PSYCHOTHERAPY
AND COUNSELLING
FEDERATION OF
AUSTRALIA

Eating Disorders Submission to the MBS review

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Executive Summary

The Psychotherapy and Counselling Federation of Australia (PACFA), as peak body for the self-regulating profession of counselling and psychotherapy, is submitting to the Medicare Benefits Schedule Review on the need for new services to be provided for people with eating disorders.

PACFA has serious concerns that eating disorders are seriously under-serviced under *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (*Better Access*). As eating disorders are increasingly common, and among the most severe of mental disorders, there is a need for new specialist services to be provided through Medicare. The new services should include specialist eating disorder assessments to be undertaken by multi-disciplinary teams, and specialist psychological therapies to be delivered by mental health practitioners who have undertaken training in evidence-based interventions for eating disorders.

PACFA's submission is suported by the extensive research undertaken by the Butterfly Foundation and the National Eating Disorders Collaboration (NEDC), which research has informed this submisison, as well as a review of recent research evidence undertaken by PACFA.

Recommendations

The Medicare Benefits Schedule should be amended to incorporate all elements of the proposed Specialist Eating Disorders Program as outlined in PACFA's recommendations:

1. Discontinue GP Mental Health Plans to access psychological therapy for eating disorders.
2. Use Specialist Eating Disorder Assessments and six monthly Specialist Eating Disorder Reviews as the basis for all psychological therapy to be provided for eating disorders.
3. Ensure Specialist Eating Disorder Assessments and Reviews are undertaken by Eating Disorder Mental Health Practitioners.
4. Group therapy is not recommended as the primary choice of therapy for eating disorders but may be a useful supplementary treatment option.
5. Offer a range of evidence-based interventions for eating disorders, including but not limited to CBT, FBT, MANTRA and SSCM, to be delivered by Eating Disorder Mental Health Practitioners.
6. Treatment should allow for consultations with family members, either with or without the client being present, if required to support effective treatment.
7. Create new Medicare items for Specialist Eating Disorder Assessments, Reviews and Therapy to be delivered by Eating Disorder Mental Health Practitioners.
8. The number of therapy sessions available for eating disorders should not be arbitrarily limited but should be based on clinical necessity. Caps on services should be indicative only and extensions should be posible where this is clinically necessary.
9. Offer multi-disciplinary care for eating disorders which includes twenty sessions of psychological therapy for basic care or fifty sessions of psychological therapy for complex care.
10. Base eligibility to provide Specialist Eating Disorder Therapy on training and accreditation to specialise in eating disorders, rather than using the pool of existing Medicare providers.
11. Include counsellors and psychotherapists who are trained to specialise in eating disorders as Eating Disorder Mental Health Practitioners.

Background to PACFA

The Psychotherapy and Counselling Federation of Australia (PACFA) is the leading national peak body and professional association representing the self-regulating profession of counselling and psychotherapy. PACFA advocates for appropriate, accessible health services to meet the bio-psychosocial needs of consumers. Counselling and psychotherapy are interdisciplinary activities provided by a range of professionals, including psychologists, social workers and occupational therapists, as well as counsellors and psychotherapists.

Counselling and psychotherapy focus on the prevention of mental illness and the provision of psychotherapeutic interventions for psychological difficulties, while actively promoting the development, mental health and well-being of consumers. PACFA covers a range of therapeutic modalities including family therapy, relationship counselling, hypnotherapy, mindfulness-based interventions, integrative counselling, body-focused psychotherapy, spiritually-informed counselling, expressive arts therapies and psychodynamic psychotherapy.

PACFA has approximately 2,300 registered counsellors and psychotherapists who have completed training in counselling or psychotherapy to at least Bachelor degree level, and many are trained at postgraduate level. PACFA Clinical Registrants have completed at last two years of post-qualifying practice (750 client contact hours and 75 hours of clinical supervision); meet PACFA's annual requirements for professional development and supervision; and follow the PACFA Code of Ethics. PACFA Registrants are distributed throughout Australia in urban, regional and rural areas.

PACFA Registrants are listed on the Australian Register of Counsellors and Psychotherapists (ARCAP), the national register and credentialing system, established jointly by PACFA and our partner the Australian Counselling Association (ACA).

1. Improving therapeutic services for eating disorders

PACFA's submission focuses on the need for new specialist evidence-based therapeutic services for eating disorders to be provided through the Medicare Benefit Scheme (MBS). The term "eating disorders" covers a range of serious and complex disorders including Anorexia nervosa, Binge eating disorder, Bulimia nervosa, Avoidant/restrictive food intake disorder (ARFID) and Other specified feeding or eating disorder (OSFED).

The current services offered through *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (*Better Access*) are inadequate to meet the needs of clients with eating disorders which are complex biopsychosocial disorders which affect clients across the lifespan and range in severity from moderately severe to life threatening. If eating disorders are not treated early, they can take a long time to resolve and can have serious consequences for physical and well as mental health, including hospitalisation.

Eating disorders share common treatment approaches that are supported by a substantial body of research evidence. There is a need to address the medical, nutritional and psychological aspects of eating disorders through a multi-disciplinary approach. PACFA's submission focuses on the psychological aspect of treatment and how to integrate this within the multi-disciplinary approach.

PACFA has also made an earlier submission to the Medicare Benefits Schedule Review (PACFA, 2018) which proposes replacing *Better Access* with a new, better targeted, Primary Care Mental Health

Program. PACFA's recommendations for new MBS items for Specialist Eating Disorders Assessments and Therapy should be read in conjunction with PACFA's main submission. The new items recommended for eating disorders are *in addition to* the other items recommended by PACFA for the new Primary Care Mental Health Program.

1.1 GP Mental Health Plans

Multi-disciplinary specialist assessment instead of Mental Health Plans

Better Access requires a Mental Health Plan in order to access psychological therapy services. This is inappropriate for eating disorders which require more detailed, specialist assessment that addresses the medical, nutritional and psychological aspects of the disorder. GP Mental Health Plans should be replaced with a multi-disciplinary specialist assessment for diagnosing the eating disorder. Assessment for an eating disorder could be completed by a GP or Paediatrician working as a part of by a multi-disciplinary team which should also include a Dietitian and an Eating Disorder Mental Health Practitioner. These specialist assessments should be the basis of psychological therapy services provided, rather than a GP Mental Health Plan.

GP Mental Health Plans are a barrier to psychological therapy services. Requiring a Mental Health Plan for clients, who have already undergone specialist eating disorder assessment, in order to unlock psychological therapy pathways is an unnecessary duplication which wastes precious mental health resources that could be allocated to provide additional services.

In particular, the requirement to have a Mental Health Plan to access services is detrimental to family-based therapies, which are the first line interventions for a number of eating disorders and which require therapeutic sessions with other family members. This creates a situation where a Mental Health Plan is required for the parents or caregivers of a young person with an eating disorder if they wish to particiapte in interventions such as Family-Based Treatment. This involves giving every family member a diagnosis of an mental disorder which is not appropriate or necessary.

Furthermore, approximately one-third of Mental Health Plans are prepared by GPs who have not completed the AMA-approved mental health training. This raises serious concerns about the quality of Mental Health Plans that would be made, particularly for complex eating disorders, and the value that is being contributed beyond unlocking access to psychological therapy.

Depending on the diagnosis, two options for psychological therapy should be available. First, those diagnosed with Bulimia nervosa, Binge eating disorder and OSFED, with no significant medical or psychiatric comorbidities and who are assessed as low to moderate risk of suicide, should receive a package of basic integrated care for eating disorders. Second, those diagnosed with Anorexia nervosa or any eating disorder with significant medical instability, significant psychiatric comorbidities or significant risk or suicide or rapid weight loss and malnourishment, should receive a package of integrated care specialised for complex needs.

The multi-disciplinary, specialist assessment for an eating disorder should be coupled with six-monthly reviews and re-assessment to assess the quality and effectiveness of ongoing care. The psychological component of the assessment should be undertaken by an Eating Disorder Mental Health Practitioner. See page 10 for details of these practitioners.

Recommendations:

1. Discontinue GP Mental Health Plans to access psychological therapy for eating disorders.
2. Use Specialist Eating Disorder Assessments and six monthly Specialist Eating Disorder Reviews as the basis for all psychological therapy to be provided for eating disorders.
3. Ensure Specialist Eating Disorder Assessments and Reviews are undertaken by Eating Disorder Mental Health Practitioners.

1.2 Options for psychotherapeutic interventions

Cognitive Behavioural Therapy (CBT)

There is strong evidence for the effectiveness of CBT for eating disorders. PACFA's systematic literature review of interventions for eating disorders (Knauss & Schofield, 2009) focuses on Anorexia nervosa, Bulimia nervosa and OSFED and identifies a range of evidence-based interventions which are effective, particularly CBT.

A particular form of CBT, Cognitive Behavioural Therapy - Enhanced (CBT-E) has been found to achieve better outcomes than CBT for Binge eating disorder and Bulimia nervosa (Mitchell, Agras Crow, Halmi, Fairburn, Bryson & Kraemer, 2011) and for mild presenations of Anorexia nervosa (Fairburn, Cooper & Doll, 2009).

Mindfulness-based interventions

A recent meta-analysis found evidence for the effectiveness of mindfulness-based interventions for Binge eating disorder (Godfrey, Gallo & Afari, 2015). Four mindfulness-based interventions have evidence to support their effectiveness: Mindfulness-based Stress Reduction (MBSR), Mindfulness-based Cognitive Therapy (MBCT), Dialectical Behaviour Therapy (DBT) and Acceptance and Commitment Therapy (ACT). Overall, these mindfulness-based interventions were associated with a large or medium-large effect on Binge eating disorder with some studies finding greater effectiveness when delivered to a smaller group (Godfrey et al., 2015).

Group Therapy

There is only limited empirical evidence available for the effectiveness of group therapy for Anorexia nervosa (APA, 2006). Evidence is stronger for the effectiveness of mindfulness-based interventions for Binge eating disorder, which are delivered in groups, and these are supported by PACFA.

Group therapy is an appropriate part of treatment in specialist eating disorder programs where it is delivered alongside individual therapy (Downey, 2014). The benefits of group sessions are of a lesser magnitude than individual therapy (Stangier, Heidenreich, Peitz, Lauterback & Clark, 2003). As such, group therapy should generally not be the primary choice of therapy. However, psychoeducation and nutritional education groups may benefit clients in addition to individual psychological therapy.

Recommendation:

4. Group therapy is not recommended as the primary choice of therapy for eating disorders but may be a useful supplementary treatment option.

Evidence-based treatments not covered by Medicare

Some specific therapies have been developed for eating disorders. These have a strong evidence base and have therefore been endorsed by the Butterfly Foundation, a leading Australian organisation assisting people with eating disorders. These interventions should therefore be supported by Medicare. However, these interventions are not currently allowed under the *Health Insurance (Allied Health Services) Determination 2014* which limits the interventions available under *Better Access* to Cognitive Behavioral Therapy, Interpersonal Therapy, skills training, psycho-education and relaxation strategies.

There is also an issue with family-based therapies as currently these can only be provided under *Better Access* as group therapy. However the fee available for group therapy would not be appropriate for a small family and requires all family members to get a Mental Health Plan themselves in order to participate. Furthermore, the system doesn't allow for family sessions to take place without the client being present, which may sometimes be required for clincial reasons.

Family-Based Treatment (FBT)

Family-Based Treatment for adolescents (Maudsley FBT) is delivered as an intensive intervention with parents taking a crucial role in therapy, particularly in the home environment. Parents are supported in this by the therapeutic supervision of the multi-disciplinary team. The therapy has three phases over a period of six to twelve months, which integrates the family in weekly and monthly sessions, and includes some family meals being undertaken with the supervision of a therapist. FBT is the first line therapy for adolescents with Anorexia nervosa (NICE, 2017) as well as being adapted for adults, and for the treatment of Bulimia nervosa and Binge eating disorder. FBT was also found to be effective in PACFA's systematic literature review (Knauss & Schofield, 2009).

Parent-Focussed Therapy (PFT) is version of FBT adapted for delivery to parents or caregivers. Research has found this to be as effective as FBT (Le Grange, Hughes Court, Yeo, Crosby & Sawyer, 2016). Multi-family therapy for groups of families has also been shown to be as effective as FBT (Eisler, Simic, Hodsoll, Asen, Berelowitz, Connan, Ellis, Hugo, Schmidt, Treasure, Yi & Landau, 2016).

Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)

The MANTRA model is a collaborative cognitive-interpersonal approach that aims to addresses the personality traits and styles of thinking that maintain Anorexia nervosa in adults. Treatment takes place while the client continues with their normal daily activities (Schmidt & Treasure, 2006) and includes significant others in the treatment process. This intervention is tailored to meet needs of adults with Anorexia nervosa and should be recognised as the first line intervention (NICE, 2017).

Specialist Supportive Clinical Management (SSCM)

SSCM is an intervention for adults with Anorexia nervosa that combines medical management to alleviate symptoms with therapeutic support from a therapist. The goal is support the client back to normal eating and a healthy weight. This achieved through a supportive therapeutic alliance. Research has demonstrated the effectiveness of this intervention (Jordan, McIntosh & Bulik, 2015).

Other effective practice-based interventions

While the interventions identified above are a good starting point when identifying evidence-based treatments for eating disorders, PACFA cautions against having a restriced list of approved interventions. New research evidence is always emerging that would potentially change the evidence-based treatments being offered.

Treatment effectiveness is also highly dependent on the therapeutic alliance. A strong and positive therapeutic alliance, in the form of a collaborative, empathic and accepting bond between client and therapist, is an established predictor of outcome in psychotherapy (Martin, Garske & Davis, 2000). This is true for psychotherapy in general, and specifically for working with clients suffering from an eating disorder (Constantino, Arnow, Blasey & Agras, 2005; Geller, 2006; Loeb, Wilson, Labouvie, Pratt, Hayaki, Walsh, Agras & Fairburn, 2005).

Both clients and therapists have reported that the therapeutic alliance is an important factor in the quality of the therapy for eating disorders (de la Rie, Noordenbos, Donker & van Furth, 2008). From the client's perspective, trust in the therapist has been found to be the most important criterion for the quality of the therapy for eating disorders (de al Rie et al., 2008).

Other factors impact on the effectiveness of treatment (Vall & Wade, 2015). For example, one meta-analysis found that where clients had good interpersonal functioning, positive self-esteem or motivation to recover, outcomes were better, whereas those with depression, low self-esteem or familial problems had worse outcomes (Vall & Wade, 2015). Therefore therapeutic interventions targeting these factors in clients with depression, low self-esteem, relationship issues or poor motivation to recover, may impact on outcomes from the eating disorder treatment.

Recommendations:

5. Offer a range of evidence-based interventions for eating disorders, including but not limited to CBT, FBT, MANTRA and SSCM, to be delivered by Eating Disorder Mental Health Practitioners.
6. Treatment should allow for consultations with family members, either with or without the client being present, if required to support effective treatment.

New MBS item numbers

New Medicare item numbers are required for Specialist Eating Disorder Assessments, Reviews and Therapy *in addition to* the other items numbers recommended by PACFA for the new Primary Care Mental Health Program in its main submission to the MBS Review (PACFA, 2018). Suggested fees are benchmarked against the fees recommended by PACFA in its main submission. These ten recommended items are for services provided by any Eating Disorder Mental Health Practitioner.

Item No.	Description	Proposed Fees
NEW	Specialist Eating Disorder Assessment (<50 mins)	$84.80
NEW	Specialist Eating Disorder Review (<50 mins) other location	$106.00
NEW	Specialist Eating Disorder Assessment (>50 mins)	$124.50
NEW	Specialist Eating Disorder Assessment (>50 mins) other location	$145.65
NEW	Specialist Eating Disorder Review (<50 mins)	$84.80
NEW	Specialist Eating Disorder Review (<50 mins) other location	$106.00
NEW	Specialist Eating Disorder Therapy (<50 mins)	$84.80
NEW	Specialist Eating Disorder Therapy (<50 mins) other location	$106.00
NEW	Specialist Eating Disorder Therapy (>50 mins)	$124.50
NEW	Specialist Eating Disorder Therapy (>50 mins) other location	$145.65
NEW	Specialist Eating Disorder Group Therapy per consumer (>60 mins)	$31.65

Recommendations:

7. Create new Medicare items for Specialist Eating Disorder Assessments, Reviews and Therapy to be delivered by Eating Disorder Mental Health Practitioners.

1.3 Session caps

Better Access currently limits the number of sessions a client may access to ten per the calendar year. There is no underlying clinical justification for this limit and in some cases this cap can result in clients being unable to access the clinical services they need for a full recovery which in turn shifts the burden towards inpatient treatment.

The policy decision to restrict services under *Better Access* to ten sessions seems intended to ensure that the program is efficient by limiting the number of sessions for consumers with mild or moderate mental illness. This was described in the 2011/12 Federal Budget documents as 'rebalancing the number of annual allied health sessions to better align treatment to the needs of people' (Australian Government, 2011). However, this is inappropriate for eating disorders which generally require more intensive therapy.

The number of sessions available to a client with an eating disorder should be based on the Specialist Eating Disorder Assessment. For example, a course of Family-Based Treatment is twenty sessions of manualised therapy delivered by a multi-disciplinary team (Lock, Le Grange, Agras, Moye, Bryson & Jo, 2010). Psychotherapy for eating disorders also requires a minimum of twenty sessions of an evidence-based therapy specific to eating disorders if the client has no complex comorbidities or risk of suicide. However, a longer course of therapy may be required for people with complex presentations. Clients with complex, high-risk presentations may require up to fifty sessions of therapy, or possibly more. This group includes Anorexia nervosa, comorbidity, rapid weight loss or risk of suicide.

The cap on therapy sessions must be increased in order to allow best practice treatment of eating disorders. Clients who are limited to a lower number of sessions receive less effective care and are more likely to require hospitalisation at a later stage of their illness.

The recommended session numbers for group therapy would depend on the program being delivered. Where a group treatment is manualised, for example DBT, MBSR or MBCT, the length of the treatment should not be limited by an arbitrary cap on the number of group sessions. Family Therapy is an alternative to individual therapy so should have the same cap as individual therapy.

Recommendation:

8. The number of therapy sessions available for eating disorders should not be arbitrarily limited but should be based on clinical necessity. Caps on services should be indicative only and extensions should be posible where this is clinically necessary.

2. A Multi-disciplinary approach to eating disorders

2.1 Principles

The flaws in the *Better Access* model and the corresponding MBS item numbers mean that a new model for primary care mental health service delivery for eating disorders is required. PACFA supports the position of the National Eating Disorders Collaboration (NEDC) for a multi-disciplinary approach to eating disorders. PACFA also supports the principles set out in the NEDC's National Standards for Eating Disorders (NEDC, 2012) as an approprriate foundation for effective multi-disciplinary treatment of eating disorders. Care should be coordinated and individually tailored.

The priniciples in the National Standards Scheme for Eating Disorders are supported by PACFA as they proivde a useful foundation for the new Medicare services recommended by PACFA.

Person and family-centered care – Care addresses the needs of the individual while being sensitive to the individual's family and culture, and working from a strengths-based approach.

Prioritise prevention, early identification and early intervention – Early intervention reduces the severity of the eating disorder and improves treatment outcomes.

Safety and flexibility in treatment options – Treatment addresses all aspects of the eating disorder: physical, nutritional and psychological, by providing a range of treatment options.

Partnering to deliver multi-disciplinary treatment – Treatment is provided by a multi-disciplinary team working in partnership with the client, their family and other health providers.

Equity of access to services – Services are provided when and where needed, including in rural and remote areas. Requirements to access services, and the rebates available, take into account long-term and complex nature of eating disorders.

Tertiary consultation available at all levels of treatment – Professionals have access to consultation, supervision and advice when needed.

Support for families and carers as integral members of the team – Family members are part of the support team and receive the support and information they need in order to support the person with the eating disorder.

2.2 A multi-disciplinary approach

A multi-disciplinary approach provides coordinated psychological, medical and nutritional care to address all aspects of the eating disorder. Combined psychological, medical and nutritional interventions are considered essential to recovery (NICE 2017; Hay, Chinn, Forbes, Madden, Newton, Sugenor, Touyz & Ward, 2014).

Typically a person with an eating disorder will require medical assessment and monitoring, nutritional support and education, and psychological therapy. This requires a minimum core team made up of a General Practitioner or Paediatrician, a Mental Health Practitioner and a Dietitian. For clients with severe or complex presentations, a Psychiatrist may need to be a part of the multi-disciplinary team. A wider team, depending on needs of the client, could include a nurse, social worker, occupational therapist, physiotherapist and exercise physiologist.

The interaction between the various therapies requires close coordination between practitioners to ensure a consistent response to the client's needs. Isolated interventions without coordination between members of the multi-disciplinary team, undermine treatment outcomes. An integrated approach shifts the focus from individual professional practice towards collaborative care. Strong and frequent communication is essential (Hay et al. 2014).

Counsellors and psychotherapists who undertake specialisation in eating disorders have a contribution to providing both mental health and family therapy services for people with eating disorders, in addition to other mental health practitioners such as Psychologists, Mental Health Social Workers and Mental Health Occupationsal Therapists.

Basic Multi-disciplinary Care

Clients whose diagnosis is not considered complex based on the Specialist Eating Disorder Assessment should have access to evidence-based Specialist Eating Disorder Therapy delivered by an Eating Disorder Mental Health Practitioner. This is the psychological aspect of the multi-disciplinary intervention, which is delivered in a community setting.

The minimum scope of this treatment should include:

- Specialist assessment for medical, dietary and psychological aspects of the illness
- Medical assessment, monitoring and treatment by a GP or Paediatrician
- Nutritional support and education from a Dietician
- Specialist Eating Disorders Therapy from an Eating Disorder Mental Health Practitioner for at least twenty sessions
- Multi-disciplinary team review and re-assessment

Complex Multi-disciplinary Care

Clients with complex and high-risk presentations require more intensive monitoring and treatment in order to reduce the risk of hospitalisation, chronicity and premature mortality. The treatment should be delivered in the same community setting as above but a member of the multi-disciplinary team is accessible to the client at least once a week. The multi-disciplinary team may include a Consultant Psychiatrist and the team communicates frequently including a face to face meetings.

The minimum scope of treatment includes:

- Specialist assessment for medical, dietary and psychological aspects of the illness
- Medical assessment, monitoring and treatment by a GP or Paediatrician
- Nutritional support and education from a Dietician
- Specialist Eating Disorders Therapy from an Eating Disorder Mental Health Practitioner for at least fifty sessions
- Consultant Psychiatrist consultation if required
- Multi-disciplinary team review and re-assessment

Recommendation:

9. Offer multi-disciplinary care for eating disorders which includes twenty sessions of psychological therapy for basic care or fifty sessions of psychological therapy for complex care.

2.3 Eating Disorder Mental Health Practitioners

A lack of suitably trained therapists to provide psychological therapy for eating disorders has been identified as a barrier to effective treatment (NEDC, 2015). This is specifically because eating disorders are typically not covered, or not covered in appropriate depth, in counselling and psychotherapy education. As such, the capacity to work effectively with eating disorders is learned through professional development, clinical expertise and practice experience providing Specialist Eating Disorder Therapy.

PACFA's proposed model is premised on the ability of people to access mental health professionals who are trained in evidence-based Specialist Eating Disorder Assessment and Therapy rather than just those professions already registered with Medicare to provide services under *Better Access*. The

specialist providers should include suitably trained and experienced counsellors and psychotherapists.

Within this model PACFA suggests that the eligible mental health professionals should be:

- Registered with a relevant professional body;
- Trained and accredited to deliver evidence-based Specialist Eating Disorder Therapy;
- Meet national competencies which could be developed to guide the treatment and management of eating disorders.

The minimum acceptable training hours recommended by PACFA is thirty-six hours of professional development focussed specifically on eating disorders, including theoretical and practical skill-based training in the delivery of evidence-based eating disorder interventions.

Practitioners that provide evidence that they meet these requirements should be eligible to provide services for the new Eating Disorders item numbers. Counsellors and psychotherapists who are specifically trained in eating disorders are ideal professionals to be providers of Specialist Eating Disorder Therapy.

Recommendations:

10. Base eligibility to provide Specialist Eating Disorder Therapy on training and accreditation to specialise in eating disorders, rather than using the pool of existing Medicare providers.
11. Include counsellors and psychotherapists who are trained to specialise in Eating Disorder Therapy as eligible health professionals.

Service access issues in rural and regional areas

The current *Better Access* program has substantial issues catering to the demand for mental health services in regional and rural Australia. Demand is high and is not being met by the current pool of Medicare providers. In rural, regional and remote areas, only 4% of psychiatrists and 21.5% of psychologists provide services (Vines, 2011), compared to 28.3% of counsellors and psychotherapists (Schofield, 2008; Schofield & Roedel, 2012). This is particularly concerning given the importance of access to a multi-disciplinary team for clients with complex eating disorder presentations. The inclusion of counsellors and psychotherapists, who are trained in evidence-based eating disorder treatments, within the pool of Medicare providers, will help provide better access to specialist services for clients in regional and rural areas.

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