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Implementing Canadian practice guidelines for children and adolescents with eating disorders: a qualitative study on barriers, facilitating factors and implementation strategies

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Abstract

Background In Canada, access to timely, evidence-based care for eating disorders is limited, with long wait times and fragmented services. Clinical practice guidelines can improve consistency and quality of care, but successful implementation remains limited. Canadian practice guidelines and a virtual care addendum have been developed for the treatment of youth with eating disorders (EDs). This study aims to qualitatively seek perspectives on the barriers, facilitating factors and implementation strategies from various interested parties.

Methods One semi-structured qualitative focus group was conducted in each of nine Canadian provinces. Focus groups consisted of a combination of clinicians, administrators, and individuals with lived experience who elaborated upon barriers and facilitating factors to guideline uptake as well as possible strategies to enhance implementation. Focus group transcripts were analyzed using conventional content analysis.

Results Findings suggested that participants found it difficult to implement guideline recommendations due to a myriad of factors such as a lack of external resources and minimal training in guideline recommended therapies. Facilitating factors of uptake included support from leadership and explicit training on guideline therapies. Potential implementation strategies included the creation of adapted versions for families and healthcare professionals, as well as enhanced education materials.

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Conclusions The findings of this study indicate areas within healthcare provision that can be enhanced and expanded upon to further enhance the uptake of the Canadian practice guidelines for children and adolescents with eating disorders.

Plain English summary

In Canada, many young people with eating disorders face long wait times and uneven access to appropriate care. Although national treatment guidelines have been developed to improve care, these guidelines are often not commonly used in practice. This study explored how these guidelines could be better implemented across the country. Researchers held one focus group discussion in each of nine provinces with clinicians, healthcare administrators, and people with lived experience of eating disorders. Participants shared what makes it difficult or easier to use the guidelines in real-world settings, as well as ideas for improving their use. Participants reported several barriers, including limited resources, long waitlists, and a lack of training in guideline-recommended treatments. Factors that helped implementation included strong support from organizational leadership and eating disorder training. Participants also suggested that the guidelines could be more widely used if they were adapted for different audiences, such as families and various healthcare professionals, and supported by clearer educational materials. Overall, the study highlights practical ways the Canadian eating disorder guidelines could be better supported and more effectively used to improve care for young people.

Keywords Clinical practice guidelines, Pediatric eating disorders, Implementation science, Canada, Qualitative research, Focus groups

Background

Eating disorders (EDs) cause significant impairment in mental and physical health [1] and have one of the highest mortality rates of all psychiatric illnesses [2]. Canadian community surveys report 2.2% of males and 4.5% of females under 18 years of age meet diagnostic criteria [3, 4]. These disorders are often chronic and difficult to treat, especially if intervention is not received within the first three years of symptom onset [5]. Since the COVID-19 pandemic, increased waitlists and fragmented care for children and youth with EDs has only amplified these systemic issues [6]. Clinical practice guidelines are defined as "systematically-developed statements to assist practitioners in making decisions about appropriate health care for specific clinical circumstances" [7]. Although guidelines are widely established across healthcare, it is estimated that 30–40% of patients do not receive evidence-based treatment, and 20–25% may receive potentially harmful treatment [8]. While guidelines can help to reduce these statistics, they must be implemented successfully to result in practice and policy change.

Previous literature has outlined both barriers and facilitating factors to guideline uptake among healthcare professionals in various healthcare contexts. A recent scoping review on barriers and facilitating factors to guideline implementation divided themes into three categories: 1) personal factors, 2) guideline-related factors and 3) external factors [9]. Personal factors included personal views and beliefs about the guideline recommendations. Guideline-related factors included lack of clarity of the guideline and lack of conciseness in the guideline [10–12]. External factors included the complexities of the treatment(s) proposed and whether clinicians needed training, as well as the ability of the organization to adopt the interventions [13–15]. Successful guideline implementation requires an examination of these factors as a first step prior to proceeding with a guideline implementation strategy.

Implementation strategies work best when tailored to the context and target audience [9]. In addition, strategies should be multifaceted and address practitioners' pre-established knowledge and attitudes in order to be effective [9]. It has been suggested that stakeholders be involved to discuss barriers and develop strategies [9, 16]. Furthermore, adherence of professionals and organizations to guidelines can be improved when they are developed locally or adapted [17]. Given the limited evidence on barriers and facilitating factors to guideline uptake in ED care, the present study is well-positioned to address this gap in the literature.

Prior to 2020, no national clinical practice guidelines existed in Canada for the treatment of EDs in children and youth, with professional consensus and institutional protocols guiding practice in their absence. To address this gap, the research team developed the Canadian Practice Guidelines which outline evidence-based treatments for children and youth up to the age of 18 with a range of EDs, including Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Avoidant/Restrictive Food Intake Disorder, Other Specified Eating Disorder, and Eating Disorder Not Otherwise Specified [18]. The guidelines address an array of treatment modalities, including psychotherapy, pharmacotherapy, and level of care recommendations ranging from outpatient, day treatment, and inpatient settings, When the COVID-19 pandemic emerged and the rapid shift to virtual care created an

urgent need for updated guidelines, our dedicated panel of stakeholders came together again during the pandemic to publish a virtual care addendum to these guidelines [19]. Although the guidelines are published in an open access journal and efforts have been made to distribute our findings, a systematic approach to implement our guidelines has not been developed nor studied. Using qualitative methods, this project seeks to understand the perceived barriers and facilitating factors to using the clinical practice guidelines with an aim to create a guideline implementation strategy.

Methods

Study design

This study drew on principles of implementation science [20] and a learning health systems approach [21], engaging partners with relevant personal or professional experience of EDs across multiple contexts to support improvements in ED care. It was embedded within a larger guideline implementation protocol, in which the identification of partner insights is an integral step in enhancing the uptake and use of our clinical practice guidelines. [22]

A qualitative descriptive design was used to explore perceived barriers and facilitating factors to guideline implementation, as well as strategies to enhance uptake [23]. This approach was selected for its emphasis on staying close to participants' accounts and its suitability for health services research aimed at producing straightforward, practice-relevant descriptions rather than theory generating approaches [23]. Data was generated through virtual semi-structured focus groups and analyzed using conventional content analysis [23]. Reporting of the results of this study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ). [24]

Participants

For each province, focus group recruitment aimed to include 3–4 clinicians with experience in pediatric ED care, 1–2 program administrators of pediatric ED programs, 1–2 caregivers of individuals who received pediatric ED treatment, and 1–2 youth and young adults with lived experience of an ED. Each focus group consisted of at least one member of each of these categories. Local primary investigators in each province led participant recruitment, initiating contact through their existing professional networks. Clinicians and program administrators were recruited from both specialist eating disorder and general pediatric in-patient and community programs. The sole exclusion criteria was inability to communicate in English. Participants were not excluded based on ED diagnosis. Clinicians and program administrators were eligible regardless of practice setting, including hospital-based, outpatient, inpatient and private practice environments, however all had had experience treating EDs in a pediatric setting. Prior to the focus group, the clinical practice guidelines and a virtual care addendum were circulated electronically to all participants. Upon completion of each focus group, all participants were given a token of appreciation in the form of a gift card for participating in the study.

Data collection

Demographic surveys were sent to participants before the focus groups, which asked about variables such as age, gender, race and ethnicity, province, education level, household income, and role (caregiver, clinician, administrator, or person with lived experience). Nine semi-structured focus groups were conducted virtually via Zoom for Healthcare between May 2024 and October 2025, with each session lasting approximately two hours. The same interviewer (MN) led all focus groups to ensure consistency and reliability. Discussions focused on perceived barriers and facilitating factors to guideline implementation (personal, guideline-related, and external) [11], as well as potential implementation strategies, guided by the Lavis knowledge transfer framework: 1) the message, 2) the messenger, 3) the target audience, 4) strategies and infrastructure, and 5) evaluation [25]. Participants were also asked to identify approaches to support implementation among diverse populations. Open-ended probes were used to elicit further information on these topics. Focus groups were organized based on province and included a mixed number of individuals from each of the five partner groups. Mixed-participant focus groups — including those combining people with lived experience alongside clinicians and administrators — reflect an established methodology in health services and implementation research, where heterogenous dialogue is valued precisely because it generates perspectives that may not surface in single-group settings [25]. Researchers also followed several steps to mitigate any implicit power imbalances between participants in the focus groups. These steps included notifying all participants prior to joining the group that these were mixed focus groups that would include both professional and lived experience perspectives. During the focus groups, the interviewer made concerted efforts to include perspectives from people with lived experience and caregivers prior to continuing to the next question. The interviewer also gave all participants the option to contact the research team directly via e-mail after the focus groups with any additional thoughts or concerns. Sessions were video- and audio-recorded with participant consent and transcribed verbatim. The focus group guide is provided in the Supplemental Material.

Data analysis

Focus group transcripts were analyzed using conventional content analysis and the constant comparison technique [26] using *NVivo* data analysis software. Specifically, iterative reviews of text within and across transcripts were completed by two members of the research team (EN, TY) to identify salient content related to barriers, facilitating factors, and implementation strategies. Codes and corresponding extracts were reviewed with the research coordinator (MN) and lead investigator (JC) to establish clarity and trustworthiness prior to finalizing the analysis.

Ethics

Ethical approval for this study was obtained through a central research ethics board (Hamilton Integrated Research Ethics Board; HiREB) and through local ethics review at participating sites in eight of the nine Canadian provinces (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, New Brunswick, and Prince Edward Island). Local ethics approval was not required for this study in Quebec. Written informed consent was obtained from all participants upon recruitment, with verbal consent re-confirmed prior to the focus groups, wherein participants were reminded of the voluntary nature of their participation.

Positionality statement

FBT is highly recommended in the guidelines, so the research team's professional ties to FBT should be noted. Several authors on this paper are trained in FBT and are actively engaged in FBT-related research in pediatric EDs. While efforts were made to maintain neutrality, these professional experiences may have influenced both the facilitation of focus groups and the interpretation of qualitative data. In addition, the research team is based in a province with relatively well-resourced and accessible ED services. This position of privilege may have shaped the perceptions of challenges faced in provinces with fewer resources. To mitigate biases, team members with limited FBT training were involved in data analysis and interpretation, contributing alternative interpretations and a more nuanced understanding of the data.

Strategies to enhance rigour and trustworthiness

Rigour and trustworthiness were enhanced using Lincoln and Guba's evaluative criteria for qualitative research [27]. *Credibility* was established by engaging in persistent observation through the triangulation of data analysis across multiple team members and peer debriefing with the team about the findings. *Transferability* was established by including participants from diverse contexts across Canada. This was supported by the researchers documenting the various contexts of focus groups in their study notes, though the content of these notes will not be published to maintain participant confidentiality. *Dependability* was established by implanting stepwise replication, wherein multiple researchers analyzed the data independently to compare findings. The use of audit trails further assisted in documenting the research process. Lastly, *confirmability* was established by reflexively acknowledging and reflecting upon the influence of individual researcher bias on data collection and analysis. Again, findings were triangulated across the research team to strengthen the credibility of the interpretations.

Results

Demographics

As summarized in Table 1, a total of 69 participants were included, spanning five partner groups: ED-specific clinicians (n = 29), non-ED-specific clinicians (n = 9), program administrators (n = 9), caregivers (n = 15), and young people with lived experience (n = 10). Among clinicians, the most frequently-represented disciplines were social work (18.4%) and psychiatry (15.8%), followed by dietetics and nursing (each 10.5%). Clinical psychology, occupational therapy, and pediatrics were also represented. Most participants identified as female/women (95.7%), and the mean participant age was 39.8 years (SD = 11.64). Most participants identified as White (87%), with smaller proportions identifying Middle Eastern (4.3%), East Asian, (2.9%), South Asian, (2.9%), as well as Métis (1.4%), and Latin American (1.4%). Educational attainment for 69 of the participants was high, with 84% of respondents having earned at least a bachelor's degree, and within that group, 41% had obtained graduate or professional qualification.

Focus groups

Content analysis identified various views of the guidelines, barriers and facilitating factors to guideline implementation, as well as suggestions for improving guideline uptake. An overview of the categories, number of extracts, and illustrative quotes is provided in Table 2, and described in detail below.

Overall impressions of the guidelines

Participants voiced positive initial impressions of the guidelines. Eleven participants across eight provinces reported that the guidelines validated practices or treatments they already relied upon. As one caregiver remarked:

> *"FBT is something we worked on and off and found quite effective, given that our daughter was living in our home. It seemed to me a natural fit. And so, I was glad to see that was a high recommendation.*

Table 1 Participant demographics

Characteristic	N = 69
	Mean (SD) [Range]
Age, *years*	39.8 (11.64) [18–63]
Gender	N (%)
Female	66 (95.7%)
Male	4 (5.8%)
Role	N (%)
Program Administrator	9 (13%)
Clinician	38 (55.1%)
Social worker	7 (18.4%)
Psychiatrist	6 (15.8%)
Dietician	4 (10.5%)
Nurse	4 (10.5%)
Clinical psychologist	3 (7.9%)
Pediatrician	1 (2.6%)
Occupational therapist	1 (2.6%)
Other	1 (2.6%)
Not reported	11 (28.9%)
Person with Lived Experience	10 (14.5%)
Caregiver of Person with Lived Experience	15 (21.7%)
Ethnicity	N (%)
White	60 (87%)
Middle Eastern	3 (4.3%)
East Asian	2 (2.9%)
South Asian	2 (2.9%)
Latin American	1 (1.4%)
Indigenous-Métis	1 (1.4%)
Other	1 (1.4%)
Province	N (%)
Alberta	6 (8.7%)
British Columbia	8 (11.6%)
Manitoba	5 (7.2%)
New Brunswick	10 (14.5%)
Nova Scotia	8 (11.6%)
Ontario	10 (14.5%)
Prince Edward Island	4 (5.8%)
Quebec	7 (10.1%)
Saskatchewan	11 (15.9%)
Education	N (%)
Completed secondary school	4 (5.8%)
Non-university or college certificate	3 (4.3%)
Bachelor's degree	30 (43.5%)
University degree or certificate above bachelor's degree (e.g. Master's, MBA, MD, DMD, PhD)	28 (40.6%)
Partial post-secondary completion	4 (5.8%)
Combined Household Income	N (%)
Less than $50,000	4 (5.8%)
$50,000–$80,000	4 (5.8%)
$81,000–$100,000	1(1.4%)
$101,000-$150,000	32 (46.4%)
More than $150,000	28 (40.6%)

It means that we were kind of on the mark there…" (Caregiver).

Further, five participants described the guidelines as helpful for establishing best practices and "gold standards" of treatment, while three participants described appreciation for the extensive detail of the guideline as a particular strength. One clinician learned new information from the guidelines that they anticipated may be useful to implement within their program.

Barriers to guideline uptake

Participants identified multiple barriers to guideline uptake, spanning personal, guideline-related, and external factors. Starting with personal barriers, eleven participants highlighted lack of buy-in from clinicians and program managers were a significant barrier to uptake, while nine attributed poor uptake to hesitation from program and hospital leadership. For example, one participant noted that program leadership showed hesitancy toward adopting guideline-recommended interventions due to their novelty and perceived risk:

"…, the way that we get strong recommendations for interventions in research is because these interventions are actually trials in real life with real life patients. So, it's this degree of risk and uncertainty that I think a lot of clinicians and program directors …. or systems are ready or willing to take..." (Clinician)

Several barriers were explicitly related to the guidelines themselves. Thirty-four participants were critical of the guideline's length: "*It's a bit dense… Maybe hard to find what you're looking for if you're a clinician or a parent*" (Youth). Additionally, six participants emphasized that the guidelines do not address the real-world impact of clinically complex patient presentations:

"Treating an eating disorder and overlooking the other struggles somebody had prior to or during the process I think doesn't do a service to a client … I think those insights are important to factor in as well in adapting that kind of guideline … such as on coexisting OCD or traumatic events." (Clinician)

Three participants underscored that the guidelines inadequately address treatment for equity-deserving populations, including 2SLGBTQIA + community and Indigenous peoples:

"I'm thinking about people who are LGBTQ or live in larger bodies to begin with or who are racialized or BIPOC. I think a lot of these folks present in

Table 2 Qualitative summary table (total sample included nine focus groups, and 69 participants)

Prompting question	Primary category	Subcategory	Focus group count	Participant count	Reference count	Participant quote
Overall impressions of guidelines	Validating – "We already did this"		6	11	14	"They almost feel like second nature to me. When I'm reading it or thinking about it, I'm, like, yeah, this is… this makes sense to me because this is common practice." (Clinician)
	Helpful		2	3	5	"The guidelines are really helpful. Part of it is when laying out what we know and what we don't know in the field… But from a non-specialist in eating disorders or for someone who's just starting in the field, I feel like it lays out actually a really helpful roadmap."(Clinician)
	Detailed		2	3	3	"I think the guidelines does really well is talk about settings. Like, eating disorders are so complex and longitudinal. But at some point it really becomes, like, do we need to admit this patient? If we're not admitting this patient, what's the minimum that they need to receive based on what evidence is available?" (Clinician)
	Learned something new		1	1	1	"But some things that really jumped out to me were talking about exercise or practicing exercise in a day hospital unit. That was something that was talked about in the guidelines at some point… I thought that was interesting and maybe, like, something I'd like to learn more about in the future." (Clinician)
Barriers to guideline uptake	Personal factors	Lack of program buy-in	6	8	11	"We don't really know how to implement it concisely. People are doing maybe different things. So, I think that would be a bit of an observation that I have… It is definitely challenging and the operational manager to be able to get everybody on the same page for this model of care." (Clinician)
		Lack of leadership buy-in	4	6	9	"In some cases, in the hospital environment, those doors are hard closed or hard open, right. There isn't a lot of room for wiggle room or for being like, "well, these guidelines would actually suggest this." They're like "no, this is our cut off."" (Clinician)
	Guideline-related factors	Length	9	30	35	"… If people want to nerd out and do a deep dive in terms of how those recommendations were reached, reading the original studies, that can all be in an appendix or something like that. Really, just including even an infographic with the bullet points of the primary recommendations as opposed to an 80-page document that's landed on their desk that is very intimidating to break open." (Clinician)
		Do not acknowledge comorbid conditions	4	5	6	"It can sometimes be challenging or feel kind of quite rigid trying to meet the needs of patients who have multiple struggles… So, then you feel like you're having to artificially pick and choose or prioritize different illnesses or treatments or cobble together treatment plans with different agencies that don't naturally kind of communicate."(Clinician)
		Do not address EDI concerns	3	3	3	"I see that a lot in my work just as a therapist … socioeconomic situation, poverty, those things can be huge barriers to FBT. You really have to be able to have a lot of the resources as parents to be able to administer FBT. So, I think that, yeah, that's a real big challenge often as well." (Clinician)
	External factors	Poor access to ED treatments	7	11	12	"I've been told there's only one eating disorder therapist in [City]… but one appointment is $150… I'm a university student, so money is a big issue for me… One session at $150 makes me feel like recovery doesn't matter, because paying that much is ridiculous…" (Youth)

Table 2 (continued)

Prompting question	Primary category	Subcategory	Focus group count	Participant count	Reference count	Participant quote
		Lack of resources to implement guidelines	7	9	14	"I find that in [Province], we're very lacking resources, severe… like, there's no essentially inpatient treatment centre in [Province]. And I know they're gradually working towards trying to open something up… I just… it's very hard to fathom that we're still just trying to open something up still." (Clinician)
		Lack of professionals trained in guideline-approved treatments	6	10	11	"It was really hard to find clinicians that were interested and committed to doing that training and genuinely committed. And I think that's really important because obviously there's lots of movement within and outside of the system, right?… So I think that's a big barrier, is just finding the clinicians to do it." (Clinician)
		Lack of awareness from non-ED professionals	6	8	9	"I don't think there was anything on eating disorders that was discussed. The guidance counsellors do not have pamphlets on eating disorders. I've been in all the schools, and I don't see anything…" (Caregiver)
		Lack of EDI education for clinicians	5	8	9	"Then also, just making sure that our teams are aware of different cultural pieces when it comes to even designing what a menu plan or a refeeding diet is going to look like, right? So, we've had families on the unit who are recent immigrants from [country], and our dietician is like, "What is a typical [country] supper so that I'm making the right kind of food?" So, then, again, needing to be flexible and adapting treatment to groups that may not have been part of our training." (Clinician)
		Transitions in care (from child to adult)	4	13	14	"… We do have patients that come and spend time on our inpatient unit who are from many hours away from [City], and then to transition back to their community and with the different resource setup… that makes it harder." (Clinician)
		Complexity of guideline treatments	3	6	8	"Implementing FBT has always been a bit of a balancing act in terms of really trying to ensure that we're supporting families based on what FBT is intended to look like. While we're also really working on things like ensuring that a kiddo is appropriately medically stable so that they can get home and sleep overnight and the family can start to really work on the FBT in that home environment…" (Clinician)
		Applicability to complex patients	3	5	6	"There is sometimes a bit of a disconnect between research and clinical work on the field, as we very rarely adhere to a manualized implementation when we do therapy in reality. In reality, most of the effectiveness of a psychotherapy is to adjust to the patient. When I do FBT, I do FBT, CBT, EFFT. I bring in DBT, all kinds of things in my psychotherapy based on who's in front of me, what's happening that day." (Clinician)
		Wait times to access programs	3	4	4	"One thing that comes to mind as a parent when reading these is access. Access to care has often been a challenge for us, with waitlists and complications. So, while these therapies may be great, I always wonder if they're truly accessible." (Caregiver)
Facilitating factors to guideline uptake	Training and supervision		6	8	9	"The training clinics that we have developed, we've developed for FBT and then also modelled off of what we were doing for FBT, for CBT provincially… I think we started with one [trainee], we now have 40…And I think that there's just a lot that we could share I think nationally with what we have done." (Clinician)

Table 2 (continued)

Prompting question	Primary category	Subcategory	Focus group count	Participant count	Reference count	Participant quote
	Utilizing a combination of strong and weak treatments		4	7	7	"You need to look at what the overall picture is: an integrative treatment. It's not relying on one model. It's also having a skill base from others like EFFT or, in some case, some colleagues, CBT-E or trauma-informed or even GAD, like you were saying." (Clinician)
	Buy-in from leadership		4	6	6	"I was so lucky, that [redacted name] and the rest of our leadership team allowed us to develop the program, and that staff could take the time to do all this training. It makes me think of the $10,000 bill to be trained in FBT." (Clinician)
	Embedding guidelines in staff orientations		2	2	2	"I think I was given this article right when I started working here by the psychiatrist that we work with or one of them at least. And it was, like, okay, here, read this. And so, for me, it was very clear that, like, okay, this is kind of why we do things the way we do and giving it a little bit more context." (Clinician)
	Knowledge champion on team		2	2	2	"Though, I'm always so amazed by my colleagues who just seem to know these things. Like, [redacted] who is one of the authors on this paper, [they're] just someone who's always sharing information. I really look to [them] as someone within my own team, someone who's a colleague to share these sorts of updates as well…" (Clinician)
	Support from an external guideline expert		2	2	2	"I know when [trainer] came and did the workshop, one of the things that I really loved is, one of our managers was there. And they sat in when [they were] talking about the research and how efficient it is and how effective… Then we had a lot of really good conversations after because [they] really bought into the idea that this would help with the wait list and it really did." (Clinician)
	Prioritizing non-intensive and short-term treatments		1	3	3	"The part that I agreed with the most is leaning towards the least intensive type of treatment possible. And I've really seen that on our unit, moving away from lengthy admissions is something that I really feel like we're doing a good job, and I'm glad it kind of aligns with the guidelines here as well." (Clinician)
Areas of improvement for the guideline	Guideline needs to include broader outcomes (such as quality of life)		4	8	11	"And so how do we then shift our focus to some of the other things that are going to make their life meaningful, worthwhile? I think with any mental health or chronic illness we run into that of, like, we get stuck on the score. Like, this one measure or this one thing, right. And it does neglect looking at the rest of someone's life and saying, how are you living a life that is worthwhile for you in spite of having illness?" (Clinician)
	Including an update on EDI		3	4	5	"I think currently the guidelines to be honest don't really seem like they address care for equity deserving groups. Because they're so specific for the very specific people who are adolescents in this specific age who don't have anything else going on. Like, it is very focused… the ideal patient and the stereotypical eating disorder patients. And so, I think the guidelines would have to kind of change a bit fundamentally. Because I just don't think they really acknowledge the diversity of people who can have eating disorders." (Youth)

Table 2 (continued)

Prompting question	Primary category	Subcategory	Focus group count	Participant count	Reference count	Participant quote
	Including an update of recent research on other treatments		2	2	2	"… It would be 2020 or even earlier depending on how long it takes to actually go through the huge number of research studies that this group had to go through. In terms of research for [DBT], I think it's only been in the last few years that they've been really looking at research for that… If they were to do it again, what the guidelines would say? It would be really interesting to see if the recommendations would change." (Clinician)
Strategies for guideline implementation	Adapted versions	Patient/parent	9	21	27	"When you first come into this program, you're not going to sit down and read an 80-page paper with statistics and studies… But I would imagine just like the very basics, like, "this is the frontline treatment that we recommend." I imagine the language would be very different between a clinician's paper and then what we would give to families." (Clinician)
		Provider	5	7	9	"I personally would love just a very shortened, like one, two pager with the types of psychotherapies in a table. I probably wouldn't need the information necessarily on the use of antipsychotics. I mean, it's helpful to have and again… But I guess more so focused on the psychotherapies for myself." (Clinician)
		Disorder-specific	3	5	7	"I think it could even be… a great idea might to be customizing it for each disorder. So based on what the psychiatrist who saw you thinks you are struggling with… I think having that kind of specialized, very specific kind of information that you can access that you know since it's focused on one thing you can also include more information in it too." (Youth)
		Age-specific	3	4	4	"One thought I did have about the FBT is the age of the patient. Because I'm just thinking my relationship with my kids when they're eight or ten or twelve and when they're teenagers, is quite different…" (Caregiver)
	Educational materials (website, infographics)		8	17	19	"I also like this idea of a website. I think that would be a really nice way to chunk it. Like, you could have a little dropdown menu of recommendation number one, FBT. Here's a definition. Here's what it might look like. Definition number two, CBT and then DBT. Like, all those things with infographics and pictures." (Clinician)
	Promoting guidelines in professional training/education		6	12	19	"I think if we could get to the psychiatrists at least earlier in the training, not just at the end before they've decided what area to go into, that if we could get to them earlier through … or even to get to paediatricians earlier. Like, adolescent medicine providers are such a huge provider of this kind of care." (Clinician)
Evaluation of guideline uptake	Methods	Focus groups	1	1	1	"Do focus groups. Like, pulling together a focus group again, with key people I think is a great way to get information. If you can speak to the people and know where… what their experience is, is that we can learn so much from the frontline folks that are doing the work." (Program administrator)
		Pre-post surveys	1	1	1	"Well, I think general surveys, I know some provinces have done this, but around clinician awareness of what different evidence-based programs are for eating disorders and also what they're trained in… So seeing a pre-post to see is that shifting over time?" (Clinician)

Table 2 (continued)

Prompting question	Primary category	Subcategory	Focus group count	Participant count	Reference count	Participant quote
	Outcomes	Evaluating patient experience	3	4	4	"I think having more feedback from families and people with lived experience… And I think that's something that would be very helpful, especially after the acute crisis phase is over where they're able to take a bit of time and think back to their experience and what could have been helpful for them, for these families and these patients." (Clinician)
		Program reviews	2	4	4	"I think the best would actually be to survey the centre that does treatment and ask them what approach they're using. Then you'll know. You'll be able to match how many centres are using FBT, and you can ask, if you want to add a qualitative portion." (Clinician)
		Examining referrals and attrition	2	3	3	"Hopefully, we'd see a decrease in reoccurring admissions. Hopefully, we'd see a decrease in length of people having significant illness before they're getting help. There'd be some things, obviously, that we could measure that would be helpful." (Clinician)
		Clinician confidence	1	1	1	"But if it's more a question of "what's your comfort level?" "What is your subjective feeling of competence?" In my experience, people have been more willing to answer those a little bit more honestly. Because there's room to grow then… "Here's some resources we can provide you", or "here's the short and snappy guideline thing."" (Clinician)
Promoting guidelines with EDI and hard to reach communities	Community outreach		5	6	6	"Come on the field and teach them. Go to community centre. Go up North to the Cree village. If you come into the public sector…we are reaching those people mostly, but I think also expanding to community centre and prison, the guideline in a way that's digestible, like you just said. I think you need to come meet the people." (Clinician)
	Supporting rural/ smaller programs		2	6	6	"One thing that we did was a provincial scan… You might do a provincial scan in each province and say, you know, how much are you utilizing? Or how much does your program fit with these practice guidelines?" (Clinician)
	School embedment		1	4	6	"If you're going to go into schools or whatnot, talking about things like transgender populations and how they experience eating disorders… Like, some of the minority groups across different cultures and races. Just talking about that experience, how they experience eating disorders and how it's different from the conventional sort of understanding of what it was…" (Caregiver)
	Cultural brokers		1	1	1	"I think one of the things that could be helpful when we're talking about developing these more targeted summary documents to drive people towards the guidelines would be to utilize cultural brokers. It's one way to sort of get into that leadership piece in the community of, "how do we talk about eating disorders in a way that makes sense for your community?" (Clinician)
Benefits of guidelines	Guidelines serve as "road map" for best practices		6	6	8	"This helps advance care… So, everyone's participation is super helpful, and hearing your perspective as well because that's the goal, right? The guidelines are to advance care." (Clinician)

Table 2 (continued)

Prompting question	Primary category	Subcategory	Focus group count	Participant count	Reference count	Participant quote
	Implementing guidelines consolidates program (shorter wait times, patient buy-in)		5	7	8	"I would say they've been a really important resource and that they're generally, at least within… in our group of medical practitioners very commonly recognized as being things that you have to go through in detail to work in the field." (Clinician)
	Helps advocate for funding		2	3	3	"I think it's going to be helpful. We really want to make change within our system, within our child and youth system. So, like, breaking it down and, like, here you go, [Program], help us. So, breaking it down and having that is going to be helpful for us I think moving forward to get what we need to help kids" (Clinician)
	Builds an evidence base for best practices		2	2	2	"If I may tell you, it feels really good. It feels like we are going to marry research and clinical. I would encourage you to keep doing it because… we're actually going to maybe make things better for the patient." (Clinician)
	Guides directions of training development		1	1	1	"The other things that we have used from the guidelines is how to develop our training… to figure out what specifically should we have our training modelled after? So, we definitely used the guidelines in that way in terms of really informing our redesign of our inpatient unit." (Program administrator)
	Canada-specific		1	1	1	"I like knowing that there are Canadian guidelines. As with so many things the literature comes out of the US, and the systems are just so very different… But just knowing that it's Canadian is helpful because it speaks to some of those differences."(Clinician)

CBT-E Enhanced cognitive behaviour therapy, *DBT* Dialectical behaviour therapy, *ED* Eating disorder, *EFFT* Emotion-Focused Family Therapy, *FBT* Family-Based Treatment, *GAD* Generalized anxiety disorder

> *much different ways than the stereotypical way that an eating disorder 'looks.' And so even just screening these people into treatment, they don't find their way into treatment. And then they don't find their way into research studies. And then they don't find their way into guidelines." (Clinician)*

External, system-level barriers were also prominent in the focus group discussion. Thirteen participants described challenges with transitions in care—from in-patient to community settings and from pediatric to adult services— with one participant stating that *"…since I graduated high school, it's very lacking resources right now. I'm just left alone. I'm just floating around."* (Youth).

Other barriers were limited funding to train clinicians in guideline-recommended treatments, such as FBT (n = 10), poor access to ED treatment in many provinces (n = 11), and inadequate institutional resources or capacity (n = 9) to integrate new recommendations.

Nine participants identified low awareness around ED detection among non-ED professionals, such as family doctors, as a major barrier for patient access to guideline-recommended treatments, while four participants highlighted long wait times for ED services in their province.

Finally, several participants described difficulties applying the guidelines to complex cases, where guideline-recommended interventions are not favoured with patients. Five observed a mismatch between strongly recommended treatments and their own clinical practices:

> *"I do find there's a huge emphasis on the importance of FBT, and I understand that it is a gold standard for treatment. But too often I see patients who don't fit that mould or the ability to do FBT. I have patients who don't have families or don't have families who are capable of supporting them. And then somebody had said earlier, you know, they're seen as failed FBT. And I think that's really tricky because they're not failing. They just weren't candidates for it to begin with"." (Clinician)*

Another eight participants expressed they had insufficient education on cultural or equity-related considerations in ED care.

Facilitating factors to guideline uptake

Participants identified several facilitating factors to guideline uptake, including training, leadership support,

and practical implementation strategies. Eight participants underscored that training in guideline-recommended therapies enhanced their confidence to apply these interventions. Similarly, two participants noted that embedding the guidelines into staff orientation helped normalize their use within clinical practice:

> *"When I began my onboarding, somebody had sent me the guidelines. They seemed really thorough and really well thought out and clearly a lot of work went into putting them together. So, I found it was a good little bit of a roadmap for me as I got settled within the team." (Clinician)*

Several facilitating factors related to how the guidelines were operationally implemented within programs. Three participants felt that prioritizing non-intensive and short-term treatment options, as recommended in the guidelines, alleviated resource strain on their programs. Seven participants described greater success when applying a combination of strongly- and weakly-recommended treatments, allowing flexibility to meet patient and program needs.

Leadership and team-level supports were also important. Six participants noted program leadership support as a facilitating factor to guideline uptake. Further, two participants underscored the important role of "knowledge brokers" within clinical teams: individuals who introduced the guidelines and served as a point of contact and guidance to support implementation. Two participants noted that hosting a workshop with an external guideline expert, such as clinicians proficient in FBT, further consolidated guideline uptake.

Areas of improvement for the guidelines

Participants identified several areas where the guideline content could be strengthened. Eight participants felt that the guidelines focused too narrowly on BMI and weight restoration as outcomes, instead of broader or more holistic outcomes, such as quality of life. Five participants suggested that future updates should better address how ED presentation and treatment intersect with equity-deserving populations, such as Indigenous youth and gender-diverse individuals, and how ED treatment can be combined with "*gender-affirming care*" (Clinician). Lastly, two participants suggested the need for an updated guideline reflecting more recent research conducted since the guideline's original publication:

> *"I'm interested in what would be next because I think for a lot of people who aren't caught in that three years of illness onset…it doesn't work as well. But then there doesn't seem to be a whole ton of things looking at that. And again, this was done in 2020. So, there's still research I'm sure that's been done since then." (Program administrator)*

Strategies for guideline implementation

Participants proposed several strategies to enhance guideline implementation, most commonly emphasizing the need for adapted versions tailored to specific audiences. Many non-clinician participants echoed the sentiment that "*it was hard to read through fluently*" (Youth). Twenty-one participants identified the need for a version of the guideline for adolescents and their caregivers, which would contain "*just the very basics*" (Caregiver) in plain language. Eight participants advocated for provider-specific guidelines designed for different professionals within a patient's circle of care:

> *"Having some customization for different levels of care… making it very relevant to their practice. And then you can use all of the good information in the guidelines in giving that information to family doctors and then continues to drive them back to the guidelines of 'when you go back to your practice, here's where you find this information again…" (Clinician)*

Participants also suggested creating shortened summaries of the guideline recommendations that were tailored to specific disorders (e.g., for Bulimia Nervosa or Binge-eating Disorder; n = 5) and for different ages, such as emerging adults (n = 4).

Implementation strategies also focused on education and dissemination. Twelve participants emphasized integrating the guidelines into professional education and training programs, including but not limited to nursing programs or psychiatric residencies. Seventeen participants suggested disseminating the guidelines via multiple formats, such as websites, infographics, or QR codes. Participants further highlighted the importance of targeted, upstream dissemination to family physicians and emergency department clinicians, as they are frontline points of contact for newly diagnosed individuals with EDs and for families navigating referral pathways.

Evaluation of guideline uptake

Participants suggested multiple methods to evaluate guideline uptake. Suggested methods included surveys administered before and after guideline implementation or education and focus groups to further explore program-specific barriers and facilitating factors of guideline uptake.

Moreover, participants highlighted multiple measures for assessing uptake. Four participants believed that evaluating patient experience may elucidate how guidelines are being implemented:

> *"I think that [people with lived experience] are very underrepresented in this. And I think that they need to be actively sought out… I think the emotional capacity and the impact on people with lived experience is important to consider." (Youth)*

An additional four participants suggested internal or external program reviews. Two participants felt that examining referral patterns, attrition, and discharge outcomes represented "*more concrete*" (Clinician) indicators of uptake than tracking treatment modalities alone. Lastly, one participant suggested assessing changes in clinician confidence and competence prior to and after guideline implementation.

Promoting guidelines with EDI and hard to reach communities

Several strategies to promote the guidelines among equity-deserving and hard-to-reach communities were noted. Six participants emphasized community outreach or "*meeting the people*" (Clinician) in their own community settings. Four participants especially emphasized the importance of embedding the guidelines within schools as a key strategy for broader reach, such as in pre-established "*teen mental health literacy programs*" (Caregiver) or via "*paper pamphlets and brochures*" (Program administrator) that outlined guideline recommendations.

Six participants emphasized the importance of building connections with smaller and rural programs through guideline supervision or provincial service scans. Lastly, one clinician proposed engaging "cultural brokers" or trusted community leaders to ensure guideline promotion is culturally relevant and contextually appropriate for certain communities.

Benefits of guidelines

Participants discussed several perceived benefits associated with the guidelines and their implementation. Seven participants noted that implementing the guidelines helped optimize service delivery, citing benefits such as shortened wait-times and increased patient engagement. Six participants felt that the guidelines provided a clear framework or "*parameters*" (Program administrator) for care that help "*inform clinical care pathways*" (Clinician). Similarly, two participants further valued the guideline's ability to bridge research and clinical practice by providing empirical support: *"being able to match the right therapy with the right condition, and being able to show that there's statistics to back that… I think that that's the way for people to have buy in."* (Caregiver).

Three participants underscored the utility of the guidelines to reinforce support and advocacy for additional funding:

> *"I think it certainly helps bolster our case when it comes to advocacy and putting together more support and funding. Obviously, if there's a set of well-established national guidelines that we can demonstrate we're not adhering to, that's helpful to strive towards." (Clinician)*

One participant suggested that the guidelines could inform future training development, while another emphasized the value of having Canadian-specific guidelines, describing them as more "*relatable and applicable*" (Clinician) than international alternatives.

Discussion

This qualitative study examined perceived barriers and facilitating factors for the implementation of Canadian Practice Guidelines for treating children and adolescents with eating disorders and identified strategies to improve their adoption in diverse real-world settings. Situated within an implementation science and Knowledge-to-Action framework, this work sought to understand how these guidelines are interpreted, negotiated, and adapted within complex ED care systems, with particular attention to system-level constraints and real-world implementation processes.

Participants described the guidelines as a clear roadmap for care. For some programs, the guidelines validated existing practices and reassured alignment with national standards; for others, they offered a framework to support program development, onboarding, and staff orientation. Together, these findings suggest that these guidelines function not only as prescriptive tools, but also as sources of professional reassurance and legitimacy within complex ED settings. The latter is a role of guidelines noted in prior research, with Woolf and colleagues describing guidelines as shared reference points for defining best care practices and supporting quality assessment and standardization across clinicians and programs. [28]

Consistent with prior research [29, 30], one of the most commonly identified barriers to guideline uptake was a lack of resources within ED programs, particularly understaffing and inadequate funding. Limited awareness around the detection and treatment pathways for EDs among primary care providers was also identified as a barrier, echoing findings from an earlier review [29]. Participants further described tension between the need for guidelines that are streamlined and accessible along with having flexibility to attend to the clinical complexity of patients with comorbidities. Transitions in care—particularly from pediatric to adult services and from inpatient to community settings—were also highlighted as additional challenges. Transitions for youth with EDs are inherently complex and often poorly coordinated,

disrupting continuity of evidence-based treatments (e.g., Family-Based Treatment), increasing vulnerability to relapse, and making it more difficult to fully integrate guideline-recommendations into practice [31]. Future research should examine how transitions from pediatric to adult care function as a distinct barrier to guideline implementation in pediatric ED settings.

Participants also identified gaps in the scope of the guidelines. Calls for a more holistic focus, emphasizing outcomes such as quality of life rather than weight alone, have been echoed in broader recommendations for patient-centred treatment [32]. Additionally, concerns regarding the limited attention to equity-deserving populations have been corroborated in other guideline studies across healthcare [33]. This gap is especially important, as individuals from marginalized and under-served populations often present with different motivations, stressors, and symptom profiles related to EDs [34]. For instance, ED pathology may be driven by resource scarcity and structural conditions (i.e., food insecurity) [35], not solely by weight and shape concerns, and such presentations are not adequately addressed in many guidelines.

Beyond issues of accessibility and scope, many described navigating tension between strongly-recommended treatments and the realities of complex clinical presentations and service settings. Rather than adhering rigidly to individual recommendations, clinicians reported combining strongly- and weakly-recommended interventions to accommodate patient needs, comorbidities, or program constraints. Given prior research demonstrating variable fidelity to ED treatment models, these findings suggest that adaptation may be necessary to deliver meaningful, contextually-appropriate care. [36]

Several facilitating factors to guideline uptake were also identified. Many ED professionals reported that exposure to the guidelines through workshops or orientation training improved their ability to apply recommendations in practice, consistent with previous research indicating the importance of education and training for guideline implementation [30]. For instance, health professionals in one study reported feeling more equipped and knowledgeable after receiving ED-specific virtual training [37]. Participants additionally highlighted the role of leadership support, internal champions, and "knowledge brokers" in introducing, contextualizing, and normalizing guideline use within teams—an observation consistent with broader research on factors influencing guideline uptake. [14, 38]

Calls to create adapted or lay versions of the guidelines for families and healthcare professionals, as well as delivery in multiple formats and visual layouts, were consistent with the wider literature on guideline implementation [16, 39]. While not always framed explicitly as equity-related, such adaptations have also been shown to improve accessibility and comprehension for equity-deserving and marginalized populations [40]. Participants' suggestions to include community partners and "cultural brokers" in implementation efforts align with emerging evidence that community engagement may help reduce barriers to ED treatment in under-served communities. [41]

Participants also emphasized that guidelines may serve functions beyond direct clinical guidance, particularly as tools for advocacy and system-level change. Several described using the guidelines to support requests for additional resources, staffing, or funding by pointing to nationally-endorsed standards of care. This highlights an underexplored role of clinical guidelines in not only shaping treatment delivery but also in strengthening advocacy efforts in resource-constrained systems.

Finally, unlike implementation studies set against a backdrop of pre-existing guidance, this work unfolded in a field where no pediatric ED CPGs had previously existed in Canada. Clinicians and institutions were therefore navigating not only the adoption of new recommendations, but also a reorientation of care in the absence of any prior standardized framework. Thus, awareness gaps and barriers to uptake observed in our findings may reflect not only the friction inherent to guideline implementation more broadly, but also the nascent state of *any* CPGs within this clinical domain in Canada. The absence of prior Canadian guidelines likely reflects a confluence of factors, including the historically limited recognition of eating disorders in pediatric populations as a distinct and urgent clinical priority, fragmented care pathways across jurisdictions, and insufficient investment in knowledge synthesis infrastructure within this subspecialty [42, 43]. Situating our findings within this dual context is important, as the implementation outcomes observed here reflect an early stage of adoption rather than engagement with a well-established, pre-existing evidence base.

Strengths and limitations

A major strength of this study was its rich dataset spanning nine provinces, providing a broad geographic perspective of the implementation context for pediatric ED guidelines in Canada. Clinician participants represented a wide range of professional disciplines, enhancing the diversity of perspectives and increasing the relevance of the findings to multidisciplinary ED care settings. Together, these features support the transferability of the results and reflect the varied realities of guideline implementation across jurisdictions.

Another strength was the consistency of data collection, with the same interviewer present in nearly all focus groups, supporting methodological coherence. In addition, the analytic process involved both independent and

collaborative review, which strengthened the credibility and rigour of the findings.

Several limitations should be considered. Canada's three northern territories were not represented, and all focus groups were conducted in English, limiting inclusion of Francophone participants and recent newcomers with limited English proficiency. Further, most participants identified as White, female and higher-income which limits insights for equity-oriented implementation [40]. Finally, participants were recruited through provincial leads at major ED services located in urban centres, which may have introduced sampling bias toward more resourced and guideline-aware settings.

Future directions

This study is part of a larger project focused on improving the use and sharing of guidelines within ED care. Using the material provided in these focus groups, our implementation strategy will be developed and evaluated. We anticipate co-designing tailored and context-specific educational strategies, such as educational videos, to reach clinicians, administrators, policy-makers, and advocacy groups. Once created, these materials will be sent to all study participants and posted to professional and advocacy ED websites.

More broadly, further research should invite and include the perspectives of under-served and equity-deserving populations as stakeholders and knowledge users. Similar focus groups with rural or low-resource mental health programs, as well as populations such as those who are Black, Indigenous, 2SLGBTQIA + and those whose first language is not English would further enrich the known barriers and facilitating factors to guideline uptake in these communities.

Conclusions

This study is the first to examine perceived barriers and facilitating factors of uptake of the Canadian pediatric ED guidelines, and partner-informed strategies to enhance their future implementation. Clinical practice guidelines have the potential to narrow the gap between evidence-based recommendations and the realities of localized clinical practice. By gathering perspectives from a diverse range of partners across the national ED community, this study illuminates practical and contextually-grounded strategies to improve guideline uptake. Participants identified barriers such as limited access to ED resources and lack of leadership support, while facilitating factors included increased training in guideline-recommended treatments. Strategies to enhance implementation emphasized the use of adapted and condensed guidelines for different audiences and targeted outreach to equity-deserving communities. In doing so, the study provides a foundation for developing implementation tools that may support more equitable access to evidence-based ED care for children and adolescents across Canada.

Abbreviations

ED	Eating disorder
FBT	Family-based treatment
OCD	Obsessive–compulsive disorder

Supplementary Information

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Supplementary Material 1.

Author contributions

JC: Conceptualization; Funding acquisition; Investigation; Methodology; Resources; Supervision; Validation; Writing – original draft; Writing – review and editing. MN: Data curation; Formal analysis; Methodology; Project administration; Validation; Visualization; Writing – original draft; Writing – review and editing. EN, TY: Formal analysis; Visualization; Writing – original draft; Writing – review and editing. MK, CF: Conceptualization; Funding acquisition; Writing – review and editing. JCoe, GD, AK, JBom, LI, JBon, HA, CS, EL, SA: Conceptualization; Resources; Project administration; Writing – review and editing. AB, GM, MNor, NO, DP, WS, SF, JG, SG, JGus, MJ, NJ, DK, NC, CG, AL, RL, TL, CStei, EW, CW, MB: Conceptualization; Writing – review and editing.

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Data availability

The data generated for this study are not publicly available due to confidentiality and privacy concerns associated with disaggregated qualitative data but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Ethics approval and consent to participate was obtained from: Hamilton Integrated Research Ethics Board (GRA-16182) (Main Site); University of British Columbia/Children's and Women's Hospital and Health Centre of British Columbia Research Ethics Board (British Columbia); Conjoint Health Research Ethics Board (Alberta); University of Saskatchewan Biomedical Research Ethics Board (Bio 5852) (Saskatchewan); Bannatyne Research Ethics Board (HS26591) (Manitoba); Children's Hospital of Eastern Ontario Research Ethics Board (Ontario); University of New Brunswick Department of Psychology (#24-26R) (New Brunswick); Izaak Walton Killam Research Ethics Board (#1030156) (Nova Scotia); and, the Prince Edward Island Research Ethics Board (Prince Edward Island).

Consent for publication

All participants consented for publication in their informed consent forms.

Competing interests

The authors declare no competing interests.

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