Consultation On Disordered Eating/Eating Disorders
Draft Report

Submitted to

The Winnipeg Regional Health Authority:
Mental Health Program

and

The Winnipeg Regional Health Authority:
Child and Adolescent Mental Health Program

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EXECUTIVE SUMMARY

The area of eating disorders, specifically anorexia nervosa and bulimia nervosa has received a lot of attention in the literature over the past decade. While we are much further ahead in our awareness of the illnesses we have only made initial steps towards achieving an understanding sufficient to develop successful treatment and prevention programs. As compared to anorexia nervosa, bulimia nervosa has been researched more successfully, having reported success using cognitive-behavioural therapy in conjunction with nutritional rehabilitation. The area of anorexia nervosa is of greatest concern because of its associated mortality rate. While we are still not able to treat some clients successfully there has been a move to include motivational enhancement therapy to deal with the inherent denial of anorexia nervosa. Although more research is needed in this area, there are signs of promise and hopefulness for its efficacy. The other key point that is reported in both the literature and by clients themselves is the need for more choices in the type of therapy included in their treatment. Some of the suggestions include individual and group therapy, recreational activities, expressive therapies, and mind/body activities such as yoga and pilates. Individuals’ needs are very different and thus the treatment plans must reflect the uniqueness of each client.

Examining programs across Canada, it is apparent that each province has organized itself somewhat differently with some provinces well coordinated and others not coordinated at all. Those provinces that have a government-funded provincial coordinator stand out as being very aware of their resources and seem to have less redundancy of services. As well, most of these provinces have formed body image networks that meet regularly to monitor service delivery and prevention programs, develop resource material and to share information. Some of the programs such as British Columbia have published their services in a provincial mental health journal. Through a coordinated effort, British Columbia has also published a manual for prevention of eating disorders that presents the leading theories and includes many resources. Alberta has produced a comprehensive prevention program for children in grades one through twelve as well as accompanying body image kits. Much of the recent literature on motivational enhancement therapy and the step program for eating disorders has been researched and published by those at Toronto General Hospital in Toronto, Ontario. As well, Ontario has developed and delivers a provincially funded training program for health care professionals who are interested in becoming more skilled in the area of eating disorders. The training is available to people from all parts of Ontario.

Within the City of Winnipeg there many who are dedicated to the prevention, early identification and treatment of eating disorders. Recovering clients, families, and health care providers are all working to their best ability to deal with issues of disordered eating/eating disorders. At present, Winnipeg has many services being offered from early detection through to tertiary care services. There is very little in the way of coordinated prevention although there are some
programs that attempt to raise awareness. Eating Disorders Association of Manitoba is an advocacy group comprised of families who advocate for services and raise awareness within the province.

Within the school systems there isn’t a coordinated effort to raise awareness of eating disorders. Most schools in Winnipeg use the health and physical education curriculum from the Manitoba Department of Education. While the curriculum does promote healthy lifestyle, it does not directly consider and target increasing protective factors and decreasing risk factors associated with the development of eating disorders. No school division in Winnipeg has a plan in place concerning the prevention and early identification of eating disorders. Programs are instituted on a school-by-school basis upon the request of students, parents or staff. Relying on requests is somewhat of a concern if one considers the denial that is often associated with anorexia nervosa and bulimia nervosa. People in the initial phase of an eating disorder often hide or deny their weight loss or purging behaviours. Individual resource teachers and guidance counsellors deal with students who have developed an eating disorder for the purpose of referral to a program for treatment.

Because of the above mentioned issue of non self-identification there is a need for specialized training to increase the assessment skills for early identification of an eating disorder. Although there is a training module offered from the University of Manitoba that is available for family physicians, it is reportedly rarely used. The educational curriculums of other health care professions include only small amounts of time dedicated to eating disorders. Teachers typically do not receive any formal education about eating disorders.

Although there are many services in Winnipeg, the lack of coordination has raised many issues and concerns for those in service delivery. At this time, it is difficult to assess where and how much service is required because the efforts are not examined inter-sectorally. In the absence of coordination there may also be missed opportunities to offer a wider variety of types of therapy. For example, if one collaborates with other agencies, as well as considers those facilities outside of the sector, clients may be afforded a variety of appropriate choices of treatment.

Those working in this field clearly have a strong commitment and many, many years of service in the area of eating disorders. This dedication has been clearly identified as a great strength within the Region. The existing services are not fully aware of each other nor do they have opportunities to share their expertise with one another. In-services and other educational opportunities are not always known by the different services and thus there may be missed opportunities or redundancy. As well, the Region would benefit from a coordinated effort to deal with the numerous requests for “speakers” that are currently dealt with individually by each agency receiving the request. Finally there has not been the
opportunity for the Region to develop an inter-sectoral plan in regards to disordered eating or eating disorders.

**Recommendations and Implementation Plan**

To best meet the needs of individuals and their families, disordered eating and eating disorders may be conceptualized within an adapted Primary Health Care Model (World Health Organization) that offers a full range of service options. This model incorporates services offered along a continuum from prevention/promotion to supportive services. People with disordered eating and/or an eating disorder are at various stages of the illness and require different types of services depending on their specific circumstances. A model must include a wide range of services to meet the clients’ needs. The primary health continuum as it relates to disordered eating/eating disorders is presented below along with examples.

<table>
<thead>
<tr>
<th>Promotion</th>
<th>Prevention</th>
<th>Curative</th>
<th>Restorative</th>
<th>Supportive</th>
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<tr>
<td>Focus on health and physical fitness through health and physical education classes and recreation facilities.</td>
<td>Discussions/presentations activities that encourage exploration of issues regarding body image, self-esteem and myths of the media with children beginning in elementary school and continuing through to high school.</td>
<td>Treatment aimed at recovery from an eating disorder/disordered eating.</td>
<td>Restoration of normal physiological functioning (menses and weight). Return to everyday functioning including school, work and play.</td>
<td>Supportive work to prevent relapse.</td>
</tr>
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Inherent in this model are several key principles that have been borrowed from the Primary Health Care Model:

- Viewing the individual with disordered eating/eating disorder as a whole being from the physical, spiritual, emotional and intellectual perspective
- Relying on the diversity of trained workers functioning as a multidisciplinary team to collaborate with individuals
- Moving towards local integration of services for those with disordered eating/eating disorder
- Health care for people with disordered eating/eating disorder is inter-sectoral including all sectors that are relevant to the client (e.g. health, education, family services and employment)
- The issues of promotion, awareness, prevention, curative (treatment) and supportive are addressed within a community from a community perspective and has community involvement
- It has the principles of equity and is affordable
In the first year it is recommended:

1. A regional eating disorders coordinator is hired for the Winnipeg Region and forms a body image network to include representatives from all those working with and interested in disordered eating/eating disorders in Winnipeg.

2. The Regional Coordinator would be responsible to initiate discussions with Manitoba Health regarding the development of a provincial coordination of services led by a provincial coordinator.

3. The Regional Coordinator would be responsible to gather the network two times per year at minimum. The network would meet once for a meeting to share information regarding services, theoretical perspectives and upcoming educational opportunities. The second meeting would be for an educational day.

4. The Regional Coordinator would be responsible to initiate the development of a respect and understanding among the many health care providers throughout the Region regarding the many treatment options and treatment philosophies available to people.

5. The Regional Coordinator would be responsible to ensure body image network members are aware of all educational opportunities concerning eating disorders/disordered eating. This would include educational opportunities in the City of Winnipeg as well as outside of the city. This may be done in a variety of ways e.g. newsletter, email etc.

6. The Regional Coordinator would initiate the researching and dissemination of motivational enhancement therapies for anorexia nervosa. Resources regarding motivational enhancement therapy to be made available to those working with people with anorexia nervosa. If possible, resources would be made available for a small number of professionals to attend training sessions on the topic or an expert may be invited to Winnipeg to train those professionals in the city.

7. Initially using the resources provided by this consultation, regular and ongoing updating of evidenced-based material and best practices material concerning disordered eating/eating disorder to be collected and be easily available to health care providers.

8. To avoid lengthy waiting lists, exploration of methods to increase the ability of the Adult Eating Disorders Program to assess and treat more clients.
In the second and third years it is recommended:

1. To initiate the process of offering training to primary care physicians and other health care professionals in the Region. The focus of the training would be on the early identification and primary care of people with disordered eating/eating disorder.

2. To begin to work inter-sectorally to focus on primary and secondary prevention including relapse prevention. Such an initiation should include, but not be limited to: Health, Education and Family Services.

3. To formally develop a community-based prevention program carried out by those in the community: self-help groups, advocacy groups, community-based treatment agencies, clients and their families. Planning of a prevention program should consider the experiences of experts in the field as well as those working in the secondary and tertiary care systems.

4. To collaborate with current resources such as EDAM, Klinic Community Health Centre and the Women’s Health Clinic and organize a yearly campaign of awareness and prevention within elementary, middle and high schools. Where possible using the available prevention programs (Health Canada’s Vitality Program, Prevention Curriculum developed by the Alberta Mental Health Board Prevention Program) and encouraging that programs be implemented by teachers in the school system from grades 1-12 with a focus on beginning the programs as early as possible.

5. To begin to develop and make readily available, a list of treatment resources in an easily accessible and readable format (e.g. Resource for People with Fetal Alcohol Syndrome).

6. To assist teachers, parents, children’s activity groups etc. in getting education materials for self-teaching as well as support for those teaching the information to children.

7. To initiate contact with parallel services across Canada for future networking and sharing of information and resources.

8. To increase the amount of training about disordered eating and eating disorders available to professionals thus enhancing access to services.

- Increase amount of training within professional curriculums (e.g. undergraduate medical training, residency programs, psychology programs, nursing programs, occupational therapy programs, education programs and human ecology programs)
- Increase opportunities for continuing education certification (e.g., the University of Manitoba and Red River College offer an applied counselling certificate for addictions as well as for family violence; perhaps a certificate in eating disorders could be initiated?)
- Increase education for primary care physicians, public health nurses and others who are first line caregivers.
- Continuing education for health professionals in practice through a mentorship program or train the trainers program.

9. To identify and promote the appropriate use of specific Internet websites for people of all ages. For example, encourage schools to provide specific links on their school websites to helpful websites.

10. To provide greater primary and secondary prevention to be aimed at both boys and girls in elementary schools. The focus in elementary school should be on reducing the risk factors and increasing the protective factors for an eating disorder. Physical education programs should work hard to include all students and to ensure the program is a contribution to self-esteem.

11. To monitor resources focused on anorexia nervosa specifically to deal with the inherent denial that is the hallmark of the disease.
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INTRODUCTION

The most common eating disorders that are discussed by people as well as in the literature are anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified. They are characterized by disturbed eating behaviour associated with an inappropriate and unhealthy preoccupation with body weight and shape. Eating disorders are accompanied by a psychological disturbance such as disturbance in mood and thinking. The duration of an eating disorder varies from a brief single episode to severe disorders with prominent weight loss and maladaptive behaviours (Selzer, Bonomo, & Patton, 1995).

Anorexia Nervosa is characterized by an obsession with and the endless pursuit of thinness to the point of self-starvation. The result of anorexia nervosa is an increasing preoccupation with body image and thinness with increasing amounts of weight loss. As part of this pursuit, people become compulsive about exercising while eliminating more and more food. Over time, the person becomes increasingly preoccupied with food and exercise and typically weighs herself/himself several times a day. Two other behaviours, often seen in someone who has anorexia nervosa are purging and/or binging. The amount of weight loss as well as the binging and vomiting may lead to serious medical problems. (University Health Network, American Psychiatric Association Work Group on Eating Disorders, 2000; Rome, et al., 2003).

Repeated binging and purging are the trademark symptoms of bulimia nervosa. The person ingests large amounts of food and then attempts to rid themselves of the food and calories by vomiting and/or using laxatives, diuretics, fasting or over-exercise. Many of the people with bulimia nervosa get into a chronic routine of binging and purging. They become so consumed by this cycle that it begins to overtake their lives. After a time, this interferes with their everyday living and is a risk for serious medical complications. It is thought that about half of the people with anorexia nervosa become bulimic. The binging and purging cycle may leave a person increasingly depressed and feeling more and more out of control. In an attempt to regain control a person may further restrict their food intake thus initiating the cycle over and over again (University Health Network).

In the developed countries of Europe, North America, Japan, Singapore, Australia and New Zealand anorexia nervosa is one of the most serious chronic illnesses of young adult females and adolescent girls (Beaumont & Touyz, 2003). According to the Report on Mental Illnesses in Canada (Health Canada, 2002), approximately 3% of Canadian women will be affected by an eating disorder sometime during their lifetime. For the population within the Winnipeg Health Region this translates into over 10,000 women who will have an eating disorder sometime during their life (Winnipeg Regional Health Authority, 2000, Reference Information, Appendix 3 & 4). This percentage only accounts for those women who will meet the Diagnostic and Statistical Manual IV (DSM IV) criteria for an
eating disorder and does not count the many people with disordered eating or the increasing number of males with an eating disorder. According to National Eating Disorders Association Information Centre (NEDIC) and the American Psychiatric Association (1994), women account for approximately 90% of all people who develop an eating disorder, while men account for the remaining 10%. In recent years there has been an increase in the number of males with an eating disorder.

Approximately one third of women who develop an eating disorder do so in college (Winzelberg, et al., 2000). The typical age of onset is between 12 years of age and 30 years of age although there are many cases of people younger than 12 as well as cases where patients are older than 30 years. The ends of this range seem to be expanding in both directions (Gilbert, Shaw, & Notov, 2000). NEDIC estimates that 15% of young woman have some symptoms of bulimia while 85% of the female population have some degree of body image dissatisfaction. The Toronto General Hospital Eating Disorders Program states that approximately one in twenty women between the ages of 14 and 25 will suffer from anorexia nervosa or bulimia nervosa or both (University Health Network, Description of Programs: Canada, Appendix 4).

The reported prevalence of anorexia nervosa in adolescent females, ages 15-19 years is .48% and for bulimia nervosa 1%-5% (Pinzon & Jones, 2003). In Canada, anorexia nervosa is the third most chronic health condition after obesity and asthma (Fisher, et al., 1995; Health Canada, 2002). Approximately .5% to 4% of women will develop an eating disorder during their lifetime. In recent years it has been noted that there has been an increase in hospitalizations for eating disorders within general hospitals throughout Canada. Health Canada (2002) estimates that there has been a 34% increase among women who are under the age of 15 and a 29% increase among women 15-24 years old. The largest group of women who have been hospitalized for an eating disorder is by far the 15-19 year olds; 65 per 100,000 compared to 10-14 years olds; approximately 21 per 100,000; and 20-24 years olds where there are just under 20 per 100,000. There are very few girls hospitalized for an eating disorder below the age of 10 while the incidence gradually decreases for women after age 24.

It is believed that many factors contribute to an eating disorder including biological factors, psychological factors, developmental factors and social factors. As published in the Report on Mental Illness in Canada (2002), there are many direct and indirect risk factors for the development of an eating disorder. Biological factors such as one’s gender, genetic risk, appetite regulation and energy metabolism are all considered to be direct risk factors. Psychological factors including poor body image, maladaptive eating attitudes, maladaptive weight beliefs, specific values or meanings assigned to food, body and overvaluation of appearance are also direct risk factors. There are also developmental factors such as: aversive mealtime experiences, identification with body-concerned relatives or peers and finally social factors such as: maladaptive
family attitudes to eating and weight, pressures to be thin, teasing, pressure to be thin due to pursuit of athletics or ballet. While the aforementioned are thought to be direct risk factors, there are also many indirect factors such as: impulsivity, temperament, neurobiology, poor self-image, identity problems, overprotection, felt rejection, family dysfunction, difficulties with peer relations and poor social support networks that are also thought to contribute to the development of an eating disorder (Reference Information, Appendix 1).

Considering the multitude of risk factors, it is often thought that eating disorders and disordered eating are best conceptualized in a bio-psychosocial model (Pinzon & Jones, 2003). According to NEDIC, 70% of women and 35% of men are dieting at any given time. Today most Canadian children live in a home where at least one parent is dieting. Considering the high numbers of people dieting it is important to note that approximately 95% of all diets fail (NEDIC). In an editorial of the American Family Physician, Josie Tenore puts this issue in context, “We are a nation obsessed with dieting and thinness, yet as a nation we are becoming more overweight with each passing year” (p.368). It is thought that the repeated cycle of dieting and failing, dieting and failing, contributes to a lower self-esteem and may increase one’s vulnerability to an eating disorder.

It is well recognized that people with an eating disorder often present with co-morbid psychiatric conditions and are at high risk for the development of other psychiatric symptoms and physical illnesses (American Psychiatric Association Work Group on Eating Disorders, 2000; Pinzon & Jones, 2003; Bulik, 2002; Health Canada, 2002). Some of the more common co-morbid illnesses include: obsessive-compulsive disorder, substance abuse, unipolar depression, posttraumatic stress disorder and personality disorders (Ross & Ivis, 1999; Herzog, Nussbaum & Marmor, 1996; O’Brien & Vincent, 2003; American Psychiatric Association Work Group on Eating Disorders, 2000). Substance abuse seems to be more common among those people with bulimia nervosa and the binge-eating/purge subtype of anorexia nervosa. Those with restricting type of anorexia nervosa are more likely to not become substance abusers. The highest co-morbid diagnosis seems to be depression for both anorexia nervosa and bulimia nervosa (American Psychiatric Association Work Group on Eating Disorders, 2000; Geist, Davis & Heinman, 1998). Suicide and issues dealing with sexual intimacy are also of concern with this population. The two most often cited causes of death in this population of patients are as a result of cardiac arrest or suicide (Keel, et al., 2003).

As one can read the issue at hand is very complex in nature. Eating disorders are of great concern because they affect the mental health and physical health of many young Canadians. The spectrum of disordered eating and eating disorders is not well documented in the Canadian literature (Health Canada, 2002). The Report on Mental Illness in Canada (2002), outlines several areas that require further research (Reference Information, Appendix 2).
Working in the area of eating disorders presents a multitude of issues and concerns. As well there are aspects of the illnesses that we do not understand and thus have not been successful in treating. Such a predicament is very frustrating to the clients, families, educators and health care providers alike. When the scenario includes the risk of death the experience becomes frightening, overwhelming and at times too much to bear.
SCOPE OF THIS REPORT

In an attempt to gain a better understanding of the continuum of disordered eating in the Region, the Winnipeg Regional Health Authority (WRHA) requested that the following information be provided to them:

1. Review research and evidence based information sources across the continuum of disordered eating, with a focus on providing an analysis of best practice information.

2. An environmental scan of programs and services that have a continuum framework across the age span.

3. Consult with key stakeholders within Winnipeg to complete a local environmental scan and SWOT Analysis (Strengths, Weaknesses, Opportunities and Threats), including an inventory of current programs and activities. These consultations will be inter-sectoral.

4. Construct, for consideration, a framework for Disordered Eating within the WRHA, consistent with the principles of the Primary Health Care continuum (prevention, promotion, curative, restorative and supportive) and in the context of a biopsychosocial/spiritual model.

5. Map out a staged implementation process.

This report reviews best practice literature and evidenced-based literature from a variety of sources. The information is discussed in the context of the primary care continuum: promotion, prevention, curative, restorative and supportive services. As well, information regarding disordered eating/eating disorder programs from across Canada were explored, collated and summarized (Description of Programs: Canada, Appendices 1-5). The cross Canada descriptions focus on those programs which were based on the evidenced-based literature and best practices and are only examples of some of the programs that exist in the country. In conjunction with consultations with the major stakeholders in Winnipeg, a continuum of current services for clients in the Region is described in some detail. The program descriptions of the services offered in the Region are collated for future use (Description of Programs: Winnipeg, Appendices 1-13). The programs are described in terms of the type of service(s) they offer along the health care continuum of promotion, prevention, primary care, secondary care or tertiary care. A summary of the SWOT analysis is also included to consider gaps in service and future directions for this area of service delivery. Based on all the information received: evidence-based literature, best practice literature, consultations across Canada and within the Winnipeg Region recommendations are offered in terms of a conceptual framework and
recommendations. Service recommendations are described in terms of those needed to enable the region to provide the full range of services: promotion, prevention, curative, restorative and supportive services. As well, philosophies and models that will facilitate the principles of the primary health care model are presented for consideration.
DOCUMENTS REVIEWED

For the purpose of this report, many documents and internet sites were reviewed.

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5. Meal Support Schedule, Fall 2002, Child and Adolescent Eating Disorder Service, Health Sciences, Winnipeg, Manitoba
6. Eating Disorder Day Hospital Service Orientation, Child and Adolescent Eating Disorder Service, Health Sciences, Winnipeg, Manitoba
7. Eating Disorder Day Agreement for Day Treatment Service, Child and Adolescent Eating Disorder Service, Health Sciences, Winnipeg, Manitoba
8a. Why Weight, Parent Manual, Southlake Regional Health Centre, Ontario
8b. Why Weight, Group Leader’s Guide, Southlake Regional Health Centre, Ontario
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68. Provincial Eating Disorders Service (Alberta), Promotion and Prevention Strategic Plan, 2002-2003
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73. Teen Talk Program Description, Klinic Community Health Centre
Eating Disorders Project North, Final Report, 2000
74. MacDonald Youth Services, Description of Our Voices Group for Teens
75. Women’s Health Clinic, Prevention Program Plan
77. Email communication from stakeholders: clients
78. Alma-Ata 1978, Primary Health Care, World Health Organization
79. Primary Health Care Strategy, Health Services Commission, 1999
81. Mental Health Resource Guide, Canadian Mental Health Association
82. Ontario Outreach Education Program
83. Sheena’s Place Program Guide, Self-help Manual and website
84. Ottawa Civic, Eating Disorders Program Information
85. Hospital for Sick Children, Eating Disorder Program Information
86. Bridgepoint Program Description and website
87. Capital Health, Eating Disorders Program Information
88. Children’s Hospital, Calgary, Eating Disorders Information
89. University Health Network, Eating Disorders Program Information
90. Ste. Justine, Eating Disorders Program Information
91. McGill University, Student Program for Eating Disorders
92. Douglas Hospital and Montreal General Hospital Program for Eating Disorders
93. Queen Elizabeth II, Eating Disorder Program Information
DEFINITION OF TERMS

The following definitions were taken from the Paper entitled Manitoba Health, Mental Health Renewal: Vision, Goals and Objectives September 2002 (Reference Information, Appendix 5).

**Best Practices:** methods of delivering services and planning initiatives that are based on the most current, relevant knowledge and evidence.

**Natural Supports:** individuals (family members, friends etc.) who play a significant role in the lives of consumers who are not necessarily a part of the formal care system and who are not remunerated for offering this support.

**Primary Care:** The level of care where the health system is entered, basic services are received and where all health services are mobilized and coordinated (It refers to care that is received from any health care professional such as physicians, nurses, social workers, occupational therapists, physical therapists, dietician and others).

**Primary Health Care:** is a broader concept-extends beyond the health sector and encompasses the broad determinants of health for example, education and income. It includes community-based, community driven, intersectoral services that encompass the broad determinants of health.

**Stakeholders:** Government, Regional Health Authorities, consumers, family members, natural supports, service providers, self-help agencies and any other agency or individual interested in the area of disordered eating.

**Inter-sectoral:** is examining an issue, considering many areas such as housing, employment, justice, addictions and family services.

**Primary Health Care Continuum:** Considers the range of services being provided along the continuum from promotion, prevention, curative, restorative and supportive.
One of the most common statements in the literature about anorexia nervosa and bulimia nervosa is how very difficult they are to treat (Toronto General Hospital Eating Disorders Program; Health Canada, 2000; American Psychiatric Association, 2000; Wilson, Vitousek & Loeb, 2000). According to Beumont and Touyz (2003) the DSM and the ICD-10 by virtue of how they describe eating disorders trivializes their seriousness. These authors state that anorexia nervosa and bulimia nervosa are not part of the same illness and believe that they need to be examined differently. This separation of the three types of eating disorders; anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified, is beginning to be reflected in the most recent literature (American Psychiatric Association Work Group on Eating Disorders, 2000; Wilson et al., 2000; Beumont & Touyz, 2003). Attitudes, behavioural abnormalities and associated cognitions are thought to be similar between people with anorexia nervosa and bulimia nervosa however the psychopathology is different. People with bulimia nervosa are self-deprecating because they are bulimic rather than the cause of their bulimia. They often feel if they could maintain their "ideal" body then they would be happy and content. This is also true for the person with anorexia nervosa but only during the early phase of the illness. As the illness progresses they have “anorexic cognitions” such as feeling not worthy of eating, feeling not entitled to have any form of gratification and a belief that they must punish themselves. Their sole purpose in life becomes their illness (Beumont & Touyz, 2003).

Acknowledging the differences between anorexia nervosa and bulimia nervosa, the two major types of eating disorders are discussed separately.

The amount of information available concerning anorexia nervosa, bulimia nervosa and eating disorders in general has exploded over the past decade. With increased access to electronic information via the World Wide Web, including the many online professional publications, the amount of information within one’s grasp is vast. This review of the literature, while not all encompassing, does identify some of the key issues to consider when working with someone with an eating disorder or disordered eating. The discussion also identifies many areas of study that have not been able to provide conclusive information in regards to efficacious treatment models for the treatment and prevention of eating disorders/disordered eating. Keeping this fact in mind, the literature has provided many areas on which to focus further research as well as some indices for best practice. The review of the literature presented has been divided into sections; one for anorexia nervosa and another for bulimia nervosa. This separation is intentional, to reflect the current thinking about the two illnesses being separate and apart from one another. The presentation of the literature if further separated into treatment considerations and descriptions of treatment models.
**Anorexia Nervosa**

**Treatment Considerations**

In regards to anorexia nervosa, very few clients fully recover (Herzog, et al., 1996). Only 44% of adults who were treated for anorexia nervosa were considered to have done well, with their weight within 15% of the ideal, four years after initial treatment. Another 24% of adult women fall between “good” and “poor” and 5% of adult women die from anorexia nervosa. It is estimated that about two thirds of patients continue to have morbid food and weight preoccupation and about 40% have bulimic symptoms. As well, there is a very high incidence of co-morbid psychiatric illness associated in those with anorexia nervosa. Many patients who were considered “fully recovered” continue to have other co-morbid difficulties such as dysthymia, social phobia, obsessive-compulsive symptoms and substance abuse (Halmi et al., 1991).

In one of the longer follow-up studies that examined outcome for the adolescent population, reports indicate that 76% of teens with anorexia nervosa have a full recovery (Strober, Freeman & Morrell, 1997). It suggests that even those who have a full recovery rarely return to completely normal health. Residual effects may include osteoporosis, anovulation, chronic dysthymia, obsessive-compulsive symptoms, and isolation with a failure to establish autonomy. The average duration of anorexia nervosa is seven years (Beaumont & Touyz, 2003). Considering the duration, it is not surprising that the length of treatment varies from 57-79 months (Strober, et al., 1997). The study reported a 30% relapse post hospitalization but prior to clinical recovery. In this study of 10-15 years where the adolescents received intensive treatment, there have been no reported deaths. Typically mortality increases the longer you follow the clients. In this study they found that disturbance in family relations was linked to poorer outcome. As well, being asocial was also a predictor of poor outcome. In a succeeding study the authors note that the absence of weight phobia and body image distortions were predictors of a less chronic course of the illness (Strober, Freeman & Morrell, 1999). This later study, while it does not provide a definitive predictor of course, is worthy of further exploration and attempts at replication.

For those clients who are severely underweight, re-feeding and nutritional rehabilitation is the initial focus (American Psychiatric Association Work Group on Eating Disorders, 2000). During the acute phases of treatment the focus must also be on motivation of the client as well as the therapeutic alliance. For some clients, they have developed initial relationships with healthcare providers long before agreeing to attend a formal program. At this point formal psychotherapy is thought to be of little use. The *American Psychiatric Practice Guidelines for the Treatment of Patients with Eating Disorders (Revision)* concludes that most severe clients with anorexia nervosa need inpatient admission and that very little occurs as an outpatient (Reference Information, Appendix 6). Although one study shows clients did very well in a partial hospitalization program, the program ran 12 hours a day seven days a week. The most severe clients would be those
considered to be 25-30% below the ideal weight. On the inpatient units the typical weight gain that is considered safe and ideal is 2-3 pounds per week, in an outpatient program clients may gain .5 pounds per week. These goals are considered safe but are not representative of the typical weight gain course. Most often weight gain is very slow with gains and losses during the course of treatment (American Psychiatric Association Working Group on Eating Disorders, 2000). There is general agreement that distorted attitudes regarding weight and shape of body are the least likely to change and that excessive exercise may be one of the last behaviours to abate. It is documented that the closer the client is to their ideal weight at the time of discharge the lower the risk is of relapse (Baran, Weltzin & Kaye, 1995; Committee on Adolescence, 2003). Pharmalogic interventions have for the most part been ineffective in treating anorexia nervosa (Garfinkel, 2002).

As well, during the most acute stage, group therapy is thought to be ineffective and perhaps detrimental to the clients because of the clients’ competitive nature. Once weight has been gained, cognitive-behavioural therapy maybe considered effective for some in maintaining their weight. Cognitive-behavioural therapy or interpersonal therapy may be helpful for increasing cognitive restructuring and for promoting more effective ways of coping (American Psychiatric Association Work Group on Eating Disorders, 2000). Some literature supports psychodynamic therapy after weight gain to increase insight and maturation. In dealing with difficult clients, often those clients who have been admitted to hospital several times and have had the disorder for several years, it is suggested that the focus of therapy is on establishing the alliance with the client and understanding their plight. This type of treatment may increase the ability to commence nutritional protocol (American Psychiatric Association Work Group on Eating Disorders, 2000, p.2).

Therapy for clients who prefer nonverbal types of interventions may be successful such as movement therapy or creative arts. As well, occupational therapy focused on self-concept and self-efficacy has been reported to assist with the clients’ recovery. Programs that follow an addictions philosophy alone have not been well supported. Although of late there has been increased interest in the techniques of motivational enhancement therapy and motivational interviewing (Kaplan, 2002). Those that utilize the 12-step program, as well as other programs, seem to work better (American Psychiatric Association Work Group on Eating Disorders, 2000).

Models of Practice

Beumont and Touyz (2003) suggest a model of diagnosis that assists in better understanding the current situation for any given client. This type of model of diagnosis would give better sensitivity to the issue of early identification and intervention by labelling the more subtle indications of an eating disorder, specifically anorexia nervosa. As previously mentioned, the authors believe that
the ICD-10 and DSM IV do not allow for early diagnosis of anorexia nervosa. Thus, treatment professionals are dealing with a person who already has a very chronic illness even though they may be presenting with the diagnosed illness for the first time. In their proposed classification they recognize the staging of the symptoms that are most often indications of anorexia nervosa. For early identification, classification must have staging in terms of severity. The following is the proposed classification guide:

Severity:
   a. Nutritional disturbance
   b. Medical manifestations
   c. Psychopathology, behavioural abnormality
   d. Psychosocial function

Duration:
   a. Acute episode
   b. Partial
   c. Complete remission
   d. Partial relapse
   e. Complete relapse

Final Outcome:
   a. Recovery
   b. Fatality
   c. Chronicity
   d. Residual

Models of practice may include theoretical models as well as structural models. Some facilities have organized themselves based on a particular structure that they believe best meets the clients’ needs as well as delineates the roles of different professionals. For example, the literature examining tertiary care, generally supports two inpatient structural models:

   a) The client is treated only from a psychiatric or mental health treatment team.

   b) The client is treated by interdisciplinary management team, whereby the general medical management issues are managed by specialists in each area e.g. nutrition, weight gain, exercise and eating patterns. In this model, the psychiatrist addresses only the psychiatric conditions (American Psychiatric Association Work Group on Eating Disorders, 2000).

One model cited often in the literature is the stepped care treatment or model (Wilson, et al., 2000). This type of service delivery is most often seen within adult
hospital-based programming. The intensity of the treatment is matched with the severity of the illness. The more severe the illness, the more involved the services. Typically clients are involved with the lower steps before the more intense types of treatment are considered. For example, someone with bulimia nervosa may be offered a cognitive-behavioural therapy group should she/he require more involved treatment. This may include individual therapy, nutritional counselling, meal supervision etc. It is suggested that the lower levels of stepped-care such as: self-help strategies and psycho-educational groups are inappropriate for anorexia nervosa. In the acute phase of anorexia nervosa where one’s medical state is comprised refeeding, a nurturing context is a priority of treatment (Woodside, 2002). Considering the earlier mentioned evidence that the closer a person is to their target weight upon discharge from a treatment program the less likely they relapse, successful nutritional rehabilitation is crucial. Unfortunately, this aspect of treatment may require a lengthy admission. At this time research is lacking to better understand the context options that are likely to be successful for a person with anorexia nervosa i.e. inpatient treatment versus day program or community residential program.

Recently there is evidence to suggest that understanding the degree of motivation for treatment is essential for successful outcome. According to Kaplan (2002) anorexia nervosa remains to be a treatment resistant illness with very severe consequences of significant levels of morbidity and mortality. The resistance is often explained by the nature of anorexia nervosa as ego-syntonic and thus there is little or no internal motivation to change (Garfinkel, 2002; Vitousek, Watson, & Wilson, 1998). In other words from the client’s point of view the illness is functional, meeting their needs and has “adaptive advantages which the patient does not wish to relinquish” (Touyz, Thornton, Rieger, George & Beaumont, 2003, p.165). Kaplan and his colleagues discuss a new promising approach using the trans-theoretical model of change (Velicer, 1998).

This approach to treatment views the denial and ambivalence typically associated with eating disorders as the targeted primary symptom. This has been identified as a key issue of working with someone with anorexia nervosa. The denial is so strong that these clients are most often described as very challenging and opposing. It has been suggested that one may overcome this denial by working directly with the denial rather than attempting to circumvent this symptom. The purpose would be to match the intervention to the stage of change of the individual. This represents a paradigm shift away from more traditional models that focus on the symptoms of anorexia nervosa and their contributing behaviours such as caloric restriction, purging and excessive exercise. Much of the work in this area is from research conducted with people who abuse substances and become addicts. Authors such as Velicer and Prochaska (1998) have described successfully using this model of change. The original authors of the model, Prochaska and DiClemente (1983) described the Transtheoretical Model of Change to help people make health behaviour change. As mentioned previously, this approach to therapy aims to identify where in the
stages of change any particular client may be functioning at a given time. The current stage is identified in terms of the degree of motivation the client has to change and then therapy focuses on enhancing the motivation to the next level. According to this model, a client cannot use traditional types of treatment until they are at the “action” stage of change.

This model describes a series of stages that one passes through while attempting to change behaviour. The basis of the model is the understanding of the stages of change and then subsequently using the particular stage to engage the client. Initially, the stage of change that the patient is currently functioning in is identified and then this becomes the focus of the therapy. Kaplan describes these approaches as Motivational Enhancement Therapy. In essence, rather than the symptoms and their associated behaviours of anorexia nervosa being the target for therapy, the client’s ambivalence and denial become the critical area to which treatment is focused.

Kaplan (2002) identifies the stages of change as they relate to eating disorders.

**Precontemplation.** At this stage there is no intention to change the behaviour in the foreseeable future. Most people in this stage deny they have a problem. The suggestion for the focus of treatment at this stage is on the ambivalence and resistance to change. According to Kaplan “a true therapeutic alliance cannot develop if the patient and caregiver do not have the same agenda.”

**Contemplation.** The person is aware that the problem exists but has not made a commitment to change behaviour to eliminate the problem. It must be recognized that people with anorexia nervosa may be stuck in this stage for years.

**Preparation.** The person is preparing for change and has, in fact, usually made some small amount of change. As well, the person now has intentions to change the behaviour. It is not unusual for individuals in this stage of change to have attempted to make changes in the past but have fallen back to contemplation. Someone with anorexia nervosa in this stage may make small increases in their intake and small decreases in their purging or exercising activities.

**Action.** This is the stage where people modify their behaviour. Individuals spend a great deal of their time working with their caregivers attempting to change their behaviour. For people with anorexia nervosa this is a stage where weight gain will occur.

**Maintenance.** At this stage individuals work hard to prevent relapse and consolidate gains achieved. This is a very important stage for
people with anorexia nervosa because of the noted high rates of relapse.

Within this model the process of change includes 10 stages: consciousness-raising, self-revaluation, self-liberation, counterconditioning, stimulus control, reinforcement management, helping relationships, dramatic relief, environmental revaluation, and social liberation (Reference Information, Appendix 7).

The complement to the transtheoretical model of change is motivational interviewing. This style of therapy is aimed at increasing the intrinsic motivation for change and is based on the assumption that motivation arises from an interpersonal process rather than from a pre-existing trait within the individual (Kaplan, 2002; Rollnick & Miller, 1995). Underlying motivational interviewing is the belief that motivation to change occurs from within the individual, rather than from imposing change externally as well that therapist behaviour influences outcome (Treasure & Schmidt, 2001).

There are six therapy skills that are essential for a motivational therapist to be able to perform proficiently (Rollnick & Miller, 1995):

1. Understand the other person’s frame of reference
2. Express acceptance and affirmation
3. Filter the client’s thoughts so that motivational statements are amplified and non-motivational statements dampened down
4. Elicit client’s self-motivational statements: expressions of problem recognition, concern, desire, intention to change and ability to change
5. Match processes to stage of change, ensure they do not jump ahead of the client
6. Affirm the client’s freedom of choice and self-direction.

Vitousek et al. elaborate on these skills by describing a “therapist set and style” (1998, pp. 397-405). In general, a therapist needs to focus on empathy and validation, appreciate the ego-syntonic nature of thinness and self-control, recognize the desperation that drives symptom choice, not to add surplus meaning to resistance, acknowledge the difficulty of change, use a modest and tentative approach, speak the client’s language, respect the client’s individuality, be collaborative, honest, curious, focused, systemic and patient. Psycho-education is always a part of motivational interviewing. In this process, the client is given the most up to date information concerning the physical and psychological effects that accompany restrictive eating, binging, purging and low weight, the importance of a balanced diet, the determinants of appetite and energy expenditure, influence of genetics on body weight, fat distribution and metabolism, exercise physiology (truths and myths), the relationship between diet, shape and weight as being very complex in nature.
Central to the process of motivational enhancement therapy is the therapeutic alliance (Touyz, et al., 2003). Touyz and his colleagues examine the work that has been done with adolescents. A key issue is the match between the therapist and the stage of change of the patient, a mismatch is a major contributor to a break in the therapeutic alliance that is deemed essential in this therapy. The therapy recognizes that the choice to change lies with the client and thus therapy should not become a battleground for control. It should also be emphasized that a lack of readiness should not be interpreted as an indication to withdraw treatment but rather the therapist needs to work with the client to maintain respect and empathy. Within this model the need for medical monitoring and the possibility of hospitalization is accepted as a natural consequence to the client’s choice of maintaining a chronic illness.

The paradigm shift not only recognizes that patients will be at different levels of readiness to change their behaviour but that their current stage of change must be matched with appropriate treatment. A mismatch between the stage of change and the intervention will result in “resistance” (Touyz, et al., 2003). This type of therapy implies a shared responsibility for the resistance (Treasure & Schmidt, 2001). Motivational Enhancement Therapy is in the early phases of research. Rieger et al. (2000) have developed an instrument to assess readiness to recover in an individual person. Currently this group of researchers are in the process of establishing the psychometric properties of the instrument that has been named, the Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ) (Rieger, Touyz & Beaumont, 2002). The small amount of research that has been done has had promising results, however, it is noted that no randomized controlled trials evaluating the efficacy of motivational enhancement therapy alone or combined with other therapies have been done. Although the work that has been done has been measured to provide a significant increase in motivation, it is unclear if this leads to a better treatment outcome for people with an eating disorder, specifically those with anorexia nervosa. Also worthy of further exploration would be utility of motivational enhancement therapy in the area of secondary and tertiary prevention (relapse prevention).

Programs that use cognitive-behavioural strategies may be useful once clients have gained some weight and are medically stable, however, there is little evidence in the literature regarding efficiency of this treatment (Wilson & Fairburn, 1993; Vitousek, 2002). In the absence of evidenced-based information, clinicians have turned to best practices literature that is principally based on clinical trials to understand the utility of cognitive-behavioural therapy in the treatment of people with anorexia nervosa. Generally cognitive-behavioural therapy in a 1:1 situation may be recommended once there has been a “reasonable” weight gain. The focus of treatment is on the set of beliefs that are associated with the desire to control eating and weight. Cognitive-behavioural therapy is reported to work well in conjunction with family therapy and psycho-educational therapy. There is some evidence that clients engaged in cognitive-behavioural therapy have a lower rate of premature termination of treatment.
Further discussion of the cognitive-behavioural approach as it relates to the treatment of bulimia nervosa is discussed in the next section of this report.

According to the National Eating Disorders Association (United States) there is a need for treatment to be available to males as well as to females. Of those who appear for treatment, males comprise about 10% of individuals. It is thought that the male requests for treatment of eating disorders is on the rise (Lewinsohn, Seeley, Morerks & Striegel-Moore, 2002). Many of the studies reviewed examined very few cases of eating disorders in males. Carlat, Camargo and Herzog (1997) and Andersen (2002) reported on their findings of male patients. They concluded that males and females with eating disorders are quite similar with some differences in their experiences of puberty as well as the sociocultural environments with its positive reinforcement for dieting and weight. As well, homosexuality/bisexuality were said to be risk factors associated with males having an eating disorder. It is suggested that males seen in treatment groups should, where possible, be separated from the females to deal with specific issues of concern to them.

Other studies have examined the effects of family therapy and have repeatedly shown that they may enhance the response to treatment in young clients (Russell Dare, Eisler & LeGrange, 1992). It is recommended that in families where parental criticism is high, parents and children or adolescents are seen separately (American Psychiatric Association Work Group on Eating Disorders, 2000). Bearing this in mind, family therapy is often recognized as a treatment option with young adults and/or children and adolescents. It is suggested that adolescents may need to be considered somewhat differently than adults. According to Lock (2002) family-based treatment for adolescents with anorexia nervosa is the treatment approach that has the best evidence for success. This type of treatment is distinct from family therapy because it does not view the family as the source of the problem. This type of therapy, the Maudsley approach, empowers and supports the families to make the necessary changes. The fundamental difference with this approach is that it presumes that the cause of anorexia nervosa is unknown. It does not view the family as the reason or as pathological. Most therapists, 97%, use individual versus a family approach (66%). Studies by Dare and Eisler (2002) as well as by Russell et al. (1992) have reported that adolescents rather than older clients improved with family treatment more than with individual treatment. At one-year follow-up of the vast majority of clients who had received family treatment had a “good” or “intermediate” outcome compared to only 18% of those who received only individual therapy. Studies that reviewed outcome at five years maintained that those clients who received family treatment continued to have a better outcome. It was also noted that families where parents were highly critical do better when the parents and child were seen separately. The majority of studies need to be interpreted with some caution due to their small numbers, however, they do
present some promise. The outcome is especially positive with clients who have short duration of illness and are young in age.

The specifics of this type of treatment are briefly outlined in the article in three phases. The entire length of treatment is from 9 to 13 months. A comprehensive description of the approach has been detailed in a book by Lock (2001). Other types of family therapy may also be helpful if they include some of the key elements from the Maudsley approach such as the “re-feeding.” The author notes that while there is promise, definitive success has not been shown and further research is needed.

Some research is also focused on the area of relapse prevention. To date, there is little evidence that we are successful in the prevention of relapse. In the follow-up study by Strober et al. (1997) none of the variables were predictive of relapse. Studies are underway that examine the utility of CBT combined with medication aimed at preventing relapse in people with weight-restored anorexia nervosa. As well, it is recognized that many forms of expressive or experiential therapy are used with this population. To date, there is no research to support their success.

In summary, there is very little empirical evidence on which to base treatment for people with anorexia nervosa. In terms of best practice, it is agreed that nutritional rehabilitation is necessary although insufficient on its own. There is also some evidence that family therapy is useful for those who are young and who have had the illness for a short time. It is also generally acknowledged that within any treatment warmth, genuineness, understanding and acceptance, openness and honesty, are essential for the individual approaches (Kaplan, 2002). For clients who are in the more ill and chronic stages, therapists must accept that their role must focus on the quality of life issues and decreasing the sense of isolation and aloneness.

**Bulimia Nervosa**

*Treatment Considerations*

Binge eating and purging were first identified as part of anorexia nervosa. According to Keel and Mitchell (1997) bulimia nervosa was not identified as a distinctive illness until 1979. A greater number of patients with anorexia nervosa versus bulimia nervosa present for treatment and therefore it is difficult to get a sense of the prevalence and rate of recovery for bulimia nervosa. As well, it is assumed that a significant proportion of people with bulimia nervosa never seek treatment. According to the literature, it is difficult to understand what occurs for people with untreated bulimia nervosa. It has been reported that 25-30% of clients with bulimia nervosa spontaneously improve without any type of treatment. According to the American Psychiatric Association (2000) patients with bulimia nervosa who have sought treatment have a short-term success rate
of 50-70% with a relapse of 30-50%. Keel and Mitchell (1997) reviewed 88 studies with follow-up of a minimum of 6 months. In the short-term follow-up the mortality rate was between 0%-3%. At the 5-10 year follow-up about half the patients had full recovery and about 20% of the patients met the criteria for bulimia nervosa. It must be noted that the sample size decreased substantially as the length of follow-up increased. At five years there was a sample of 342 women and at nine years that number had decreased to 68 women. About one-third of the patients who had initially recovered had a relapse during the first four years following their initial presentation. Another study by Keel et al. (1999) followed 173 women for more than ten years. They reported that 69.9% of this group were in full or partial remission, 11% met the criteria for bulimia nervosa, another .6% met the criteria for anorexia nervosa and 18.5% met the criteria for an eating disorder not otherwise specified. They also concluded that duration of the illness and a history of substance abuse may contribute to prognosis. One study that was a six-year follow-up stated that the recovery for 60% of the patients with bulimia nervosa was rated as “good” (American Psychiatric Association Working Group on Eating Disorders, 2000).

Models of Practice

Cognitive-behavioural therapy is commonly accepted as the treatment of choice for people with bulimia nervosa (Bryne & McLean, 2002; Wilson & Fairburn, 1993). The most common models of cognitive-behavioural therapy are based on the concepts explained by Fairburn who in the mid-1980’s developed a manual to assist those working with clients who had bulimia nervosa. The following concepts were reviewed by Wilson and Fairburn (1993) and are still referred to as relevant today (Byrne & McLean, 2002). The goal of treatment is the modification of abnormal thoughts about the importance of body shape and weight as well as the binging and purging cycle and a return to more “normal” eating patterns. Most cognitive-behavioural treatments are time-limited, for example, 20 weeks in duration. The process involves several stages including education about bulimia nervosa. As well, explanations of treatment goals and the process for achieving the goals are discussed with the client. This stage usually involves discussing possible outcomes including weight regulation and normal eating patterns. Unlike other psychotherapies, the therapist is very active in the process as both a teacher as well as a person who may provide advice and/or encouragement (Wilson & Fairburn, 1993). A typical tool used in cognitive-behavioural treatment is that of self-monitoring of eating habits. The client is asked to track what they eat and when they eat it as well as any binges. While the initial gathering of information is behavioural the analysis with the client of their eating patterns examines the cognitive processes that perpetuate the eating disorder. The second stage of the cognitive-behavioural approach involves teaching the clients how to identify and change the unhealthy thoughts about weight, shape and eating. The unhealthy thoughts are challenged with factual information and experiences. The third and final stage of the approach focuses on prevention of relapse and consolidating of new patterns of thinking and
behaving. The approach is meant to occur outside of a controlled environment such as a hospital or residential facility in order that the client experiences “risky” situations that may have, in the past, induced vomiting and/or binging. Several studies have confirmed the utility of cognitive-behavioural therapy for people with bulimia nervosa. Results have focused on the reduction of binge eating, purging and remission and attitudes towards weight, eating, depression and poor self-esteem (Wilson & Fairburn, 1993; Garner et al., 1993). As the treatment of choice for someone who has bulimia nervosa cognitive-behavioural therapy may:

a. Decrease the treatment dropout rate.
b. Decreases the frequency of binge eating and purging.
c. Maintain the effects of treatment for the following 6-12 months.
d. Impact by decreasing binge eating, purging, dietary restraint, overevaluation of shape and weight. It helps to increase self-esteem and social functioning.
e. Be as effective as interpersonal psychotherapy but produce effects quicker.
f. Be effective in conjunction with an antidepressant medication to decrease the accompanying effects of bulimia nervosa (anxiety and depression).

Limited work has been done to determine the efficacy of other therapies. Most of the focus has been on interpersonal psychotherapy and psychodynamic approaches to therapy with much of the literature using case studies and clinical experiences. Interpersonal therapy is usually used with those people who seek treatment for bulimia nervosa in the community or as an outpatient (Fairburn, 2002). Sessions are typically 1:1 lasting anywhere from 12-20 sessions. The thought is that these types of therapies may be very effective by working on the intrapersonal and interpersonal issues that may be sustaining the symptoms of bulimia nervosa. (Apple, 1999; Fairburn, 1995).

While cognitive-behavioural therapy has been accepted as the best choice in the treatment of a client with bulimia nervosa it has not been well studied in the adolescent population and particularly not in a family-based therapy. Typically, cognitive-behavioural therapy for people with bulimia nervosa aims to reduce the restriction of eating and return eating to a more normal eating pattern. It includes self-monitoring of food intake, ceasing dieting and usually includes weekly weighing. The later stages of treatment focus on cognitive restructuring, underlying faulty assumptions and methods to prevent or deal with relapses. The basis for including parents and families is developmental. Parents are able to support the client, perhaps make necessary changes to the home environment and most importantly support the treatment being used. While there is no empirical evidence to suggest the usefulness of including parents in the treatment of bulimia nervosa, treatment of other psychiatric disorders would lend some evidence to this approach. The authors have modified a cognitive-behavioural therapy manual based on the work of Fairburn to include the family.
The treatment is described in three phases and treatment is usually about 6 months in duration.

Some work has also been done examining the utility of cognitive-behavioural therapy in self-help. While treatment using cognitive-behavioural therapy has been successful, treatment is not always available for a variety of reasons and therefore self-help may be an alternative (Carter & Fairburn, 1998). As well, there are some studies that have explored the use of written material in self-help. The general report is that they may be helpful to those with less severe cases of bulimia nervosa and for those without a co-morbid psychiatric diagnosis. According to Shafran (2002) there are over 27,000 World Wide Web Internet sites relating to eating disorders. The general comments concerning the receipt of information from the Internet applies to eating disorders as well. The Internet has provided easy access to information concerning identification of an eating disorder, location of therapy and access to others who have experienced an eating disorder, however one may also receive inaccurate information and be exposed to those who exploit the users of the websites. Internet sites that are “pro-anorexia” have also been identified and may have a negative impact on people dealing with anorexia nervosa. Successful self-help may reduce the need for more costly types of intervention as well as provide treatment much earlier. The personal benefit of successful self-help is one of empowerment, however unsuccessful self-help may impact negatively on one’s self-efficiency. Unsuccessful self-help may reduce the likelihood of seeking treatment and/or delay the receipt of treatment (Carter, 2002).

Several authors reported that clients who either have anorexia nervosa or bulimia nervosa and are seeking treatment within tertiary health care centres often have co-morbid psychiatric conditions; 50-75% of the clients had a major depression or dysthymia, 4-6% had a bipolar disorder, 25% had obsessive compulsive symptoms, 42-75% have a personality disorder and 20-50% have been sexually abused. The complications of co-morbid disorders with an eating disorder are part of the uniqueness of each individual case (American Psychiatric Association Work Group on Eating Disorders, 2000; Pinzon & Jones, 2003).

In summary, we continue to have difficulty ascertaining what treatment approaches are effective because it is unique to each individual with the disorder. Most of the literature stresses the importance of working with each person and their unique situation to attain the best prognosis. It is thought that because of the interplay of the many determinants of an eating disorder: biological factors, psychological factors, developmental factors and social factors, each person presents with a very different road map to recovery. Often the road to recovery involves a series of very small steps with many backslides. The need for specialized and individualized treatment approaches as well as the long length of treatment time required for recovery, contributes to the lack of success with this group of people. Most programs for people with a severe eating disorder are very labour intensive and require a large amount of money to effectively operate.
At this time, anorexia nervosa remains for most patients a treatment-resistant chronic illness with significant morbidity and mortality rate (Kaplan, 2002). In recent years we have been able to identify the illness more successfully and have reduced the mortality rate, however, full recovery continues to be limited. In regards to the treatment for people with bulimia nervosa, cognitive-behavioural therapy and interpersonal psychotherapy have been shown to be effective (Wilson et. al., 2000).

Primary and Secondary Prevention

Typically when one discusses prevention programs they are referring to primary and secondary prevention. Primary prevention or universal prevention is aimed at prevention of eating disorders prior to the development of any symptomotology. Secondary prevention includes: indicated prevention which is aimed to decrease early symptoms of an eating disorder and selective prevention which is to target high-risk populations (Fairburn, 1995; Levine & Piran, 2001; Piran, 2002). Tertiary prevention is assumed to be what we commonly term “treatment” of people with an eating disorder. Considering the cost of tertiary prevention programs as well as their low rate of long-term success in treating people with anorexia nervosa in particular, and to a lesser extent people with bulimia nervosa, it seems reasonable that primary and secondary prevention programs need to be developed (Neumark-Sztainer, 1996). Levine and Piran (2001) make the point that prevention is not a “luxury”, but is in fact, an urgent necessity because it is the only way to reduce the incidence of eating disorders (Piran, Levine & Steiner-Adair, 1999). Considering this suggestion, the question remains as to what prevention programs should look like?

In general, prevention programs have been aimed at female teenagers with mixed results. In some studies improved knowledge about eating disorders has been gained, however, this has had no effect, or an inverse effect on behaviour or on the number of cases of eating disorders over the past several years (Steiner-Adair et al., 2002; Peters, 2003). In programs that specifically focus on the eating disorders, describing the symptoms such as excessive exercise, purging methods and restrictive eating, negative effects have been reported. This is seen especially when this type of program has been targeted at young girls. It has often been reported that following this type of prevention program, teens have an increased awareness of the disorders, but there has been little reported change in their behaviour. The typical program includes explanations about the illnesses of bulimia nervosa and anorexia nervosa with the idea of preventing illness. More recently, authors propose prevention programs need to be based on a perspective that acknowledges and deals with society’s pressure on people to look a particular way (Peters, 2003; Alberta Mental Health Board, 2003; Eating Resource Centre of British Columbia (EDRCBC), 2001). Perspectives such as a feminist approach consider disordered eating/eating disorders in the boarder context of society’s values. Such a perspective considers the place of women and perceived “ideals” in society and how this negatively impacts people’s self-esteem, body image and identity. The
perspective may be broadened to include males as well (EDRCBC, 2001). Most perspectives in the literature assume that the cause of eating disorders is multifaceted, however there is little empirical evidence to validate this conclusion (Stice, 2001). One area that does have some validation is our society’s pressure to be thin and the internalization of the ideal equalling “thinness” and our resulting dissatisfaction with our bodies (Sands & Wardle, 2003). Findings regarding body mass, negative affectivity, perfectionism, timing of puberty and poor impulse control may be risk factors associated with the onset of an eating disorder. Another perspective includes examining early predictors of eating disorders such as early serious health problems before age 5, more anxiety-depression in the children by age 9, and reported to have more behavioural problems by age 15 (Moorhead, et al., 2002).

In examining best practices, it is thought that the focus of prevention needs to be on building protective factors as well as reducing risk factors. The past trends have predominantly focused on reducing perceived risk factors through increased education as to the effects of an eating disorder rather than on equipping young people with the protective factors. High self-esteem, participation in sports and competency in lifeskills and social skills are general protective factors (Crago, Shisslak & Rubie, 2001). These authors believe that general protective factors may assist in planning primary prevention programs, however more specific protective factors need to be identified for secondary prevention. They suggest the issues such as positive body image and the culture of the family in regards to weight preoccupation, may be more important in secondary prevention. The Eating Resource Centre of British Columbia (2001) considered the protective factors to include healthy self-expression, healthy body image, healthy eating habits, and physical activity. To date, all of the prevention programs have been done in a group format primarily with teenage females (Peters, 2001).

Stice, Trost and Chase (2003) looked at dissonance-based intervention in people who had bulimia nervosa and those with healthy weights. The study was based on the idea that discussing issues to assist others will improve their own body satisfaction. They reported success in reducing the thin-ideal internalization, negative affect and bulimic pathology, but were not able to improve body dissatisfaction or dieting behaviours.

Another area that is often not included in prevention programs is the development of media literacy and social activism. These are considered to be important components of prevention (Mussell, Binford & Falkerson, 2000). Media literacy is the direct teaching of how to critically examine media and the messages that are being promoted. By showing young children and teens how to evaluate media and the secrets of advertising, equips them to critically analyse and challenge the beliefs about thinness, body shape and fat prejudice (Friedman, 2002; Wade, Davidson & O’Dea, 2003). It may also promote young people’s ability to challenge what appears to be “perfect” in the media.
Taking media literacy one step further, with increased understanding of the media and its intent, young people may be encouraged to advocate for the removal of media that perpetuates the thin “ideal.” By becoming socially active through protest, those who may otherwise feel disempowered begin to understand their power. They may chose to advocate healthier images being portrayed in the media as well as teach others about media literacy. This sense of empowerment contributes to the development of protective factors as well as reducing risk factors. As well, it perpetuates and reinforces their new learning of the media and helps to promote healthy images of people (EDRCBC, 2001).

A group of professionals in British Columbia developed and published a best practice manual for the prevention of eating disorders (Prevention Program Information and Resources, Appendix 1). After reviewing the evidenced-based literature and the best practice literature, one may conclude that past attempts at prevention have primarily focused on the reduction of risk factors through increased education about the anorexia nervosa and bulimia nervosa as well as the detrimental effects of an eating disorder. Strategies being employed are not targeted with any differentiation between primary and secondary prevention and without a focus on increasing protective factors or reducing risk factors. Few, if any programs have focused on the younger population of elementary school children. As well, few programs have included both boys and girls with specific attention on the factors that are considered to be protective in nature. Such a program would also attempt to reduce the risk factors by replacing them with health and resiliency.

The prevention model from British Columbia is based on two theories, the Relational Theory and the Resiliency Theory. The relational theory is based on the idea that the state of our connections to others is a critical determinant of health. Connections are defined as “an interaction between two or more people that is mutually empathic and mutually empowering” (Baker & Pierce, 1998 p.45) They believe that connection is the process that facilitates healthy growth. Disconnection in relationships is seen as one of the factors that may develop and perpetuate the continuation of disordered eating. Disconnection occurs in many spheres such as the family, peer group, school or workplace, community and the larger society. As well, disordered eating also develops as a means to cope with disconnection from society. It should be noted that most of the literature in this area focuses on girls and woman.

The resiliency theory examines the contributing factors of how well people cope with adversity or risk.

…the capability of individuals and systems (families, groups, and communities) to cope successfully in the face of significant adversity or risk. This capability develops and changes over time, is enhanced by protective factors in the individual/system and the environment, and contributes to the maintenance and enhancement of health (Mangham et. al., 1995 as cited in EDRCBC, 2001)
Resiliency is considered to be accumulative, in other words, successful coping in one situation strengthens an individual’s or group’s ability to deal with adversity in the future. It may also be true that one failure to deal with adversity, successfully decreases the likelihood of future successes.

The theory considers two concepts that are associated with resiliency: protective factors and risk factors. Protective factors being those factors that decrease the likelihood of adversity, while risk factors are those things which occurs prior to adversity that increase the likelihood of a problem. The overall effect of risk factors depends on when they occur and which protective factors are functioning at the time. These two factors are cumulative, the more factors you have in either direction the more likely one will have or not have disordered eating. Most risk factors are psychological, interpersonal and socio-cultural and some are biological. The Manual for Preventing Disordered Eating (2001) highlights self-esteem as a key risk factor. Feelings of inadequacy or low self-worth develop from multifaceted problems which may occur in the family, peer pressure, athletic or vocational pressures and from not measuring up to ideals presented in the media to mention a few (Resources for Prevention Programs, Appendix 1).

Another model of prevention is provided by Halton Region Health Department through the Common Messages Discussion Paper. This model believes in making a shift from a “weight” focus in programs to “achieving health” (Prevention Programs Information and Resources, Appendix 3.). The model utilizes the vitality program produced by Health Canada (Prevention Programs Information and Resources Binder, Appendix 3). The shift in focus avoids the issues of focusing on symptoms that may not be appropriate for all people. For example, the focus on obesity and weight loss may increase dysfunctional eating, unhealthy and dangerous weight loss methods, eating disorders and size prejudice. Such a program would be considered appropriate as a primary prevention program.

The prevention program in the Halton Region, Ontario (Halton Region Departments of Health and Social & Community Services, 2002) did not find any differences pre and post interventions in the schools in which they ran the body image programming. The authors questioned the sensitivity of the instrument to verify the impact of the program however, there remains no empirical evidence that such a program is effective. The program emphasizes healthy eating, active living and self-acceptance. As well, the program also stresses the need for inter-sectoral roles in the helping of children and youth to develop healthy body image and positive self-esteem. Upon conclusion of the study, the following recommendations were made:

a. Health promotion and disease prevention programs must target young children, males and females prior to the teen years. Strategies specifically for males need to be developed.
b. Develop, implement and evaluate a sequential, comprehensive school health curriculum, from pre-school to secondary school, which is developmentally appropriate, gender sensitive and culturally relevant.

c. Provide training to school staff and other adults.

d. Provide educational materials and opportunities to parents and other family members.

e. Promote healthy lifestyles behaviours:
   i. Promote healthy eating through education, supportive environments and policies.
   ii. Promote regular physical activity, emphasizing the active living approach, through education, supportive environments and policies.
   iii. Promote self-acceptance and the development of healthy coping skills, through education, supportive environments and policies.

f. Work with community partners to develop consistent messages regarding healthy eating, active living and self-acceptance.

A highly developed prevention program has been developed by the Alberta Eating Disorders Program (Prevention Program Information and Resources, Appendix 5). It too incorporates many of the principles considered for best practice. The program is designed for grades one through twelve with specific curriculum and lesson plans for each group (grades 1-3, grades 4-6, grades 7-9 and grades 10-12). There is a focus on the development and maintenance of self-esteem, body image, media literacy and general reduction of risk factors. For each group there is an accompanying body image kit that may be purchased. The program is designed to allow teachers to begin the prevention in grade one. Beginning prevention programs early in the children’s development has been supported by the research that demonstrates that girls who had weight concerns or high body dissatisfaction at ages five to seven were showing higher restriction of food intake, more maladaptive eating attitudes and an increased likelihood of dieting by age 9 (Davison, Markey & Birch, 2003).

Unfortunately, similar to other research in the area, the research on prevention has been plagued with many issues including inadequate sample sizes, lack of control groups and sensitivity of assessment instruments. While it has been acknowledged that it is important for prevention programs to work with families, peers and the media, few programs have, in fact incorporated these factors into their programs (Levine & Piran, 2001; Mussell et al., 2000). At this time we do not have enough information to determine best practices (Piran, 2002).
HIGHLIGHTS OF CURRENT SERVICES ACROSS CANADA

Over the course of several months many programs across Canada have been examined for their best practices. The following list of programs is not exhaustive, but rather a sample of services offered from each of the provinces across the continuum of: promotion, prevention, curative, restorative and supportive. Information on all the programs reviewed has been collected in a binder and may be available for examination by interested parties (Program Description: Winnipeg, Appendices 1-13). The following account is some of the highlights:

Province of British Columbia

The Province of British Columbia has a provincial co-ordinator that offers services through the Eating Disorder Resource Centre of British Columbia. The Eating Disorder Resource Centre of British Columbia is a provincial, non-profit organization that provides educational, referral and research services to people struggling with disordered eating. As well, they support networks, community based organizations, educators and professionals working in the area of disordered eating. Their services include a resource counsellor, help and information telephone line, an educational outreach program and a referral directory. As well, they have a resource library of books, videos, journals, educational handouts and references pertaining to disordered eating and related issues. Their philosophy includes recognition that disordered eating is an illness that is complex and multi-determined in nature. It is perceived as a coping strategy for both males and females. Within this perspective, their work focuses on the development of disordered eating within a socio-cultural context:

The socio-cultural context affects the development of disordered eating through self-expression, social relationships, and the resiliency (risk and protective factors) of a person. This context is comprised of our society, schools, workplaces, families, community and peers. From this perspective, the context is the focus of social change (EDRCBC, 2001)

The Eating Disorders Resource Centre of British Columbia’s philosophy advocates social change and social action based on prevention, skills training and educational awareness. It is their goal to create a healthy context for self-acceptance through prevention. As well they aim to challenge the attitudes, beliefs and behaviours that contribute to the incidence of disordered eating. These beliefs and behaviours include: body consciousness (shape and size), weight consciousness (calorie counting, over-exercising, weight scales, dieting, and fat phobia) and the pursuit of thinness (associated with autonomy, achievement and self-control).

The Eating Disorder Resource Centre of British Columbia’s mission is to provide access to: public community education outreach programs, the provincial professional referral directory, counselling resource services and collect research data. Currently the Resource Centre has put together a panel
of people, men, women and parents to discuss the issue of eating disorders. The focus of the discussion is on empowering parents. The panel will link to the audience by video conferencing, from six locations across British Columbia.

As well as their focus on prevention, the Eating Disorders Resource Centre provides information regarding all of the provincially funded programs in the province. Their website, http://www.disorderedeating.ca, divides the province into five regions with links to treatment programs and support groups in all five regions: Vancouver Island, Lower Mainland, Okanagan/Thompson, East and West Kootenay and Northern British Columbia.

In 2001 the Eating Disorder Resource Centre, along with the British Columbia Ministry of Health Services, Ministry of Children and Family Development, Prevention Project Advisory Committee, and the British Columbia Provincial Eating Disorders Program, produced and published: Preventing Disordered Eating: A Manual to Promote Best Practices for Working with Children, Youth, Families, and Communities. (Prevention Program Information and Resources Appendix 1). This manual presents theories about prevention of eating disorders as well as issues to be included in a comprehensive prevention program. Ideas for prevention programming and access to many resources are included in the manual.

In 2000 the Ministry of Education in Victoria produced a resource for teachers on teaching students with mental health issues. The guide has been separated into volumes, each describing how to teach students with a particular mental health disorder. Volume 1 deals specifically with eating disorders. It is a lengthy document that includes: definitions of eating disorders, identifying at-risk students, teaching students with an eating disorder, opportunities for pro-active intervention, and many resources (Treatment Resources, Appendix 1). The guide is provided free of charge and is available electronically.

In the late 1990’s with provincial and federal funding, a group of practitioners in the area of eating disorders began a project called, Eating Disorders Project North. The aim of this 18-month project was to assist communities to decrease the incidence and severity of eating disorders in the northern communities of the province. While the isolation and remoteness of the north is not relevant to the region of Winnipeg, some of the methods used for training are worth considering for those involved in primary health and the school system. All of the training sessions were open to professionals, lay people, parents and volunteers. The sessions used both personal and professional learning, experiential exercises, group discussions and didactic teaching. Three sessions on each of the following topics were held: prevention, intervention (including diagnosis), combined prevention/intervention and therapy. Following the sessions, an evaluation reported that over 70% of the participants in the prevention sessions felt confident to implement classroom presentations, develop their own prevention strategies and to facilitate a group. Seventy-one percent of
participants in the intervention sessions indicated that they felt very confident supporting someone with an eating disorder, 66% felt that they could facilitate a classroom presentation, 65% that they could counsel someone with an eating disorder and 51% that they could facilitate a group (Program Descriptions: Canada, Appendix 1).

The vast majority of the therapy session participants found the information on dealing with resistance and therapeutic interventions most helpful. Prior to all sessions information packages were given and utilized during the sessions. A Physician’s Working Manual was developed and handed out to all participants in the sessions on medical diagnosis. The manual was thought to be very helpful in demystifying eating disorders and decreasing the family physician's feelings of being overwhelmed. The manual provided the participants with phone consultation backups, facilitated diagnosis and treatment within the community.

The British Columbia chapter of the Canadian Mental Health Association produces a journal entitled: Visions: BC’s Mental Health Journal. In the fall of 2002 the entire issue was dedicated to eating disorders and disordered eating. The idea of such a journal is innovative in itself and worthy of consideration for Winnipeg and/or Manitoba. This issue also provides a fairly comprehensive summary of services available and specialists in the Province of British Columbia (Program Descriptions: Canada, Appendix 1). The services include:

1. Private Practitioners from a variety of professional backgrounds e.g. psychotherapists, divinity, counselling, education, nutritionists and dieticians etc.
2. Educators
3. Authors
4. Awareness and Networking Around Disordered Eating (ANAD)
5. Eating Disorders Association of BC
6. Community Health Nurses
7. South Fraser Eating Disorder Program (Surrey, Delta, White Rock, Tsawwassen and Langley)
8. Thompson Cariboo Shuswap Health Service, Community Eating Disorder Program
9. Kelowna Eating Disorder Program
10. East Kootenay Eating Disorder Clinic, Cranbrook, BC
11. Tertiary Care Services (see below)
12. Eating Disorder Resource Centre of BC (see above)

In British Columbia the most commonly discussed tertiary treatment facilities are British Columbia’s Children’s Hospital Eating Disorders Program for Children and St. Paul’s Hospital Eating Disorders Program. Generally both programs are client-centred and multi-disciplinary offering a range of services including inpatient, residential, day treatment and outpatient treatment.
**St. Paul’s Hospital Eating Disorders Program**

The program begins with a referral and depending on the severity of the eating disorder, determines the path of treatment (Program Descriptions: Canada Program, Appendix 1).

In brief, the program offers medical emergency admission for those clients who are most severe, medically unstable. For those much less severe, they may receive referrals to the community resources and/or individual therapy. They may also offer a client medical and psychosocial assessment. For those clients who have been assessed there are several options offering a variety of services, some more or less intensive. For some clients they may be referred to attend a six-week psycho-education sessions for clients while their families may attend a four-week program. Another treatment option may be that following assessment it may be determined that a short (1-3 weeks) inpatient stay is required. This program, the Extra Care Program, focuses on assessment, renourishment and medical stabilization. Some clients, following assessment, may only require monitoring or the Community Outreach Partnership Program. The later program offers a short-term program (1-3 months) and a long-term program (generally 1-2 years). The outreach program focuses on “quality of life issues” as identified by the client. Another option following assessment is the Readiness Program. This program is a half day a week program preparing clients for Discovery/Vista Program. The Discovery Program is an intensive group program, 12-15 weeks in duration. Throughout the time in this program the clients live at a community residence called Vista (Program Description Binder, Appendix E).

**British Columbia’s Children’s Hospital**

This program has been in existence for about 20 years. They serve clients and their families with anorexia nervosa and “related disorders.” It offers inpatient, outpatient, day treatment and a residential component. They believe strongly in a multidisciplinary team and understanding of eating disorders within the biopsychosocialspiritual model of care (Program Description Binder, Appendix F).

The mandate of the program is to provide leadership in the areas of clinical services, education, family-focused child and adolescent health promotion and research and outreach activities in the area of eating disorders. The clinical team assesses and treats children and adolescents with anorexia nervosa and bulimia nervosa and “related disorders.” The outreach component of the program supports and integrates services together with locally based treatment resources throughout the Province of British Columbia.

They offer many treatment options, all of which begin with the intake service. During the intake process the client will receive a medical and psychosocial or psychiatric assessment and a diagnostic interview. As well, some clients may receive a nutritional assessment and a family assessment. Following this
process, the assessment is reviewed and treatment options are discussed with the client and the family.

For those clients who require medical stabilization, there are three beds on the Adolescent Care Unit for people with an eating disorder. The focus here is medical stabilization, nutritional rehabilitation, psychological support, family counselling and preparation for further treatment in the program or community.

The day treatment program is geared towards clients with a moderate to severe eating disorder who requires intensive treatment. The program operates five days a week and has space for ten clients. Generally, the program offers school in the mornings, group therapy in the afternoon as well as a strong emphasis on family education. All meals and snacks are supported. The length of time one stays in the program varies depending on the need of the individual.

In the outpatient program clients receive ongoing medical and dietary assessment, family and individual psychotherapy. This program’s aim is to assist clients to gain control over their eating difficulties, address problems with self-image and family dynamics. Finally, they provide aftercare and relapse prevention for clients who have been in the more intensive programs. As well, a parent support group is open to all parents of clients involved in any aspect of the program.

The eating disorders program provides a range of outreach services on behalf of the Province of British Columbia. The outreach services include community education and training of staff, telephone consultation to professionals who are treating children and adolescents with an eating disorder. The British Columbia Children’s staff has on request, traveled to provide assistance with the development of local assessment and treatment programs.

**Province of Alberta**

The Province of Alberta in partnership with the Health Authorities and the Provincial Eating Disorder Steering Committee, through the Alberta Mental Health Board, initiated coordination of services for people with an eating disorder in 2000. The Eating Disorder Steering Committee continues to oversee the implementation of all service components. The Committee monitors issues and provides advice to the Alberta Mental Health Board on core services, guiding principles and future funding recommendations. The Health Authorities carry out much of the services and have their own mission statements, philosophy and program objectives (Program Descriptions: Canada, Appendix 2). Their goals are very complementary to one another and clearly display their collaboration and partnership.

To this end, a continuum of care spanning promotion, prevention, early intervention, treatment, and specialized services has been designed. They
currently have a provincial coordinator. The Provincial Eating Disorder Services has several components. The services include ensuring a provincial coordinated approach for service delivery for clients with an eating disorder. They are also responsible for providing information to the public and professionals and to facilitate access to appropriate services throughout the province. As well, the service has an outreach component that supports those working with people who have an eating disorder. Through workshops, in-services and resource material education, consultation is available to community practitioners, dieticians, psychiatrists, physicians and other health-care providers. There are five eating disorder specialists located outside of Edmonton and Calgary who provide general information about eating disorders, information about access to services, and outreach. The five specialists are located in Fort Saskatchewan, Grande Prairie, Lethbridge, Medicine Hat and Red Deer.

**Prevention and Promotion**

In the areas of prevention and promotion, specialists work with educators, school staff, public health teams, physicians and community practitioners to promote self-acceptance and a healthy body image among all age groups, and to assist with early identification of potential eating disorders. They have developed an action plan that includes the following goals for the year 2002 to 2004:

a. Monitoring international, national, provincial and local trends in eating disorder promotion and prevention.

b. Participating in the development, implementation, and evaluation of health promotion strategies that reduce the incidence of eating disorders.

c. Providing consultation to the general public and professionals regarding eating disorder prevention and health promotion strategies.

d. Developing, maintaining, and evaluating an inventory of promotion and prevention educational materials and resources.

e. Collaborating with other community initiatives, both regionally and provincially, involved in eating disorders related health promotion/prevention (Promotion and Prevention Action Plan, 2002-2004, Provincial Eating Disorder Service, Program Description, Appendix 2).

The province has three prevention and promotion specialists located throughout the province (Edmonton, Calgary and Red Deer). The service has developed guides which are available over the Internet (Treatment Resources, Appendix 2). There are separate guides written for: Parents, Family and Friends, Physicians, Schools and Health Professionals. A very recent development is the body image kits. (Prevention Program Information and Resources, Appendix 5). This program
is unique across Canada. The Provincial Eating Disorder Program developed a series of body image kits for different age groups:

A. Grades 1-3, includes four lesson plans
B. Grades 4-6, includes five lesson plans
C. Grades 7-9, includes seven lesson plans
D. Grades 10-12, includes seven lesson plans
E. Parent’s Resource

The design of the kits and lesson plans allows them to be a basis for, or an addition to primary and/or secondary prevention program. The Provincial Eating Disorders Program lend the kits, free of charge to facilities, schools, groups and/or individuals within the Province of Alberta. The kits are also available for purchase. Pictures of each kit, as well as all of the available lesson plans are in the resource binder. According to the director of the Provincial Eating Disorders Program, the education and prevention material uses a “wellness” approach that seeks to change the circumstances that promote, sustain or intensify factors contributing to eating disorders. As well, they provide a listing of resources available such as; books, videos, and web links.

The provincial eating disorders service is also charged with the responsibility to advance the knowledge of eating disorders and to ensure Albertans have access to the best possible information and treatment.

There is community care available in both Edmonton and Calgary for people of all ages. The service includes: assessment, treatment, consultation and support services. Services are provided via individual, family and group interventions.

In terms of hospital based treatment, they attempt to recognize that the treatment needs of people with anorexia nervosa or bulimia nervosa vary. While a variety of treatment options are offered, they are limited to specific geographical areas and specific age requirements. The treatment options recognize the need for different treatment options for children and adolescents and for adults and attempt to provide the best possible seamless transition.

**Day Treatment Calgary**

The program is structured in nature and geared for those clients with an eating disorder who are medically stable, but require an intensive program. This program is for those who are 14 years of age to 25 years of age. The focus of the program is primarily on improvement of psychosocial functioning such as self-esteem, family relationships, and interpersonal relationships. The goal of the program is to transition people back to the community and their occupations such as school, work and other meaningful activities. There is a support home for those that attend the day treatment program but reside outside of Calgary or alternatively, they require a different living arrangement.
The program in Edmonton is for clients 14 years old and up (Program Descriptions: Canada, Appendix 2). The Eating Disorders Program has a 6-bed inpatient unit located in the hospital as well as an 8-bed residence that is located adjacent to the hospital. The six beds are used for medical stabilization and usually for the sickest clients, perhaps suicidal. All patients attend the same program regardless of where they sleep. The residence may be used for people from outside of Edmonton or for people who are ill when there are no beds left on the unit. The unit is a separate unit specifically for people with an eating disorder. The program operates from 7-11 pm everyday 7 days a week. There are 19 full time staff, primarily nursing and psychology. In the residence, you must be over 16 years of age because there is no supervision at night. They use a variety of therapies and it is based completely on the needs of the clients at the time. Most are put on a 1500 calorie diet when they are admitted to the program. There are no contracts; they do a lot of “coaxing.” The program uses and adheres to the American Psychiatric Association Practice Guidelines. According to the coordinator of the Program, the relationship between the clients and the therapists is key as well as the milieu and the peers. The peers are seen as a “big” factor. There are 30 clients at a time and at times they go over capacity to 35. The context is said to be a “very warm milieu.”

Recently, the program surveyed parents and clients for input into their program. At the time of this writing, they had received a return of 50 surveys which were very positive. According to one of the primary staff, the only consistent feedback was a lack of group therapy opportunities. Upon further discussion, it was explained that the shortage of group therapy opportunities was due to insufficient staff.

According to their published information, the program offers the following:

a. Restoration and maintenance of weight
b. Treatment of physical and psychiatric complications
c. Individual psychotherapy
d. Group psychotherapy (insight-oriented, psycho-educational, cognitive-behavioural and supportive)
e. Life skills assistance and teaching
f. Nutritional education and support
g. Meal supervision and supervision following meals
h. Medication (prescription, dispensing and education)
i. Daily one-on-one sessions with the attending psychiatrist
j. Family and couples therapy
k. Community liaison and education
l. Continuous guidance through inpatient to long-term outpatient follow-up
All clients go to “post meal” group where they discuss their illness and their feelings around eating. Women 25 years old and older attend a women’s voices group that is psychodynamic in nature. Groups may be psycho-educational, psychodynamic, restaurant group.

There is a very flexible approach; if a client is not ready and the staff thinks they cannot coax the client, then the client may be discharged for a short period of time. During this “discharged time” the clients are encouraged to think about what they want to do. This is very rare. Half of all inpatients then go to the residents. Length of stay of inpatients is 44 days and length of stay of residents is 40 days. Patients are followed forever. Initially they are followed weekly if they experience periods of stress or if they feel like they would like to resume “eating disorder” behaviours they re-enter the program. They have a significant focus on relapse prevention. Each successive admission is shorter getting closer to success. They have only had one person leave prematurely and not return to the program. The waiting list is about 6 months, but if someone is severe they will be brought in as an emergency.

Children under age 13 go to Glenrose or Royal Alexander where they are not on a specific unit for people with an eating disorder and a behavioural strategy is used. They use family therapy for all clients under 18 yrs old.

Finally, within the regions of Calgary and Edmonton there is information and referral services that provide professionals who work with people with an eating disorder at various stages of the illness. This service is provided free of charge.

**Province of Saskatchewan**

The Province of Saskatchewan does not have formalized provincial coordination, but does have a consultant on staff at Saskatchewan Health. The provincially funded BridgePoint Eating Disorder Centre provides some coordination for the province. This facility coordinates a newsletter twice per year as well as a yearly network meeting. The network includes:

a) BridgePoint Eating Disorder Centre  
b) University of Regina Counselling Services and Women’s Centre  
Saskatoon District Health  
c) Swift Current District Health  
d) Yorkton Body Image Interest Group  
e) Moose Jaw-Thunder Creek Health District

Each district meets once per year as a large group with many small meetings during the year in their respective districts. They report on their year’s activities and update the group on ongoing and/or new programs. The Counselling
Services and the Women’s Centre at the University of Regina hosted a “Celebrating Ourselves and Natural Sizes Week.” The objectives of the week are:

i. Challenging myths and stereotypes based on body image of women and men
ii. Promoting health, well being and acceptance of diversity
iii. Preventing disordered eating

Within the Saskatoon District, the Adult Community Mental Health Services provides a psycho-educational series to provide support for people with an eating disorder. The team is multidisciplinary and includes members from Psychiatry, Psychiatric Nursing, Social Work, Occupational Therapy and a Nutritionist. Their service also offers nutritional assessment and counselling.

The Swift Current District has formed the Interagency Committee for the Prevention and Management of Eating Disorders. Their committee is inter-sectoral. It includes professionals from both health and education. Generally they meet to develop resources and share information.

In Yorkton they have formed the Yorkton Body Image Interest Group that has developed the “Community Reach and Teach Kit for Women and Body Image Issues.” The group loans the kit out to those in the local community and are in the process of assisting with the development of a self-help group.

Moose Jaw-Thunder Creek Health District focuses primarily on awareness and prevention by providing promotional and educational sessions throughout the District.

BridgePoint Eating Disorder Center is a non-profit community-based organization that provides treatment and support services to individuals with eating disorders (Program Descriptions: Canada, Appendix 3). They work in partnership with Midwest District Health and Saskatchewan Health in the delivery of programs. Their many services span the continuum of services: intensive rehabilitation, recovery and healing for persons who are experiencing an eating disorder. All services are run as programs and have offerings at various times throughout the year. Each program has a different focus, such as the introductory programming, friends and family, adolescents and adult follow-up. Programs vary in duration from 1-4 days. BridgePoint Center provides intensive rehabilitation through a community-based team approach, which integrates professional support with self-help and social support from peers, family and friends. The more intensive programs are called “modules.” There are three modules, which range from 2 to 3 weeks in duration. Within the treatment eating disorders are considered within the broader context of personal health and well being, support and community resources. Each of the three modules include: experimental learning, a teaching session done in a group format, individual discussions and processing of
personal issues. They provide opportunities for creative expression and body awareness activities to emphasize the mind-body relationship.

*Module 1: Laying the Foundation*

The emphasis of Module 1 is on self-awareness in respect to an eating disorder. Patterns of living and ways of coping with stress become fixed as habitual and restrictive routines for which there is little conscious awareness. These routines can have negative effects on health and general well being. The facilitation of self-awareness in Module 1 allows for learning about different choices in living and coping that have a positive impact on life and that can assist recovery.

*Module 2: Building Bridges*

The focus of Module 2 is on the development of the self in personal relationships. Continued self-discovery and practice of different choices in living and coping cannot be done in isolation. Personal growth and recovery from an eating disorder is best facilitated and supported in relationships with others. The facilitation of relationship skills in Module 2 encourages personal contact with others as a context for learning and as a resource in times of crises.

*Module 3 is currently in development.*

*Adolescent Module*

This module has specifically been developed for people ages 15-18 years. The adolescent program is available for individuals from 15 to 18 years of age. It recognizes adolescence as a significant developmental period for individual growth in the context of family and the pressures of society. Self-definition is stressed as an important concept in the transition to adulthood. This program also prepares individuals for participation in the adult module series.

The program does not describe itself in terms of a particular frame of reference but in terms of major content or themes and refers to their model as a “bridge.” (Program Descriptions, Appendix 3).

Like many other provinces there is an extensive list of community resources for help in dealing with an eating disorder as well as a list of people who work in prevention services.
Province of Ontario

The eating disorder programs in Ontario are not provincially coordinated, however the province does fund the Provincial Outreach Program. This is an educational program that is run throughout the province. This program is described in greater detail below. Ontario, with its large number of residents provides a number of programs for people with an eating disorder/disordered eating. The breadth of services offered in the province is vast. The following information is a sample of some of their most noted programs for people with disordered eating/eating disorders. All funded eating disorder programs in the province are listed in Program Descriptions: Canada, Appendix 4.

Sheena’s Place

Many people across the country look towards Sheena’s Place with awe (Program Descriptions: Canada, Appendix 4). A mother of a young woman who died of anorexia nervosa in 1995 initiated the program. Sheena’s Place is a registered charity offering support services at no cost to people with eating disorders and their families. The Program does not receive government funding and relies completely on private donations to sustain its programming. The focus of the programs is on those who have an eating disorder and their families. The services are grouped under one of the following titles:

- a. Open Programs-no pre-registration necessary
- b. Body Image Groups
- c. Skill Building Groups
- d. Expressive Groups
- e. Support Groups
- f. Workshop Series
- g. Single Workshops
- h. Programs for Family and Friends
- i. Programs for Teens and Young Adults

Services are described to be non-institutional and client-centred. The services include a broad spectrum of programs from “medical to spiritual" and from “traditional to non-traditional”. For example, under the heading Body Image Groups there are groups on hypnosis, getting acquainted with your body, reclaiming your body, solution-focused body image, how to talk about sex, yoga and pilates to name a few. The groups are tailored for the clients considering their age (children to post-menopausal women), size, length of time the person has been dealing with disordered eating issues, cultural considerations, gender (men and women), special high-risk populations, sexual orientation and disabilities.
Sheena’s Place has developed programs to encompass families, peers, educators and other care providers. People self-refer to the program. Initially, the program was set-up to support people who had received treatment and were re-entering the community. Presently, Sheena’s place considers itself as a “link” between people with an eating disorder and the hospital-based programs, schools agencies, therapists and families. The vision, mission of Sheena’s Place is in Program Descriptions: Canada, Appendix 4. The programs take place in the community, in an old house in downtown Toronto.

In effect, the objective is for Sheena’s Place to work with the entire system as it currently exists and in so doing, act as a conduit between those affected or living with eating disorders and the various systems as they currently exist. Sheena's Place enlists professionals on a fee-for-service basis, who provide group support to those identified as having eating disorders, and their families. (Sheena’s Place, www.sheena’splace.org).

They offer group programs four times per year: winter, spring, summer and fall. Groups focus on support, body image, expressive arts and skill building. Experienced professionals who work holistically when dealing with issues around food and body image facilitate groups. Group programs are usually eight to nine weeks in length. As well, some one and two day workshops are also offered. Individuals are required to register in advance for groups and workshops. Sheena's place hosts a Drop-In program and Open Studio once per week. These programs do not require pre-registration.

The facility also does education and outreach with the help of dedicated, knowledgeable volunteers. Sheena’s Place provides in-school talks focusing on prevention and education. Fact sheets are available for use by educators, students and parents. In conjunction with the Self-Help Resource Centre of Greater Toronto, Sheena's Place developed a tool kit for starting a self-help group (Treatment Resources, Appendix 5). They cover a wide variety of topics and specific areas of concerns. Sheena's Place responds to requests for information on an ongoing basis from high schools and university and college level students. In addition, Sheena's Place provides placements, supervision and training to several students each year. The programs are primarily focused on young adults with some specific programs for teens.

**Hopewell Eating Disorders Support Centre of Ottawa**

Another community-based program is Hopewell Eating Disorders Support Centre of Ottawa. Feeling the frustrations associated with the lack of information and resources for people with eating disorders and inspired by the work of Sheena’s Place, a group of women began a centre in Ottawa. They were founded by three parents of teens who had anorexia nervosa. Their funding is from private and corporate donations. They have successfully formed partnerships with a variety of eating disorder programs in their area. Currently they offer support groups, expressive art programs, family support groups, prevention programs and library and educational resources (Program Descriptions: Canada, Appendix 4.)
recently, they have partnered with the Royal Ottawa Hospital’s early intervention program team to deliver a youth program in schools. The program encourages discussion about attitudes and behaviours associated with body image.

The outreach program is the only aspect of the services available for people with an eating disorder that is provincially coordinated. The Ontario Ministry of Health and Long Term Care fund the program, in partnership with the Hospital for Sick Children and the Toronto General Hospital Eating Disorders Program. (Program Descriptions: Canada, Appendix 4). The mandate of the outreach program is to provide a full range of age-appropriate care throughout the entire Province of Ontario. Their focus is on educating and supporting practitioners thus increasing access to community-based care for people with eating disorders. The Outreach Program’s goals are as follows:

a. Identifying partnerships within the health care system
b. Providing education and training experiences to partners
c. Fostering regionalization of specialized services
d. Facilitating easier access to community-based services by the consumer

In attempting to reach their goals they offer the following services:

i. Training and assessment, management and prevention of eating disorders.
ii. On-site visits to Ontario communities to promote professional linkages
iii. Distribution of the psycho-educational intervention Program (Turning Points).
iv. Ongoing professional support to the network of professionals.
v. Linking the Ontario public to practitioners and facilities on the network.

The services are more fully described in their brochure. There are seven regions within Ontario and each region has a provincial outreach worker.

Some regions in Ontario have developed coalitions and/or body image networks (Program Descriptions: Canada, Appendix 4). For example, the areas of the Wellington, Dufferin and Guelph formed the Wellington-Dufferin-Guelph Eating Disorders Coalition; a listing of several services and professionals that offer assistance for people with an eating disorder who live in these particular areas of Ontario. There is also five other coalitions in Ontario; Body Image Coalition of Peel, Eating Disorders Awareness Coalition of Waterloo Region, Body Image Network of Halton, York Region Eating Disorders Community Coalition and TABI (Tackling Awareness of Body) and Perth Region. These groups primarily focus on the treatment and prevention of eating disorders. Typically the groups are
comprised of professionals, educators, recovered individuals, parents and other family members.

**Toronto General Hospital Eating Disorder Program**

Toronto General Hospital Eating Disorder Program is perhaps among the best known tertiary care programs in the country and internationally (the program was awarded a gold award from the American Psychiatric Association as the best clinical program in North America in 1990). Both Dr. Allan Kaplan, who is the current Head of the Program and his predecessor Dr. Paul Garfinkel are internationally known. The program began in 1984 and currently employs about 30 staff from a variety of disciplines including nursing, nutrition, occupational therapy, psychiatry, psychology and social work. The hospital is part of the University Health Network that links Toronto General with Toronto Western Hospital and Princess Margaret Hospital (Program Descriptions: Canada, Appendix 4). The program is said to have a “three-tier focus: clinical services, research and education (Ontario Community Outreach Program For Eating Disorders, (Program Descriptions: Canada, Appendix 4).

The eating disorder program has different components: a 10-bed inpatient unit, a 12-person day treatment program, consultative service, an outpatient clinic, and an information centre (NEDIC). The program uses a “stepped care” model of treatment where the patient’s treatment needs are matched with the service provided through steps. The least intensive treatment is provided to the largest number of patients initially and those who do not respond to this step receive more intensive forms of treatment. The program sees close to 400 patients from across Ontario each year.

The inpatient program sees only the most severely ill patients with anorexia nervosa. The main focus is nutritional rehabilitation along with psychological and family support. The average length of stay is three to four months. The day hospital program operates only on weekdays for eight hours per day. They work with people who are seriously ill with either anorexia nervosa or bulimia nervosa. The focus of the day program is nutritional rehabilitation and stabilization of disordered eating. Their main treatments include intensive group psychotherapy, family therapy and pharmacotherapy. The average length of stay is six to twelve weeks. The outpatient clinic includes a variety of time-limited groups that proceed from the most intensive to the least intensive and vary from time to time.

- **Step one:** *Psychoeducational Group* is a cycle of six lectures
- **Step two:** *Symptom Group* meets once per week for 16 weeks focusing on cognitive behaviour techniques to promote normalization of eating
- **Step three:** *Nutrition Group* assists patients to develop personalized eating plans
Step three: *Beyond Dieting Group* is for large women to help achieve their goals.

Step four: *Family Groups* may include family psychoeducation, family therapy and family support services.

A person receiving outpatient care will attend step one however they may or may not attend any or all of the other groups. As well, there is *Step-down After-Care Treatments* for patients who have completed the Inpatient or Day Hospital Programs. This program may run up to six months and focuses on relapse prevention strategies and establishing normal eating habits.

The consultation service provides initial consultation and treatment recommendations to primary care physicians and specialists throughout the province. Approximately 60% of the consultations are within Toronto and 40% of them are outside the metropolitan area. Six full-time and part-time psychiatrists complete the consultations.

The National Eating Disorder Information Centre (NEDIC) is located at the Toronto General Hospital. This is a health promotion and primary prevention centre that provides information about treatment centres throughout the country.

Hand-in-hand with the clinical services, the Program at Toronto General has a strong emphasis on research and currently has several areas that are of focus:

a. Neurobiology of Eating Disorders  
b. Genetics  
c. Treatment and Outcome  
d. Relapse Prevention  
e. Cognitive and Psychological Functioning  
f. Epidemiology  
g. Association between Eating Disorders and Medical/Physical State

For more specific information on the studies please see Program Descriptions: Canada, Appendix 4.

In terms of education, the Eating Disorders Program directly provides education to many health professionals and students from around the world e.g. Argentina, Hong Kong, Israel, New Brunswick, British Columbia, New Zealand, United States etc. As well the program is involved with the provincial outreach program.

**Ottawa Civic Hospital**

Other hospital-based programs are more restricted in terms of the type of clients they work with directly. For example, the Ottawa Civic Hospital has an eating disorders clinic that provides outpatient and day hospital assessment and treatment only (Program Descriptions: Canada, Appendix 4). Similar to other
programs for people with less severe cases of anorexia nervosa and bulimia nervosa, this program uses a cognitive-behavioural orientation. As well, the clinic offers a day treatment program that is 8-10 hours per day and runs 4 days a week. The program offers a variety of group sessions such as psycho-educational group, bulimia group, anorexia group, relapse prevention group, day treatment groups, parents, families and friends group, teen group. As well, individual therapy is also available. Assessments are done within two weeks of an individual's initial contact. The clinic sees between 350-400 new patients per year. There are six staff members, five psychologists and one psychiatrist.

Hospital for Sick Children

The Hospital for Sick Children in Toronto is an eating disorder program for people under the age of 18 years (Program Descriptions: Canada, Appendix 4.). The program is interdisciplinary and offers a range of hospital-based programs: inpatients, outpatient and consultative services. Initially, all patients are assessed which includes a medical assessment, nutritional assessment and a mental health assessment. The inpatient unit is a specialized unit for young people with eating disorders. It has 9 beds and is primarily staffed by nurses. The outpatient program assesses, treats and monitors those in need of services. Through consultation, the Program offers recommendations for treatment to physicians and other professionals who provide treatment.

Southlake Regional Health Centre

Those who initiated the adolescent program currently operating at Health Sciences Centre, PsycHealth Centre in Winnipeg, have explored in some detail the program in New Market at the Southlake Regional Health Centre. This is a day treatment program for teens between the ages of 13 and 18 years. The program works with teens that have a serious eating disorder but are medically stable. The primary modality is group sessions. The program operates for 10 hours per day Monday to Thursday with a slightly shorter day on Fridays. There is a parent support group offered that is open to parents of children who are dealing with an eating disorder. The service developed and published a fairly widely used program called Why Weight. The program has been incorporated into the adolescent program at Health Sciences Centre in Winnipeg (Treatment Resources, Appendix 3). The program is psycho-educational and is described and included in the portion of this report that discusses the services in Winnipeg.

North York General Hospital

In 2001 North York General Hospital began running an expanded day hospital program for children and adolescents. The uniqueness of this program is that it operates seven days per week. The program appears similar to others with the inclusion of school and group therapy, meal supervision as well as family
therapy. The programming on the weekend is a half-day with a focus on recreation and leisure.

**Other Ontario Programs**

Some regions in Ontario such as Halton have been successful in establishing programs in their areas but still identify the need for inpatient services (Prevention Programs Information and Resources, Appendix 3).

There is a fairly new program established in London, Ontario and is funded by the Ministry of Health and Long-Term Care (Program Descriptions: Canada, Appendix 4). This will service the southwest portion of the province by providing assessment and treatment for children up to 18 years of age. The program includes inpatient, day hospital and outpatient services as well as community outreach. They will also provide a one-time consultation to people with an eating disorder who are 18-25 years of age. Similar in design to the other outreach programs in the province there will be outreach to Chatham, Sarnia, Woodstock, Goderich, Stratford and Owen Sound, allowing people to receive some services in their community.

**Province of Quebec**

**Ste. Justine Hospital**

The services listed included hospital based and private practitioners. Programs were only briefly described (Program Descriptions: Canada, Appendix 5). Ste. Justine Hospital provides services for children 12-18 years old. Inpatient services are done on the adolescent medicine unit which is a 26 bed unit for children 10-18 years old. The unit is not specific for those with an eating disorder. The majority of their services are on an outpatient basis. As well, Montreal Children’s Hospital provides services for adolescents. They offer both verbal and expressive or non-verbal types of therapy. Assessments are completed within two weeks of the initial contact.

**Anorexia Nervosa and Bulimia Nervosa Quebec (ANAB Quebec)**

Anorexia Nervosa and Bulimia Nervosa Quebec provides services about prevention and awareness. They offer several workshops on body image, eating disorders, feminist perspective, nutrition and the importance of activity, how to develop a relaxed relationship with food and how to help someone who may have an eating disorder. They also provide follow-up discussion to allow students to explore issues further. Anorexia Nervosa and Bulimia Nervosa Quebec also provides many support groups throughout the Montreal area. The groups are typically together six to ten months. This program has partnered with McGill University, School of Dietetics and Human Nutrition. There is a student
dietician in each group. People who have received training by ANAB Quebec lead the groups.

**McGill University**

McGill University delivers services strictly to their students. They assist people with anorexia nervosa, bulimia nervosa, weight-related or body image problems. The students pay a one-time fee of $30.00 to utilize any or all of the following services:

- a. 1:1 counselling
- b. Psychiatric Evaluation
- c. Medical Evaluation
- d. Nutritional Counselling
- e. Psycho-educational Groups

**Douglas Hospital and Montreal General Hospital**

The Douglas Hospital in Verdun offers inpatient, day program and outpatient treatment for adults. The Montreal General Hospital was the only facility that treated anorexia nervosa, bulimia nervosa, compulsive eating and obesity. The services are available to those who are 16 years or older. There is a fee for their service which was not published, but it was noted that a sliding scale was available. The services offered were on an outpatient basis and typically used a cognitive-behavioural approach.

**Maritime Provinces**

**Queen Elizabeth II Hospital**

There was very little information for the programs offered in the Maritimes. Queen Elizabeth II Hospital offers a multidisciplinary team that helps individuals overcome anorexia nervosa and bulimia nervosa. Group-oriented treatment is offered on an outpatient basis. A family support group educates family members about eating disorders and gives them the opportunity to share experiences and coping strategies.

**IWK Health Centre Child and Adolescent Mental Health Program**

IWK Health Centre Child and Adolescent Mental Health Program is a multidisciplinary team that helps its young clients deal with the physical and psychological consequences of anorexia nervosa and bulimia. Taking referrals from across the Maritimes, the team is involved with direct clinical services, consultation and in developing education programs.
Yukon Territory, Northwest Territories and Nunavut

Services for the Yukon, Northwest Territories and Nunavut were explored on the Internet. The only services that were easily identified were telehealth conferences offered from Alberta and British Columbia, and Internet sites, which had links to other sites for information, much of which was from the United States of America.
CURRENT SERVICES IN WINNIPEG

Within the Winnipeg Region a fairly comprehensive study was done. First key stakeholders were consulted. The vast majority of the consultations with key stakeholders were conducted through a personal visit. Where time did not allow for a personal visit, consultations were done by telephone. During consultation meeting, the stakeholders were initially asked to describe their services in terms of type of services being offered for people with issues regarding eating, specifically anorexia nervosa and bulimia nervosa as well as to whom their services were offered. Secondly, key stakeholders participated in a discussion that asked them to discuss the strengths, weaknesses, opportunities and threats (SWOT) they perceived for their particular service as well as for the entire spectrum of services for disordered eating/eating disorders within Winnipeg.

A complete listing of all stakeholders consulted is provided in Reference Information, Appendix 6.

SWOT Analysis

Based on an individual’s or group’s own experiences, knowledge and attitudes one perceives and prioritizes the issues related to disordered eating and eating disorders differently. Each individual, be it a client, a parent, a family member, friends or professionals, views the issue of eating disorders or disordered eating very uniquely. This is true of most issues regarding health. How we perceive the issues regarding disordered eating and eating disorders has an effect on how and where we intervene and even a greater impact on where we think more services are needed. It is because of these different beliefs, rather than in spite of them that Winnipeg Region does have somewhat of a continuum of service for people with disordered eating and those with an eating disorder. While there are gaps in service and there is not a comprehensive conceptual framework that is coordinated, services do exist.

The key stakeholders were asked to examine their particular area of practice and the area of services for those with disordered eating/eating disorder within the City of Winnipeg and to consider the strengths, weaknesses, opportunities and threats. The summary themes are detailed below.

Community-Based Services

The community-based agencies included Teen Talk from Klinic, Women's Health Clinic, Laurel Centre and Fort Garry Women’s Resource Centre. The strength they perceived was in the dedication of their staff. Many agencies identified staff members that have remained constant for many years thus developing expertise in the area and their ability to train more junior staff. Several agencies felt they offered very timely services with short waiting lists if any at all. As well, several
of the agencies identified a feminist model of practice and felt this to be the model of choice in working with this population. The model includes coming to understand how the eating disorder has developed for the individual in the broader context of family, peers and society. The community based-programs do not monitor the weight of clients per se. The monitoring of weight, if offered, is done at “arms-length” from the counselling. Depending on the client’s needs, monitoring may be done by either by a physician within the agency or a general practitioner in the community. As well, the community-based agencies believed another strength to be their ability to deal with cultural diversity in the most relevant manner. The community-based programs believed that their services should serve the communities such as schools and agencies. Another strength identified was the implication of philosophies about the disordered eating. For example, several of the agencies made the point that the women seeking assistance are not defined by their eating disorder. Another advantage of the community-based agency is that often a philosophy such as weight preoccupation is integrated into the entire agency. This integration allows for screening and early intervention and/prevention/awareness. One agency in particular identified that weight preoccupation has been a priority service for over 20 years. Many agencies felt they had good connections with others across the country. Generally, agencies felt they have good communication with other agencies in Winnipeg and the hospital in regards to specific clients.

Some of the weaknesses relate to financial constraints of the agency such as the inability to expand prevention and early intervention services. As well, the agencies identified that as there is no network in the city, this creates some isolation of each agency. For example, a few of the agencies perceive that the “formal or psychiatric mental health system does not view the agency as part of the mental health system. Several times during consultation meetings, agencies were unaware of learning opportunities being offered within the City of Winnipeg. Another area of some concern was the inability to obtain necessary information because of confidentiality; they do not have access to family or schools. Some agencies felt the lack of a system (concerning eating disorders) in general. As well, some community agencies do not think they are considered part of the current mental health system. At times agencies feel that their particular philosophies hamper open dialogue with others such as hospitals and/or EDAM.

In terms of opportunities, most agencies would like to expand to include more awareness and prevention programs. Agencies would like to be involved in developing and implementing a curriculum for schools. Another opportunity is expanding to serve males with disordered eating/eating disorder. This might include direct service as well as their involvement in awareness/prevention programs. Finally, many of the agencies saw themselves as outside the “loop” and would like to coordinate services and build a network within the city and/or province.
Threats involved the assumption that there is a “pot” of money and should funding be directed to the hospitals i.e. a day hospital program that there would not be resources to expand community-based programs. The perception of a day hospital was that it does not necessarily work with more severe clients, nor are clients better served in this setting. As well day hospital programs typically serve very few clients per year and it is expensive.

**Secondary Care**

A strength of the secondary care in the city is the commitment of the physicians. The physicians are on contract and thus are better able to provide the appropriate treatment to those with an eating disorder that come to the community office. The office is a satellite program of Children’s Hospital and thus offers a more comprehensive service for children and adolescents. Time and time again other health professionals, advocacy groups, clients and families identified the physicians within the satellite program as a solid strength. The clinic sees many clients per week with disordered eating/eating disorder. For example, two of the primary physicians see approximately 10 patients per week.

There were no identified weaknesses, opportunities or threats by this group.

**Advocacy Group and Families**

The three physicians within the Children’s Hospital were identified as a great strength within the system. People identified the Adolescent Day Hospital Program as a strength and evidence of some commitment by the Government of Manitoba. This group drew special attention to the fact that professionals followed adolescents after attending the program; this was seen as especially positive. The strengths of the group are many. Raising awareness about the illness and supporting many families who are dealing with a loved one who has the illness are among the most primary strengths. The group in Winnipeg is fairly small and achieves many goals such as public speaking in schools, agencies, health care forums etc. The group has raised the needs of the clients to high levels within the government and healthcare departments.

The weaknesses include a lack of services for the most severe cases of anorexia nervosa. The waiting list for psychiatric assessment for adults is too long for those who are in great need. Although they (the parents and families) feel support by each other, “no one else lives with it 24/7.” Inherent in the disease is the “denial” which the families feel is very difficult to deal with constructively. As well, many families identified feeling stigmatized. Some families have incurred a huge financial burden by seeking treatment outside of the province. A sense exists that doctors in general are not interested in this area and are, “clued-out.” The group believes the mass media is a huge problem that is difficult and it is time consuming to take-on this issue. Another weakness included was the high cost of private practice therapists. In general, many of the consumers did not
feel that the adult services offered meets their needs. They felt there is a lack of physician contact, programming, follow-up and monitoring. Some families have had positive experiences with individuals within the System (both hospital and community-based).

In terms of opportunities, people thought there was an urgent need for training of general practitioners. There was also a need for more support of moderate and severe cases of eating disorders. A general suggestion was that education regarding eating disorders should be incorporated into the curriculum of all health care education programs. Another general suggestion was that there needs to be a media campaign to raise public awareness such as those done with “drinking and driving.” Prevention programs need to include people who have recovered from an eating disorder. Another opportunity is to advocate for the inclusion of prevention programs in the education of grade six students or earlier. They identified a need for more community-based programs and a residential community program for those most in need. There is a strong need to ensure the monitoring of patients discharged from programs. For those clients who are unable to come to a facility, it was suggested that perhaps a professional in the community could provide follow-up monitoring and counselling in the client’s home. The group also suggested that should they receive some government funding they could do a lot more such as fundraising for programs, newsletters of support and writing of grant proposals for funding. In summary, the group advocates for a “full continuum of services.”

The threat that this group identified is the lack of funding and that in general, there is no support for families, parents or adults.

**Clients**

In speaking with two young adult clients, they were very helpful in describing their journeys and their perspective on the needs of the client. Immediately, both clients expressed that different types of therapies work for different people. One client did not experience success until the creation of the Adolescent Day Program. Prior to this program she had been admitted to Children’s Hospital and the PsychHealth Centre many times. She described utilizing the adolescent program until such a time as she felt she was able to discharge herself. After discharge she continued to use the adolescent services as an outpatient and then finally transferred to a private therapist. She identifies the groups that focused on body-image, coping mechanisms, family experiences, stressful situations, managing her eating and learning to deal with emotions as most helpful. While she identified that groups are what worked, she also clearly discussed her distain for groups and a strong preference for individual therapy. She noted that one’s preference for group therapy or individual therapy was personal and believed that many of her fellow clients had preferences for one or the other.
She was also asked about what she felt was needed to better meet the needs of people with eating disorders. She identified her awareness of the difficulty successfully treating people with an eating disorder. She emphasized the need to be able to intervene at the beginning of “the nasty cycle.” She felt that funding was a key issue and that these illnesses do not have the level of funding required by either government or private/public foundations. As she was a client from outside the City of Winnipeg, she also felt that it was very important to raise awareness of the illnesses outside the city. This client summarized the treatment needs as follows, “intensive, professional and self directed treatment.”

The second client had faced a very long battle with anorexia nervosa. She identifies the anorexia nervosa starting when she was 12 years old and she did not initiate seeking treatment until she was 18 years old. Her first attempt to seek treatment was unsuccessful. She had decided to telephone a private therapist and upon hearing that treatment would cost $80.00 per hour she quickly ended her search for a therapist. As she states she was “obviously in denial” not recognizing the seriousness of her situation. About one and a half years later she went to her physician for a physical examination who directly asked her if she would like help for her eating disorder. She then waited seven months to be admitted to the Outpatient Eating Disorder Program at Health Sciences Centre, Winnipeg. At this point the client was 20 years old, a total of 8 years had passed since her anorexia first began. The following year she admitted herself to the Inpatient Program at Health Sciences Centre, Winnipeg.

While on the inpatient unit, the client felt that only a few of the nurses were specifically trained to work with people with eating disorders. The client felt this had a significant impact on how clinicians worked with her during mealtime as well as during psychotherapy group. She made the point that she had waited a very long time for the “opportunity” and felt that there was some untrained and uninterested staff working with her. She also discussed the positive effect that certain “trained” staff had on her recovery. Although at time she said it “felt awful” she knew it was very helpful. This positive experience left a long-lasting impression of what a health care provider could offer. Another identified need is for a recreational specialist to assist clients in developing a healthier relationship with physical activity, to teach clients about moderation. The client discussed the usefulness of gentle activities such as yoga or tai chi. Related to this comment the client identified the need for the days on the inpatient unit to be more structured. She perceived that there is too much “down time” and that this was an opportunity for her to become self-destructive. She suggested activities such as: massage, yoga, family dynamic groups, body imagery and movement group. Her last suggestion was for the need to develop a specialized unit that would be only for those clients with eating disorders. She felt that the mixing of clients with such different illnesses did not allow for the specialization and training that she feels is required to work successfully with people with an eating disorder. All in all, she felt that despite the pitfalls, the program it worked for her. She describes her unique journey and the desperate need for structure that the program
successfully provided for her. In summary, she describes the inpatient program as a “good basic program.”

In terms of her own recovery, she feels that family and friends were the most helpful aspects of her recovery. As someone who loves self-help books, she found several resources that assisted her once she was discharged from Health Sciences Centre.

One client who is involved with prevention and awareness programs commented that she believes from her own experiences, that prevention programs should begin by age 10. She has done some talks in the schools and believes that having someone who is struggling with an eating disorder or someone who has recovered from an eating disorder is helpful in terms of raising awareness and attempting to remove the secrecy from around the illness. Ideally, prevention programs need to be integrated into health and physical education programs for the general population. She also believes that prevention strategies need to be employed with specific “at-risk” children perhaps beginning with self-esteem enhancement programs in the schools or initiating referrals to a family therapist at the earliest signs of the illness.

Tertiary Care (Hospital-Based Services)

Adult Program

The greatest strength identified is the commitment of the staff to their clients. The staff is knowledgeable and very invested in working with this population. Among the different parts of the services there is felt to be good communication. Another strength identified is the primary nursing model on the Inpatient Program. The staff reported that they provide holistic care considering the clients physical and psychological health. There is some connection with community-based agencies around particular issues with clients. Many of the staff in the adult's service have many years of services; for many 17 to 20 years. The adult program has become flexible offering clients the opportunity to make large or small changes. They work with some of the most ill clients, particularly those clients with co-morbid disorders such as personality disorders, social anxiety, obsessive-compulsive disorder or substance abuse. The adult team has a fluid transition between outpatient care and inpatient care. The adult team follows and utilizes the American Psychiatric Association Practice Guidelines. The vast majority of the clients are voluntary. Although they are aware of being perceived as somewhat rigid, they believe that they are always trying to do new and different treatment options. They offer consultation and back-up services to Flin Flon and Thompson. The adult service is involved in the training of many health professionals such as nursing, occupational therapy and psychiatry.

The weaknesses as identified by the team include the lack of successes. As well, the program has endured recent changes in the personnel (Psychiatry).
They feel they are understaffed and require more staff to complete assessments in a more timely fashion. The other issue is one of “critical mass.” The group programs do not include clients from both inpatient and outpatient services and since there are only three inpatient beds, there is often not enough patients to operate the inpatient program. From the outside perspective, the inpatient program is a “hit or miss proposition” depending on the numbers of patients. Some staff also had mixed thoughts about the “nurse-therapist” model. It was well acknowledged that this type of care encourages a close relationship between the patient and nurse which is fundamental to providing a safe environment for change, however, it also limited the number of referrals made to dietetics and occupational therapy. The staff reported that they are lacking in ongoing education; someone to keep them up to date on the best practices. As well, the team identified that they used to network more in the community and that this does not occur any longer. The service also discussed that although they have become very experienced in the area of eating disorders, they do not promote themselves to the community or nationally. Finally, staff identified the difficulty inherent in working with this population. The denial of many clients is so strong that success is a very slow process and which, for many, may never be attained.

There are many opportunities identified by the staff. They would like to be able to apply for more grant monies. As well, with the development of the child and adolescent eating disorders service, they perceive new opportunities to create bridges and provide a more seamless service. The staff believes they need to be creating more opportunities to meet with many in the community, but in particular with the EDAM. In the past, the service enjoyed a closer working relationship with the Women’s Health Clinic and would welcome the opportunity to re-establish this connection. The staff perceives that they have an opportunity to initiate network meetings to bring all professionals working in the area of eating disorders together to discuss common issues.

In terms of threats, the staff at the hospital recognizes the need to bridge with EDAM. At this time the hospital staff do not feel well connected with this group.

*Child and Adolescent Eating Disorder Service*

The team reported that the opportunity to learn during the past two years has been excellent. Over the course of the past two years the staff feel they have truly become a “team.” The program has very high-energy staff, which is needed for this population. The staff is very proud to offer a multidisciplinary team based service. When the program initially opened referrals were slow, allowing the staff to do an *Adventure Camp* that was very successful. They have now begun to train students of the various health professions as well as present to other groups of professionals and at national conferences. The staff has developed a good working relationship with staff from CH5. They are very pleased to have access to experienced Paediatricians. The day treatment team feel they have a similar
vision and goals of the program making them a more cohesive group. They are consistently re-evaluating their approaches and making changes as necessary. As a treatment team they are open and are willing to try new approaches. They consult and are in contact with other treatment teams in Canada, such as: Southlake Regional Health Centre and BC Children’s. They have been successful in having the public become aware of the program. There are three levels of treatment available to clients: CH5 inpatient, day treatment and outpatients. There is a genuine interest in learning and professional training. As well, their philosophy includes a respect and inclusion of the families. The newness of the team was perceived as both a strength and a weakness.

One weakness that was identified is that the team includes many staff who are fairly new to the area of practice. As well, many of them are recent graduates of their respective disciplines. There are some difficulties with roles of various disciplines on their teams, however considering the newness of the team this is not unusual. Some team members thought that roles were inflexible. In short, the mutual respect and cohesiveness is not “quite” there. It was perceived as a weakness by some that there are no psychiatric care beds available for longer-term care. As well it was mentioned that there is not a long-term vision that would include services to rural communities. At times there is a lack of support between team members and from families. The team identified that there is a need for a smoother transition to adult services. Concerning continuing professional education, at present there is limited opportunities for staff development. As well it was noted that there are gaps in service for clients who are very resistant to treatment and little motivational enhancement treatment available. The team identified a need for groups that are post outpatient service that would aim to prevent relapse. Some individuals identified a need for a program coordinator to develop a staff development program and a vision for the future as well as to facilitate resolving internal issues.

The major opportunities identified were in the area of professional development such as visiting programs across Canada or attending conferences on eating disorders. As well staff identified the opportunity for their involvement in community outreach and prevention programs. They would like to see more funding for innovative programming such as the Adventure Camp. They would also like to develop a transition process to adult services. In the long-term they see an opportunity to develop a community residential facility to better serve those from outside of Winnipeg (Manitoba and Northwestern Ontario). Other programs that the team would like to develop include outpatient groups, program evaluation, research, relapse prevention and community education. The team would also like to explore the area of motivational enhancements for those clients in the pre-contemplation stage. Finally, the team would like to pay more attention to evidenced-based practice.

The threats that were perceived by the team include time, resources and burnout. Some difficulties arise because of poor role clarity between those who
work on the day treatment program, those that work on the outpatient program and those who work on both programs. Another threat is the inherent decrease in patient population during the summer months. The team felt is was predictable and that the number of patients admitted to the program during the summer months would always be few. There also was a threat perceived by the team in that decisions made may be examined by the Winnipeg Regional Heath Authority and families. Decisions that were not agreeable to all parties were sometimes difficult to explain due to the stipulations of the Personal Health Information Act (PHIA).

Children’s Hospital Floor 5 (CH 5) Transitional Care Unit

Strengths have included the relationship with the Adolescent Eating Disorder Service. Last year the Eating Disorder Services provided a workshop for the staff of CH5. The training session was videotaped and has been incorporated into the orientation of the Unit for all new staff. The Unit perceives that its strengths are in providing a structured nutritional rehabilitation program that includes meal supervision. All staff has been trained to perform meal supervision.

It is perceived as a serious weakness that there is no formal inpatient service for children and adolescents with an eating disorder. At present there seems to be some question as to where people who require hospitalization would best be served; within PsychHealth Centre or within Children’s Hospital. Without formalizing the issue, it is thought that adequate care may not be provided. As well it is difficult to deal with the clients who are chronic in nature because they are not given services elsewhere. In regards to the clients: staff felt that it is difficult to make connections with the adolescents and as that relationship is established, the client may have to re-establish connections with staff at the Adolescent Eating Disorders Service. At the same time, the geographical separation of the Adolescent Eating Disorders Service and CH5 has also encountered some difficulty with splitting of staff. As well, as the clients on CH5 gain medical stability, the staff recognizes that they may lose therapeutic leverage. Finally, there is some systemic pressure for inpatient beds and the “appearance” of those with an eating disorder may not be seen as a priority for inpatient treatment.

The unit perceives an opportunity to develop an inpatient program for children and adolescents with an eating disorder. The unit stresses that the most critical issue is the formalization of inpatient services for this population and not where they are located geographically.
Description of Current Services in Winnipeg

Health Promotion

1. Manitoba Government, Department of Education: The department of Education has recently redone their outcomes for physical education and health for voluntary implementation in 2003. It has been stated that poor self-esteem is a major contributor to the onset of an eating disorder. While body image is not a major theme and is not mentioned directly until grade 8, other precursor themes are dealt with throughout the curriculum. As a sample of issues, the appendix lists the outcomes to be covered for kindergarten, grade 5 and grade 10 (Senior 2).

Examples: Kindergarten

a. Identify characteristics that describe self as special and unique (e.g., physical characteristics, abilities, gender...).
b. Identify daily decisions and/or choices (e.g., what to wear, eat, play; what is safe...) and how choices are made for health and well-being.
c. Identify what can happen when someone becomes angry (e.g., red face, tense muscles, loud voice, physical aggression...) and healthy ways to deal with anger (e.g., take time to think about it, talk to the person who made you angry, ask an adult for help, go for a supervised walk/run...).
d. Recognize the food guide rainbow and a variety of foods in Canada's Food Guide to Healthy Eating (CFGHE).
e. Recognize that you need food to grow and feel good.
f. Identify the need for daily food and fluid to support physical activity.

Grade 5

a. Identify qualities (e.g., honesty, support, reliability, common interests, loyalty, fairness...) that are important in establishing and maintaining a friendship.
b. Identify and assess strategies (e.g., using decision-making/ problem-solving process, saying "no" assertively, walking away/staying away, using conflict-resolution skills...) for preventing or avoiding uncomfortable or dangerous situations.
c. Identify how social and cultural influences affect sexuality and gender roles (i.e., similarities and differences, such as cultural rituals and traditions).
Grade 10

a. Assess **personal attributes and talents across a variety of domains** (e.g., academic, athletic, musical, artistic, interpersonal, intrapersonal...) and **assess how each contributes to self-esteem/self-confidence.**

b. **Apply stress management strategies** (e.g., mental imagery, relaxation skills, rest habits, focusing...) and **communication skills** (e.g., listen, comfort, seek help...) **for stress reduction for self and/or others in case scenarios related to stressful situations** (e.g., family breakdown, violence...).

c. **Demonstrate a knowledge of healthy lifestyles practices that contribute to disease/illness prevention, including mental illness/disorders.**

d. **Determine the nutritional value of a variety of foods** (e.g., fast food, fad diets, snack foods...) using Canada’s **Food Guide to Healthy Eating (CFGHE) and other resources.**

For a complete list of all grade outcomes kindergarten to senior 2 please go to the website listed:


2. The following is a list of membership Wellness Centres or programs that encourage healthy lifestyles including proper nutrition and exercise. None of these facilities have programs aimed directly at the prevention of eating disorders while they are focused on the general attainment and maintenance of health and prevention of disease and/or illness. As well, the websites provide links to other websites that focus on health and nutrition.

   a. The YM/YWCA focuses on providing some specialized program for women including a women’s retreat.

   b. The Kinsmen Reh-fit Centre offers programs generally focused on healthy lifestyle, targets coronary disease, osteoporosis.

   c. Max and Rose Rady Jewish Community Centre, no specific program. General programs offered to adults and youth.

3. Seven Oaks Wellness Centre offers general programs to promote healthy living. They offer three specialized programs: one for people who are over weight and one for children ages 9-12 and their parents that focuses on control attitude, nutrition, exercise and self-esteem. Another program entitled; “Health and Wellness Kids Style,” is a 10 week program for children ages 8-12 and their parents. The program focuses on how lifestyle choices affect health. Courses include nutrition education as well as participation in a variety of physical activities. Parents are taught how to encourage their children to practice a healthy lifestyle.
**Awareness of Disordered Eating/Eating Disorders and Prevention**

1. Eating Disorders Association of Manitoba has as its mandate:
   a. Health Promotion by setting up displays in various public places in the city (e.g. shopping centres and major health facilities).
   b. Speakers to schools and agencies in the community (e.g. Fort Richmond Collegiate, University of Winnipeg, Department of Psychiatry, University of Manitoba).
   c. Promote healthy lifestyles, self-esteem and acceptance of our natural self.
   d. Challenging societal and cultural values that contribute to the development of eating disorders.
   e. Work and seek any and all partnerships in the endeavour of health promotion and prevention of the development of eating disorders.

2. Women’s Health Clinic has offered services to women with a preoccupation of weight for 20 years. Their philosophy of *weight preoccupation* allows them to work with women along the entire continuum from poor body image to an eating disorder. Their services are all voluntary.

   WHC offers three presentation workshops:
   a. Body Image/Weight Preoccupation/Eating Disorder Prevention Workshop, delivered to girls in grade 4-12 (ages 9-18 years). The schools involved are from all Winnipeg school divisions (last year they spoke to 2001 students).
   b. A 12-week Prevention Program was developed and piloted on a grade 6 class of girls.
   c. Self-esteem Workshop-offered to girls in grades 4-12 in all school divisions.
   d. Coping with Stress Workshop-offered to girls in grades 7-12 in all school divisions.

   **All three workshops are offered to adult women in the community**

   They offer a large collection of resources that are available for borrowing.

3. Klinic Community Health Centre provides a full range of health related services from medical care to counseling to education. Their philosophy focuses on assisting clients to make choices for themselves and about their health. The service is open to all families, teens, children, adults and seniors.
The following are the services offered:

a. Health Services provided by physicians, nurses practitioners, community health nurses, social workers and dieticians.

b. Counselling Services-in-person counselling, drop-in counselling at Klinic and at community offices (Elmwood, Fort Garry, Seven Oaks and St. James).

c. Community Health and Education Services-volunteer programs such as peer training program, public education.

** All services for provided free of charge.

During the past year the Teen Talk Program has provided educational sessions on a variety of topics. Currently the Teen Talk Program delivers 14 different workshops, all of which include 3 common topics: body image, self-esteem and identity. Over the past year they estimate to have provided 12 workshops per day 3 times a week. They have talked with over 12,000 teens ages 14-19 years old. Of these workshops 85% of them are given within Winnipeg. The workshops are given to schools, treatment centers and at centers that work with youth with special needs.

This year the teen talk program has embarked on a 15th workshop on body image (Program Descriptions: Winnipeg, Appendix 3). They are planning to have this workshop in place for September 2003. There are a total of 6 people who staff the program; three full-time staff and three part-time staff.

4. The Winnipeg School Division, which is the largest public school division in the Province, uses the Manitoba Department of Education’s Health and Physical Education Curriculum. As well they have a health education consultant for the division. Issues related to body image are not part of the curriculum until grade 8. Within the grade 8 curriculum there is a prescribed outcome, K.5.8.C.1a “Evaluate information related to healthy body weight and body image.” There are suggested activities for instruction (please see Appendix or www.edu.gov.mb.ca).

In discussing the issue with the Health Consultant, she stated that there is no consistent information that is part of the curriculum. However, she does offer an optional workshop entitled, Body Image/Weight Preoccupation Workshop that has fluctuated in attendance from year to year. Attendance at certain workshops is mandatory while other workshops are optional. The workshop has been done in conjunction with the Woman’s Health Clinic. As well she stated that individual schools might include speakers into their Health Curriculum but that this varies from school to school.
Most of the other school divisions, Pembina Trails School Division, Louis Riel School Division, River East Transcona School Division, St. James-Assiniboia School Division or Seven Oaks School Division also do not have a mandated in-servicing or workshops for teachers. All school divisions use the Department of Education's Health and Physical Education Curriculum. As well all school divisions reported that individual teachers do explore the issue. This varies from school to school depending on the classroom, individual teacher and the resource teacher, guidance counselor or school counselor.

In discussion with the Director of Child Guidance Centre (CGC) within the division there are no divisional initiatives however, individual guidance counselors have developed an interest and specialization in the field e.g. Ms. Karen Dana who is a social worker at both Grant Park High School and Kelvin High School.

According to Ms. Dana, the focus on this area is dependent on the students’ raising this as an issue they feel requires attention. During this year Kelvin High School held several sessions on eating disorders and body image, which included a presentation from EDAM.

The independent schools deal with the issue of disordered eating/eating disorders similarly to the public schools. While talking with one school whose students are all females, they stated that they perceive this is an issue for their school and attempted to have a speaker from EDAM this past year. As well they have discussed the issue with the Health Consultant from the Winnipeg School Division. In planning for the following year they have scheduled a session with a speaker.

5. The Eating Disorder Treatment and Prevention Group of Manitoba is a private practice group that focuses on prevention and early intervention of eating disorders. According to the director, Ms. Shannon Gander, they use a cognitive-behavioural approach.

**Advocacy For Services**

Advocacy is an integral part of the mandate of Eating Disorders Association of Manitoba; their role in advocacy includes the following:

a. Obtaining local and national media attention to emphasize the seriousness and magnitude of this illness in young people.

b. Establishment of EDAM chapters throughout the Province of Manitoba.

c. Fundraising program events to support program initiatives.

d. Advocacy for services to the different levels of government and Health Authorities Advocacy for services to the different levels of government and Health Authorities.
e. Advocating for a coordinated community approach to treatment, awareness and prevention.

**Early Identification and Intervention**

1. Recognizing the positive effect that may occur with early identification and intervention EDAM:
   
a. Encourages collaboration and partnerships between all who are concerned and interested in the area of disordered eating and eating disorders.
   
b. Provides online resources and information for early identification.
   
c. Educating and disseminating information to families, health care providers, educators and the general public regarding the signs and symptoms of eating disorders (e.g. participating in the Manitoba Provincial Health Conference in the Fall of 2002, participation in a Forum at the University of Manitoba, Department of Psychiatry).
   
d. Seeking and participating in partnerships for the early detection and early intervention for people with eating disorders.
   
e. Maintenance of a provincial directory of services for people with an eating disorder (e.g. psychiatrists, psychologists, nutritionists, dieticians, social workers and school counsellors etc.).
   
f. Establishment of a lending library for articles, books and videos.
   
g. Establishment of a stress line for eating disorder patients.
   
h. A maintained website that offers information regarding early detection of an eating disorder, a resources list, internet links regarding eating disorders.

2. As a community-based agency, Women’s Health Clinic (WHC) may be one of the first places a women seeks assistance for mental health concerns. Given that eating disorders occurs disproportionately in women (90-95%) and that WHC is known for its long standing program for weight preoccupation, early identification is a priority for the agency.

a. Resources are offered to the public, books videos on weight issues, body image and nutrition.
   
b. Offers a suggested reading list comprised of books for dealing with weight preoccupation, body acceptance, body image, being healthy, fitness.
   
c. Sponsors and develops professional and community education events on the topic of weight preoccupation. They have sponsored events with noted experts such as Ms. Sandra Friedman.
3. The University of Manitoba, Department of Family Medicine offers a teaching resource entitled “Eating Disorders-A Self Instruction Unit.” This is a module designed to help the health professional to counsel patients with an eating disorder. The module is case-based, interactive format that helps health professionals design appropriate management plans that address diet-related issues, important education and counseling. The module uses references as well as provides additional reading material for professionals and the general public.

4. There are a variety of Internet resources aimed at encouraging early detection and intervention. Below is a list of the most commonly sited websites:
   
b. Eating Disorders Association of Manitoba Website-http://www.edam.mb.ca
d. Mirror-mirror http://www.mirror-mirror.org/
e. Westwind Eating Disorder Recovery Centre http://www.westwind.mb.ca/
g. Caring Online http://www.caringonline.com/

For more websites please see Treatment Resources, Appendix 6
Primary Care for Clients: Mild to Moderate

1. In terms of primary care WHC offers:

   a. Offers counselling related to weight preoccupation, body image and eating disorders. Services are offered free of charge or, for those who are able to pay there is the low cost counselling program (the clients decide how much they are able to pay for the service). Counselling to teens is provided free of charge.

   b. Weight preoccupation support groups are offered for women to share concerns and explore issues together about weight, body image, food and control. Groups for adult women are generally offered twice per year.

   c. Dietician offers individual nutritional counselling for women; the focus is on weight preoccupation and eating disorders. Nutritional Counselling is done at no charge.

   d. Medical Care physicians and nurse practitioners on a limited basis, consultation to people who have a health concerns related to anorexia or bulimia or poor eating habits.

2. Fort Garry Woman's Resource Centre is an agency funded through United Way and the Family Violence Prevention Branch of Family Services through the Province of Manitoba. The centre is open to all women in the city. Their focus is on violence against women and other women’s issues. Working from a feminist perspective, the agency works to empower women who are dealing with issues. They find that clients who have a low self-esteem and who are dealing with emotional issues may cope in a variety of ways, one of which may be through an eating disorder. They offer a “Body Image Group” on an as needed basis. The group is for 8-10 clients. (For a complete list of groups that are offered please see Program Descriptions: Winnipeg, Appendix 8).

   As well they offer different levels of counselling:

   a. One time individual counselling (1-3 sessions)
   b. Crisis Intervention (6-8 sessions)
   c. Short-term (up to 3 months)
   d. Long-term (up to 1 year)

In their experience they find that the women they work with may have an eating disorder associated with other difficulties such as abuse, violence, poverty, compulsive behaviour, drug and alcohol use.
The Centre also operates what they term “backdoor programs” where clients are involved with the centre in a less formal more casual type of relationship through programs such as:

a. Clothing  
b. Crafts Corner  
c. Mom Drop In

The Fort Garry Woman’s Resource Centre works with 2 other “sister” agencies in the city: The North End Woman’s Resource Centre, in Winnipeg’s north end, and Pluri-Elle Centre in St. Boniface.

3. The staff of the Laurel Centre see approximately 300 clients per year. They work with clients who have an eating disorder or disordered eating in conjunction with dealing with having been sexually abused. Their services are offered free of charge.

4. Klinic Community Health Centre offer a wide variety of counselling services. Although they do not have an identified clinic that deals specifically with people with weight issues, they do counsel women and men on a variety of issues that may include concerns about weight and shape.

5. From time to time MacDonald Youth Services runs a group for young women struggling with body and weight issues. The group is entitled “Our Voices” and targets teenage women between the ages of 14 and 16 years old. The group is a time-limited group for about 12 weeks. The criteria for the group includes those women who do not meet the criteria for an eating disorder as stated in the Diagnostic and Statistical Manual IV but are attempting to deal with one or more of the following issues:

a. Body dissatisfaction  
b. Food and weight preoccupation  
c. Feeling fat  
d. Fear of becoming fat  
e. Unhealthy weight loss strategies

The teen perceives that one or more of these issues are negatively affecting their ability to live a pleasurable life.
6. Eating Disorder Treatment and Prevention Group of Manitoba is a private practice counselling group that has developed a special interest in working with people with an eating disorder or disordered eating. The clinic offers a cognitive-behavioural approach for treatment of eating disorders and body image issues through individual therapy, group therapy and family therapy. All clinicians operate on a fee for service basis. The group includes clinicians from a variety of backgrounds:

a. Dr. Vivan Rowan (Ph.d., C.Psych) works with people with Obsessive Compulsive Disorder, often a co-morbid diagnosis with an eating disorder.

b. Sandra Thompson (Ph.d candidate) works with people with an eating disorder and weight preoccupation. As well she specializes in violence in relationships.

c. Shannon Gander (BPE) focuses specifically on people with an eating disorder or disordered eating.

7. The following is a sample of private practice clinicians who offer services to clients with disordered eating or an eating disorder:

a. Dr. Lillian Esses (Psychologist) works with approximately 15 clients with either disordered eating or an eating disorder per year. Treatment may be as short as 5 sessions or as long as a year. She charges $110.00 per hour.

b. Janice Hirst (Masters of Arts). She operates a clinic with 3 colleagues. She sees approximately 6 clients with either disordered eating or an eating disorder per year. She charges $64.20 per hour.

c. Ms. Lucille Meisner (MSW, RSW) provides services for people with anorexia nervosa, bulimia nervosa, emotional eaters and athletes who have eating issues. Generally she sees 4-6 clients per week with disordered eating or an eating disorder. She typically does not do the monitoring of weight but has several physicians with whom she works collaboratively. The majority of her clients are in the mild to moderate range. However, some of her work is with clients who are more severe, and for those clients she works with them until they have been admitted to hospital or to the Adult Outpatient Program at Health Sciences Centre.
Secondary Care for Clients: Moderate

Paediatric Adolescent Clinic is a paediatric/adolescent satellite program of Children’s Hospital. There are three physicians who are at the clinic part time. The two primary physicians are Dr. Maureen Collison and Dr. Susan Collison who see approximately an average of 10 patients a week with eating disorders. The third physician is Dr. Margo Lane. The clinic sees only patients who have been referred by their primary care physician. These physicians are also involved with the inpatient care of children and adolescents with eating disorders on CH5.

Tertiary Care for Clients: Severe

Services for Children and Adolescents:

Both the Adolescent Eating Disorders Day Hospital Program and the Adolescent Eating Disorders Outpatient Program are located at the PsycHealth Centre, Health Sciences Centre. The Child and Adolescents Eating Disorder Service initially developed three main goals for their service:

a. To develop a centre for excellence in the areas of assessment, treatment, prevention, education and research of eating disorders
b. To provide a continuum of clinical service delivery which matches the client’s treatment needs with the appropriate services offered
c. To develop a community outreach component aimed at early intervention with high-risk youth.

The Service currently offers two Programs as well as a small amount of outreach, primarily done by a social worker who provides services on a part-time basis. It is unclear at this time how much public education or research has been able to be initiated by the service. It should be noted that the Service has been operational for approximately two years and that many of the staff are not only new to the area of eating disorders but are also fairly new to their respective professions. As well the service has experienced a change of physician during this time period. In meeting with several of the professional staff they have clearly learned a tremendous amount during the past two years and seem to now be confident to change aspects of the service delivery to meet their clients’ needs. One fundamental concept that was stated several times was the need to be flexible in order that the needs of clients may be met.
1. Adolescent Eating Disorder Day Hospital Program is a group-based program for children and adolescents ages 12-17 years. The maximum number of patients at any one time is eight. The program is primarily group-based although some clients do receive individual therapy based on their needs and/or requests. The clients attend five days a week from 8:00 a.m. till 6:00 p.m. (Monday to Friday) and return home for evenings and weekends. The Service offers nutritional rehabilitation, academic studies on site, several therapeutic groups and family therapy. The morning program is a combination of meal support and school. The afternoon begins with lunch/meal support and continues with a variety of groups such as:

   a. Relaxation Group
   b. Community Meeting
   c. Creative Arts/Music Group
   d. Body Image
   e. Power Within
   f. Recreation Group

The day concludes with supper/meal support.

All patients and families are expected to participate in the program. Family involvement is seen to be a key component of the program. The family involvement may take many forms such as:

   a. Why Weight psycho-educational group (Treatment Resources, Appendix 3)
   b. Emergency meetings
   c. Participate in prognosis and discharge planning
   d. Attendance at family therapy sessions
   e. Attendance at parent support group

For complete details for the Eating Disorders Day Hospital Program please see Program Descriptions: Winnipeg, Appendix 11.

2. Child and Adolescent Outpatient Program offers individual psychotherapy, nutritional counselling, family therapy and treatment groups. As well individuals and families may access the following groups:

   a. Psycho-educational Group is offered to support clients and their parents or caregivers by educating them on the process of change and eating disorders.
c. Parent Support Group designed to help family members understand and cope with an eating disorder, share strategies, and provide mutual support.

3. Children’s Hospital Floor 5, Transitional Care Unit(CH5) provides inpatient care to patients with an eating disorder who are medically unstable with a weight that is 70% or lower of their ideal body weight and poor vital signs. The focus is on establishing medical stability and re-feeding. The number of eating disordered patients on the unit at a given time fluctuates with an average of three to four patients. At one point this past year the unit had admitted seven clients with eating disorders. The average length of stay on the unit for this population is two to three months. The length of stay on CH5 for the majority of patients other than those with an eating disorder is three to four weeks. The unit has provided services to children as young as 10 years old with a severe eating disorder.

The unit is closely associated with the Adolescent Eating Disorder Services at the PsycHealth Centre. The two programs have established a strong connection and partnership. Liaison between the two programs includes the manager of patient care and a physician from CH5 attending rounds at PsycHealth Centre once per week. As well patients who are in need for counselling/therapy while on CH5 receive care from a psychiatrist from the Eating Disorder Service.

Discharge is typically dependant on the client’s weight. Those patients who are attending the day treatment program at the PsycHealth Centre may be discharged when they reach 85% of their ideal body weight while those who are not connected to this program are discharged when they reach 90% of their ideal weight.

Services for Adults:

The services for adults with an eating disorder are within the Eating Disorder Program, Adult Mental Health Program, at Health Sciences Centre. The adult eating disorder program offers both inpatient and outpatient services. Both services follow the American Psychiatric Association Practice Guidelines that were published in 2000 (Reference Information/ Evidenced-based and Best Practices Literature, Appendix 7).

The Program has three general goals:

a. Provide assessment and treatment to people suffering from anorexia nervosa or bulimia nervosa.
b. Educate the public, professionals, patients and their families about eating disorders.
c. Provide consultation and recommendations to other mental health professionals.

A referral from a family physician is required. Assessments of patients are prioritized according to the severity of individual’s medical and psychological difficulties. The program is voluntary and patients must take an active role in their treatment.

1. The outpatient program uses a case management service delivery model. Primarily using a cognitive-behavioural approach, the program offers individual therapy that aims to: increase insight, self-esteem and awareness of feelings as well as improve coping skills. The outpatient program is open Monday to Friday from 8:00 a.m. to 4:30 p.m.

Nutritional counselling and rehabilitation is an essential component of treatment. The focus is on establishing healthy eating patterns based on Canada’s Food Guide and achieving and maintaining a healthy body weight. Therapy groups are also offered as part of the program. A list of group sessions that may be offered as part of the treatment program include:

a. Cognitive Behavioural Group
b. Nutrition Group
c. Life Skills Groups (Stress Management, Anger Management, Self-esteem and Assertiveness Training)
d. Body Image Group
e. Family Education

2. Inpatient treatment is recommended when an individual is medically unstable or unable to make significant changes as an outpatient. There are three inpatient beds that are designated for patients with eating disorders. Typically only those clients with anorexia nervosa require inpatient service.

Inpatient and outpatient treatment approaches include:

a. Individual therapy
b. Group therapy
c. Nutrition counselling and rehabilitation
d. Skill development
e. Pharmacotherapy
f. Family/Marital therapy
Private Intensive Residential Program:

Westwind Eating Disorder Recovery Centre is a Private (fee for service) Treatment Centre intensive residential program treatment centre located in Brandon, Manitoba. Typically 40% of their clients are from the City of Winnipeg. Another 20% of clients are from the rest of Canada and the remaining 40% are from the United States. They offer residential treatment for people with anorexia nervosa and bulimia nervosa. The patients stay somewhere between six weeks to five months depending on their needs and desire.

For a more complete program description Program Descriptions: Winnipeg, Appendix 13.

Their program uses motivational theories, cognitive-behavioural therapy, solution-focused therapy and interpersonal therapy. As well, the program offers Christian-based spiritual counselling if desired. The program partners with family physicians in the community for medical monitoring. Although the program is residential it operates five days a week. The client is charged $250.00 per day, five days a week ($1250.00 per week) although most clients reside at Westwind seven days a week.

Treatment consists of either individual and/or group sessions. Psychotherapy uses a problem solving/skill building model, examining a client’s strengths and building on them. Issues addressed include:

- Self-worth
- Problem solving/coping skills development
- Nutrition education
- Awareness of biological/medical consequences
- Body Image and attitudes toward weight and shape
- Appropriate Exercise
- Stress Management
- Relationship/Family dynamics
- Weight controlling behaviours such as dieting and purging

The program is a 12-hour per day treatment program, which includes all meals and snacks. The average stay for a patient with bulimia nervosa is six to eight weeks. Westwind provides follow-up for one year.
PROPOSED CONCEPTUAL FRAMEWORK OF SERVICE DELIVERY

The exploration of disordered eating and eating disorders has been developed within an adapted Primary Health Care Model (World Health Organization) that offers a continuum of options for services to better meet the needs of individuals and their families. People with disordered eating and/or an eating disorder are at various stages of the illness and require different types of services depending on their specific circumstances. A model must include a wide range of services to meet the client’s needs. This model incorporates a full range of services offered along a continuum from prevention/promotion to supportive services. The primary health continuum as it relates to disordered eating/eating disorders is presented below along with examples.

Promotion | Prevention | Curative | Restorative | Supportive
---|---|---|---|---
Focus on health and physical fitness through health and physical education classes and recreation facilities. | Discussions/presentations activities that encourage exploration of issues regarding, body image, self-esteem and myths of the media with children beginning in elementary school and continuing through to high school. | Treatment aimed at recovery from an eating disorder/disordered eating. | Restoration of normal physiological functioning (menstruation and weight). Return to everyday functioning including school, work and play. | Supportive work to prevent relapse.

Inherent in this model are several key principles that have been borrowed from the Primary Health Care Model:

- Viewing the individual with disordered eating/eating disorder as a whole being from the physical, spiritual, emotional and intellectual perspective
- Relying on the diversity of trained workers functioning as a multidisciplinary team to collaborate with individuals
- Moving towards local integration of services for those with disordered eating/eating disorder
- Health care for people with disordered eating/eating disorder is intersectoral including all sectors that are relevant to the client (e.g. health, education, family services and employment)
- The issues of promotion, awareness prevention and curative (treatment) and supportive are addressed within a community from a community perspective and has community involvement
- It has the principles of equity and is affordable
## Continuum of Disordered Eating

<table>
<thead>
<tr>
<th>I. Body Image Acceptance</th>
<th>Body Image Dissatisfaction</th>
<th>Food/Weight Preoccupation</th>
<th>Emotional Eating</th>
<th>Anorexia, Bulimia, Compulsive Overeating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating due to body’s own needs</td>
<td>“Feeling fat”</td>
<td>Frequent dieting</td>
<td>eating when sad, happy, stressed</td>
<td>starvation</td>
</tr>
<tr>
<td>Listening and responding to hunger signals</td>
<td>Not satisfied with appearance</td>
<td>Yo-yo dieting</td>
<td>eating for no reason</td>
<td>self-induced vomiting</td>
</tr>
<tr>
<td>Comfort with Food</td>
<td>Occasional dieting</td>
<td>Preoccupation with food, weight</td>
<td>out of control eating</td>
<td>use of laxatives and/or diuretics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>fasting</td>
<td></td>
<td>guilt or shame associated with eating</td>
</tr>
<tr>
<td></td>
<td></td>
<td>excessive exercise</td>
<td></td>
<td>compulsive exercise, steroid use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>loss of control</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### A Continuum of Prevention

<table>
<thead>
<tr>
<th>III. Body Image Acceptance</th>
<th>IV. Self Acceptance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary prevention</strong></td>
<td><strong>Secondary prevention</strong></td>
</tr>
<tr>
<td>Healthy lifestyles</td>
<td>all those mentioned in primary prevention</td>
</tr>
<tr>
<td>Development of self esteem</td>
<td>Recognize and address gender differences in the experience of disordered eating</td>
</tr>
<tr>
<td>Love of self and body</td>
<td>Provide places for voices to be heard</td>
</tr>
<tr>
<td>Respect for the right of children and youth</td>
<td>Train medical and mental health practitioners</td>
</tr>
<tr>
<td>Support of social action that promotes acceptance of diversity</td>
<td>Eating disorder awareness into all schools</td>
</tr>
<tr>
<td>All community involved in development of programs</td>
<td>Concerted effort to change societal influences</td>
</tr>
<tr>
<td>Recognize the unique needs of children/youth and families</td>
<td>Safe environments for people to develop relationships that ensure their voices are heard</td>
</tr>
<tr>
<td>Encourage peer support and positive modelling</td>
<td>Harnessing peer culture for positive change</td>
</tr>
<tr>
<td>Support schools and workplaces in creating conditions for healthy development of young people including a culture of caring, respect, acceptance and belonging</td>
<td>Prevention programs beginning in elementary programs</td>
</tr>
<tr>
<td>Ensure that school based programs involve consistent combined efforts of the entire school and the larger community</td>
<td>Encourage communities to challenge negative societal norms and exposing the media</td>
</tr>
<tr>
<td>Programs that encourage healthy choices</td>
<td><strong>Tertiary prevention</strong></td>
</tr>
<tr>
<td>Promote community responsibility and support communities in defining and creating conditions for the healthy development of the children and youth</td>
<td>Community treatment centre</td>
</tr>
<tr>
<td>Helping children youth and adults deal with developmental issues that bring changes in their lives</td>
<td>Inpatient/outpatient/day treatment or residential treatment</td>
</tr>
<tr>
<td>Strengthening resiliency</td>
<td>Primary Health, family physicians, psychologist and other private practice</td>
</tr>
<tr>
<td></td>
<td>Centre of excellence</td>
</tr>
</tbody>
</table>
A Model for Prevention

Taken from Preventing Eating Disordered Eating-A Manuel to Promote Best Practice

1. Society

- Spirituality/Religion
- Age
- Sexual Identity/Orientation
- Gender
- Abilities/Disabilities
- School/Workplace
- Language Practices

PERSON

- Family
- Community
- Socio-economic Status
- Culture/Ethnicity

Society
RECOMMENDATIONS AND IMPLEMENTATION PLAN

In the first year it is recommended that:

1. A regional eating disorders coordinator is hired for the Winnipeg Region and forms a body image network to include representation from all those working with and interested in disordered eating/eating disorders in Winnipeg.

2. The Regional Coordinator would be responsible to initiate discussions with Manitoba Health regarding the development of provincial coordination of services led by a provincial coordinator.

3. The Regional Coordinator would be responsible to gather the network two times per year at minimum. The network would meet initially for a meeting to share information regarding services, theoretical perspectives and upcoming educational opportunities. The second meeting would be for an educational day.

4. The Regional Coordinator would be responsible to initiate the development of a respect and understanding among the many health care providers throughout the Region regarding the many treatment options and treatment philosophies available to people.

5. The Regional Coordinator would be responsible to ensure body image network members are aware of all educational opportunities concerning eating disorders/disordered eating. This would include educational opportunities in the City of Winnipeg as well as outside of the city. This may be done in a variety of ways e.g. newsletter, email etc.

6. Immediate researching and dissemination of motivational enhancement therapies for anorexia nervosa. Resources regarding motivational enhancement therapy to be made available to those working with people with anorexia nervosa. If possible, resources would be made available for a small number of professionals to attend training sessions on the topic or an expert may be invited to Winnipeg to train those professionals in the city.

7. Initially using the resources provided by this consultation, regular and ongoing updating of evidenced-based material and best practices material concerning disordered eating/eating disorder to be collected and be easily available to health care providers.

8. To avoid lengthy waiting lists, exploration of methods to increase the ability of the Adult Eating Disorders Program to assess and treat more clients.
In the second and third years it is recommended:

1. To initiate the process of offering training to primary care physicians and other health care professionals in the Region. The focus of the training would be on the early identification and primary care of people with disordered eating/eating disorder.

2. To begin to work inter-sectorally to focus on primary and secondary prevention including relapse prevention. Such an initiation should include, but not be limited to: Health, Education and Family Services.

3. To formally develop a community-based prevention program carried out by those in the community: self-help groups, advocacy groups, community-based treatment agencies, clients and their families. Planning of a prevention program should consider the experiences of experts in the field as well as those working in the secondary and tertiary care systems.

4. To collaborate with current resources such as EDAM, Klinic Community Health Centre and the Women’s Health Clinic and organize a yearly campaign of awareness and prevention within elementary, middle and high schools. Where possible using the available prevention programs (Health Canada’s Vitality Program, Prevention Curriculum developed by the Alberta Mental Health Board Prevention Program) and encouraging that programs be implemented by teachers in the school system from grades 1-12 with a focus on beginning the programs as early as possible.

5. To begin to develop and make readily available a list of treatment resources in an easily accessible and readable format (e.g. Resource for People with Fetal Alcohol Syndrome).

6. To assist teachers, parents, children’s activity groups etc. in getting education materials for self-teaching as well as support for those teaching the information to children.

7. To initiate contact with parallel services across Canada for future networking and sharing of information and resources.

8. To increase the amount of training about disordered eating and eating disorders available to professionals thus enhancing access to services.

   a. Increase amount of training within professional curriculums (e.g. undergraduate medical training, residency programs, psychology programs, nursing programs, occupational therapy programs, education programs and human ecology programs).
b. Increase opportunities for continuing education certification (e.g. the University of Manitoba, and Red River Community College offer an applied counselling certificate for addictions as well as for family violence, perhaps a certificate in eating disorders could be initiated?).
c. Increase education for primary care physicians and public health nurses and others who are first line caregivers.
d. Continuing education for health professionals in practice through a mentorship program or train the trainers program.

9. To identify and promote the appropriate use of specific Internet websites for people of all ages. For example, encourage schools to provide specific links on their school websites to helpful websites.

10. To provide greater primary and secondary prevention to be aimed at both boys and girls in elementary schools. The focus in elementary school should be on reducing the risk factors and increasing the protective factors for an eating disorder. Physical education programs should work hard to include all students and to ensure the program is contributing to self-esteem.

11. To monitor resources focused on anorexia nervosa specifically to deal with the inherent denial that is the hallmark of the disease.
REFERENCES


University Health Network: Toronto General Hospital Eating Disorder Program. *Information and Overview*. Toronto: Author.


