recommending a specific item for those severe AN. In light of this, the EDWG would like to draw the Allied Health Reference Group's (AHRG) attention to the following MBS items for consideration and review:

△ **MBS support for chronic medical conditions under Chronic Disease Management MBS items**

– **Suggestion:**

- Expand Multidisciplinary case conference MBS items 735, 739, 743 to include payments to appropriately trained dietitians and accredited mental health professionals including mental health nurses, social workers, occupational therapists, counsellors and psychotherapists who are **specialised in the treatment of eating disorders**.



- EDWG considered the need for reimbursement for allied health professionals and accredited mental health professionals to receive rebates for their involvement in case conferencing, similar to item 729 for GP contribution into a MDT care plan or case conferencing items listed in MBS items subgroup A15.
- Increase the annual limit of dietitian sessions (item 10954) for patients with severe cases of AN.
- Increase the annual limit of dietitian sessions (item 10954) for moderate to severe binge eating disorder (BED) and BN.
- The EDWG acknowledges EDs are covered under this item as it is a chronic disease.

– **Rationale:**

- This request focuses on encouraging collaboration and enhancing the integration of health professionals from different disciplines.
- The most effective interventions for severe forms of eating disorders are delivered through a multidisciplinary team (MDT) comprising of at least two members including: GP, psychiatrist, dietitian and/or an allied health/mental health practitioner with specialist eating disorder training (e.g. a psychologist or mental health nurse).^{82 83 84 85 86}
- Regular medical assessment, combined with nutritional therapy and psychological therapy are critical components of the successful treatment of all eating disorders.⁸⁷
- The EDWG therefore recommends that AHRG consider expanding allied mental health items (10950-10970) to diagnosed eating disorders, to facilitate collaboration between medical and allied health practitioners.

⁸² BUTTERFLY FOUNDATION, 2018, Improving Access to Evidence Based Eating Disorders treatment through Primary and Allied Health Services. Butterfly Foundation.

⁸³ DIETITIANS ASSOCIATION OF AUSTRALIA, 2018, Expanding access to Accredited Practicing Dietitians under Medicare [online]. Dietitians Association of Australia. [Accessed 8 July 2018]. Available from: <https://daa.asn.au/wp-content/uploads/2018/04/DAA-Pre-Budget-Submission-Jan-2018.pdf>

⁸⁴ ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS, 2014, Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders [online]. [Accessed 8 July 2018]. Available from: <https://www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/Eating-Disorders-CPG.aspx>

⁸⁵ NATIONAL EATING DISORDER COLLABORATION, 2014, Eating Disorders: A Professional Resource for General Practitioners [online] InsideOut Institute. [Accessed 10 July 2018]. Available from: [https://insideoutinstitute.org.au/assets/eating per cent20disorders; per cent20a per cent20professional per cent20resource per cent20for per cent20general per cent20practitioners.pdf](https://insideoutinstitute.org.au/assets/eating%20disorders;%20a%20professional%20resource%20for%20general%20practitioners.pdf)

⁸⁶ Eating Disorders Association INC, 2012, Eating Disorders: Information Pack for General Practitioners [online] InsideOut Institute. [Accessed 8 July 2018]. Available from: [https://insideoutinstitute.org.au/assets/eating per cent20disorders; per cent20an per cent20information per cent20pack per cent20for per cent20general per cent20practitioners.pdf](https://insideoutinstitute.org.au/assets/eating%20disorders;%20an%20information%20pack%20for%20general%20practitioners.pdf)

⁸⁷ BUTTERFLY FOUNDATION, 2018, Improving Access to Evidence Based Eating Disorders treatment through Primary and Allied Health Services. Butterfly Foundation.



- Financial constraints inhibit patients with AN or severe forms of BN from frequently attending consultations with health practitioners.⁸⁸ Patients do not make enough progress to remain out of hospital and the financial burden is eventually transferred to the government.⁸⁹
- Currently, patients can access up to five allied health sessions. Evidence states that this is insufficient to treat AN and severe forms of BN. The EDWG recommend this be increased. Expert groups recommend up to a total of 10 sessions for moderate to severe BED or BN and up to a total of 12 sessions for AN⁹⁰ be administered by allied health/mental health practitioners (i.e. mental health nurses, counsellors, psychotherapists, social workers, occupational therapists and dietitians) with nationally recognised training specific to the treatment of eating disorders. Current 'best practice' clinical guidelines recommend both family-based therapy (FBT) for AN patients under 18 years of age living with family, or cognitive behavioral therapy (CBT) in its many forms (such as CBT-Advanced (CBT-E)) for all AN patients. CBT-E is most commonly used in the treatment of BN, fixed length sessions consisting of 20 sessions over 20 weeks.

⁸⁸ *ibid*

⁸⁹ *ibid*

⁹⁰ *ibid*



Memorandum to the General Practice and Primary Care Clinical Committee

14th August 2018

Dear General Practice and Primary Care Clinical Committee,

In September 2017 the Medicare Benefits Schedule Review Taskforce (the Taskforce) established the Eating Disorders Working Group (EDWG). The Taskforce was requested by the Minister to investigate current treatment options for those suffering with eating disorders.

The EDWG have investigated current approaches to the treatment of people with eating disorders as funded by the Medicare Benefits Schedule (MBS), examining whether they are adequate. The EDWG also reviewed new approaches to improving treatment pathways.

The EDWG's investigation is framed through the following lenses:

- △ The goal of the Taskforce is to ensure that the MBS funds 'affordable and universal access [to] best practice health services'. MBS funding should represent both 'value for the individual patient [and] value for the community'.
- △ It is widely accepted that treatment services for people with eating disorders are fragmented and difficult to locate. This can be exacerbated by the patient's geographical location in relation to treatment services, and item restrictions. These two factors can potentially limit access.
- △ Of all psychiatric disorders, eating disorders have one of the highest impacts on health-related quality of life. Eating disorders affect about 1 in 20 Australians, with an increasing prevalence in both women and men, with Anorexia nervosa (AN) and bulimia nervosa (BN) often associated with high rates of hospitalisation, premature death and suicide. The Australian Government have therefore flagged eating disorders as a priority.

Following the completion of the investigation, a report is expected to be provided to the Minister by the end of 2018.

The EDWG will be recommending a specific item for those with severe AN. In light of this, the EDWG would like to draw the General Practice and Primary Care Clinical Committee's (GPPCCC) attention to the following MBS items for consideration and review:

△ Promoting and expanding chronic disease management (CDM) services

– Suggestion:

- The EDWG noted that items 721-732 are often underutilised by General Practitioners in the treatment of people with eating disorders. GPs often do not recognise eating disorders as a chronic condition. The EDWG requests GPPCCC to recognise and name eating disorders as one of the eligible chronic conditions listed under this item. The EDWG acknowledges EDs are covered under this item as it is a chronic disease.

– Rationale:



- The EDWG notes the key role General Practitioners (GPs) play in patient treatment and management. GPs are often the initial diagnostician. CDM MBS items can be used by GPs with patients diagnosed with an ED. This is not always occurring.
- The EDWG therefore suggests that eating disorders be named as a chronic condition within the MBS item. Further education and training for GPs on best practice guidelines for treating patients with eating disorders should be considered. Apart from providing medical assistance, GPs are the key link in access to specialist services and psychological therapies.



Memorandum to the Mental Health Reference Group

14th August 2018

Dear Mental Health Reference Group,

In September 2017 the Medicare Benefits Schedule Review Taskforce (the Taskforce) established the Eating Disorders Working Group (EDWG). The Taskforce was requested by the Minister to investigate current treatment options for those suffering with eating disorders.

The EDWG have investigated current approaches to the treatment of people with eating disorders as funded by the Medicare Benefits Schedule (MBS), examining whether they are adequate. The EDWG also reviewed new approaches to improving treatment pathways.

The EDWG's investigation is framed through the following lenses:

The goal of the Taskforce is to ensure that the MBS funds 'affordable and universal access [to] best practice health services'. MBS funding should represent both 'value for the individual patient [and] value for the community'.

It is widely accepted that treatment services for people with eating disorders are fragmented and difficult to locate. This can be exacerbated by the patient's geographical location in relation to treatment services, and item restrictions. These two factors can potentially limit access.

Of all psychiatric disorders, eating disorders have one of the highest impacts on health-related quality of life. Eating disorders affect about 1 in 20 Australians, with an increasing prevalence in both women and men, with Anorexia nervosa (AN) and bulimia nervosa (BN) often associated with high rates of hospitalisation, premature death and suicide. The Australian Government have therefore flagged eating disorders as a priority.

Following the completion of the investigation, a report is expected to be provided to the Minister by the end of 2018.

The EDWG will be recommending a specific item for those people with severe AN. In light of this, the EDWG would like to draw the Mental Health Reference Group's (MHRG) attention to the following MBS items for consideration and review:

MBS support for severe mental health disorders under Better Access items

Suggestions:

The EDWG considered expanding mental health items (80100-80171) to enable delivery of Focused Psychological Strategies (FPS) for patients with ED, by the following additional practitioners with **specific training and experience in the treatment of ED**:

- Appropriately trained mental health nurses
- Appropriately trained counsellors
- Appropriately trained psychotherapists
- Appropriately trained social workers



- Appropriately trained occupational therapists

– **Rationale:**

The EDWG recommends that allied mental health items (80100-80171) be extended to mental health nurses and other skilled practitioners. The EDWG recognises the significant contributions of mental health nurses, counsellors, psychotherapists, occupational therapists, psychologists and social workers in treating patients with eating disorders.

People with eating disorders experience higher rates of other mental illnesses, almost 97 per cent of people with eating disorders have a comorbid condition.⁹¹

The EDWG recognised that mental health nurses may be in the best place to bridge gaps in mental health services because nurses, in general, are distributed more evenly across major cities, inner regions and remote areas as compared to other specialists, psychiatrists and psychologists in particular.

Patients living in rural and remote Australia are expected to benefit from these changes as services in these localities are scarce and access to eating disorder treatment are limited.

Δ **MBS Support for Family-based therapy (FBT) items 170-172**

–

- Moved to extended psychological therapy item numbers as discussed

– **Rationale:**

- This request focuses on ensuring that MBS listed mental health services align with best practice and evidence-based forms of therapy. FBT is considered part of the first line of treatment for children and adolescents with AN and BN, and has been shown to be an effective approach to treatment.⁹²
- It is the view of the EDWG that appropriately qualified mental health professionals should be able to administer FBT. It was the view of the EDWG that family therapy items were underutilised due to lack of awareness among clinicians, and the use of FBT in the treatment of patients with or recovering from ED should be better promoted in general practices.
- The EDWG recognised the important role families play in the assessment and overall treatment processes for young people and recommend that appropriate support should be provided to manage the burden to families of AN.³
- Eating disorders have one of the highest burdens on carers among the mental illnesses, equivalent to that of psychosis.⁴ Eating disorders affect mental and physical wellbeing, with primary effects being on eating and meal times. Therefore, they have a systemic impact on families and carers, and on all activities of family life. Family therapy as well as skills building sessions⁵ have been demonstrated as evidence based in eating disorders.

⁹¹ Eating Disorders Association INC, 2012, *Eating Disorders: Information Pack for General Practitioners* [online] InsideOut Institute. [Accessed 8 July 2018]. Available from: https://insideoutinstitute.org.au/assets/eating_per_cent20disorders;_per_cent20an_per_cent20information_per_cent20pack_per_cent20for_per_cent20general_per_cent20practitioners.pdf

⁹² Butterfly Foundation for Eating Disorders. (2018). *Improving Access to Evidence Based eating Disorders Treatment through Primary and Allied Health Services*.



- The use of FBT is recommended by best practice guidelines for treating AN in children and adolescents. Family based therapy is a recommended treatment option for young people with AN (up to the age of 18) living with family.⁶
- The EDWG also recognises the significant contributions of mental health nurses, counsellors, psychotherapists, occupational therapists, psychologists and social workers in treating patients with eating disorders. The EDWG therefore recommends that such individuals with appropriate training in mental health, eating disorders and within their profession, be able to provide these services to some patients as prescribed by specialist psychiatrists and paediatricians using evidence-based criteria.

Δ **Separating GP delivered Focused Psychological Strategies (FPS) Services from other psychological therapy services**

– **Suggestion:**

- The EDWG supports the decoupling of GP items 2721 – 2727; professional attendance at consulting rooms or at a place other than a consulting room by a general practitioner, for providing focused psychological strategies for assessed mental disorders lasting at least 30 minutes, but less than 40 minutes, from MH PCRG items 80000, 80001, 80010, 80011, 80100, 80110, 80111, 80125, 80126, 80135, 80136, 80150, 80151, 80160. This would ensure that services provided by the GP do not count towards the ten individual allied mental health/psychological services per calendar year.

– **Rationale:**

- Decoupling these items would ensure that services provided by the GP do not count towards the 10 individual allied mental health/psychological services per calendar year. Decoupling medical practitioner psychological services from other item codes potentially improves patient access to additional allied health and mental health professionals.
- The EDWG noted the importance of a diagnosis from a specialist psychiatrist or pediatrician and the use of evidence-based therapies in the treatment of eating disorders. Clinical guidelines and the EDWG recommend both FBT for young AN patients living with family, and cognitive based therapies (CBT) such as Enhanced CBT (CBT – E) for both adults and children with AN. Decoupling the MBS items could increase the number of FBT and CBT – E sessions a patient could access from specialist psychological services.
- Decoupling the items codes will ensure that patients can receive appropriate post-treatment care, maximising their potential of long term recovery from the illness.



Memorandum to the Principles and Rules Committee

14th August 2018

Dear Principles and Rules Committee,

In September 2017 the Medicare Benefits Schedule Review Taskforce (the Taskforce) established the Eating Disorders Working Group (EDWG). The Taskforce was requested by the Minister to investigate treatment options for those suffering with eating disorders.

The EDWG have investigated current approaches to the treatment of people with eating disorders as funded by the Medicare Benefits Schedule (MBS), examining whether they are adequate. The EDWG also reviewed new approaches to improving treatment pathways.

The EDWG's investigation is framed through the following lenses:

- △ The goal of the Taskforce is to ensure that the MBS funds 'affordable and universal access [to] best practice health services'. MBS funding should represent both 'value for the individual patient [and] value for the community'.
- △ It is widely accepted that treatment services for people with eating disorders are fragmented and difficult to locate. This can be exacerbated by the patient's geographical location in relation to treatment services, and item restrictions. These two factors can potentially limit access.
- △ Of all psychiatric disorders, eating disorders have one of the highest impacts on health-related quality of life. Eating disorders affect about 1 in 20 Australians, with an increasing prevalence in both women and men, with anorexia nervosa (AN) and bulimia nervosa (BN) often associated with high rates of hospitalisation, premature death and suicide. The Australian Government have therefore flagged eating disorders as a priority.

Following the completion of the investigation, a report is expected to be provided to the Minister by the end of 2018.

The EDWG would therefore like to draw the Principles and Rules Committee's attention to the following MBS items for consideration and review:

△ MBS psychiatry items

– Suggestion:

- The EDWG suggests that in instances where a psychiatrist is unable to consult with a patient in the same physical location, **a new MBS item be created to allow psychiatrists to supervise other health professionals** who do not have adequate qualifications specific to eating disorders. This supervision should include the planning and coordination of care of patients with diagnosed eating disorders.

Rationale:

- The EDWG recommends this new item recommendation for the treatment of people with eating disorders be contingent on a diagnosis by a specialist psychiatrist or



paediatrician in order for the patient to be eligible for extended treatment programmes. The EDWG also recognises the need for limitation of expanded Medicare benefits to patients diagnosed with AN or moderate-to-severe cases of BN.

- The EDWG acknowledged that there are no major outstanding issues with the psychiatrist consultation MBS item group.
- The EDWG recommends the funding of secondary consultation services, such as case conferencing. This new supervision item will support patients and health professionals who do not have psychiatrist training access to specialist knowledge.
- The additional item will enable psychiatrists to partake in treatment planning and the supervision of patients with AN or BN.
- This would specifically benefit patients living in rural and remote Australia as specialist services are scarce and access to eating disorder treatments are limited.
- The EDWG is aware that currently Medicare benefits are available for video consultation between psychiatrists and patients who are located in telehealth eligible areas.



Appendix E: Summary for consumers

This table describes the medical service, the recommendation(s) of the clinical experts and why the recommendation(s) has been made.

Recommendation 1.1

| Item | What it does | Committee recommendation | What would be different | Why |
|------|--------------|--|---|---|
| n/a | n/a | <p>The Working Group is of the view that there is an evidence base that supports a comprehensive model of care for all patients with eating disorders.</p> <p>Under a comprehensive model, the evidence shows that all patients with a diagnosed eating disorder should get access to up to 20 psychological sessions in total per year and 10 dietetic sessions in total per year. Under this model, patients requiring more intensive treatment would be eligible to receive up to 40 psychological sessions in total and 20 dietetic sessions in total.</p> <p>The Working Group views that the expansion of MBS arrangements for all patients with eating disorders is necessary and should be implemented as soon as practical after the implementation of the new items outlined in recommendation 1.2.</p> | <p>This recommendation acknowledges that there is an evidence base supporting the implementation of a comprehensive model of care for all patients with a diagnosed eating disorders.</p> <p>This recommendation sets out a phased approach to expand the MBS arrangements to other patient groups over time.</p> | <p>To align eating disorder treatment options in Australia with evidenced based clinical best practice.</p> |



Recommendation 1.2

| Item | What it does | Committee recommendation | What would be different | Why |
|------|--------------|--|--|---|
| n/a | n/a | <p>The Working Group recommends the introduction of a new suite of items to provide a comprehensive stepped model of care for:</p> <ul style="list-style-type: none"> all patients with anorexia nervosa; and patients with bulimia nervosa, binge-eating disorder and other specified feeding or eating disorders who have complex needs and have not responded to treatment at a lower level of intensity and are assessed as 'high-risk' of serious medical and psychological complications. <p>The new items would provide for:</p> <ul style="list-style-type: none"> the development and review of a treatment and management plan by a medical practitioner (such as a GP). This item would trigger eligibility for a comprehensive model of care, consisting of an initial and more intensive course of psychological and dietetic treatment depending of the patients needs. <p><u>Initial course of treatment</u></p> <p>Triggered by the development of a treatment and management plan by a medical practitioner (GP):</p> <ul style="list-style-type: none"> an initial course of up to 20 psychological sessions; and an initial course of up to 10 dietetic sessions. <p>The GP will assess the patients out through the treatment process, but should assess whether the</p> | <p>Patients would get access to up to 40 psychological (30 more than currently available) and up to 20 dietetic (15 more than currently available) per year.</p> <p>The patient will be required to have regular assessments with their GP for continued access to psychological and dietetic services (up to 20 psychological and 10 dietetic services).</p> <p>Before the patient can access more than 20 psychological and 10 dietetic services, the patient must be reviewed by a psychiatrist or paediatrician.</p> | <p>To align eating disorder treatment options for patients with anorexia nervosa and other patients with other eating disorders who have not responded to treatment at a lower intensity with evidenced based clinical best practice.</p> <p>Providing Medicare rebates for additional psychological and dietetic services will support patients to receive the treatment that they need to get better. Cost of health services has been identified as a barrier to patients accessing and continuing with their treatment course.</p> <p>Requiring the patient to have regular assessments with their GP will ensure that the patient's medical and physical aspects of their health are being managed.</p> <p>Requiring the patient to be assessed by a psychiatrist or paediatrician will ensure that the correct diagnosis has been given and the treatment course it appropriate for the patient. This also ensure that the GP can receive specialist advice to support patient management.</p> <p>Implementation of a comprehensive stepped model of care for a subset of the eating disorders population will allow for an assessment of the operation of such a care model within Medicare.</p> |



Recommendation 1.2

| Item | What it does | Committee recommendation | What would be different | Why |
|------|--------------|--|-------------------------|-----|
| | | <p>patient should progress beyond 10 psychological sessions and 5 dietetic sessions by conducting a review consultation (with a New Item Number) before or around 9 or 10 sessions completed mark, to approve and trigger another course of 10 psychological sessions and 5 dietetic services (up to 20 psychological sessions and up to 10 dietetic sessions).</p> <p><u>More intensive treatment</u></p> <p>If the patient has not responded to treatment at a lower intensity, upon formal review and assessment of the patient by a psychiatrist or paediatrician, the patient would be eligible for:</p> <ul style="list-style-type: none"> ○ an additional course of up to 20 psychological sessions (40 sessions in total per year) ; and ○ an additional course of up to 10 dietetic sessions (20 sessions in total per year). | | |



Recommendation 1.3

| Item | What it does | Committee recommendation | What would be different | Why |
|------|--------------|--|---|---|
| n/a | n/a | The Working Group recommends that the impact and operation of the new items should be reviewed as soon as practical after introduction of the new items to assess the viability of expanding the Medicare Benefits Schedule (MBS) to provide for a comprehensive stepped care models to all patients with eating disorders | There will be no changes to the MBS as a result of this recommendation. | A review of the new items will assess viability for expanded a comprehensive care model to patients with eating disorders |

Recommendation 1.4

| Item | What it does | Committee recommendation | What would be different | Why |
|------|--------------|--|---|---|
| n/a | n/a | The Working Group recommends the services referred to in recommendation 1.2 be allowed to be provided via telehealth (under the same eligibility requirements that exist for other MBS services) in order to increase access to services for patients in rural and remote areas. | Any new items introduced would be allowed to be provided via telehealth under the same conditions that apply to existing MBS items. | Allowing these services to be provided via telehealth will increase access to services for patients in rural and remote areas where there may not be a practitioner who can provide treatment for a patient with an eating disorder |

Recommendation 2.1



Recommendation 2.1

| Item | What it does | Committee recommendation | What would be different | Why |
|------------------------|--|---|---|---|
| 729 735,739 and 743 | <p>GP contribution to MDT plan developed by another practitioner</p> <p>Enables case conferencing between practitioners to:</p> <p>(a) discuss a patient's history;</p> <p>(b) identify the patient's MDT care needs;</p> <p>(c) identify outcomes to be achieved by members of the case conference team giving care and service to the patient;</p> <p>(d) identify tasks that need to be undertaken to achieve these outcomes, and allocates those tasks to members of the case conference team; and</p> <p>(e) assess whether previously identified outcomes (if any) have been achieved.</p> | <p>The Working Group requests that the Allied Health Reference Group investigate and consider expanding access to provide multidisciplinary team (MDT) case conference MBS items 735, 739, 743 and to item 729 (contribution to a MDT care plan prepared by another practitioner) to allied health professionals who are trained in the treatment of eating disorders.⁹³</p> | <p>The Working group requests that the expert committee looking at the MBS items for allied health consider issues around remunerating allied health and mental health practitioners for their participation in case conferences and for contributing to MDT plans. If changes were made to enable allied health and mental health practitioners to provide services under these items, it would enable patients to receive Medicare benefits for these services.</p> <p>Currently only medical practitioners are remunerated through the MBS for their involvement in a MDT case conference. Similarly, currently Medicare rebates are only available for medical practitioners to contribute to a MDT plan.</p> | <p>The safe treatment of an eating disorder is best provided by a MDT and often multiple service agencies. Strong relationships and frequent communication between the treatment providers prevents deterioration in the patient's physical and mental health, and reduces the likelihood of chronicity and hospitalisation.</p> <p>The availability of Medicare rebates will assist in the promotion of MDT collaboration.</p> |

⁹³ The term allied health and mental health professional is used refers to dietitians and accredited mental health professionals including GPs who have completed accredited mental health training, psychologists, mental health nurses, social workers, occupational therapists, counsellors and psychotherapists.



Recommendation 2.2

| Item | What it does | Committee recommendation | What would be different | Why |
|---------------------------------------|---|--|---|---|
| 80100-80171 and any new items created | These items provide for the delivery of focussed psychological strategies by mental health professionals. | Allow appropriately trained practitioners to provide family-based therapy (FBT) under the items for focussed psychological strategy services and any new psychological services provided under the new MBS items (to which recommendation 1.2 refers). FBT should be delivered in line with the evidence base in this area. FBT services will count towards the patient's allocation of psychological services provided through the new MBS items. | Allows appropriately trained practitioners to provide the family based therapy. | <p>The family are usually an integral part of the decision-making process and this increases access to family centric care.</p> <p>Family based therapy can supports the family throughout the diagnosis and assessment. Families are also usually the support unit that help to bridge the gap between initial diagnosis and eating disorder specific treatment.</p> |



Recommendation 2.3

| Item | What it does | Committee recommendation | What would be different | Why |
|------|--------------|---|--|--|
| n/a | n/a | The Working Group identified a number of other changes that could be made to MBS items to support the delivery of care for patients with eating disorders. The Working Group requests that the Clinical Committees responsible for these items consider the identified issues during the Committees' work. Appendix D provides the full referrals made to these Committees. | In brief, the recommendations to the clinical committees include: (a) Reimbursement for allied health professionals and accredited mental health professionals involved in case conferencing and contribution to MDT care planning (b) Increase the annual limit of dietitian and psychological sessions funded through the MBS. (c) Name eating disorders as one of the eligible chronic conditions listed under MBS items 721 – 735 (d) Expand access to mental health items (80100-80171) to enable delivery of Focused Psychological Strategies (FPS) by appropriately trained mental health professionals for patients with eating disorders. (e) Where a psychiatrist is unable to consult with a patient in the same physical location, allow psychiatrists to supervise other health professionals who do not have adequate ED qualifications. | Strengthen the MBS infrastructure to: <ul style="list-style-type: none"> • Support the delivery of care of evidence based best practice care at a subsidised cost; • Support MDT collaboration; and • Enable appropriately trained practitioners to provide care to people with eating disorders under the existing MBS arrangements. |

**Recommendation 3.1**

| Item | What it does | Committee recommendation | What would be different | Why |
|------|--------------|---|--|--|
| n/a | n/a | Support and education should be provided to GPs regarding locally available services for patients with eating disorders and their families. | Further information will be provided to GPs to assist them to identify services or practitioners in their local area that provide treatment for patient with eating disorders. Support services for family members, such as support groups, should form part of the information provided to GPs. | GPs are the primary health care professional responsible for patient care. GPs are usually the coordinators of care and are ideally placed to provide patients and their families with information about local services. |



Recommendation 3.2

| Item | What it does | Committee recommendation | What would be different | Why |
|------|--------------|---|---|--|
| n/a | n/a | Professional associations and other relevant training organisations should develop and/or extend specific training, education and clinical guidance for working with people who have eating disorders. This training should be included in undergraduate and post graduate university health programs, continuing professional development programs for disciplines involved in the treatment and management of patients with eating disorders, and in particular, any health professionals providing services under the new MBS items. | Increased training which is specific to the diagnosis, treatment and management of patients with eating disorders should be made available which is specific to each of the professionals involved in providing care to patients with eating disorders. | Improving training for all health professionals could also increase the number of timely diagnoses, referrals and decrease the overall number of eating disorder related hospitalisations. |



Recommendation 3.3

| Item | What it does | Committee recommendation | What would be different | Why |
|------|--------------|--|--|--|
| n/a | n/a | A credentialing process should be established, specific to practitioners who diagnose and provide treatment to patients with eating disorders. Once established, these credentials should be used to determine practitioner eligibility to provide services under the new MBS items. | Practitioners that work with people diagnosed with eating disorders have appropriate accreditation and have been credentialed accordingly. | Ensure that high quality services are delivered by practitioners with the required knowledge and experience in eating disorders. |



Recommendation 3.4

| Item | What it does | Committee recommendation | What would be different | Why |
|------|--------------|---|--|--|
| n/a | n/a | A credentialing process should be established, specific to practitioners that provide treatment for patients with eating disorders. Once established, these credentials should be used to determine practitioner eligibility to provide services under the new MBS items. | Practitioners that work with people diagnosed with eating disorders have appropriate accreditation and have been credentialed accordingly. | Ensure that high quality services are delivered by practitioners with the required knowledge and experience in eating disorders. |