Eating Disorder Inpatient Treatment

Proposal for Inpatient Treatment | Eating Disorder Working Group
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Executive Summary

At any given time in Canada, 600,000 to 990,000 Canadians may meet the diagnostic criteria for an eating disorder, primarily anorexia nervosa, bulimia nervosa, or binge eating disorder\(^1\). Eating disorders are characterized by “a persistent disturbance of eating or eating-related behaviour that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning.”\(^2\) Eating disorders are associated with life-threatening medical complications and a mortality rate higher than any other psychiatric disorder. It is estimated, anorexia nervosa and bulimia nervosa combined, result in between 1,000-1,700 deaths annually in Canada\(^3\).

While the Newfoundland and Labrador system offers some services and supports across the continuum of care for eating disorders, there is a serious gap at present. This gap relates to the lack of dedicated specialized inpatient treatment services for adult patients with eating disorders. As outlined in detail in the report, such services are urgently needed for individuals who are medically compromised and unresponsive to out-patient treatment.

This $1.4M proposal includes: a new 4 bed specialized eating disorder program to be located at the General Hospital Psychiatry Unit at the Health Sciences Centre; a full multidisciplinary team to provide specialized treatment as well as consultation to other services within Eastern Health and across the province; and a clinical leadership position to ensure strong coordination of all eating disorder services; thereby providing a smooth transition from inpatient to outpatient care and continuity of care for individuals with eating disorders and their families.

Given the costs associated with out of province treatment, the demonstrated need which, unfortunately, is projected to increase and the potential that exists to provide high quality care to people diagnosed with the highest mortality rate of any mental illness, the working group strongly encourages the establishment of an inpatient unit as soon as possible.

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Introduction

Eating disorders are complex psychiatric disorders that have a devastating effect on both the individuals who experience these disorders as well as their families and loved ones. Eating disorders negatively impact a person’s emotional and physical health, and social and occupational functioning, as well as cause serious impairments in quality of life.

Eating disorders frequently occur alongside other mental health disorders, most commonly depression and anxiety. While the symptoms revolve around eating, they are more about coping with feelings and deep-seated insecurity than they are about food. Restricting food may be used as a way to feel more in control or to manage emotions such as shame, insecurity and anxiety. Purging may be used to relieve guilt and deal with the fear of weight gain. Overeating may be used to soothe depression or ease tension and stress. The most common types of eating disorders are anorexia nervosa, bulimia nervosa and binge eating disorder. This proposal will address the continuum of services for anorexia nervosa and bulimia nervosa, which are the types of eating disorders that usually require an inpatient admission.

In August 2015, the Minister of Health and Community Services established a working group in response to concerns raised by individuals, families, service providers and the Eating Disorder Foundation of Newfoundland and Labrador that specialized inpatient treatment is urgently needed for individuals experiencing severe eating disorders who are medically compromised and unresponsive to outpatient treatment.

The working group consists of representatives from the Department of Health and Community Services, Eating Disorder Foundation of Newfoundland and Labrador, Eastern Health, Memorial University of Newfoundland and Labrador and family representatives. The mandate

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Primary Types of Eating Disorders

According to the House of Commons’ Report of the Standing Committee on the Status of Women, eating disorders are defined as “a form of mental illness characterized by a persistent disturbance of eating or eating-related behaviour that results in altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning”. Three specific disorders are:

Anorexia nervosa, which is characterized by distorted body image and severe dietary restriction that lead to significantly low body weight in the context of age, sex, development and physical health, accompanied by an intense fear of gaining weight.

Bulimia nervosa, which is characterized by recurrent episodes of eating an excessive amount of food and losing control during that episode, which is called a binge, followed by purging behaviours, such as self-induced vomiting or misuse of laxatives, in order to avoid weight gain.

Binge eating disorder is characterized by recurrent episodes of consuming an excessive amount of food in a short period of time, without purging behaviour, and is accompanied by feelings of embarrassment, self-disgust, loss of control and distress.

of the working group is to identify best practices, scope of the problem and possible solutions or next steps for the successful establishment of a specialized eating disorder inpatient treatment program for adults.

This proposal will outline the issues people with eating disorders in this province experience, gaps in service delivery for those too sick to attend outpatient programs and a recommendation for a 4 bed specialized unit within the General Hospital Psychiatry Unit; and strengthening the coordination of all eating disorder services across the continuum of care.

**Defining the Problem**

Eating disorders involve extreme behaviors, feelings and attitudes about weight and food. They can develop when a person thinks about weight and food so much that it begins to control their life and causes a person to adopt harmful eating habits. People with eating disorders engage in extreme food restriction, excessive exercise, self-induced vomiting and laxative abuse in order to control their weight. These behaviors are driven by an obsession with control over eating and weight that stems from low self-esteem and extremely distorted thinking patterns. Due to the serious negative effects of malnutrition and purging behaviors on psychological and physical health, renourishment and supportive counselling are the first steps in treatment for eating disorders.

Eating disorders can affect people of all ages, shapes, sizes, genders and ethnic backgrounds, while they most commonly begin in adolescence, they are also seen in older adults and children\(^5\). Anorexia Nervosa usually develops in early adolescence, but over 50% of cases have an illness persisting for over 7 years and extending into adulthood. Available research indicates anorexia relapse rates are high at 35% over what can be a 7 year recovery time-frame resulting in frequent and more intensive treatment protocols\(^6\). Researchers have established that 10% of individuals diagnosed with anorexia nervosa will die within 10 years of diagnosis and the overall mortality rate for anorexia nervosa is estimated at 15%\(^7\).

Eating disorders are widely acknowledged to be one of the most challenging psychiatric disorders to treat. Many people have been sick for years before seeking help; therefore the disorder and accompanying behaviours are often entrenched and severe. Also, cognitive functioning is negatively impacted due to the effects of starvation and being underweight, making the engagement of people with severe eating disorders very challenging, especially during the first few weeks of treatment. People with eating disorders are typically terrified to

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stop their extreme food restriction despite being dangerously malnourished and often underweight.

Research from the Toronto General Hospital Eating Disorders program has shown increasing motivation to change and engaging people in treatment during the first four weeks of inpatient treatment is critical to a good outcome\(^8\). Increasing motivation needs to occur alongside renourishment and medical care. The person’s ambivalence about change is part of the illness and must be addressed during treatment. Therefore, intensive strategies to build motivation to change, and engage individuals in the treatment process are needed early on in treatment.

Eating disorders are also associated with greater health care costs and lower rates of employment and earnings\(^9\). Living with an eating disorder can result in a significant financial burden for the individual, their partner, and family members. Many individuals with eating disorders will at some point in their lives rely on disability or employment insurance for income. For other individuals, seeking treatment is not an option as they cannot afford the financial cost of leaving their jobs. The great financial burden placed on individuals and families who are caring for someone, often children – young or grown up with an eating disorder, can result in financial instability and increased economic costs\(^10\).

**Eating Disorders in Newfoundland and Labrador**

The statistical data in the following Tables 1-4 is provided to begin the process of understanding eating disorders in this province; however, caution must be taken when considering the data. Current eating disorder data does not accurately demonstrate the full scope and impact of the illness due to the nature of, and manner in which, the data is currently being collected.\(^11\) It is the belief of this working group that this holds true for data in Newfoundland and Labrador.

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Rigorous data collection techniques are needed to produce valid and reliable data to inform practice decisions and policy development. For countries like Australia and Malaysia, the development of a central registry in mental health has proven useful in research and clinical management by providing epidemiological analysis, comorbidity studies, outcome studies, association studies and quantitative analyses. Newfoundland and Labrador currently does not have a registry for the population diagnosed with eating disorders. There is also no single data collection system which can give an accurate picture of the prevalence or incidence of eating disorders; therefore, from an epidemiological perspective, data linkage using two or more data systems may provide some insight into the prevalence/incidence of eating disorders.

In 2002, Health Canada’s Canadian Community Health Survey added several eating disorders questions to its survey for the 2002 year only and stated there were over 7,500 cases of eating disorders in Newfoundland and Labrador. The Eating Disorders Foundation, based upon its experience in responding to families and individuals affected by eating disorders and consistent with the literature, indicates this is likely an underestimate as many individuals do not come forward for treatment due to stigma as well as the nature of the illness which is characterized by denial. The 2014 Report of the Standing Committee on the Status of Women estimates 990,000 cases across the country. Furthermore, the criteria for making a diagnosis of anorexia nervosa was changed in the latest edition of the Diagnostic and Statistical Manual V for Mental Disorders (DSM V, 2013) which will lead to the diagnosis being made earlier and possibly more frequently.

Referrals for eating disorders have increased for both youth and adults in Eastern Health and Western Health (Central Health and Labrador Grenfell Health have not collected data to identify changes). Referrals for eating disordered clients to Western Health outpatient services more than tripled between 2011 and 2012 from 7 referrals to 24. There were no increases to inpatient admissions.

In the past few years, referrals to the Renata Elizabeth Withers Centre for HOPE (HOPE Program) have been increasing. In 2013, there was an increase by 20 referrals and in 2014 there was an increase by 26 referrals. The HOPE program currently has a two month waitlist.


Identified Data Systems

- Hospital Inpatient (Clinical Database Management System/out-of-province; CIHI’s Portal – DAD)
- NLCHI Mortality System
- MCP Fee–for-Services Physician Billing
- Canadian Community Health Survey
- Client Referral Management System
- Canadian Chronic Disease Surveillance System

Please see Appendix A for further details. Source: Newfoundland and Labrador Centre for Health Information
Although there has not been a significant increase in the number of referrals to Eastern Health for eating disorders services, there has been an increase in the number of visits.

Table 1: Unique Individuals Referred to the HOPE Program by Fiscal Year:

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>133</td>
</tr>
<tr>
<td>2010</td>
<td>102</td>
</tr>
<tr>
<td>2011</td>
<td>119</td>
</tr>
<tr>
<td>2012</td>
<td>93</td>
</tr>
<tr>
<td>2013</td>
<td>113</td>
</tr>
<tr>
<td>2014</td>
<td>139</td>
</tr>
<tr>
<td>2015</td>
<td>141</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>840</strong></td>
</tr>
</tbody>
</table>

Table 2: Number of Diagnosis by fiscal year for acute care hospitalizations, Newfoundland and Labrador.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia nervosa</td>
<td>9</td>
<td>12</td>
<td>12</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>Bulimia nervosa</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Other eating disorders</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Eating disorder unspecified</td>
<td>9</td>
<td>10</td>
<td>12</td>
<td>16</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>22</td>
<td>31</td>
<td>30</td>
<td>36</td>
<td>31</td>
</tr>
</tbody>
</table>

*Includes acute care hospitalizations only.

**Frequencies are based on total number of patients. A single patient hospitalized multiple times during the fiscal year would have been counted only once.

***Cells with -- are suppressed due to low numbers.

Table 3: Number of Hospital Separations and Number of Unique Patients Hospitalized with an Eating Disorder Diagnosis, Newfoundland & Labrador, 2006/07-2013/14

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Number of separations with an eating disorder diagnosis (percent of total acute hospital separations)</th>
<th>Number of patients with an eating disorder diagnosis (percent of total hospitalized inpatients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>61 (0.12%)</td>
<td>39 (0.11%)</td>
</tr>
<tr>
<td>2007/08</td>
<td>42 (0.08%)</td>
<td>31 (0.08%)</td>
</tr>
<tr>
<td>2008/09</td>
<td>60 (0.12%)</td>
<td>40 (0.11%)</td>
</tr>
<tr>
<td>2009/10</td>
<td>54 (0.10%)</td>
<td>43 (0.12%)</td>
</tr>
<tr>
<td>2010/11</td>
<td>67 (0.13%)</td>
<td>39 (0.10%)</td>
</tr>
<tr>
<td>2011/12</td>
<td>78 (0.15%)</td>
<td>50 (0.13%)</td>
</tr>
<tr>
<td>2012/13</td>
<td>55 (0.10%)</td>
<td>41 (0.11%)</td>
</tr>
<tr>
<td>2013/14</td>
<td>80 (0.15%)</td>
<td>60 (0.15%)</td>
</tr>
</tbody>
</table>
The above data only includes hospitalizations of residents of Newfoundland and Labrador and a single individual may have had more than one hospital separation due to eating disorder during the fiscal year. Hospital separations with an eating disorder diagnosis refer to any acute care hospital separation with one or more of the following ICD-10-CA codes recorded in any diagnosis type (i.e., may not be the main reason for the hospitalization):

- F50.0 Anorexia nervosa
- F50.1 Atypical anorexia nervosa
- F50.2 Bulimia nervosa
- F50.3 Atypical bulimia nervosa
- F50.4 Overeating associated with other psychological disturbances
- F50.5 Vomiting associated with other psychological disturbances
- F50.8 Other eating disorders
- F50.9 Eating disorder, unspecified

The Canadian Centre for Health Information (CIHI) identifies admissions to hospital for various types of eating disorders are increasing. The data collected by CIHI, however, does not include repeat admissions in the same year, and therefore, is likely an underestimate of the total number of admissions. Also, it is important to note that many people who should be hospitalized are not for a variety of reasons (stigma, denial, shame, etc.).

Between 2011 and 2015, 25 referrals were approved by the Department of Health and Community Services for out of province treatment for an eating disorder at an estimated cost of $1,266,500. It should be noted, these referrals reflect only those who received funding from government for out-of-province treatment for eating disorders, not the actual number of people who received treatment out of province. The working group is aware that individuals may have received treatment for an eating disorder out of province and paid for it through other means.

Existing Eating Disorder Treatment Services in Newfoundland and Labrador

In Newfoundland and Labrador, individuals with eating disorders and their families can avail of support and treatment services from the community, regional health authority or through an out-of-province treatment facility.

Community Outreach
The Eating Disorder Foundation of Newfoundland and Labrador was formed in 2006 and is the province’s only community outreach group dedicated to promoting research and providing public support services and information about matters related to eating disorders. The Foundation offers client and family consultations, support groups for individuals and families, workshop seminars and community presentations. It acts as a resource to support system navigation and coordinates treatment paths. The Foundation is also a strong community advocate for mental health services. It was a key player in the establishment of Eastern Health’s
Renata Elizabeth Withers Centre for HOPE (HOPE Program) and is currently advocating for the establishment of an adult specialized eating disorder inpatient treatment unit for Newfoundland and Labrador. The Foundation provides extensive education and support for individuals and families who, in most cases, contact the Foundation first for direction on how best to access and obtain available treatment and related support services. Some of the Foundation’s programs are as follows:

- **Client and Family Consultation**: Provision of support or guidance
- **Families Supporting Families**: Information session on eating disorders
- **Bridge to Hope Education & Support Group**: An eight week program (one night a week) providing support, education and hope to those who are assisting their loved ones on the journey to wellness
- **Emotion-Focused Family Therapy**: A two-day workshop where parents and caregivers are educated on mastering the skills and tasks needed to assist a loved one with an eating disorder
- **Let’s Talk Eating Disorders School Program**: Offers presentations to teachers of the signs/symptoms and how to recognize and help students who may have an eating disorder
- **Public Awareness & Education Presentations**: Available on request
- **Resource Center**: Contains extensive need-to-know information
- **Workshops**: For families and clinicians utilizing eating disorder specialists
- **Siblings of HOPE Program**: Designed to support siblings of persons with eating disorders

**Regional Health Authorities**

The province’s four regional health authorities offer outpatient counselling and support for individuals and their families experiencing eating disorders through their mental health and addictions programs. For individuals who are medically unstable and require medical treatment, regional hospitals admit patients with eating disorders into medical and/or psychiatric inpatient beds. There are no dedicated or specialized inpatient treatment beds for eating disorders available with the regional health authority medical or psychiatric inpatient beds.

Eastern Health manages two provincial programs which offer outpatient treatment for individuals with eating disorders. The provincial services include the Janeway Adolescent Medicine Program and the Renata Elizabeth Withers Centre for HOPE.

1. **Janeway Adolescent Medicine Program**: "Adolescent Medicine is a pediatric subspecialty that focuses on the assessment, diagnosis and management of complex health issues within the context of the major biopsychosocial events that define the transition to adulthood."  

    At the Janeway Children's Hospital, a tertiary care referrall centre for Newfoundland and Labrador, adolescents from their 13th until 18th birthday can be seen through a medical

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referral to Adolescent Medicine. The initial assessment is completed by a member of the medical team with referral to other team members or resources as appropriate.

The Adolescent Medicine Team at the Janeway is highly and uniquely trained in the assessment and management of adolescents with eating disorders. Due to this specialized level of care, the Adolescent Medicine team offers focused inpatient and outpatient treatment to adolescents with eating disorders. The team is also available for consultation and/or management for children younger than thirteen years.

The number of eating disorder referrals has been increasing with over 30 new eating disorder diagnoses per year since 2013. An average of 600 inpatient days per year are coded as being admitted due to an eating disorder. Specialist physicians within the Adolescent Medicine Team admit patients requiring an inpatient stay to the medical or psychiatric units of the Janeway. Other team members include pediatricians, nurse practitioners, dietitians, social workers and psychologists. The majority of patients with eating disorders are followed in the Adolescent Medicine Outpatient Clinic. Patients and families may also be followed by the dietitian and receive individual and/or family therapy from a social worker and psychologist. The team works closely with other programs and professionals throughout Newfoundland and Labrador who provide support to individuals and families with eating disorders. Team members also have roles in education, research, and advocacy.

2. Renata Elizabeth Withers Centre for HOPE: The Renata Elizabeth Withers Centre for HOPE (HOPE Program) is an interdisciplinary provincial outpatient and partial day treatment program for adults with eating disorders. It is committed to helping change eating disorder symptoms, challenging thoughts and behaviours, and developing new means of coping with everyday stressors. Clients must be 15 years of age or older and meet the specific criteria for eating disorders as described in the DSM V for mental disorders.

Staff composition includes: 2 psychologists III (includes 0.5 research position), 0.5 physiotherapist, 1 clinical dietitian III (clinical leader for the program), 1 psychiatric nurse, 1 dietitian II, 1 occupational therapist II, 1 occupation therapy support worker, 1 social worker III, 1 clerk typist III, 1 cook I, 0.3 family physician (1 ½ days a week), 0.1 consulting psychiatrist (1/2 day a week), and 1 program manager.

A referral to the program can be made by a healthcare provider. Treatment goals are individualized according to the needs of the client and may include such therapies as developing a healthy lifestyle, improving relationships with food, exploring alternative coping strategies, creating/improving healthy interpersonal relationships, improving sense of self-worth and body esteem and facilitating effective communication between clients and their loved ones. The client must be motivated to participate in group-based therapy and must be medically stable as per Eastern Health’s guidelines to be accepted into the program. The program strives to provide a trusting, supportive and consistent environment for individuals and their families on the journey to recovery and wellness.
Many people with severe eating disorders are ambivalent about change and/or are medically unstable making them ineligible for this program. HOPE, therefore, also offers an outpatient clinic and pre-treatment groups for individuals who are not ready to participate in the program. These individuals often need more medical and motivational support before they are stable and well enough to engage in treatment at HOPE.

**Out-of-Province Inpatient Treatment**

Government funding to attend an inpatient treatment facility outside of Newfoundland and Labrador is available for individuals who require more intensive treatment than is available in the province.

**The Gaps in the Adult System**

Researchers, individuals and families, health care practitioners and advocates all agree that adequate care for individuals with eating disorders requires a range of comprehensive services across a full continuum of community based, outpatient, day treatment and inpatient care, which are interconnected and work collaboratively to maintain continuity of care.

A number of emerging issues related to patients with eating disorders have been brought to the Department’s attention. Issues which have been highlighted include: the needs for medically compromised patients to access specialized inpatient treatment locally, the need for psychology vacancies to be filled to increase access to specialized therapy, and teachers to be hired for the HOPE program to keep young adolescents from leaving the program because they were falling behind in school. As a result of the increased need being expressed for services for those with eating disorders, the Department initiated a series of roundtable discussions in 2014 to investigate the issues and concerns identified primarily by service providers and families. Discussed at each roundtable was the need for a dedicated team that would cover an inpatient program for adults who are medically compromised and too ill to attend the HOPE program; as well as the need for a teacher at the HOPE program so that young people will be able to stay in treatment and not fall behind in school.

While services exist for outpatients who are willing and able to avail of treatment, those who are medically unstable, lacking motivation to change, or non-responsive to available treatments are being managed in the community with no specialized intensive treatment services currently available to them in the province. Existing treatment guidelines recommend a period of specialized inpatient treatment for people who are severely underweight, medically unstable, or non-responsive to outpatient treatment. Such individuals require constant supervision by health care professionals with specialized training, as well as more structure than can be provided on an outpatient basis. Currently, these patients often cycle through emergency departments and when admitted to a general medicine or psychiatry bed, do not receive the specialized care they require to recovery fully.

Eating disorder patients require a dedicated inpatient team with the expertise in food reintroduction to safely avoid the potentially fatal re-feeding syndrome and address the
concurrent psychiatric and psychological issues. At different points along the continuum of their treatment, a patient with an eating disorder may require full day treatment with supervision during meals; or hospitalization due to concurrent psychiatric or psychological issues and medical instability. These unique features make it difficult to adequately treat eating disorders in a general medical or psychiatry unit. For example, when first admitted these patients require constant observation to safely introduce food by a staff member who can help the patient to manage their food and hospitalization related anxieties. This support is eventually weaned to about 9 hours per day to supervise meals.

Access to local eating disorders inpatient treatment for individuals 18 years and older continues to be a gap in service delivery for Newfoundland and Labrador. Although Eastern Health offers many of the essential components of a continuum of care, it is recognized that these services need to be better coordinated. The HOPE Program, successfully provides the adult eating disorder population a place to receive outpatient treatment; however, if a client is not medically stable or they are not motivated to participate, they are not suitable for the HOPE program. Likewise, if an individual is currently in the HOPE program and becomes medically unstable or requires hospitalization they are released from the HOPE program and then may be followed on an outpatient basis or admitted to a medical bed. When individuals are admitted to medical beds throughout the province, they are treated with IV to correct electrolyte imbalances and other blood levels. When lab values return to normal, patients are usually discharged without addressing the underlying mental health issues associated with an eating disorder. Patients are often discharged only to return to emergency departments when their blood values become abnormal again.

The Health Sciences Centre medicine beds are routinely full on a regular basis. Medical floors are known to be extremely busy environments which are not able to meet all the needs of a patient with an eating disorder. Although consultation to internal medicine is available, these patients require daily specialized medical monitoring by a physician and others skilled and knowledgeable professionals who understand both the physical and psychological aspects of eating disorders. The required level of daily monitoring is not available with current physician allocations.

In Budget 2015, funding was provided for a part time general practitioner to help provide medical oversight to individuals with eating disorders when they are admitted to the General Hospital Psychiatry Unit at the Health Sciences Center. However, interprofessional specialized expertise does not currently exist in medicine or psychiatry services, compromising successful outcomes. Patients may get admitted to either service, but the complexities of their illnesses are often not addressed.

When admitted to psychiatry units across the province, eating disorder protocols exist, but units are not staffed to provide constant supervision and do not have the expertise to address the life-threatening medical complications or the challenging psychological complexities associated with these disorders. There are currently two ‘dedicated’ eating disorder beds at the Health Sciences Centre Psychiatry Unit; however, if the eating disorder beds are vacant when
an individual requires hospitalization for another mental illness (e.g. bipolar disorder, schizophrenia), the beds will serve the current need and will not be held vacant for a possible eating disorder patient. This sometimes results in a situation where both of the ‘dedicated’ eating disorder beds are being used by other patients. Furthermore, without a specialized structure and team trained to treat individuals with eating disorders, the likelihood of a successful intervention is compromised. Because the environment of a psychiatric unit can be at times, chaotic and alarming, the patient experience is far from ideal for those affected by eating disorders who are often not motivated for treatment.

In summary, a key gap that exists in local inpatient treatment either through medicine beds or psychiatry beds is the lack of a specialized interdisciplinary program to provide inpatient care for severe eating disorder cases.

Eastern Health has strengthened linkages between medicine and psychiatry; as well as between children’s services and adult services. One manager now oversees many of these services at Janeway and the Health Sciences Centre and an inter-program coordinating committee is being established to ensure continuance of collaboration across programs and ensure ease of transition across the continuum of care. However, neither of these services is currently equipped to address the medically unstable eating disorder adult patient and similar challenges occur within other regions.

Finally, while out-of-province inpatient treatment is available, this is not an optimal option. Individuals must be medically stable to travel to the program which presents a barrier for some individuals who are unwell. It also means leaving support systems and families which are often key to recovery, behind. Continuity of care can be compromised when individuals leave the province for an inpatient treatment facility only to return home where they may or may not have sufficient supports in place. Furthermore, like many mental illnesses, eating disorders are chronic conditions which may require multiple inpatient treatment stays.

Jurisdictional Scan

British Columbia, Alberta, Manitoba, Ontario, and Quebec have dedicated adult inpatient treatment programs for individuals experiencing an eating disorder. There are no dedicated inpatient beds in Atlantic Canada. A summary of the jurisdictional scan is below:

- **Yukon:** No dedicated beds
• **North West Territories:** No dedicated beds
• **Nunavut:** No dedicated beds.
• **British Columbia:** The Adult Inpatient Treatment Program of St. Paul’s Hospital, Vancouver, has several inpatient and outpatient programs with a total of 22 beds (not including the 10 residential beds).
• **Alberta:** The University of Alberta Hospital (UAH), Edmonton, has 12 inpatient beds and the Calgary Eating Disorder Program – Foothills Medical Centre, Alberta Health Services has 6 inpatient beds, for a total of 18 beds (not including 8 residential beds).
• **Saskatchewan:** Has a residential program for eating disorders for youth and adults, but does not have an inpatient treatment program or dedicated beds.
• **Manitoba:** The adult inpatient program at the Health Sciences Centre, Winnipeg, has 6 beds.
• **Ontario:** Toronto General has 20 adult beds and 28 pediatric beds for a total of 48 beds (not including 12 residential beds).
• **Quebec:** The Douglas Institute, Montreal, has a 6 bed inpatient unit and the Ciuss de la Capital Nationale, Quebec City, has 4 dedicated beds in the General Psychiatric Unit.
• **Prince Edward Island:** Does not have an inpatient treatment program or dedicated beds.
• **New Brunswick:** Does not have an inpatient treatment program or dedicated beds.
• **Nova Scotia:** Does not have an inpatient treatment program or dedicated beds.

**Best Practices**

A full continuum of services should include promotion and prevention, early intervention, treatment and aftercare services as per the following diagram:

With respect to the treatment portion of the continuum, this includes outpatient counselling and support, day treatment, day hospital treatment and inpatient treatment. The following diagram depicts what the continuum may look like, recognizing, individuals may start and stop anywhere on the continuum depending on individual need.
According to the *Australian & New Zealand Journal of Psychiatry* (2014), the general treatment principles for all eating disorders should consider the following:

- Person-centered informed decision-making;
- Involving family and significant others;
- Recovery-oriented practice;
- Least restrictive treatment context;
- Multidisciplinary approach;
- Stepped and seamless care;
- Dimensional and culturally informed approach to diagnosis and treatment; and
- Indigenous care. ¹⁵

Research has shown inpatient treatment is effective in achieving weight restoration at least in the short term; thus, providing time for individuals to stabilize and engage in further treatment. A full continuum of care is considered necessary as it allows patients to start treatment at the intensity best suited to meet their needs and to taper progressively through less intensive treatment from there.

Two inpatient treatment programs of note, the Douglas Mental Health University Institute in Quebec and the Toronto General Hospital, were identified by members of the provincial eating disorder working group as providing the full continuum of care.

<table>
<thead>
<tr>
<th>The Douglas Mental Health University Institute</th>
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<tbody>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>The 6-bed inpatient unit is situated in a house adapted to patient need. The living ambience is pleasant with living rooms, dining room, kitchen, and washroom located on ground floor. Four private rooms, one semi-private room, two bathrooms, an observation room, and a nursing station are located on the second floor. The program offers an admitting unit, day hospital, day program and large-scale outpatient clinic. The program can also involuntarily admit patients.</td>
</tr>
<tr>
<td><strong>Multidisciplinary Team</strong></td>
</tr>
<tr>
<td>Comprised of registered nurses, a nutritionist, a physician, psychiatrists, psychologist, social worker and occupational therapist with expertise in the field of eating disorders.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program</th>
<th>The full program includes outpatient treatment, a day program that offers highly structured group based treatment, a day hospital for more acutely ill individuals who are able to manage overnight without supervision. The In-Patient Unit is for people with severe medical and psychological complications or those for whom out-patient treatment is insufficient to resolve eating disorder symptoms. The treatment consists of full 24-hour hospitalization and intensive, specialized treatment and includes observation, stabilization, meal support, psychological and psychiatric treatment and therapeutic and recreational activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toronto General Hospital</td>
<td>This 12-bed specialized inpatient unit is located within Toronto General Hospital and provides medical stabilization, psychiatric care, nutritional rehabilitation and psychological therapy. The program includes a period of inpatient care (for severe cases), followed by day hospital care, followed by outpatient group follow-up care to maintain recovery and prevent relapse. Treatment is voluntary.</td>
</tr>
<tr>
<td>Description</td>
<td>Comprised of registered nurses, registered dietitians, diet technician, psychiatrists, psychologists, social workers, art therapist, mental health clinicians, and occupational therapists with expertise in the treatment of eating disorders. The unit is also connected to the National Eating Disorder Information Centre.</td>
</tr>
<tr>
<td>Multidisciplinary Team</td>
<td>Program</td>
</tr>
<tr>
<td>- Week 1-2: stabilization and restricted to inpatient treatment unit. - Week 3+: day passes on the weekend - Week 4: weekend pass - Length of stay depends on individual but can be 8-10 weeks for individuals who are extremely underweight. - On average, patients are stepped down to day hospital treatment after approximately 8 weeks. - Day hospital typically lasts for 8 weeks. - The main focus of inpatient and day hospital is behavior change. - Outpatient therapy is then provided for another 3 months to address underlying issues causing the eating disorder and to prevent relapse.</td>
<td></td>
</tr>
</tbody>
</table>
Options for Consideration

A dedicated inpatient treatment program would provide more structured opportunities to address eating, symptom control, dysfunctional thought processes and related behaviors in those patients who are not appropriate for HOPE (e.g. medically unstable, needing more intensive intervention, low motivation or unmotivated). Any acute psychiatric/medical issues that may arise can be addressed promptly. The multidisciplinary treatment team can provide not only supervision, but intensive therapy that may enhance motivation and support rehabilitation/recovery. The dedicated eating disorders team will not only support patients admitted to the Health Sciences Centre for an eating disorder, but also those attending the Outpatient Clinic at the HOPE Program. The team would provide support to other programs that may require consultation services for patients who present with eating disorders (e.g. emergency department of internal medicine). Their involvement would free up resources at HOPE to focus on the day programming aspects of the service and in turn, help address wait times.

The cross treatment and support programs that can be realized by coordinating best efforts of the Hope Program, Janeway, and the inpatient treatment program would be significant as most clients will journey through all three programs during their recovery. A localized and integrated inpatient program will fill the current service gap in the continuum and provide an opportunity for coordination of efforts and enhanced care by all staff and programs who serve individuals with eating disorders and their families.

Proposal Details
- Provide a 4 bed inpatient eating disorder service at the General Hospital Psychiatry Unit, Health Sciences Center in St. John’s. This 4 bed program would offer structured support and supervision and access to an interdisciplinary team to address reintroduction of food, nutrition, and therapy for psychiatric illness; and
- Improve coordination of existing services to fully support continuity of care across the continuum.

Rationale/Opportunities
- Placing the proposed eating disorder inpatient unit within the General Hospital Psychiatry Unit provides access to both therapy for the psychiatric illness and access to other medical specialties and expertise.
- The General Hospital Psychiatry Unit is also newly renovated, has access to outdoors and has a recreation therapy program on site.
- There is room to expand, if the need is presented and funding permits.

Background
The General Hospital Psychiatry Unit is a 20 bed adult acute psychiatry unit that admits patients age 18 years and over for assessment and treatment of acute psychiatric disorders. On average there are two persons admitted with a diagnosis of an eating disorder at any given time. The highest number of persons with eating disorders admitted at one time has been four. To build
capacity for four patients on an ongoing basis it is proposed to increase the current bed number to 22, designating 4 of those beds for patients with eating disorders.

Physical Space
There are currently three bedrooms at the General Hospital Psychiatry Unit that can be dedicated to this service. There are currently two private bedrooms with private washroom space and one semiprivate room that can be renovated into two private rooms with a shared washroom space. Once renovated, there will be 4 private bedrooms for individuals with eating disorders.

There is another semiprivate space that can be converted to a multipurpose/family room for day programming of patients, family meetings or visiting space in the off hours. This space could also be used as a dining area with continued observation post meals occurring in individual bedrooms.

A concept design would rework the existing space and allow for the development of two new private rooms and a multipurpose room adjacent to the nursing station. As well, medical gas upgrade would be required with the installation of additional oxygen and medial vacuum in each patient room as well as upgrades to have telemetry monitoring connectivity to monitor vitals. Installation of required power and data connections in each room will be necessary.

Program Standards
The Academy for Eating Disorders (AED), is a global professional association committed to leadership in eating disorders research, education, treatment, and prevention. In November 2012, AED released clinical practice recommendations for residential and inpatient eating disorder programs. Having designated beds at the Health Sciences Centre Psychiatry unit for persons with eating disorders, along with a trained and specialized team will offer an inpatient experience consistent with the following standards:

1) The initial assessment should be completed promptly and effectively by clinicians knowledgeable about eating disorders. Given that eating disorders are complex biopsychosocial disorders, it is essential to conduct a thorough and timely assessment to obtain information to ensure that the patient is medically stable and that the facility can provide appropriate medical and psychological care.

2) The admission process should comprise a comprehensive, interdisciplinary clinical process and form the basis for individualized treatment planning and delivery. A thorough assessment of a patient’s biopsychosocial functioning and family system/support network ensures a more accurate understanding of predisposing, precipitating, and perpetuating factors related to the eating disorder and assesses the patient’s specific medical, psychological, and nutritional needs. This facilitates a diagnostic summary, and the development and coordination of a comprehensive and effective treatment plan. The interdisciplinary team contributes to and supports the development of a holistic treatment plan for the patient.
3) Treatment planning is completed and is regularly reviewed by the interdisciplinary team to ensure comprehensiveness and evaluation of the patient’s needs. Comprehensive treatment and continuity of care initiated as soon as possible promote more successful treatment outcomes.

4) Continuity of care is provided by sharing pertinent information with appropriate individuals invested in the patient’s care and well-being. Understanding the ‘circle of care’ will be central to this process which should include all services in the patient’s continuum.

5) Discharge planning is key to ensuring appropriate after care plans and follow up for the patient and caregivers/support/families. Information sharing with the patient, family and after care team to ensure continuity of care is key

Treatment provided to patients admitted with eating disorders should reflect the treatment delivery standards outlined by AED (2012) as follows:

1) Treatment should be provided in a licensed mental health treatment facility, adequately described in terms of its setting, components and population served.

2) Treatment programs should offer four core treatment components: medical/nursing, nutritional, psychological, and psychiatric care services including milieu therapy. Milieu therapies may be supported by additional disciplines such as social work, psychiatric aides, counsellors, etc.

3) Guidelines for nutritional rehabilitation are a key component to successful eating disorder treatment. Nutritional rehabilitation goals may include: weight restoration, weight stabilization, and symptom reduction.

4) The core treatment team providers will be the therapist, dietician, nurses, primary care physician and psychiatrist in addition to other team members participating in care delivery based on program components offered.

Provincial Focus
The Health Sciences Centre Psychiatry Unit has an acute care mandate within the Eastern region of the province. Patients have access to beds in other regions of the province, but not the specialized team and programming that will be available to those in the Eastern region. Technology for videoconferencing/tele health is already available on the unit and the staffing model that is being recommended will have the capacity to at least provide consultation to other service providers in the regions. An evaluation framework will need to be constructed so that it can be determined whether four beds are enough for the region and what capacity might exist to accept patients from other regions and/or jurisdictions.

Clinical Leadership
While management structures are in place across the continuum for various components of eating disorders treatment at Eastern Health, working group members strongly support

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bringing these components together into a coordinated program which is led by a clinical expert. The clinical leader with recognized expertise in the treatment of eating disorders and the importance of a collaborative model could not only help set up the new inpatient unit treatment team, but also help coordinate clinical direction for all teams associated with eating disorder programs at Eastern Health. The clinical leader would also work with staff to offer training and explore integration of all eating disorders programs into one clinical program with a common vision, principles and overall philosophy, ultimately strengthening the continuum of services.

A key role for the clinical leader will be to strengthen communications and collaboration among health professionals, families, and individuals with experience of eating disorders, particularly during periods of transition. For example, transitioning from HOPE to outpatient counseling, from Janeway Adolescent Medicine Program to HOPE, or from the new inpatient service to HOPE, etc. will need to be seamless. The clinical lead will work with partners to develop clear policies and protocols to support smooth transitions throughout the continuum which are recovery-focused.

Eastern Health proposes that one of their psychologist positions could fulfill this clinical leadership role. Finally, it is recommended to have a facilitator external to the existing programs to work with this clinical leader in the early days of program development to ensure team building and collaboration amongst all service providers across all eating disorder services.

Training
Specialized training for physicians, psychiatrists and other clinical staff involved in the assessment and treatment of persons with eating disorders at the proposed inpatient unit HSC Psychiatry Unit is a key component to successful treatment outcomes for patients and their families. The following outlines training requirements.

Training should center on evidence based clinical skill building:

1) Theory
   a. Understanding eating disorders from medical and psychiatric perspective
   b. Transtheoretical model theory
   c. Interpersonal theory/therapy
   d. Cognitive behavioral theory/therapy
   e. Supportive Specialist Clinical Management (SSCM)
   f. Family theory/therapy
   g. Group theory/therapy
   h. Recovery Approach
   i. Team work

2) Skills:
   a. Clinical care/meal supervision/management
   b. Motivational interviewing
c. Individual counselling/therapy  
d. Supporting families; family counselling/therapy  
e. Group work  
f. Team work  

Some of this training may be provided from within Eastern Health, specifically utilizing expertise within the HOPE Program; and from Memorial University, utilizing expertise within health discipline faculties. Other training will require bringing in experts from other established programs in Canada. Some consideration may be given to site visits to established programs within Canada combined with onsite education opportunities. Train the trainer models may be efficient in some instances. Costs are associated with all training options, including replacement of staff during training, contractual costs with outside experts and facilitation costs.

Evaluation  
An evaluation framework identifying the critical components of the program to be evaluated and how they would be assessed would need to be developed. Some of the key variables to measure include clinical outcomes, client and family satisfaction, clinical utilization and workload information. These metrics will be necessary to identify the successes and challenges for the program and to determine the quality of services provided and future directions. Options to support the development of this evaluation framework include the Research Department at Eastern Health and the Newfoundland and Labrador Centre for Health Information.

Staffing Model  
Dedicated staff for the treatment of inpatients with eating disorders will be required to ensure the effectiveness of this specialized service. A part-time General Practitioner has already been hired. Other human resources required include 2.8 Psychiatric Nurse I positions, 1.0 Clinical Psychologist III position, 1.0 Clinical Dietitian II position, 2.8 Personal Care Attendant positions, 1.0 Occupational Therapist II position and 1.0 Social Worker III position.

Budget  
The following table outlines the budget necessary to achieve the objectives to fully implement a 4 bed specialized unit for eating disorders and improve coordination of existing services to fully support continuity of care across the continuum.

<table>
<thead>
<tr>
<th>Budget Item</th>
<th>One time</th>
<th>Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing Budget</td>
<td>$998,623</td>
<td>$998,623</td>
</tr>
<tr>
<td>• 2.8 FTE Psychiatric Nurse I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1.0 FTE Clinical Psychologist III</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1.0 FTE Clinical Dietician II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2.8 FTE Personal Care Attendant for constant care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1.0 FTE Occupational Therapist II</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Training Budget includes:** implementing a train the trainer model for some theoretical and skill training to build sustainability into ongoing training and orientation for new staff: $20,000; visits to best practice eating disorder programs and to complete on site education for about 10 staff: $30,000; facilitated team building for all staff involved in eating disorders treatment for one year: $20,000; replacement costs for all psychiatry unit nursing staff to attend some training components and team building sessions: $15,000; on-site training by four out of province experts in select specialized evidence based treatment approaches ( $15,000).

### Conclusion

Eating disorders are life threatening psychiatric disorders that are challenging to treat and require a full continuum of services, from promotion and prevention through to community treatment, hospital treatment and aftercare. This proposal has outlined the need and plan to fill an existing gap in that continuum with a specialized adult inpatient eating disorder program for Newfoundland and Labrador. However, the proposal goes further, in response to feedback from individuals and families, and offers a plan not only for a specialized inpatient service but also for increased collaboration, integration and coordination across the health system for all eating disorder services. It focuses on leadership to build a common vision for eating disorder services across the system which will increase the understanding of all health care professionals of the role they have and how to work more collaboratively. It provides for increased training for all staff involved in eating disorder services which will enhance current services and build capacity within the system. This will also alleviate gaps in treatment as staff work more closely and are able to assist the patient and family to transition from inpatient to outpatient care, between regions and throughout the province. The proposal also includes an evaluative component so that outcomes are measured, ensuring that these enhancements will actually provide better treatment to serve individuals and families with eating disorders now and into the future.
Appendix A

NL Centre for Health Information

Eating Disorders – Potential Data Sources
Eating Disorders – Potential Data Sources

Focus

Eating Disorders and determining the level of need for specialized inpatient care for the province.

Require

Data that will help in understanding the level of need, not only current hospital utilization but if there is any way of determining (from an epidemiological perspective) what the future anticipated needs might be.

Identified Data Systems

1. Hospital Inpatient (Clinical Database Management System/Out-of-Province; CIHI’s Portal - DAD)
2. NLCHI Mortality System
3. MCP Fee-for-Services Physician Billing
4. Canadian Community Health Survey
5. Client Referral Management System
6. Canadian Chronic Disease Surveillance System

Each of these data systems collects data relevant to health care service delivery to the population, or estimates of the prevalence/incidence of health-related conditions in the population. Limitations with respect to the identification of eating disorders in each data system are presented in Table 1.

Currently, there is no registry for the population diagnosed with eating disorders in the province. There is also no single data collection system which can give an accurate picture of the prevalence or incidence of eating disorders. From an epidemiological perspective, data linkage using 2 or more data systems may provide some insight into the prevalence/incidence of the eating disorders and of health service utilization patterns.
### Table 1: Potential Data Systems – Relevance and Limitations

<table>
<thead>
<tr>
<th>Data System</th>
<th>Relevance</th>
<th>Limitations</th>
</tr>
</thead>
</table>
| * Hospital Inpatient – NL facilities | - All inpatient hospitalizations occurring in NL acute care facilities  
- clinical and demographic information | - Differences in clinical practice across jurisdictions may need to be taken into account  
- Data quality is not checked; may vary across jurisdictions |
| * Hospital Inpatients – other jurisdictions | - NL residents seen in other jurisdictions' acute care facilities  
- clinical and demographic information |                                                                                              |
| * Mortality                        | - Deaths occurring in NL  
- all conditions present at time of death | No specific cause of death is identified; immediate cause of death is available |
| * MCP FFS                         | - visits to FFS Physicians in the community and other | - visits to salaried physicians not included  
- 3 digit ICD-9 codes used for main reason for visit. 3-digits not specific enough to identify eating disorders (“Special symptoms or syndromes, not elsewhere classified”) |
| CCHS                               | - National survey; asked respondents  
"Have you been diagnosed with an eating disorder by a health professional?"  
(Age 15+ years) | - <10 respondents indicated an eating disorder; not enough for a reliable estimate to the general population  
- Includes only people living in ‘general’ households; excludes people in institutional settings |
| CFMS                               | - mental health referrals | - Intake process/data collection for mental health referrals not standard across RHAs; best to reach out to individual CRMS coordinators in each RHA to determine approach for data extraction  
- Managed by OCIO – requires request for access |
| CCDSS                              | - composite dataset; linkage of Inpatient/MCP FFS to identify cases based on pre-determined case definition | - 3-digit ICD-9 code used in MCP FFS (see above); group eating disorders with other conditions, such as Stuttering.  
- Uses only CDNS and MCP FFS |

* Potential to link patient information across datasets (utilization patterns)
Appendix B

Macro Eating Disorder Demographics and Related Reference Information
Macro Eating Disorder Demographics and Related Reference Information

- Based on 2002 Census and generally accepted disordered eating/eating disorders rates for Newfoundland and Labrador and others are as follows:

  1.70% of NL population 525,000  
   9100 cases
  1.70% of Atlantic Canada population  
   39,000 cases
  1.70% of Canadian population  
   600,000 to 900,000 cases


  Reference: 2002 Canadian Census

- NL has the 3rd highest rate of eating disorders in Canada (Census)

  Reference: 2002 Canadian Census

- Available research indicate that 80% are female and 20% male


- Recent research by the Canadian Institute Health Information Agency clearly indicates that the rates of eating disorders have increased substantially over the 2002 Census.

  Reference: Canadian Institute for Health Information 2014

- The primary group most affected by eating disorders are in the 12-23 age range and rates are as high as 10% for this age group.
Recent research by CIHI indicate that Canadian Hospitals have witnessed an increase of 42% in the number of admissions for the age group 10 to 19 over the past two years.

Reference: Canadian Institute for Health Information 2014

Recent early research by CIHI indicate that the age groups affected by eating disorders are changing and increases in the rates for women in their mid 30’s and mid 60’s have risen dramatically by some 30%+. 

Reference: Canadian Institute for Health Information 2014

Anorexia usually develops in early adolescence but over 50% of cases have an illness that persists for over 7 years and extends into adulthood.

Reference: Dr. Janet Treasure et al: Eating Disorder Outcomes 2011

Eating Disorders have the highest mortality rate of 20% if not treated early for all categories of mental health and addictions.


Disordered Eating/Eating Disorders are now considered to be the number one adolescent health disorder.

Available research indicates that anorexia relapse rates are high at 35% over what can be a 7 year recovery time frame resulting in frequent and more intensive treatment protocols.

Reference: Dr. Janet Treasure et al Eating Disorder Outcomes 2011

A recent study by CIHI of 1500 inpatient cases revealed that about 40% were pre-teens.

Reference: Canadian Institute for Health Information 2014

Researchers have established that 10% of individuals diagnosed with anorexia nervosa will die within 10 years of diagnosis.

• The overall mortality rate for anorexia nervosa is estimated at 15%

• Death certificates often do not record eating disorders and/or suicides as the cause of death but instead record the medical complications.

• Anorexia Nervosa and bulimia nervosa eating disorders kill an estimated 1000 to 1500 Canadians per year.

• The Standing Committee on Eating Disorders recommended an increase in inpatient care beds due to the life-threatening nature of eating disorders.

• The Standing Committee concluded that eating disorder data collection is insufficient and that the data are out of date and too little is known about the incidence and prevalence of eating disorders.
Local eating disorder knowledge and related statistics

- Referrals to out of province treatment centers for the past 3 years totalled approximately 45 cases for a cost of $2.3 million.

- Admissions at the Janeway for eating disorders increased by 38% for the past year for inpatient/outpatient treatment.

- About 200 people per year seek services from Eastern Health for eating disorders.

- Over the past decade almost 400 youth have been diagnosed with an eating disorder by Eastern Health. Of that number there have been 266 inpatient hospital admissions - with the length of stay totalling 8200 days at $1500.00 a day. This represents a 66% inpatient admission rate as a percent of those diagnosed. These statistics are underreported due to many admissions being coded to other primary health matters.

- The Foundation has experienced a 10 fold increase in families participating in its 5 family support and education programs. In a 6 month period some 125 families participated in the Foundation’s Emotion Focused Family Therapy 2 day training sessions and workshops.

- The Hope Outpatient Program is experiencing significant year over year increases in new clients.
## Equipment Costs

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whiteboard, Smart, Wall-Mounted (MONOPAD)</td>
<td>$7650</td>
</tr>
<tr>
<td>Board Room Table</td>
<td>$950</td>
</tr>
<tr>
<td>Chair</td>
<td>$3420</td>
</tr>
<tr>
<td>Sofa 2 $ 2,360.00</td>
<td>$4720</td>
</tr>
<tr>
<td>Television, LED, 55&quot; 1 $ 2,500.00</td>
<td>$2500</td>
</tr>
<tr>
<td>TV Mounting Bracket 1 $ 400.00</td>
<td>$400</td>
</tr>
<tr>
<td><strong>Infrastructure</strong></td>
<td></td>
</tr>
<tr>
<td>Door, 1220x2134mm 2 $ 1,400.00</td>
<td>$2800</td>
</tr>
<tr>
<td>Door Hardware 2 $ 450.00</td>
<td>$900</td>
</tr>
<tr>
<td>Sprinkler 3 $ 1,000.00</td>
<td>$3000</td>
</tr>
<tr>
<td>Resilient Sheet Flooring 60 $ 65.00</td>
<td>$3900</td>
</tr>
<tr>
<td>Vinyl Base 40 $ 5.00</td>
<td>$200</td>
</tr>
<tr>
<td>Acoustic Tile 30 $ 40.00</td>
<td>$1200</td>
</tr>
<tr>
<td>Painting 90 $ 65.00</td>
<td>$5850</td>
</tr>
<tr>
<td>Walls 28 $ 85.00</td>
<td>$2380</td>
</tr>
<tr>
<td>Alarm Valve Box 1 $ 4,000.00</td>
<td>$4000</td>
</tr>
<tr>
<td>Oxygen Piping 20 $ 85.00</td>
<td>$1700</td>
</tr>
<tr>
<td>Medical Vacuum Piping 20 $ 85.00</td>
<td>$1700</td>
</tr>
<tr>
<td>Medical Gas Outlets 6 $ 300.00</td>
<td>$1800</td>
</tr>
<tr>
<td>Allowance for and connect to existing 1 $ 4,000.00</td>
<td>$4000</td>
</tr>
<tr>
<td>Cutting, patching, setting out and sleeving 2 $ 600.00</td>
<td>$1200</td>
</tr>
<tr>
<td>Permit/Inspections 1 $ 2,500.00</td>
<td>$2500</td>
</tr>
<tr>
<td>Duct Mounted Heating Coils 2 $ 450.00</td>
<td>$900</td>
</tr>
<tr>
<td>Ductwork 10 $ 500.00</td>
<td>$5000</td>
</tr>
<tr>
<td>Supply air diffusers/registers 4 $ 250.00</td>
<td>$1000</td>
</tr>
<tr>
<td>Return Air Grilles 2 $ 150.00</td>
<td>$300</td>
</tr>
<tr>
<td>Conduit &amp; wire 50 $ 100.00</td>
<td>$5000</td>
</tr>
<tr>
<td>Fixture Installation 10 $ 45.00</td>
<td>$450</td>
</tr>
<tr>
<td>Switches Single Pole 2 $ 150.00</td>
<td>$300</td>
</tr>
<tr>
<td>Switches - 2 Gang 3 $ 175.00</td>
<td>$525</td>
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<td>Lighting Allowance 1 $ 5,000.00</td>
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</tr>
<tr>
<td>Duplex Receptacle 5 $ 160.00</td>
<td>$800</td>
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<td>Voice Outlets 6 $ 150.00</td>
<td>$900</td>
</tr>
<tr>
<td>Data Outlets 6 $ 160.00</td>
<td>$960</td>
</tr>
<tr>
<td>Data Jack, wired back to server 6 $ 250.00</td>
<td>$1500</td>
</tr>
<tr>
<td>Infection Control 1 $ 7,500.00</td>
<td>$7500</td>
</tr>
<tr>
<td>Safety Inspection/Pressure Monitoring 1 $ 1,500.00</td>
<td>$1500</td>
</tr>
<tr>
<td>RPC Medical Gas Testing 15 $ 5,000.00</td>
<td>$5000</td>
</tr>
</tbody>
</table>

**Total:** $204,080.40