Action Plan for Provincial Services for People with Eating Disorders

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Ministry of Health Services

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I Introduction

The British Columbia (BC) Ministry of Health Services (MoHS), in collaboration with the Ministry of Children and Family Development (MCFD), has developed this action plan in response to a review of services to children, youth and adults with eating disorders in BC conducted in 2009 and early 2010.

The attached discussion paper *Prevention and Treatment of Eating Disorders in British Columbia: A Discussion Paper* (Appendix A) and this action plan were developed to fulfill commitments made by the MoHS at a forum on eating disorders held in April 2009. The forum was held in response to issues raised by some families and stakeholders that there is a need for improved treatment services for children, youth and adults with eating disorders in BC. Over the past year, significant improvements have been made to enhance these services; however, opportunities still exist to further improve the system of care for this vulnerable population.

This Action Plan will describe the actions to be taken over the next 6-12 months to improve eating disorders services delivered across the system of care. These actions will contribute to the improvement of the overall system of care, including supporting provincial health care system to build capacity and resources to treat children, youth and adults in BC. The Plan also describes improvements to the system that have been started or completed in the past year.

The objectives of this Action Plan are to:

- Develop a current inventory of eating disorder services in BC and identify potential areas for improvement.
- Identify the types of treatment and support services for children, youth and adults with eating disorders that are relevant for the BC population using best evidence.
- Identify and act on opportunities to educate the public, in particular at risk target groups, to prevent disordered eating and eating disorders.
- Identify and act on opportunities to provide primary care providers with resources to deliver eating disorder services using best evidence.

MCFD is responsible for the delivery of community mental health services to children and youth under 19 years, while responsibility for adult services falls within the mandate of the health authorities. Some community services are provided jointly to ensure consistency of services. Hospital and tertiary services for children, youth and adults are the responsibility of the health authorities, primarily the Provincial Health Services Authority (PHSA).

Although MoHS has initiated the review of provincial eating disorder services and is leading the development of this action plan it is vital that the plan target service for all ages. This is especially important given the challenges that can arise when youth transition from child to adult serving programs. MoHS is committed to working with MCFD, Ministry of Healthy Living and Sport (MHLS), the health authorities and

other partners to implement this action plan in order to strengthen the entire system of care for this population.

II Background

Eating disorders are complex and often difficult to diagnose and treat. They are characterized by a serious disturbance in eating behaviour, distortions in body image and preoccupation with body image and weight. The behaviours may involve over eating or under eating. The three main types of eating disorders are anorexia nervosa, bulimia nervosa, and Eating Disorders Not Otherwise Specified. Eating disorders are associated with disorders such as substance abuse, depression and anxiety disorders. The nature of the disease is often chronic with serious medical consequences including life threatening effects.

The current system of care in BC consists of primary, secondary and tertiary levels of care (see appendix B for an inventory of services in BC).[1]

- Primary care is provided by physicians, dietitians and other community services providers. These include services such as assessment and diagnosis, monitoring and counselling;
- Secondary care is provided for people of all ages in community based mental health centres. Treatment is provided by mental health clinicians, psychiatrists and some contracted agencies, with varying access to specialized services. Care is provided in collaboration with local physicians and health authority dietitians; secondary care is also provided in hospital units across BC to varying degrees.
- Tertiary care is provided primarily by PHSA through BC Mental Health and Addiction Services (BCMHAS). Programs include the Child and Adolescent Provincial Specialized Eating Disorders Program located at BC Children's Hospital and the Provincial Specialized Adult Eating Disorders Program. The adult tertiary program at St. Paul's Hospital is a contracted service through Vancouver Coastal Health and Providence Health Care.

Improvements have been made over the last few years to enhance the services for eating disorders clients; most of these improvements have been in tertiary services to children and adolescents. In July 2009, the Child and Adolescent Provincial Specialized Eating Disorder Program at BC Children's Hospital added four additional beds resulting in a total of 14 beds. The day treatment spaces also increased from two to six. These changes, together with improvements to the program's model of care, have resulted in significant decreases in wait times and an improved service for children and youth with eating disorders.

[1] The priority for this Action Plan is on treatment; however, it is acknowledged that prevention is an important part of the continuum of services. MoHS will collaborate with MHLS to incorporate prevention strategies into this plan.

Much of the groundwork for an integrated system and continuum of care for eating disorders has already been laid; the ultimate goal of this Action Plan is to further improve the quality of care and access to all levels of eating disorders treatment province-wide.

III Summary Analysis of Discussion Paper

The report *Prevention and Treatment of Eating Disorders in British Columbia: A Discussion Paper* (see appendix A) provides:

- an overview of the categories of eating disorders;
- the risk factors associated with the illness; and
- the scope of the illness in the general population and BC and the impact on children, youth, adults, their families, and society.

The report also describes the continuum of services for people with eating disorders including: promotion, prevention, and treatment. The purpose of the report is to facilitate further discussions. It does not analyze the current eating disorders system of care in BC but it does recommend next steps to strengthen the system.

The report provides a high level overview of the above topics. It provides important background information for further discussions and has informed the development of this action plan. It is not an analysis of the strengths and weaknesses of BC's system of care. As the title suggests, its purpose is to provide a starting point for dialogue, planning and collaborative action. It does, however, recommend strategies that will strengthen the system and it lays out a process for analyzing and addressing gaps and opportunities for improvement in the system. The challenge is to take these recommendations and translate them into actions that will achieve tangible results and benefits within timeframes that reflect the urgency this area of the health system deserves. That is the purpose of this action plan.

IV Assumptions and Principles

The Action Plan to improve services for people with eating disorders is based on the following **assumptions**:

1. Plans to strengthen the system of care developed by MoHS and the health authorities will be developed in collaboration with, and integrated into, MCFD plans.

2. Those responsible for actions in this plan will work with key stakeholders in the community to ensure that opportunities to engage and leverage community resources are realized.

3. Services provided will be consistent with evidence-based best practices.

4. The full continuum of services from prevention to community-based care through to tertiary care will be reflected in overall system planning to ensure that children, youth, and adults receive care in the safest and most appropriate location, closest to their home community.

The following **guiding principles** frame the expectations for the working relationship between MoHS, health authorities, MCFD, Providence Health Care, physicians and psychiatrists with respect to the delivery of eating disorder services in BC.

1) The partners in this plan have a joint responsibility to provide safe, high quality and sustainable services to children, youth and adults with eating disorders and their families.

2) The partners will work together to improve community-based services, access to secondary and tertiary care, transitions between hospital and community services, and to minimize the need to refer clients out-of-province and out-of-country for residential treatment.

3) The eating disorder system of care will utilize a "hub and spoke" approach to ensure that BC Children's Hospital and St. Paul's Hospital provide specialized services to children, youth and adults in consultation with health care providers throughout the province (see appendix C).

V Actions to Date

Provincial Eating Disorders Program for Children and Adolescents
The Provincial Eating Disorders Program at BC Children's Hospital is a comprehensive, multidisciplinary, specialized program to assess and treat children and adolescents with eating disorders. The program emphasizes the involvement of parents and/or primary caregivers in the delivery of care. The program has made significant improvements to its model of care to reflect emerging best practices and to reduce wait times for services. The model of care features family-based therapy for anorexia nervosa and cognitive behavioural therapy for bulimia nervosa.

In 2009 capacity increased to 14 intensive treatment beds, a six bed day treatment program, and an enhanced outpatient clinic. Wait times have been reduced from 55 to 12 days for assessment and significant reductions in wait time from assessment to treatment have also been achieved. Inpatient treatment is goal-focused, of a shorter duration and is followed by ongoing treatment at discharge. No child or adolescent has been sent out of province for treatment since 2007.

The program fully integrates medical, dietary/nutritional, psychiatric, psychosocial and other aspects of care and includes telehealth services.

Provincial Specialized Adult Eating Disorders Program
The mandate of the Provincial Specialized Adult Eating Disorders Program is to provide the highest level of assessment and treatment for adult residents of British Columbia who struggle with the most severe forms of eating disorders. The tertiary level of care is explicitly reserved for those residents whose primary and secondary level care providers require the assistance of the most specialized practitioners in the province. Many residents living with the most severe forms of eating disorders require access to safe, contained environments within which they are assessed, treated, stabilized, and begin their journey towards health.

Capacity in the program includes seven inpatient beds: four are for intensive acute treatment and three are for longer term treatment. The program also operates outpatient and group services, family and patient education, and integrates medical, psychiatric, nutritional, psychosocial and other aspects of care including telehealth.

PHSA provided funding for Providence Health Care to complete a review of components of the Provincial Specialized Adult Eating Disorders Program. This review, completed in 2009, was conducted to determine how to change existing resources and care models to provide optimal assessment and treatment for those patients requiring a tertiary level of care. Over time, the program has had an increasing portion of its resources directed to patients who need a secondary level of care and some redesign is required to best meet the needs of the population to be served.

This review, along with existing documents and evidence on the treatment of eating disorders will be used to redesign the adult tertiary services over the next year.

PHSA Supported Services
PHSA manages the Kelty Mental Health Resource Centre, a one-stop information hub designed to help BC children, youth and their families navigate the many resources available in mental health and substance use. The former Eating Disorders Resource Centre has been incorporated into the mandate of the Kelty Mental Health Resource Centre, which now provides resources, information, and system navigation for children, youth, parents, families and adults with eating disorders. The Kelty Mental Health Resource Centre utilizes ementalhealth.ca, a web-based, open source database to maintain an up-to-date inventory of eating disorder community and treatment resources across the province.

The Jessie's Legacy Program at Family Services of the North Shore, one of the BC Partner agencies, provides eating disorder prevention programs and web-based support as well as co-sponsoring the Provincial Eating Disorders Awareness Week with the BC Partners for Mental Health and Addictions Information and the Kelty Mental Health Resource Centre.

VI Actions to be Completed

Problem #1:
There is insufficient information to determine how comprehensive the continuum of care for eating disorders is in B.C.

STRATEGY:
Complete an analysis of current services for people with eating disorders and address areas that require strengthening.

Key Steps	***Responsibility***	***Target Date***
Complete an inventory of all eating disorder services in BC.	MoHS, MCFD, health authorities	June 30, 2010
Develop an evidence-based model for the continuum of services.	MoHS, MCFD, health authorities	October 31, 2010
Identify gaps in the continuum of evidence-based services in BC as well as opportunities and innovative approaches to providing services.	MoHS, MCFD, health authorities	December 31, 2010
Work with the Looking Glass Foundation on their proposal for establishing a community based residential service and determine how it would fit within the eating disorder continuum of care.	MoHS, MCFD, health authorities	August 31, 2010

Problem #2:
The roles and responsibilities of community stakeholders in planning provincial eating disorder services are not well defined. This may result in duplication and disjointed work.

STRATEGY:
Improve communication and integration of work that is underway to enhance delivery of services for eating disorder clients in BC.

Key Steps	***Responsibility***	***Target Date***
Review the role and scope of existing structures (Eating Disorder Network and Community of Practice)	PHSA, MoHS, MCFD, regional health authorities	March 31, 2011
Establish an appropriate structure that uses evidence-based research and best practices for ongoing planning for provincial eating disorder services.	PHSA, MoHS, MCFD, regional health authorities	June 30, 2011

PROBLEM #3:
Concerns have been expressed from stakeholders and patients about the wait times for admission to tertiary treatment.

STRATEGY:
Analyze capacity in the system from primary care to tertiary care and take actions to ensure this is adequate to meet current and projected demand.

Key Steps	***Responsibility***	***Target Date***
Analyze and redesign the adult tertiary model of care (St. Paul's and VISTA programs) and ensure the new model is evidence-based and consistent with current knowledge.	PHSA, Vancouver Coastal Health Authority, and Providence Health Care	Start May 1, 2010 with completion date April 30, 2011.
Expand and enhance the utilization of existing telehealth/telemedicine capacity in BC to enable more consultation with centres of excellence for eating disorders.	MoHS, MCFD and health authorities	December 31, 2010

Problem #4:
The provincial system of care for eating disorders is not well coordinated, which may result in fragmentation, duplication, variable quality, and lack of capacity.

STRATEGY:
Strengthen and expand processes that enable effective system coordination and planning. Strengthen engagement of community stakeholders.

Key Steps	***Responsibility***	***Target Date***
Establish BC Children's Hospital and St. Paul's Hospital as centres of excellence and use a hub & spoke approach to enable these centres to extend their specialized services throughout BC (see appendix C).	PHSA, MoHS and Providence Health Care	March 31, 2011
Develop multidisciplinary clinical guidelines/protocols for early intervention and treatment of eating disorders.	MoHS, MCFD, health authorities	March 31, 2011
Develop and promote health literacy materials on eating disorders that includes stakeholder input (see appendix D).	PHSA in collaboration with MHLS	March 31, 2011

VII Conclusion

This action plan has been developed by MoHS in collaboration with MCFD. The provincial government is committed to engaging all stakeholders in the implementation of these actions. The work to enhance the continuum of services in BC, from promotion to treatment, is already underway. The goal is to work towards providing a fully integrated, sustainable evidenced based model of care in BC. It is acknowledged that the actions and timelines described in this plan are ambitious; however, we are confident in our ability to meet these expectations to improve the current system of care for this vulnerable population. We look forward to working with our partners to achieve this.

Appendix A

Prevention and Treatment of Eating Disorders in British Columbia: A Discussion Paper

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Introduction

The purpose of this paper is to provide a starting point for dialogue, planning and collaborative action to strengthen British Columbia's response to disordered eating and eating disorders. In 2008, an estimated 55,432 British Columbians, aged 15 years and over, were at risk for developing an eating disorder.[2] That same year, an estimated 52,187 girls and women and 5,267 boys and men in British Columbia, aged 10-54 years, were living with a clinically diagnosed eating disorder.[3] The vast majority of affected individuals are adolescent girls and young women in their peak childbearing years. In British Columbia, women with anorexia nervosa have a mortality rate almost 15 times higher than women of the same age in the general population.[4] Anorexia nervosa has the highest mortality rate of any mental disorder and a substantial proportion of these premature deaths are the result of suicide.

The system of care in British Columbia approaches services to people with eating disorders in a variety of ways, providing community-based services as well as, promotion, prevention, secondary and tertiary bed-based services for children, youth and adults. The tertiary care for eating disorders has benefited from several in-depth reviews and program redesigns over the past decade. Current planning efforts will focus on the whole continuum of eating disorders to address gaps and coordination of services across the various levels of care. Consultation with stakeholders will be a crucial aspect of this planning.

Spectrum of Body Image, Body Weight and Eating Behaviour

Eating disorders, weight and shape preoccupation and obesity can be located along a continuum of body image, weight and eating behaviour. At one end of the continuum are healthy body image and weight, satisfaction with body image and healthy eating. At the other end are a range of eating disorders, weight and shape preoccupation and obesity. In the middle are degrees of distorted body image, body dissatisfaction, disordered eating and unhealthy weight control behaviours. People may move back and forth along this continuum throughout the course of their lives in response to life events, at key transition points, or at different developmental stages. Some people may experience mild to moderate episodes of disordered eating and weight and shape-related problems, while others may experience severe and persistent disorders with life threatening consequences.

Progression along the continuum is not linear and not everyone who struggles with weight and shape issues will develop an eating disorder. The best way to understand the

[2] BC Statistics. (2008). Population Estimates for BC – Age/Sex, 1971-2008. Using risk estimates from Statistics Canada. (2004). Risk of eating disorder, by sex, household population aged 15 and over, 2002. Canadian Community Health Survey: Mental Health and Well-Being.

[3] BC Statistics. (2008). Population Estimates for BC – Age/Sex, 1971-2008. Using prevalence estimates from BC Ministry of Health. (2007). *Treatment of Mental Health Problems, Substance Use Problems and Concurrent Disorders: A Summary of Published Guidelines*. Victoria: BC Ministry of Health.

[4] Birmingham, C.L. et al. (2005). The mortality rate from anorexia nervosa. *International Journal of Eating Disorders*, 38(2):143-146.

evolution of an eating disorder is to overlay the continuum with our understanding of risk and protective factors. A risk factor is a variable or an exposure to something that increases the likelihood of developing a disorder. A protective factor mitigates the impact of a risk factor. By itself, a protective factor does not necessarily decrease the likelihood of developing an eating disorder.

Considerable progress has been made in identifying risk factors for bulimia; however, less is known about the risk factors for anorexia. This is due, in part, to the fact that anorexia is more rare than bulimia and there have been fewer prospective or experimental studies of the disorder.

The risk factors for eating disorders are a combination of general, individual, eating-specific and weight-related, environmental, biological and genetic risk factors. The most commonly documented risk factors are puberty, being female, societal emphasis on thinness, thin-ideal internalization, body dissatisfaction, unhealthy dieting, participation in activities that place substantial emphasis on body weight and shape, negative affect, adverse life events, childhood sexual and/or physical abuse, insecure attachment and family dysfunction.[5]

In 2008, only 10 per cent of adolescent girls, grades seven to 12, in British Columbia rated themselves as very satisfied with their body image, compared to 19 per cent of adolescent boys. That same year, 53 per cent of healthy weight girls were trying to lose weight and 31 per cent of healthy weight boys were trying to gain weight. In terms of risky eating behaviours, 46 per cent of girls (all weights) reported dieting to lose weight, 36 per cent reported binge eating and 8 per cent reported vomiting on purpose after eating. These figures have not changed over the past five years.
Source: Smith, A. et al & McCreary Centre Society. (2009). *A Picture of Health: Highlights from the 2008 BC Adolescent Health Survey*. Vancouver, BC: McCreary Centre Society

[5] Evans, D.L. et al. (Editors). (2006). *Treating and Preventing Adolescent Mental Health Disorders*. Oxford University Press. In association with Sunnylands Adolescent Mental Health Initiative and the Annenberg Foundation Trust. Accessed online at http://amhi-treatingpreventing.oup.com

Obesity Prevention and Treatment as Risk Factors for Eating Disorders

Eating disorders, weight and shape preoccupation and obesity often co-occur over time and share common risk and protective factors. Adolescent girls, in particular, may suffer from more than one condition (e.g., binge eating and obesity), or they may move from one eating disorder to another depending on the severity and stage of their illness. It is important to design and implement obesity prevention programs to minimize harm and avoid causing one disorder while trying to prevent another.

Recent research suggests the key to avoiding harm to body image and eating behaviour in obesity prevention is to focus on health, not weight. Obesity prevention efforts should be reframed as health promotion and avoid the language of weight control and dieting. Effective prevention interventions for both obesity and eating disorders are "weight neutral" in that they do not have specific goals for weight change, but focus on promoting healthy living at any size. These interventions include balanced nutrition, mindful eating, healthy levels of physical activity, body satisfaction and respect for body size diversity; and they address weight-related stigma, teasing and harassment.[6]

In terms of obesity treatment, the evidence suggests that professionally administered weight loss programs for overweight children and adolescents generally do not increase the risk for or symptoms of eating disorders. Dieting alone does not lead to eating disorders among adolescent dieters. It is the other factors that frequently exist in the presence of dieting, such as genetic predisposition and negative affect, as well as the use of unhealthy weight control practices (e.g., fasting or starvation) that contribute to the development of eating disorders in overweight adolescents.[7]

What is an Eating Disorder?

Eating disorders are mental disorders that often begin in adolescence or early adulthood. They involve serious disturbances in eating behaviour and weight control and body image distortion with potentially life threatening medical complications. Left either untreated or improperly treated, eating disorders may persist into adulthood with serious, long-term consequences for health, education, employment and social adjustment.

Eating disorders range from eating too little—or a very narrow range of foods—to eating large amounts of food rapidly, sometimes followed by behaviours to compensate for weight gain, such as self-induced vomiting, compulsive exercise or abuse of diuretics and/or laxatives. Eating disorders also involve cognitive and perceptual disturbances related to body shape and weight. People with eating disorders are often fearful of weight gain and are intensely preoccupied with efforts to lose weight or to change their

[6] Danielsdottir, S., Burgard, D. & Oliver-Pyatt, W. (2009). *Guidelines for Childhood Obesity Prevention Programs*. Position Statement of the Academy for Eating Disorders. http://www.aedweb.org/media/Guidelines.cfm

[7] Evans, D.L. et al. (Editors). (2006). *Treating and Preventing Adolescent Mental Health Disorders*. Oxford University Press. In association with Sunnylands Adolescent Mental Health Initiative and the Annenberg Foundation Trust. Accessed online at http://amhi-treatingpreventing.oup.com

body shape. They are often highly self-critical of their own shape and weight and may have a distorted body image.

Signs of a potential eating disorder:

- Abnormally low weight or significant fluctuations in weight not due to medical illness
- Purging behaviours intended to induce weight loss
- Persistent, intense concerns with weight or shape
- Persistent attempts to diet or lose weight despite being at normal or low weight
- Social withdrawal or isolation for activities involving food and/or eating
- Unexplained amenorrhea (lack of menstruating)

The most widely used definitions of eating disorders are those provided by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM IV-TR, 2000). The DSM IV-TR describes two distinct syndromes, anorexia nervosa and bulimia nervosa, with a residual category, Eating Disorders Not Otherwise Specified (EDNOS), intended to capture all other eating disorders and "disorders of eating". Most adolescents and adults who present for treatment of an eating disorder do not meet full criteria for either anorexia or bulimia and are therefore classified as having EDNOS. The need to accurately characterize and sub-divide this large heterogeneous group is a significant challenge for the eating disorders field.

Disordered Eating

This refers to unhealthy eating behaviours, such as restrictive dieting, bingeing or purging which occur less frequently or are less severe than those required to meet the full criteria for the diagnosis of an eating disorder.

Anorexia Nervosa

Individuals with anorexia nervosa refuse to maintain a minimally normal body weight. They possess an intense fear of gaining weight and have a distorted perception of the shape or size of their bodies. They often deny the seriousness of their weight loss. Many girls and women with anorexia nervosa have delayed onset or cessation of menstruation. Anorexia nervosa is classified into two types: binge-eating/purging and restricting.

The onset of anorexia nervosa generally occurs between 14 and 18 years of age. The available data suggests that approximately 50 to 70 per cent of adolescents with anorexia recover, 20 per cent improve but continue to have residual symptoms, and 10 to 20 per cent have chronic anorexia. The recovery period can last up to 10 years. Anorexia has one of the highest mortality rates among psychiatric disorders, and women with anorexia are 12 times more likely to die than women of similar age in the general population. Although the mortality rate for adolescents and adults combined is over five per cent, mortality during adolescence is low. The most common causes of death among people

with anorexia are suicide and the effects of starvation. The suicide rate for women with anorexia is 57 times higher than that for women of similar age in the general population.[8]

Bulimia Nervosa

Individuals with bulimia nervosa have recurrent episodes of binge eating and recurrent use of compensatory methods to prevent weight gain, such as induced vomiting, excessive exercise or diuretic and/or laxative abuse. They also place excessive importance on body shape and weight. In order for a diagnosis of bulimia nervosa, the binge eating and compensatory behaviours must occur, on average, at least twice a week for three months.

The onset of bulimia generally occurs during the transition from adolescence to early adulthood. Most adolescents and adults with bulimia improve over time, with recovery rates ranging from 35 to 75 per cent at five or more years of follow-up. Bulimia is a chronic relapsing condition and approximately one third of people with bulimia relapse, often within one to two years of recovery. Although approximately 50 per cent of people with bulimia recover, the remaining individuals continue to be symptomatic throughout their lives, often with substantial impact on their physical and psychosocial functioning.[9]

Eating Disorders Not Otherwise Specified (EDNOS)

These are disorders that do not fit the diagnostic criteria of either anorexia nervosa or bulimia nervosa. The ED-NOS category also includes sub-clinical anorexia nervosa (e.g., symptoms do not meet the threshold for diagnosis), compulsive overeating or binge eating, and extreme body image disturbance. Children and adolescents often receive a diagnosis of EDNOS because existing diagnostic criteria for anorexia and bulimia are not developmentally sensitive enough.

Co-occurring Conditions

People with eating disorders may develop other emotional and psychological problems, including anxiety, depression, substance use disorders, obsessive compulsive disorder and, in adults, personality disorders. These co-morbid psychiatric conditions may develop before, at the same time, or during an eating disorder. It is estimated that about 59% of people with bulimia and 80% of people with restrictive anorexia also experience major depression at some point in their lives.[10]

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[8] Evans, D.L. et al. (Editors). (2006). *Treating and Preventing Adolescent Mental Health Disorders*. Oxford University Press. In association with Sunnylands Adolescent Mental Health Initiative and the Annenberg Foundation Trust. Accessed online at http://amhi-treatingpreventing.oup.com

[9] Ibid

[10] Psychiatric comorbidity in women with disordered eating behavior: a national study. Gadalla T, Piran N. Women Health. (2008)

Eating Disorders as Serious Mental Illness

The Academy for Eating Disorders (AED) recently concluded that anorexia nervosa and bulimia nervosa fit the routinely accepted definitions of biologically-based mental illnesses, serious mental illnesses and, in children, serious emotional disturbances. The AED position is based on evidence from studies of the heritability of eating disorders and the association of eating disorders with significant neurobiological abnormalities, deficits in cognitive and emotional functioning, and limited life activities, such as poor social adjustment and impaired educational and vocational functioning.[11]

> It is the position of the Academy for Eating Disorders that anorexia nervosa and bulimia nervosa, along with their variants, are biologically-based, serious mental illnesses that warrant the same level and breadth of health care coverage as conditions currently categorized in this way (e.g., schizophrenia, bipolar disorder, depression, obsessive-compulsive disorder). We advocate this position unequivocally based on an emerging science that affirms with a reasonable degree of medical and scientific certainty that eating disorders are significantly heritable; influenced by alterations of brain function; significantly impair cognitive function, judgment, and emotional stability; and restrict the life activities of persons afflicted with these illnesses. Accordingly, the denial or restriction of equitable and sufficient treatment necessary to avert serious health consequences and risk of death is untenable and should be vigorously protested.
> Source: Academy for Eating Disorders Position Paper: Eating Disorders are Serious Mental Illnesses (2009)

Who is Affected?

The lifetime prevalence of eating disorders, including anorexia nervosa, bulimia nervosa and binge eating disorder, is relatively small, more common among females, and most likely to occur during adolescence. The actual prevalence of eating disorders is difficult to estimate due to the limited number of methodologically sound studies.

It should be noted that prevalence data is based on the number of people in a given population with a diagnosed eating disorder. This data may not include people with partial syndrome eating disorders or people with sub-clinical symptoms. Prevalence data does not include people who engage in disordered eating and unhealthy dieting behaviours that put them at significant risk for developing an eating disorder.

According to Statistics Canada, an estimated 1.5 per cent of people, aged 15 years and over, are at risk for developing an eating disorder in any given year.[12] Using 2008 population estimates, approximately 55,432 British Columbians, aged 15 years and over, are at risk for developing an eating disorder.[13]

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[11] Klump, K.L. et al. (2009). Academy for Eating Disorders Position Paper: Eating Disorders are Serious Mental Illnesses. *International Journal of Eating Disorders*, 42:2, 97-103.
[12] Statistics Canada. (2004). Risk of eating disorder, by sex, household population aged 15 and over, Canada and provinces, 2002. Canadian Community Health Survey: Mental Health and Well-Being.
[13] BC Statistics. (2008). Population Estimates for BC – Age/Sex, 1971-2008. Retrieved May 21, 2009 from http://www.bcstats.gov.bc.ca/data/pop/pop/estspop.asp#agesex

General Population

Reviews of existing studies have concluded that the best estimates of one-year prevalence rates among the general population (all ages) are: [14]

	Females		Males	
	per 1000 people	**%**	**per 1000 people**	**%**
Anorexia Nervosa	3	0.3	0.3	.03
Bulimia Nervosa	15	1.5	1.5	.15
ED-NOS	20	2.0	2.0	.20

What does this mean for British Columbia? If we apply these prevalence rates to 2008 population estimates for those aged 10 to 54 years, there are just over 52,000 females and 5,200 males in British Columbia with a diagnosed eating disorder:[15]

	Females	Males
	10 to 54 years	**10 to 54 years**
Anorexia Nervosa	4,120	416
Bulimia Nervosa	20,600	2,079
ED-NOS	27,467	2,772
Total	**52,187**	**5,267**

Adults

It is generally agreed that anorexia nervosa occurs in approximately one per cent of adult women and 0.1 per cent of adult men, while bulimia nervosa occurs in approximately three per cent of women and 0.3 per cent of men. The female to male ratio of eating disorders is approximately 10:1 in adult populations.[16]

The APA estimates that lifetime prevalence for anorexia nervosa among women ranges from 0.3 per cent for narrowly defined anorexia to 3.7 per cent for a more broadly defined disorder. For bulimia nervosa, the APA estimates that lifetime prevalence among women ranges from one per cent to 4.2 per cent.[17]

A recent Finnish twin study estimates the lifetime prevalence of anorexia among women to be much higher, at 22 per 1000 or 2.2 per cent, and that only half of these cases are

[14] BC Ministry of Health. (2007).*Treatment of Mental Health Problems, Substance Use Problems, and Concurrent Disorders: A Summary of Published Guidelines*. Victoria: BC Ministry of Health.
[15] BC Statistics. (2008). Population Estimates for BC – Age/Sex, 1971-2008. Retrieved May 21, 2009 from http://www.bcstats.gov.bc.ca/data/pop/pop/estspop.asp#agesex

[16] Evans, D.L. et al. (Editors). (2006). *Treating and Preventing Adolescent Mental Health Disorders*. Oxford University Press. In association with Sunnylands Adolescent Mental Health Initiative and the Annenberg Foundation Trust. Accessed online at http://amhi-treatingpreventing.oup.com
[17] American Psychiatric Association. (2006). *Practice Guidelines for the Treatment of Patients with Eating Disorders*. Third Edition. Washington, DC: American Psychiatric Publishing.

detected by the health system.[18] A US population-based study suggests binge eating occurs among 3.5 per cent of adult women and two per cent of adult men.[19] Another population study indicates that gay and bisexual adult men are more likely to experience eating disorders than heterosexual men.[20] Approximately ten per cent of people with eating disorders have severe conditions that require intensive treatment and support. [21]

Children and Adolescents

In the case of eating disorders, "children" generally refer to those between the ages of eight and 12 years, and "adolescents" refer to those between the ages of 13 and 18 years. The literature on eating disorders in children is very limited, however, and adolescents over 16 years of age are often included in research and population-based studies of adult populations.

A review of epidemiological studies from 1993 to 2003 of young females aged 11 to 20 years suggests that the average prevalence rate for anorexia nervosa is 0.5 per cent and is just under one per cent for bulimia nervosa. The female to male ratio is approximately 11:1 for anorexia nervosa and 33:1 for bulimia nervosa.[22]

The overall lack of studies with adequate sample sizes and the considerable variation in methodologies make it difficult to confidently answer the question of how many children and adolescents experience an eating disorder. Perhaps a more compelling measure is the increasing proportion of children and adolescents who report harmful eating and weight loss behaviours—known risk factors for the development of an eating disorder.

Burden of Illness

While the number of people with clinically diagnosed eating disorders in the general population is small, the impact is profound. Eating disorders exact an enormous price on affected individuals and their families; there are also serious intergenerational consequences of an illness that occurs most frequently among adolescent girls and young women in their childbearing years. Due to the typical early onset and significant physical consequences of eating disorders, child and adolescent development may be negatively affected.

The direct costs of eating disorders include premature death, serious medical complications, long-term disability, acute care service utilization and the cost effectiveness of treatment interventions. Indirect costs include time lost from school,

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[18] Keski-Rahkomen, A., et al. (2007). Epidemiology and course of anorexia nervosa in the community. *American Journal of Psychiatry,* 164, 1259-1265.
[19] Hudson, J., Hiripi, E, Pope, E., Kessler, R. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey replication. *Biological Psychiatry*, 61, 348-358.
[20] Feldman, M. & Meyer, I. (2007). Eating disorders in diverse lesbian, gay and bisexual populations. *International Journal of Eating Disorders,* 40:3, 218-226.
[21] Andrews, G. and the Tolkien II Team. (2006). *Tolkien II: A needs-based, costed stepped-care model for mental health services*. Sydney: World Health Organization.
[22] Gowers, S. and Bryant-Waugh, R. (2004). Management of child and adolescent eating disorders: the current evidence base and future directions. *Journal of Child Psychology and Psychiatry*, 45:1, 63-83.

work, recreation and social activities due to eating disorders (and the resulting loss of productivity), as well as reduced quality of life.

Impacts on People

Disordered eating is common, particularly during adolescence and young adulthood. It has become normative for adolescent girls and young women to have substantial concerns about their weight and eating behaviour, with frequent dieting and efforts at weight loss. Disordered eating also occurs among boys and young men, although to a much lesser extent, and eating disorders tend to be more prevalent among gay males. This is likely due to a cultural norm of increased pressure regarding body shape and weight among gay men.

Some eating disorders may resolve without treatment or other interventions. For example, individuals with mild or moderate bulimia may recover after a single episode of the disorder. Other individuals may exhibit a fluctuating pattern of weight gain and relapse, while others will continue to have issues with food and weight throughout their lives. Severe and persistent eating disorders can lead to profound illness, disability or death. In addition to growth retardation and developmental delays, there are a range of short and long-term medical complications directly attributable to eating disorders. The primary long-term complications are osteoporosis, gastrointestinal dysfunction, dental problems, infertility and other reproductive health problems.

People experiencing eating disorders have a much higher rate of death than the general population. A BC study found that women with anorexia nervosa have a standardized mortality ratio of 10.5, compared to the general population ratio of 0.71.[23] As previously noted, anorexia nervosa has the highest mortality rate of any mental disorder. Death can occur as a result of severe malnutrition and the associated physical disturbances that accompany profound weight loss and changes in body composition and metabolism. These include acute malfunction of the heart, kidneys and central nervous system. In addition, a substantial proportion of people with anorexia nervosa commit suicide, a consequence of profound emotional distress and mood disorders that often accompany the condition.

Bulimia nervosa can also have serious consequences, particularly through inappropriate compensatory behaviour, such as self-induced vomiting, diuretic or laxative use. These can lead to abnormalities in the level of electrolytes in the bloodstream, and may result in organ failure, illness or death. For people with bulimia nervosa, only about half can expect to recover, with the rest experiencing significant and ongoing impacts on physical health and psychosocial functioning.

The social burden of eating disorders is equally costly and includes impaired educational and vocational functioning, poor social adjustment and reduced quality of life. Eating disorders cause young people to miss school, work and recreation activities. The physical

[23] Birmingham, C. L. et al., (2005). The mortality rate from anorexia nervosa. *International Journal of Eating Disorders*, 38(2):143-146.

impairment associated with the illness seriously affects social interactions with friends and involvement in life in general. Friends, in turn, have difficulty knowing how to react and help.

Families of individuals with eating disorders also live with significant stress. They may blame themselves, feel anxious about their loved one's future, worry that their family member will die, or they may encounter the stigma associated with having a child with a mental illness. Parents, in particular, experience the tension between their natural protective instinct to protect their child from the consequences of not eating—which can often make the situation worse—and the child's need to take responsibility for their illness and health.[24]

Impacts on Systems

The economic burden of eating disorders has received scant attention in international research literature, despite the importance of this data in making appropriate decisions regarding resource allocation. This is due in part to a lack of primary data on the costs and outcomes in eating disorders treatment. The relevant literature consists mainly of cost of illness and cost effectiveness studies and reviews of direct program spending.

Cost of illness studies consider hospitalization, rehabilitation and indirect costs due to inability to work and premature death. A 2002 German study estimated the hospitalization cost per patient with anorexia nervosa was three and a half times higher than the average hospitalization cost.[25] Cost effectiveness studies basically compare the cost to achieve results among different interventions. A 2004 US study compared the cost of the limited-intensity, "usual care" model of treating anorexia nervosa with a more comprehensive approach, consisting of inpatient weight restoration followed by treatment of gradually diminishing intensity (e.g., partial hospitalization followed by outpatient psychotherapy with medication management). The study found that comprehensive treatment of anorexia resulted in a cost per year of life saved of US$30,000.[26]

In British Columbia, a 2003 study examined the cost of long-term disability among people with anorexia nervosa. The study estimated that the total annual cost of long-term disability payments ranged from $2.5 million to just over $100 million. These costs represented the lowest and highest benefits a single person could receive under the disability program. The study noted that the high end of the range was 30 times the total yearly cost of all tertiary care services for eating disorders in the province.[27]

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[24] Government of Canada. (2006). *The Human Face of Mental Health and Mental Illness in Canada*. Ottawa: Minister of Public Works and Government Services Canada.
[25] Krauth, C., Buser, K. & Vogel, H. (2002). How high are the costs of eating disorders for German society? *European Journal of Health Economics*, 3:244-250.
[26] Crow, S. & Nyman, J. (2004). The cost-effectiveness of anorexia nervosa treatment. *International Journal of Eating Disorders*, 35(2):155-160.
[27] Su, J.C. & Birmingham, C.L. (2003). Anorexia nervosa: the cost of long term disability. *Eat Weight Disorder*, 8(1):76-79.

Stigma and Discrimination

There is a widespread misperception that individuals "choose" eating disorders in pursuit of an unrealistic socio-cultural body size ideal. As a result, people experiencing disordered eating and eating disorders often feel as if they are at fault for being ill. They are frequently stigmatized for the presumption of a loss of control around eating, stealing binge food, or bingeing and purging in secret. The person with an eating disorder may feel shame about weight fluctuations. Many parents, in particular, feel they are to blame if a child has anorexia or bulimia. This leads to a deep sense of guilt, isolation and loneliness.

The reluctance of people to talk about their experiences with eating disorders contributes to the invisibility of the illness and discourages individuals who are sick and their families from seeking help. This invisibility, in turn, enables the conditions that initially put people at risk for eating disorders to flourish and it hampers the health system's ability to respond effectively. Health professionals need to be aware of these factors in order to increase early recognition and treatment. As well, these issues need to be addressed as part of the longer-term treatment and support planning and follow-up services.

Overview of a continuum of services

Mental Health Promotion

Eating disorders are understood as complex mental illnesses with serious medical complications. Significant implications exist for the role of mental health promotion in a full continuum response to disordered eating and eating disorders. Positive mental health enables people to realize their fullest potential and to cope with life transitions and major life events. Mental health promotion is a process of enabling individuals and communities to take control over their lives and improve their mental health. It seeks to increase self-esteem, coping skills and capacities, and family and community supports, as well as to modify the broader social and economic environments that influence mental health.

Mental Health Literacy

Health literacy refers to people's abilities to access, understand, and communicate health information. In the context of mental health, it also refers to knowledge and beliefs which assist in the recognition, management or prevention of mental health problems. This includes knowledge of risk factors and causes of mental illness, sources of mental health information, and availability of professional help. It also includes attitudes that promote recognition and appropriate help seeking.

The successful promotion of mental health literacy requires:

- consumer and family involvement in all aspects of needs assessment, information development, dissemination, uptake and evaluation

- awareness of the impact of stigma and discrimination on disclosure, help seeking, treatment and recovery
- links to broader change initiatives at the organizational, community and policy level
- ability to foster change in both individual and population mental health[28]

Eating Disorders Prevention

Prevention programs seek to reduce the incidence of disordered eating and eating disorders by eliminating or reducing risk factors and enhancing protective factors. Universal prevention programs are directed at entire populations at low risk of developing eating disorders, or who have no symptoms of disordered eating. Targeted programs are directed at groups of people considered to be at higher risk because of exposure to known risk factors, or for those who exhibit early symptoms.

Each of these types of prevention programs has advantages and disadvantages. Universal programs avoid isolating or labeling particular individuals, but may be unnecessarily expensive and may intervene with many people who are not at risk. Targeted programs may be more efficient, but require accurate identification of people at risk, which can be challenging. Targeted programs may also expose identified individuals to labeling and stigma.[29]

Targeted eating disorder prevention programs have demonstrated the most promising results, while universal interventions require further assessment of outcomes.[30] It should be noted that while there are few rigorous studies of eating disorders prevention, there is considerable research on the prevention of other mental health and substance use issues which share in common many of the same risk and protective factors as eating disorders. Extensive reviews of these prevention interventions have demonstrated that the most effective prevention efforts include a variety of teaching methods, provide sufficient exposure, create opportunities for positive relationships, and are developmentally appropriate and socio-culturally relevant.[31]

Prevention in School Settings

Current research indicates that teaching students about eating disorders is ineffective in changing their eating attitudes and behaviours. Moreover, this approach may be harmful as some students might learn to glamorize disturbed eating behaviours. Schools are

[28] Rootman, I. (2007). *Integrated Provincial Strategy to Promote Health Literacy in Mental Health and Addiction in BC*. Prepared for BC Mental Health and Addiction Service. Unpublished internal report.
[29] Waddell, C. et al. (2005). *Preventing and Treating Eating Disorders in Children and Youth*. Prepared for the BC Ministry of Children and Family Development. Vancouver, BC: University of British Columbia, Children's Mental Health Policy Research Program.
[30] Pratt, B.M. & Woolfenden, S. R. (2002). Interventions for preventing eating disorders in children and adolescents. *Cochrane Database of Systematic Reviews*, Issue 2 Art. No.: CD002891.
[31] Evans, D.L. et al. (Editors). (2006). *Treating and Preventing Adolescent Mental Health Disorders*. Oxford University Press. In association with Sunnylands Adolescent Mental Health Initiative and the Annenberg Foundation Trust. Accessed online at http://amhi-treatingpreventing.oup.com

encouraged to adopt school-wide approaches that encompass (a) sensitivity training to educators and parents to raise awareness about the role important adults play in influencing children's body image and how to learn to recognize and act on incidences of weight discrimination, (b) media literacy and life skills curriculum for both male and female students, (c) school policies that address weight-based teasing, and (d) opportunities for physical activity for all children regardless of their size or shape.[32]

To date, the most promising eating disorder prevention programs are school-based psychological interventions that target at-risk, older adolescent girls using Cognitive Behavioural Therapy (CBT)-informed interventions or media literacy. The most effective programs use an interactive approach and offer multiple sessions. The CBT-informed interventions focus on promoting self-esteem, developing stress management skills and encouraging healthy weight-control behaviours. Media literacy interventions teach youth to critically analyze the media and recognize cultural pressures regarding body shape and weight. Media literacy programs challenge the perception of the "thin ideal" promoted by the media, and help youth develop skills to realistically assess what constitutes a healthy body shape and size. These CBT-informed interventions have been found to reduce body dissatisfaction while media literacy appears to reduce the internalization of the thin-ideal, both known risk factors for eating disorders. However, neither intervention has been found to significantly reduce actual disordered eating behaviour.[33]

Care and Treatment

Family-based Treatment

The most promising treatment for children and adolescents with anorexia nervosa (e.g., under 18 years with a shorter duration of illness) is therapy utilizing a strengths-based approach and providing intensive interventions for the whole family. This treatment strategy, pioneered at the Maudsley Hospital in London, England, and manualized in the United States, aims to empower parents to re-feed their children, reduces shame by assuming the illness is not the parents' fault, and includes family meals as a part of the intervention. Expert consensus indicates that family-based therapy is appropriate for treating children and adolescents in both inpatient and outpatient settings.

Despite the success of family-based therapy, a minority of patients with anorexia nervosa do not respond to this form of treatment. Older adolescents and young adults with longer durations of illness do not appear to obtain greater benefit from family-based therapy, as compared to individual therapy, and may be at risk for developing bulimic symptoms. In an effort to address this gap, the Maudsley Hospital team has developed a more intensive outpatient family treatment, Multiple-Family Day Treatment (MFDT), where family

[32] Levine, M.P, & Smolak, L. (2006). *The Prevention of Eating Problems and Eating Disorders: Theory, Research, and Practice*. Mahwah, NJ: Lawrence Erlbaum Associates.
[33] Waddell, C. et al. (2005). *Preventing and Treating Eating Disorders in Children and Youth*. Prepared for the BC Ministry of Children and Family Development. Vancouver, BC: University of British Columbia, Children's Mental Health Policy Research Program.

members learn by identifying with members of other families experiencing the same condition.

MFDT is a form of group therapy where families meet for consecutive days and share their experiences. The intent is to create a supportive learning environment. Treatment goals are designed to help the individual with anorexia nervosa take responsibility for their illness and allow their parents to help, and to empower parents to provide that help and address conflicts within the family. Preliminary evaluation findings suggest a high degree of acceptability and promising outcomes, particularly in terms of reduced stays in hospital.[34]

Psychosocial Interventions

CBT is the leading evidence-based therapy for bulimia nervosa among adults and is adaptable to the treatment of bulimia nervosa in adolescents. The flexibility of CBT and recent evidence for its utility in preventing relapse among adults with anorexia nervosa suggest that, when suitably adapted, it may be useful for a wide range of eating disturbances in adolescents. Over the longer term, another form of evidence-based therapy, Interpersonal Psychotherapy (IPT) is as effective as CBT in the treatment of adults with bulimia nervosa. It has also been successfully employed in treating depression among adolescents and may be useful for adolescents with bulimia nervosa. Efforts to enhance motivation for recovery and readiness for change are equally beneficial for children and adolescents with bulimia nervosa and anorexia nervosa. This is particularly important as many younger people are brought to treatment by others, rather than actively seeking it themselves. In addition, approaches that utilize self-management tools may be beneficial and these have been employed successfully in the treatment of different eating disorders.

Fairburn (2004) developed a form of CBT to treat bulimia nervosa (CBT-BN), which became the first psychotherapy to be recognized by National Institute of Health and Clinical Excellence as the leading treatment for a clinical condition. In 2008, Fairburn and colleagues developed an enhanced form of CBT (CBT-E), which is more potent than CBT-BN and can be used to treat a range of eating disorders. This enhanced form of CBT matches specific therapeutic interventions within the CBT model to specific symptoms of the eating disorder to make the treatment most effective.[35]

A 2009 study compared two versions of CBT-E, a simple version that focused solely on eating disorder features and a second, more complex version that also addressed mood intolerance, clinical perfectionism, low self-esteem and/or interpersonal difficulties. Researchers found that patients receiving the two forms of treatment exhibited substantial and equivalent change compared to the control group. This change was well maintained

[34] [34] Wayte, T., Pelletier, L., Weiss, J. & Becker, E. (2009). *Provincial Specialized Eating Disorders Program for Children and Adolescents: Program Redesign Proposal and Logic Model*. Prepared for BC Children's Hospital, Unpublished internal report.

[35] Fairburn, C.G. (2008). *Cognitive Behavioural Therapy and Eating Disorders*. New York: Guilford Press.

at follow-up over one year later. Approximately two-thirds of those who completed treatment made a complete and lasting response, with many of the remainder showing substantial improvement. Patients with bulimia nervosa or an atypical eating disorder responded equally well. Patients with particularly complex clinical features responded better to the more complex treatment and vice versa.[36]

Issues to Consider in Action Plans

The following issues should be considered in action plans to strengthen services to people with eating disorders in BC.

Mental Health Promotion and Health Literacy

Public knowledge about mental health in general, eating disorders in particular, can promote healthy productive lives, increase resiliency and reduce stigmatization associated with mental illness. Recommended actions:

- Promote positive mental health and building positive body image in children and adolescents, for example, build on ActNow BC by adding healthy body image and body satisfaction messaging;
- Promote healthy body image media messages;
- Include eating disorders within the BC integrated health literacy plan;
- Promote education about eating disorders for school personnel, general practitioners, mental health clinicians, substance abuse counsellors and other community service providers; and,
- Engage families and people with eating disorders in health promotion and prevention efforts.

Prevention

Healthy development and good mental health can increase resiliency to eating disorders. However, some people will still be at risk of developing this illness. Targeted prevention measures can be directed to specific settings, age groups, or other target groups. Recommended actions:

- Implement prevention strategies in target environments; for example, schools
- Implement prevention strategies that are age-appropriate.
- Implement prevention strategies that are culturally appropriate and relevant.
- Select and expand prevention programs with demonstrated effectiveness.

The Continuum of Treatment Services

BC needs to identify the types of treatment and support services that are: 1) relevant for the BC population; 2) fit with existing initiatives; and, 3) are evidence-based and effective. Ideally treatment services need to be provided at the first sign of problems, thus early recognition is fundamental. Treatment intensity needs to match the need, so

[36] Fairburn, C.G. et al. (2009). Transdiagnostic cognitive behavioural therapy for patients with eating disorders: a two-site trial with 60-week follow-up. *American Journal of Psychiatry*, 166:311-319.

services of variable intensity and in a variety of settings should be available. Finally, appropriate coordination of services and collaboration among service providers is required for a fully functioning continuum of care. Recommended actions:

- Identify the needs of the BC population with respect to eating disorders
- Identify programs and interventions that are supported by research and best practices and outline a continuum of services that includes these practices
- Review the BC inventory of services in relation to these best practices and analyze gaps in the continuum.
- Develop and implement a plan to address these gaps in a timely way.

Additional Topics

The role of Primary Care and the Private Sector:
Primary care providers are in a good position to identify and treat eating disorders early. More primary care services in BC are being delivered by multidisciplinary teams that include mental health professionals. Recommended actions:

- Promote practice change and ensure that primary care multidisciplinary teams are trained in the identification and treatment of eating disorders
- Increase screening, early identification and treatment by primary care multidisciplinary teams
- Develop guidelines for eating disorders assessment and treatment

The private sector is also in a good position to identify and treat eating disorders early, particularly through employee assistance and other such programs. Recommended actions:

- Engage private sector mental health service providers to increase their knowledge of ED and promote practice change to increase early detection and treatment of eating disorders

Knowledge Exchange
Continuous improvement in prevention as well as support, assessment, and treatment services for eating disorders needs to be based on the exchange of knowledge and partnering with the research community, the service sector, and the people utilizing those services. Recommended actions:

- Apply information from research to specific programs and initiatives
- Influence research agendas so effectiveness studies are oriented toward practical applications

Obesity
Obesity is a serious health issue progressively affecting more children and youth in BC and much action to address this problem is underway. Given the potential of conflicting obesity-reduction messages with eating disorder prevention messages, careful attention needs to be paid to the content of these campaigns. Recommended actions:

- Adopt an integrated approach to obesity prevention and ED prevention

Conclusion

The purpose of this discussion paper is to stimulate dialogue, planning and collaborative action by the Ministries of Health Services, Children and Family Development, Healthy Living and Sport and its stakeholders to strengthen British Columbia's services for children, youth and adults with eating disorders. It is a starting point, and does not present an analysis and review of our current system. It seeks to inform the commitments by the Minister of Health Services to review the current system of care, analyze potential gaps in that system and an action plan to close those gaps. Next steps should include developing an action plan that focuses on reviewing the inventory of services in BC in relation to best practices, identifying gaps in the continuum of care and implementing a plan to address these gaps in a timely way.

Appendix B: Inventory of Services for People with Eating Disorders in BC

Note: *Regional programs are designated with "R".* *Updated: March 12, 2010*

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
PHSA	Provincial Specialized Eating Disorders Program for Children and Adolescents at BC Children's Hospital www.bcchildrens.ca	Up to age 18.	Tertiary Specialized/ Intensive Program (provincial)	BCCH P3 – Mental Health Bldg. 4500 Oak Street Vancouver, BC V6H 3N1	Tel: 604-875-2200 Fax: 604-875-2099	Comprehensive, multidisciplinary, specialized program to assess and treat children and adolescents with eating disorders. The program emphasizes the involvement of parents and/or primary caregivers in the delivery of care and fully integrates medical, psychiatric, psychosocial, and other aspects of care through a combination of intensive inpatient, day treatment, and outpatient services. Assessment may lead to diagnosis and treatment recommendations that can be managed in community care, or it may lead to treatment in the program at BC Children's Hospital which includes: • An outpatient clinic • A 6-bed day treatment program • A 14-bed intensive inpatient unit Physician referral is required.
PHSA	Kelty Resource Centre (Previously known as the Eating Disorders Resource Centre of BC – EDRCBC) www.bcmhas.ca/keltyresourcecentre	All ages for Eating Disorders	Primary	Manager P3-302 –Mental Health Bldg.2 4500 Oak St. Vancouver, BC V6H 3N1 keltycentre@bcmhs.bc.ca	Tel: 604-875-2084 Toll Free: 1-800-665-1822	Provides free information, referrals, online resources and drop in access to people of all ages struggling with eating disorders.
VCHA	Healthy Attitudes Program	11-24 Vancouver	Primary Secondary	South Community Health Office	Tel: 604-321-6151 Ext. 3306	Provides free counselling and nutrition services ages 11 to 24 who have eating disorders and/or body image

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
	Prevention and early Intervention of ED Behaviour www.vch.ca Serving Vancouver & Richmond "R"	and Richmond residents		6405 Knight Street (at 49thAve) Vancouver, BC V5P 2V9 Hours are 2 pm to 4:30 pm Thursdays; by appointment healthyattitudes@vch.ca	Fax 604-321-2947	issues (without previous hospitalization). Team includes a nurse, doctor, counsellor, and dietitian. Accepts self-referrals and referrals from family physicians.
PHSA	Centre for Healthy Weights: Shapedown BC http://www.bcchildrens.ca	6-16 with Body Mass Index >95%	Secondary	Shapedown BC, BCCH A253 – Shaughnessy Building 4500 Oak Street Vancouver BC V6H 3N1	Tel: 604-875-2345 Ext. 5984	Provides individual counseling, group programs for 10 weeks and both parents and children are required to attend regular sessions and be prepared to make changes
VCHA	Chimo Crisis Services-Richmond Eating Disorders Program www.chimocrisis.com Youth Eating Disorders Program – Richmond Health Services (VCH will offer prevention and early intervention services related to eating disorders/youth.	>17 Richmond residents	Primary Secondary	chimo@chimocrisis.com 8100 Granville Ave., Richmond, BC V6Y 3T6	Tel: 604-279-7077 Fax: 604-279-7075	Provides assessment, individual counseling, art therapy and support groups for people with eating disorders. Required doctor's referral

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
	Offered in Richmond community. Anticipated to start services April 2010) "R"					
PHSA	St. Paul's Hospital Provincial Specialized Services for Eating Disorders	17+ Out of high school	Secondary (Metro Vancouver) Tertiary (BC)	St. Paul's Hospital 1081 Burrard Street Room 431 Vancouver, BC V6Z 1Y6	Tel: 604-806-8347 Fax: 604-806-8631 Intake Coordinator: 604-806-8654 Provincial Coordinator-604-682-2344 ext 62404	Referrals from primary and secondary care providers depending on region of referral. Medical, Psychosocial and Research assessments provided after referrals are accepted by the Intake Coordinator. Treatment offered: Intensive Inpatient Treatment Programs, Residential/Day Treatment Program, Outpatient Groups, and Community Outreach Partnership Program. Provincial Clinical Outreach available by request (contact Provincial Coordinator).
VCHA	Vista House (in collaboration with St.Paul's E/D program) http://vch.eduhealth.ca/%5CPDFs%5CCA/HED.1004.pdf	18+	Tertiary	Coordinator 3360 Fleming Street Vancouver, BC V5N 3V5	Tel: 604-736-9931	10 Bed residential treatment program. Two for follow-up and transitional support, and eight for clients participating in the Discovery Program**.** The Discovery Day Program at St. Paul's Hospital involves intensive group and individual psychotherapy. Referrals required from St Paul's Eating Disorder Program.
VCHA	Community Outreach	18+	Secondary Tertiary	Case Manager 3360 Fleming Street	Tel: 604-736-9983	Individual Counseling service. Clients meet with an Eating Disorders counselor in their community for one

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
	Partnership Program (St Paul and VCHA)			Vancouver, BC V5N 3V5		hour once per week or every 2 weeks. Dietitian is available on client's request. Referral required from St. Paul's Eating Disorder Program.
VCHA	Be Real Clinic www.vch.ca/nutrition/be_real.htm	11-19 North Shore, Coast Garibaldi region, Sunshine Coast, Powell River, Sea to Sky area	Primary Secondary	Intake Coordinator/ Clinician Medical Day Centre, Lions Gate Hospital 231 East 15th Street, North Vancouver, BC V7L 2L7	Intake Referral Line Tel: 604-984-3770	Clinic's mission is to provide youth (11-19) from the North Shore/Coast Garibaldi region with symptoms of disordered eating with timely access to a multidisciplinary eating disorder assessment team. Clinic operates 2 Wednesday afternoons a month. Referrals are made by physicians, counsellors, teachers or through self-referral.
VCHA	Family Services of the North Shore-Provincial Eating Disorder Support Group for Parents/Partners and caregivers www.familyservices.bc.ca	All		101-255 West 1st Street, North Vancouver, BC V7M 3G8	Tel: 604-988-5281 Ext. 202 Fax: 604-988-3961	Offers free and facilitated support group for parents, partners & caregivers, who have family members struggling with an eating disorder. The group meets every 2nd and 4th Monday of each month from 7 p.m. - 8:30 p.m. Starting Jan 2010, FSNS will take on the provincial role of the previous Jessie's Hope Society in offering Provincial Eating Disorder prevention programs.
VCHA	Lions Gate Hospital	19 years and younger	Secondary			Pediatric ward provides inpatient services by making available 4-7 acute pediatric beds to children and youth aged 19 and under who suffer from eating disorders and have been referred to the program by a pediatrician. Full time care is provided by a multidisciplinary team including nurses, a pediatrician, a psychiatrist, a

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
						dietitian, mental health therapists, spiritual counselors and an occupational therapist.
MCFD	Child & Youth Mental Health (Vancouver Coastal Region)	18 years and younger			For a listing of Child and Youth Mental Health offices in the regions visit: http://www.mcf.gov.bc.ca/mental_health/pdf/services.pdf	When a specialized eating disorder program is unavailable in the area, the general Child and Youth Mental Health teams may provide mental health services to children and youth with eating disorders including assessment and treatment. Whenever possible and available the services are provided in consultation with physicians, dietitians and other professionals.
VCHA	Child & Youth Mental Health (MCFD contract)	See Row Above			See Row Above	See Row Above
Private	Looking Glass Foundation for Eating Disorders http://www.lookingglassbc.com/	14-22	Primary	9504 Erickson Dr. Burnaby BC V3J 1M9	Tel: 604-5692262 Fax: 604-966-6011 info@lookingglassbc.com	Foundation dedicated to creating Canada's first treatment facility for adolescents with eating disorders. It provides an annual summer camp in Aug for adolescents to participate in new challenges and respite for their families. Other community initiatives include, research, an annual scholarship, engaging speakers and annual fundraising. They offer support group for people 17+ struggling with Disordered Eating and want to gain a better understanding of the role and function of their eating disorder and to explore factors that influence readiness to make changes. For registration, call 604-219-0381
VCHA	St Paul's Hospital – Nutrition Service	12+	Secondary	Nutrition counseling services	Tel: 604--806-8486	Out Pt. Nutritional Counseling Services for patients. Physician referral required.

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
	Counseling			St. Paul's Hospital Room 310 Burrard, 1081 Burrard Street Vancouver BC V6Z 1Y6	Fax: 604-806 8680	
VCHA	UBC **Hospital -** Nutrition Outpatient Counseling	18+	Secondary	Nutrition counseling services St. Paul's Hospital Room 310 Burrard, 1081 Burrard Street Vancouver BC V6Z 1Y6	UBC Hospital Tel: 604.-822-7328	Out Pt. Nutritional Counseling Services, physician referral required.
FHA/MCFD	Fraser South Eating Disorders Program www.fraserhealth.ca (MCFD and Adult Mental Health) "R"	All ages Surrey, Delta, Langley and White Rock	Secondary	Coordinator: Anne Merret Hiley Delta Mental Health Centre #129 - 6345 120th Street Delta, BC V4E 2A6	Tel: 604--592-3700 Fax: 604-591-2302	A specialized program operating with Mental Health services and supported by the Fraser Health Authority and MCFD. Provides community based outpatient service including medical, nutritional and family support, individual, group and family therapy. Referral required from a family physician and clients required to attend a1.5 hr info night session which runs on a monthly basis. Services for children 12 years and under require a referral from a pediatrician.
FHA/MCFD	Fraser North Eating Disorders Program ((MCFD) "R"	All ages (under 12 with a pediatric referral) Tri-cities (Coquitlam,	Primary Secondary	Team Leader #300 - 3003 St. John's St., Port Moody, BC V3H 2C4 Service delivery for youth is two location	Tel: 604--469-7600 Fax: 604-469-7601 For referral for youth up to 19.	A specialized program operating within CY mental Health Services and supported by the Fraser Health Authority and MCFD. Provides community based outpatient treatment including medical, nutritional and family support, individual, group and family therapy by a specialized multi-disciplinary team. Physician referral required for

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
		Port Coquitlam, Port Moody, Belcarra, and Anmore), Burnaby, Maple Ridge, Pitt Meadows & New Westminster		model with services also available in Burnaby at CYMH Halifax Office)	Tel: 604-777-8440 For referral to the adult NFED Program 18 +	the treatment of anorexia, bulimia and ED NOS. The adult program is more group therapy based and does not offer family therapy at this time.
FHA	Fraser East Eating Disorder Program (Chilliwack & surrounding area)	Youth and Adults	Primary Secondary	Abbotsford Mental Health, FHA Eating Disorder Program, #11-32700 George Ferguson Way Abbotsford, BC V2T 4V6	Adult: Tel: 604-870-7800 Fax: 604-870-7801 Youth: Te: 604-702-2311	Physician referral required. Non-acute service – sees every 6-8 weeks. Nutritional counseling for youth under 19 Group classes for adults. Tuesday & Wednesday only Will see pediatric clients once every 6-8 weeks. ED nutrition counseling for outpatients in Chilliwack, Agassiz and Hope. In Chilliwack work with MCFD counselors and physician in team treatment of adolescent eating disorders. Individual therapy and therapist will collaborate with community dietitian. In Agassiz and Hope sees patients upon referral from their family physician for the treatment of eating disorders if also seeking counseling services at the same time. Will see adults with eating disorders who are receiving counseling either from a private therapist or Adult

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
						Mental Health Services.
MCFD	Child and Youth Mental Health Abbotsford Eating Disorder Program	Under 19	Primary Secondary	Child and Youth Mental Health 2828 Cruikshank St. Abbotsford BC V2T 5M4	Tel: 604-870-5880 Fax: 604-870-5878	Referrals accepted from self or GP. Treatment involves counseling along with ongoing consultation with GP or pediatrician and patient dietitian. Services include psycho-social assessments, individual and family counseling, as well as group therapy including psycho education, meal support, art therapy, DBT adolescent support group and caregivers support group.
FHA	Eating Disorder Services Adult Mental Health, Abbotsford Servicing both Abbotsford and Mission.	Adults 19+	Primary Secondary	Abbotsford Mental Health, FHA #11-32700 George Ferguson Way Abbotsford Way V2T 4V6	Tel: 604-870-7800 Fax: 604-870-7801	Voluntary outpatient program. Individual and group counseling for adults with an eating disorder. Work in collaboration with outpatient dietitian. Outpatient Dietitian: Physician referral required. Non acute services – sees every 6-8 weeks, group classes for adults.
FHA	Tri-cities Ed (for adults) Program is located together in Port Moody.	Adults 19+	Secondary Service	Tri-Cities Mental Health Centre 1 – 2232 Elgin Ave. Port Coquitlam, BC V3C 2B2	Tel: 604-777-8400 Fax: 604-777-8411	A specialized program operated by Mental Health Services. Provides community based outpatient service including medical, nutritional, individual and group therapy. Referral required from a family physician.
MCFD	Child & Youth Mental Health, Team (Fraser Region)	Under 19	Primary Secondary	For a listing of Child and Youth Mental Health office in the regions please visit: http://www.mcf.gov.bc.ca/mental_healt/pdf/services.pdf	Tel: 604-870-5880 Fax: 604-870-5878	When a specialized eating disorder program is unavailable in the area, the general Child and Youth Mental Health team provides mental health services to children and youth with eating disorders including assessment and treatment. Whenever possible and available, the services are provided in consultation with physicians, dietitians and other professionals.
FHA	Burnaby Hospital		Secondary	3935 Kincaid Street, Burnaby, BC	Tel: 604-412-6200	Out Pt. Nutritional Counseling

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
				V5G 2X6		
IHA	100 Mile House – Eating Disorder Program	Adult	Primary Secondary	PO Box 399 555 Cedar Ave 100 Mile House, BC V0K 2E0	Reception: Tel: 250-395-7676 EDP for adult, tel: 250-395-7655	Self referral and treat all types of eating disorders. Providing consultation/treatment with physician who is specialized in Eating Disorders.
MCFD	100 Mile House Child Youth Mental Health Team	Under 19		100 Mile House CYMH 160 Cedar Ave, 100 Mile House, BC V0K 2E0	Tel: 250-395-5633	Provides assessment, consultation to health professionals
MCFD	Child and Youth Mental Health – Interior Region	Under 19	Primary Secondary	For a listing of Child and Youth Mental Health office in the regions please visit: http://www.mcf.gov.bc.ca/mental_healt/pdf/services.pdf		When a specialized eating disorder program is unavailable in the area, the general Child and Youth Mental Health team provides mental health services to children and youth with eating disorders including assessment and treatment. Whenever possible and available, the services are provided in consultation with physicians, dietitians and other professionals.
IHA/MCFD	West Kootenay Eating Disorder Clinic "R"	All Ages	Primary Secondary	707 – 10th Street Castlegar, BC V1N 2H7	Tel: 250-505-7252 Fax: 604-412-6175	Provides assessment, consultation to health professionals. Dietitian, Dr. Counsellor
IHA	Nelson Mental Health Team	over 19	Primary	2nd floor 333 Victoria street Nelson, BC V1L 4K3	Nelson Mental Health Office Tel: 250-505-7274 Fax: 250-505-7246	Provides assessment, consultation to health professionals
IHA	East Kootenay Eating Disorder Clinic		Secondary Primary	20 – 23rd Ave S Cranbrook, BC V1C 5V1	Tel: 250-489-6416	Offers community education, assessment, consultative services, and assistance with treatment planning for both adults and youth diagnosed with Anorexia

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
	"R"					Nervosa, Bulimia Nervosa or an Eating Disorder Not Otherwise Specified.
MCFD	Cranbrook CY Mental Health Team	18 and under		CYMH Cranbrook 201-1212 2nd ST N Cranbrook, BC V1C 4T5	Tel:250-426-1514	Provides assessment for children and youth with eating disorders
IHA/MCFD	Kamloops Eating Disorders Program (Thompson Shuswap Health Services) "R"	Adult and Youth	Primary Secondary	Intake worker 235 Lansdowne Street Kamloops, BC V2C 1X8	Intake Worker Tel:250--377-6500	A community based regional service that provides individuals who struggle with anorexia, bulimia or disordered eating with information, assistance, assessment and treatment. Accept self referral from family members, friends, physician, school counselors, community agencies.
IHA/MCFD	Child and youth Mental Health, Central Okanagan (joint with IHA)	Children and youth in the central and south Okanagan areas	Primary Secondary	204-260 Harvey Ave., Kelowna, BC V1Y 7S5	Tel:250-861-7301 Fax:250-861-7359	A youth therapist and part time dietitian provide mental health services to children and youth with eating disorders including assessment and treatment.
IHA/MCFD	Kelowna Eating Disorders Program (Joint with MCFD) "R"	Adults 19+	Secondary	Kelowna Mental Health and Addictions #100-540 Groves Ave Kelowna BC V1Y 4Y7	Adult : Tel : 250-861-5777 Fax: 250-861-5774	A specialized outpatient multidisciplinary treatment service for youth and adults diagnosed with anorexia or bulimia nervosa. The program is supported by and operates from both MH&A and CYMH sites. Assessment and treatment services may include group education, group therapy, nutritional counseling, individual therapy, psychiatric consultation and/or family group education. Consultations also available to allied health care providers.
IHA	Trail Family & Individual Resource		Secondary	860 Eldorado Street Trail, BC V1R 4V8	Tel: 250-364-2326	No funding to provide eating disorder services since 2007 March but will take cases related to Mental

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
	Centre					Health & Addiction, women having pregnancy issues and family issues
MCFD	Trail Child and Youth Mental Health	Under 19		Intake worker 278-1051 Farwell St, Trail, BC V1R 4S9	Tel: 250-364-0540	Provides assessment for children and youth with eating disorders
IHA/MCFD	Williams Lake Child & Youth Mental Health Team	Under 19/Adult		Child and Youth Intake worker 2nd Floor 280C N Mackenzie Ave Williams Lake, BC V2G 1N6 Adult: Intake Worker 487 Borland Street Williams Lake, BC V2G 1R9	Child and Youth Tel: 250-398-4963 Adult: Tel: 250-392-1483 Fax: 250-392-1484	Offers individual counseling and physician. Self referral.
IHA/MCFD	North Okanagan Eating Disorders Program (CMHA Program) "R"	13+ Service Area encompasses the regional catchment between Vernon, Salmon Arm and Revelstoke	Primary Secondary	Program Coordinator edp303@hotmail.com #105 - 3402 – 27th Ave Vernon, BC V1T 1S1	Tel: 250-542-7111 Fax: 250-542-7111	A specialized program operating with Mental Health & Addiction services and supported by Interior Health and MCFD. Provides information, support and treatment for individuals, family and friends. Treatment Team includes, nurse, dietitian, pediatrician, family therapist and psychiatrist. Parents and significant others support group offered 1x/mth. Consultations are available to other health care professionals. GP referral. Co-located with MCFD.
VIHA	**TeleEating Disorders**	Adults	Secondary	VIHA centre for Telehealth	Email: Telehealth@viha.	Eating disorders include anorexia nervosa and bulimia. Patients with an eating disorder often experience other

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
	http://www.viha.ca/telehealth/initiatives/#TeleEating%20Disorders Eating disorders program, south Vancouver Island Psychiatrist.			IM/IT Memorial Pavilion Royal Jubilee Hospital 1952 Bay Street Victoria, BC V8R 1J8	ca	conditions at the same time such as depression, anxiety and obsessive-compulsive disorder. A psychiatrist in Victoria specialized in eating disorders provides eating disorder consultations via Telehealth to locations where these services are needed.
VIHA	North Island Regional Eating Disorder Program (VIHA & MCFD) http://www.viha.ca/finding_care/community_services_directory/default.htm?search=true&id=1561 "R"	Youth & Adults (19+) Parents (Campbell River) Adults (19+) Parents Children and youth for early intervention/ prevention (Comox Valley)	Primary Secondary	Campbell River – #207 - 1040 Shoppers Row Campbell River, BC V9W 2C6 And Comox Valley Nursing Centre 961 England Avenue Courtenay, BC V9N 2N7	Tel: 250- 850-5838 For Comox Valley 250-331-8504 (ext 38119) Tel: 250-898-2200 ext.2116 Fax: 250- 338-9985	The North Island Regional Eating Disorder Program provides direct client services in both the Comox Valley and in Campbell River. Upon request, clinical support through education and services to health care providers is offered to other communities in the North Island Region. Services include individual, and group therapy, nutrition counseling, parental support as well as education and outreach to schools and other agencies. Services will include clients with anorexia, bulimia, EDNOS, compulsive eating. Early intervention/ prevention (Comox Valley Office)
MCFD	Disordered Eating & Severe Body	13-19	Primary Secondary	371 Festubert St. Duncan, BC	Tel: 250-746-5521	For youth struggling with food, weight and shape; Anorexia Nervosa, Bulimia Nervosa, EDNOS,

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
	Image Concerns Program (CMHA, contract with MCFD) "R"			V9L 3T1	Fax: 250-748-2806	compulsive eating. Individual therapy, dietitian, youth worker, family meeting evening groups for parents self or doctor referral.
MCFD	Disordered Eating Support Services, Associated Family & Community Support Services (MCFD Contract) "R"	child and youth only as of March 31, 2010)	Primary Secondary	155 Weld Street Box 1534 Parksville, BC V9P 2H7	Tel: 250-248-0076 Fax: 250-248-3465	Provides counseling for Anorexia, Bulimia, Compulsive Overeating and Disordered Eating. Individual therapy, groups, parental support, community consultation and prevention. GP involvement required .
MCFD	Eating Disorders Program in South Vancouver Island Region Victoria (C&Y Mental Health, MCFD) "R" Serves South Vancouver Island Region	All Ages	Primary Secondary	#302 - 2955 Jutland Rd. Victoria, BC V8T 5J9	Main reception: Tel: 250 - 387-0000 Fax: 250- 387-0002 ??250-709-3000	Multidisciplinary community mental health team committed to collaboration with youth, adults and families, focusing on resilience and strength. Program services children, youth and adults struggling with Anorexia Nervosa, bulimia nervosa and ED NOS. Open referral – individuals can self refer. GP involvement is required. Provides consultation, intake assessment and treatment. Individual, family therapy, family based treatment (Modified Maudsley), nutritional counseling, psychiatric consultation, meal support. Variety of group therapies including CBT or DBT for bulimia and binge eating, nutrition group, expressive therapies, body image, yoga nidra, meal support other mental health groups shared with other teams.

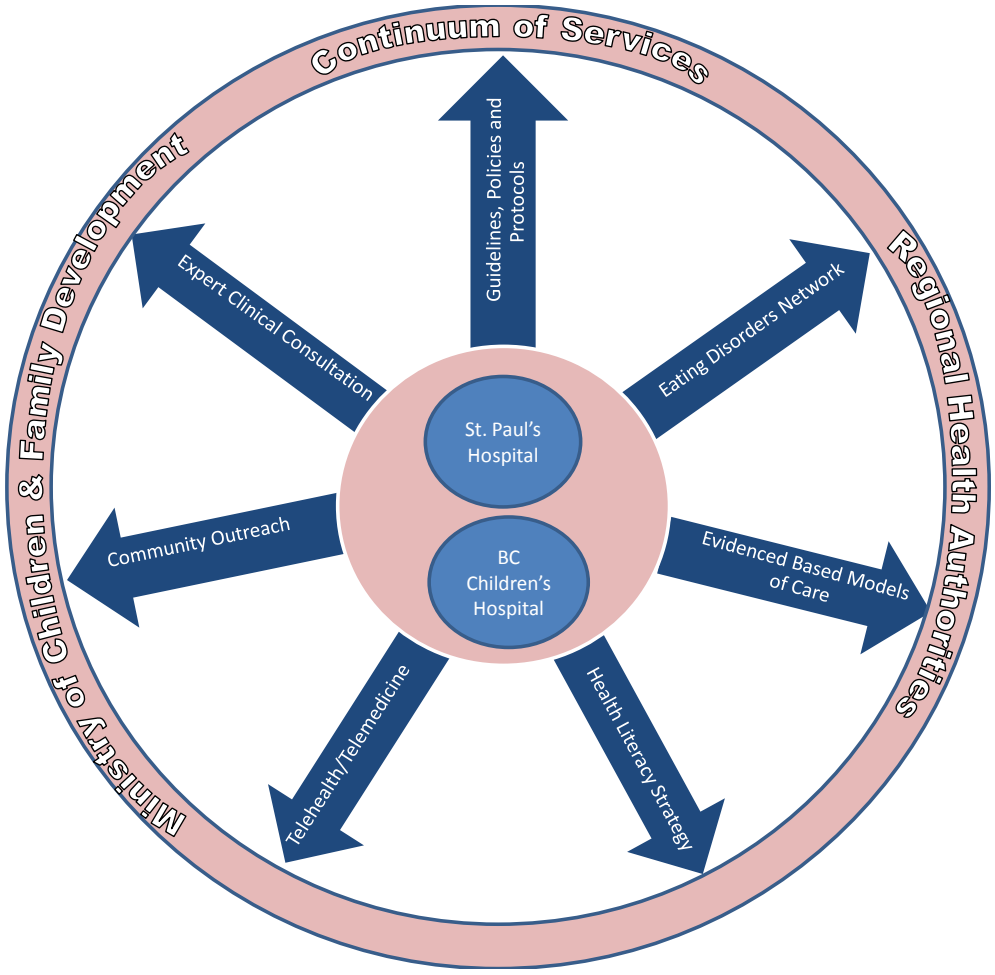
Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
						Liaison with family physicians and professionals. Services and collaboration across the care continuum when client requires hospital admissions. Parents: weekly psycho education groups for family and significant others; monthly family support groups; additional parent therapy groups as needed. Treatment selection is based on consultation with the client, family and team and within the available resources.
VIHA	Cowichan District Hospital	19+	Tertiary	3045 Gibbins Rd Duncan BC, V9L 1E5	Tel: 250-746-4141 Fax: 250-746-4247	Admission for severe Anorexia Nervosa & Bulimia. Assessment, renourishment, education. Dietitian support, general nursing, referral to groups such as the Eating Disorder Program in Capital Hill, weight and medical stabilization.
VIHA	Port Alberni Child & Youth Mental Health Services	Under 19	Primary Secondary	Intake Worker 4088 8th Ave Port Alberni, BC V9Y 4S4	Tel: 250-720-2650	Open referral for clients with anorexia, bulimia & EDNOS. Individual assessment and treatment, parenting support, family therapy, psychiatric assessments. Education to the community groups upon availability only.
VIHA	Cowichan Valley Adult Mental Health Team	Adults including Duncan, North Cowichan, Mill Bay, Chemainus, Lake Cowichan, Ladysmith,		3088 Gibbins Road Duncan, BC V9L 1E8	Tel: 250-709-3040 Fax: 250.709.3045	Clinician, individual counseling.

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
		and Thetis and Kuper Islands.				
MCFD	CMHA Cowichan Valley (MCFD contract)	Youth<19	Primary	Inatake Workers 371 Festubert Duncan, BC V9L 3L1	Tel: 250-746-5521 Fax: 250-748-2606	Admission through self-referral for clients with anorexia, bulimia and EDNOS. Individual therapy. Therapist will work collaboratively with community dietitians and doctors.
VIHA	Victoria General Hospital www.viha.ca	Under 17	Tertiary	1 Hospital Way Victoria, BC V8Z 6R5	Tel: 250- 727-4212 Fax: 250-381-2444	Admission for Anorexia Nervosa. Weight and medical stabilization only. Dietitian and meal support, supervised activity, referral to eating disorder program.
VIHA	Eric Martin Pavilion	19+	Tertiary	administrator@victoriamedicalsociety.org The Victoria Medical Society Eric Martin Pavilion 190-2334 Trent Street Victoria BC V8R 4Z3	Tel: 250- 598-6021 Fax: 250- 370-8274	Admission for Adults with eating disorders in consultation with the Eating Disorders Program, South Vancouver Island.
VIHA	St. Joseph's Hospital-Adolescent Outpatient Services http://www.sjghcomox.ca/psychiatry.php	14-19 as well as adult	Primary Secondary	2137 Comox Avenue Comox, BC, V9M 1P2	Adolescent outpatient Tel 250- 339-1525 Outpatient Adult Tel : 250-339-1496 St Joseph Hospital ED Day Program	Accepts referrals for therapy directly from families seeking service. Caregivers or school personnel may also phone to facilitate referrals on behalf of teens and their families. To access a psychiatric assessment, physicians can request a physician referral form. Accepts clients with anorexia nervosa, bulimia nervosa, EDNOS. Provides individual therapy, family therapy, education on how to prevent/ short admission to inpatient services, case management, home visits. Works collaboratively with community dietitian.

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
					Tel: 250-339-5954	Adults' referral to St. Joseph's Hospital Outpatient program or North Island Eating Disorder Program
VIHA	Nanaimo Regional General Hospital http://www.viha.ca/finding_care/facilities/nrgh.htm		Tertiary	1200 Dufferin Crescent Nanaimo, BC V9S 2B7	Tel: 250- 754-2141/ 250-755-7691 For Parksville/ Qualicum, Tel: 250-248-2332	Admission for urgent or emergency medical stabilization.
MCFD	The Eating Disorders Program and Sexual Abuse Programs run by NARSF Programs Ltd. contracted through MCFD www.narsf.org	Referred youth Under 19 and families in the Nanaimo/ Ladysmith area		admin@narsf.org 201 - 170 Wallace St, Nanaimo, BC V9R 5B1	Tel: 250-754-2773 ext 213, 101 Fax: 250-754-1605	Provides individual counseling, family counseling, group support, classroom and community education. Clients come from agency referrals and the community. There is no fee for service.
VIHA	West Coast General Hospital	Under 19	Tertiary	3949 Port Alberni Hwy, Port Alberni, BC V9Y 4S1	Tel: 250- 723-2135 Fax: 250-724-8842	Admission for medical stabilization – emergency situations only.
VIHA	Campbell River Hospital	All age group	Tertiary	375 - 2nd Avenue, Campbell River, BC V9W 3V1	Tel: 250-281-7111	Admission for urgent or emergency medical stabilization only.
NHA	Prince George Eating Disorders Clinic "R"	Youth and adults	Primary Secondary	Prince George Eating Disorders Clinic Nechako Centre, 2nd Fl. 1308 Alward Street Prince George, BC	Tel: 250-565-7479 Fax: 250-649-7662	Provides assessment and counseling services for individuals and their families throughout the Northern Health Region, local support to those clients who are not living in Prince George through their local support professionals (family doctor, dietitian, counsellor as well as tertiary referrals to St Paul and BCCH Eating

Ministry or Health Authority Responsible	Name of the Service	Target Age Range	Service Level	Address	Phone/ Fax/Email	Service Description
				V2M 7B1		Disorders Programs. Accepts self referral or referrals by healthcare professionals
NHA	Child & Youth Mental Health MCFD	Under 19	Primary Secondary	For a listing of Child and Youth Mental Health office in the regions please visit: http://www.mcf.gov.bc.ca/mental_healt/pdf/services.pdf	Tel: 250-638-2330	When a specialized eating disorder program is unavailable in the area, the general Child and Youth Mental Health team provides mental health services to children and youth with eating disorders including assessment and treatment. Whenever possible and available, the services are provided in consultation with physicians, dietitians and other professionals.

Appendix C: Eating Disorders Services Hub & Spoke Approach



This diagram shows how BC's two centres of excellence for eating disorders- St. Paul's Hospital and BC Children's Hospital are "Hubs" in BC's system of care in collaboration with the ministries of health services and children and family development. The "spokes" depict how these two hospitals extend their specialized services to other centres and service providers throughout the province.

Appendix D- Health Literacy Initiative – Disordered Eating

Introduction
At the Provincial Eating Disorders Stakeholder Forum held in April 2009, health literacy in eating disorders was identified as a key priority, and it was recommended that efforts be directed towards improving public understanding of this serious mental health issue.

Health Literacy in Mental Health and Substance Use in British Columbia
Research has demonstrated that mental health promotion and prevention interventions and policies can have a positive impact on mental health itself, as well as on the emotional and economic toll these disorders have on patients, their families, caregivers and society at large. Previous work has also established the need for improved public education and dissemination of information on mental health and addiction in BC, including addressing issues of health literacy.

Health literacy refers to people's abilities to access, understand, assess and communicate health information. In the context of mental health and addiction it also refers to knowledge and beliefs which assist in the recognition, management or prevention of mental health or substance use issues or disorders and includes:

- The ability to recognize specific issues/disorders
- Knowing how to seek mental health and addiction information
- Knowledge of risk factors and causes, self management and professional help available
- Attitudes that promote recognition and appropriate help seeking

The Provincial Strategy to Improve Health Literacy in Mental Health and Addictions is a capacity building initiative to support the implementation of a best practice framework to improve public understanding (e.g. mental health promotion, prevention, early intervention, help seeking, self management and recovery), and reduce the stigma related to mental health and substance use problems. This comprehensive framework also involves increasing linkages and use of other complementary and effective approaches, including health promoting policies and targeted interventions.

Health Literacy Initiatives in Eating Disorders
Evidence indicates that effective eating disorder prevention programs should be targeted around media literacy and cognitive-behavioural interventions. Evidence suggests that such programs reduce risk factors associated with eating disorders but do not necessarily result in a significant decrease in eating disorder symptoms. The following is a quick summary of evidence-based health literacy initiatives in this area.

Cognitive-Behaviour Based Programs

- These programs, typically run in a school setting, include strategies to alter maladaptive attitudes such as body dissatisfaction and maladaptive behaviors such as fasting or overeating. Larger intervention effects are seen in programs that are targeted, interactive, and multi-session. It is also suggested that females over the age of 15 benefit most from such programs.

- Programs that focus on building life skills, including activities on stress management, relationships, self-esteem enhancement, and healthy living have been shown to improve body image satisfaction, self-esteem, and eating attitudes and behaviours.

Media Literacy

- Media literacy and advocacy programs involve examination of media images, critical analysis of media messages, and planning and carrying out activism/advocacy projects. They have been shown to enhance participant's ability to critically analyze media images and increase positive body image. Reviews show small improvement in protective psychological factors for participants of media literacy projects.

Healthy Schools-Healthy Kids Program

- This comprehensive school-based universal prevention program includes parent education, teacher training, in-class curriculum, peer support groups, and poster/video presentations. An evaluation found the program reduced media ideals among males and females and reduced disordered eating among females.

Go Girls! Program (Giving Our Girls Inspiration and Resources for Lasting Self-Esteem – Developed by Eating Disorders and Awareness, Inc.)

- This program has demonstrated the development of media literacy and advocacy skills, peer-based relationships among high school girls, and positive self and body image. Evaluation of this program has shown reduced internalization of media messages, increased media knowledge and critical review of messages, and increased self-confidence.

Proposed Health Literacy Initiative

The following is a proposal for the development of a health literacy initiative in the province of British Columbia, to be led by BCMHAS in collaboration with key stakeholder organizations. These organizations include the Jessie's Legacy Program at Family Services of the North Shore, BCMHAS and the BC Partners for Mental Health

and Addictions Information, the Child and Adolescent Eating Disorder Program at BCCH, the St. Paul's Specialized Adult Eating Disorder Program, the Looking Glass Foundation, and representatives from community eating disorder programs (MCFD and RHA funded).

1. An environmental scan will be completed to identify best and promising practices in Canada and other jurisdictions. The province of Ontario will be looked at in particular since they have developed a comprehensive Provincial Eating Disorders Network and are in the process of developing and implementing prevention/health promotion initiatives in eating disorders (with significant health literacy components) as part of a comprehensive strategy. The environmental scan will include health literacy initiatives across the spectrum from health promotion to treatment to recovery.

2. Consultation with the identified stakeholder group (noted above) will be undertaken to seek advice on the selection, development and implementation of a discrete health literacy project. Environmental scan results will be presented to the stakeholder group with a focus on exploring opportunities for synergies and building upon existing capacity.

3. Utilizing principles derived from the BCMHAS health literacy conceptual and knowledge exchange frameworks, a target population and setting along with an evidence-informed strategy for dissemination, adoption/uptake, and evaluation will be developed.

4. A detailed project plan will be established with specific deliverables, including timeline and costs. It is anticipated that the project plan will be completed by September 30, 2010.

5. The project proposal will be developed over the course of the fall 2010 with implementation set for winter 2010-11.

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