

Senate Community Affairs References Committee

Inquiry into Commonwealth funding and administration of mental health services

Monday, 5 September 2011

Questions on Notice – Christine Morgan, CEO Butterfly Foundation

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**Question 1: UNDER ATAPS, WHAT IS THE STANDARD CONSULTATION RATE CHARGED AT EACH DIVISION LEVEL?**

**Source:**

**CHAIR:** If they charge a co-payment for those sessions, what is the value of the co-payment.

**Mrs Morgan:** I understand that they will cover \$120 per session under Medicare.

**Senator MOORE:** So it is about \$100 on average.

**Mrs Morgan:** Yes.

**Senator MOORE:** And under ATAPS a standard rate is worked out at each division level—

**Mrs Morgan:** Correct—

**Senator MOORE:** and that varies. But the practitioners in your survey have indicated that they would not be able to survive if they continued to operate in that way.

**Mrs Morgan:** I believe so. I do not have the exact figure. I can come back to you with it if you would like. But I believe it is a hundred and something under ATAPS.

**ANSWER:**

The reference to the co-payment relates to the Better Access scheme. Pursuant to further enquiries, I confirm that the rebate per session is \$120. The Australia New Zealand Academy for Eating Disorders has confirmed that the range of cost of services per session (as charged by the psychologist) is \$130-\$220 which means that the gap range to be funded by the client after application of the Medicare rebate is \$200 - \$2,000 for 20 sessions.

In relation to ATAPS the amount paid to the psychologist engaged by the relevant Division of General Practice is usually around \$110 per session, however the ability to charge a copayment is subject to the individual agreement a mental health practitioner has with their Division.

Based on the ANZAED data, the assumption is that the rate of \$130 - \$220 per session is the charge necessary for the psychologist to viably undertake the work the 'cost' the psychologist would carry in providing their services under ATAPS is \$20 - \$110 per session. If that psychologist commits to providing

either of the programs referred to in our submission requiring 20 sessions, and they are unable to charge a copayment, the total cost per client per program is between \$400 and \$2,200.

**Question 2: WHAT ARE THE REFERENCES FOR THE IMPROVED RECOVERY RATES FOR MAUDSLEY FBT?**

**Source:**

**Senator BOYCE:** You mention the Maudsley family based treatment and its improved recovery rates. Are you able to give us a reference for that? Your submission did not mention where those statistics come from. I am looking at page 3 of your submission.

**Mrs Morgan:** If you go to the last pages, page 14 and 15, we do have some references there.

**Senator BOYCE:** Oh, I thought I had done that.

**Mrs Morgan:** I will certainly take that on notice and make sure we come back to you with the specific reference, but I believe it is included in those references on page 14. I will double-check that for you.

**ANSWER:**

As noted in our submission, recent randomized controlled trials and research has demonstrated an average length of illness in children and adolescents provided with the Maudsley FBT of between 12-18 months with an 80-90% 5 year recovery rate, compared with an average length of illness of 7 years and a recovery rate of less than 50% in patients treated as adults.

I refer also to the submission of the Australian and New Zealand Academy of Eating Disorders. As noted in this submission in relation to the Maudsley Family Based Therapy – it confirms the reduced length of illness to 12 months for good recovery rates of 80% and at 5 years a recovery rate of 90%. The relevant reference for this is **Lock J, Couturier J, Agras WS. (2006) Comparison of long-term outcomes in adolescents with Anorexia Nervosa treated with family therapy *Journal of the American Academy of Child and Adolescent Psychiatry*; 45: 666-72.**

It also notes the recovery rate of less than 50% at 5 years for adult patients being referenced at **Steinhausen HC. (2002) The Outcome of Anorexia Nervosa in the 20<sup>th</sup> century: *Am J Psychiatry* 2002; 159(8):1284-1293.**

Again, it also references the findings of the clinical team specialising in Eating Disorders at The Children's Hospital at Westmead in NSW that on average, 30 sessions of this treatment improves the outcomes for Anorexia Nervosa patients, including halving the rate of readmission for an inpatient session. The references for this information are **Rhodes P, & Madden S. (2005). Scientist practitioner family therapists, post-modern medical practitioners and expert parents: Second order change in the eating disorders program at the Children's Hospital at Westmead *Journal of Family Therapy*; 27:171-82; and**

**Wallis, A., Rhodes, P., Kohn, M. & Madden, S. (2007) Five years of family based treatment for Anorexia Nervosa: The Maudsley Model at the Children's Hospital at Westmead. International Journal of Adolescent Medical Health 19(3):277-283.**

**Question 3: CAN YOU PROVIDE MORE DETAIL REGARDING WAITING LISTS AT PUBLIC HEALTH PSYCHOLOGY UNITS AND WHAT LEVEL OF EXPERTISE IN EDs IS AVAILABLE AT THESE?**

**Source:**

**Senator BOYCE:** On page 8 you talk about the waiting lists for public health psychology units. Are you able to perhaps put a bit more detail around that comment that the waiting lists are already long.

**Mrs Morgan:** That is a question that I myself have asked, and I am waiting back to hear back the numbers on it. I anticipated that that might be a question. I do not have a specific number for you, but I think the particular challenge we have with the public health psychology clinics is with both the expertise of the clinicians in relation to eating disorders and just the general waiting lists. I would be guessing at the waiting list numbers, but I can try and find out for you.

**ANSWER:**

In Western Australia, the children's services at Princess Margaret has a relatively short waiting list with assessments within one month – this has been the result of significant investment by the State Government in the child program enabling a sizeable increase in services. It has also been assisted by the Better Access Medicare rebate. For youth (+16 years) and adults in WA the only publicly funded treatment program is provided by the Centre for Clinical Interventions. The services provided include evidence based Family Based Therapy for adolescents with anorexia nervosa and Enhanced Cognitive Behaviour Therapy for youth and adults. The current waiting list at CCI is 8 months.

A paper by Dr Anthea Fursland, who is the ANZAED President and Principal Clinical Psychologist of the Eating Disorders Programme at CCI, recently presented at an ANZAED conference had some interesting findings pertinent to the impact of delay in treatment for those suffering from an eating disorder. Based on a study of 189 consecutive referrals to CCI, individual predictors and process factors were identified relating to dropout. The individual predictors were avoidance of affect and having a history of very low weight. The process factor was time spent on a waiting list.

In New South Wales Westmead Children's Hospital outpatient program for children and young people up to the age of 15 has a waiting list of 4-6 weeks. Family Based Therapy is provided for approximately 50% of eligible patients. There is another publicly funded service at Bulli with a waiting list of 3-4 months. This service offers individual outpatient psychological treatments.

In South Australia we understand that the waiting list is approximately a couple of months.

In Queensland there are only two adult outpatient specialist clinics for eating disorders, both situated in the south east. To ease the pressure on these services, patients are encouraged to access the private sector where possible and training is provided by the public eating disorders services team to private clinicians to use appropriate evidence based treatments.

We are still waiting for information on waiting lists in Victoria. In relation to services in the Northern Territory, the Australian Capital Territory and Tasmania this information is not readily to hand.

**Question 4: WHAT DEMOGRAPHICS ARE CURRENTLY ACCESSING THE BETTER ACCESS PROGRAM?**

**Source:**

**CHAIR:** I would like to go back to this issue of copayments. If I understand correctly, the families and the patients make a \$100 copayment each time, so we are talking about 20 sessions at \$100, which is \$2,000. I suggest to you that for low income families trying to find \$2,000 is very hard. What I would like to know if possible, if you have the figures, is what is the demographic of the people who are currently accessing the program. I suggest that even \$2,000 puts it way beyond the means of low income families and perhaps even some middle-income families.

**Mrs Morgan:** It certainly does. I would certainly agree with that. I will come back to you with the demographics as best I can find them.

**ANSWER:**

Unfortunately it has not been possible for us to obtain a demographic profile of families who are currently accessing the Better Access program. However, as noted in our response to the first question, the gap payment that needs to be met by families is in the range of \$200 - \$2,000 over 12 months, which can be less than \$20 per month.

**Question 5: ARE ANY PATIENTS WITH AN EATING DISORDER ACCESSING ATAPS AT THE MOMENT?**

**Source:**

**CHAIR:** I now go to the issue around ATAPS. To your knowledge, are any patients with an eating disorder accessing ATAPS at the moment?

**Mrs Morgan:** I do not have any accurate information on that. Once again I will see if I can find that out.

**CHAIR:** That will be appreciated. I would like to know if patients are accessing it already.

**ANSWER:**

Based on our enquiries it appears that patients are not currently being treated under ATAPS, with the possible exception of some services in **Victoria and Queensland**. ANZAED has provided information that they are not aware of any members of that organisation providing services under the ATAPS scheme. Butterfly also understands from discussions with DoHA that the ATAPS program was never developed with any particular treatment type or condition in mind, but in fact was designed to provide greater access to mental health services for the low socio-economic and disadvantaged demographics.

Given the financial uncertainty around the ATAPS funding model, ANZAED members have indicated that broadly, this scheme does not provide incentive to provide services to sufferers of eating disorders or to invest in the specific training that is required to provide effective treatment of these disorders.

### **Question 6: WHAT PUBLIC HEALTH SERVICES ARE AVAILABLE FOR SUFFERERS OF EDs?**

#### **Source:**

**Senator MOORE:** Mrs Morgan, because your organisation does so much work in this area, I am really interested in the issues about the public health services. I am from Queensland, and my understanding is that service is available through the public mental health system for people who are seeking that support. I would really like to hear from your organisation your understanding about what public health services are available. I totally take your point that you put in your submission that there are waiting lists—that is a given—but I am asking just in terms of the issues about the New South Wales system, where we know one of the great experts in the field operates out of the public health system. In getting a full picture, that would be really useful.

**Mrs Morgan:** I certainly would be happy to do so.

**Senator MOORE:** That would be lovely.

**Mrs Morgan:** I do know that what is done in Queensland has some excellent people working in it.

**Senator MOORE:** In the public area?

**Mrs Morgan:** In the public sector.

**Senator MOORE:** I know some practise privately as well, but, just in terms of getting a snapshot of all the services across the board, that would be very good—and I will follow up with the department as well.

#### **ANSWER:**

Our enquiries into what services are currently being provided in the public health system in each State and territory are ongoing. As noted, this is an exercise which is being undertaken in considerable detail for the Department of Health and Ageing through the National Eating Disorders Collaboration. It is due to be delivered to the Department in June 2012.