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Chair

Ms. Hélène LeBlanc

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● (1530)

[*Translation*]

The Chair (Ms. Hélène LeBlanc (LaSalle—Émard, NDP)): I would like to welcome you to the 11th meeting of the Standing Committee on the Status of Women. Today, we are continuing our study on eating disorders among girls and women.

During the first hour, we welcome Dr. Leora Pinhas and Dr. Gail McVey. They will each give a presentation of approximately 10 minutes, and then we will go to questions.

Ladies, once again, welcome to our committee.

[*English*]

Dr. Leora Pinhas (Department of Psychiatry, The Hospital for Sick Children): Thank you. I would like to thank you for inviting us.

I'm going to strive to be efficient and concise. I had an opportunity to review the transcripts from the previous presenters. I'm going to endeavour not to repeat their points, although I did agree with the majority of them. Because you'll be seeing a number of witnesses who are going to present you with numbers and a kind of state of the union, I've decided that I would opt out and give you a first-hand account, but of course, I have to start with a few numbers just to contextualize what I'm going to talk about.

Yesterday I did a search on the CIHR web page to look at the number of dollars that have been spent on operating grants for eating disorders in the last five years. I came up with a number of $7.5 million, which sounds like a lot, but then I keyed in “schizophrenia” and I came up with a total of $86 million. That's more than a factor of 10 in terms of allocation of money. Eating disorders are as severe and more prevalent than schizophrenia, which is why I chose schizophrenia as a comparison. So it's $7.5 million versus $86 million.

There are other numbers I want to highlight.

The rate of obesity in adolescent girls in Canada is 9%. That's Stats Canada data. The rate of eating disorders is estimated to be around 18%. The rate of new cases of restricted eating disorders in children between the ages of five and twelve is four times the rate of new cases of type II diabetes in the same population.

In Canada we have no intensive specialized mental health programs that would specifically treat children with eating disorders. When it comes to adolescents, that is also true in at least three of our provinces and all of our territories where no intensive specialized treatment exists.

Psychiatry residents are more likely to be exposed to negative stereotypes of eating disorders and to be discouraged from treating patients with eating disorders than they are to receive appropriate training and education on eating disorders.

I am here today as one of the senior psychiatric experts in child and adolescent psychiatry, and that is not a good thing. I am still too early in my career to be in a senior position; however, I'm senior because there is no one ahead of me. I started the first-aid treatment program for adolescents with eating disorders while I was still in training as a fellow. Since then I have gone on to help develop two... [*Technical Difficulty—Editor*]...programs, a second day treatment program, in-patient programming, outpatient programming. I was the founding member of the Eating Disorder Association of Canada and its first president, all because there was no one else doing the work, no one else to fill in the gaps.

A couple of years ago I gave up applying to CIHR for research grants. I've also given up on the idea of academic promotion. I will likely always remain an assistant professor, and more recently I left a full-time position at an academic children's hospital that houses our local specialized eating disorder services. This is not because my work is subpar—I have won awards throughout my career for my work—it's because the barriers are too great and I'm tired of trying to get around them.

Now if this was only my story, I would be wasting your time. The problem is that this is a story of almost every child psychiatrist in Canada who has attempted to work in the field of eating disorders.

The reason there are no psychiatrists more senior than me is that after about 10 years of hitting their heads against the wall—it does seem to be a 10-year cycle—those who came before my generation burned out and went elsewhere.

Now I am witness to the colleagues of my generation as they leave the field. Across the country senior child psychiatrist experts are falling away, leaving...[*Technical Difficulty-—Editor*]...care programs with vacancies that are filled by new graduates with little training and less experience, or are filled by pediatricians, or remain empty. This has occurred in some fashion in all but one of the seven provinces that could have tertiary or specialized intensive programs for treating eating disorders in adolescents.

● (1535)

The Chair: Dr. Pinhas, could you slow down a little? The sound is not that great and the interpreters are having a hard time making sure that we get all of your very important testimony.

Thank you very much, Dr. Pinhas.

Dr. Leora Pinhas: Thank you.

I'm just going to back up here for a minute.

Across the country, senior top psychiatry experts are falling away, leaving tertiary care programs with vacancies that are filled by new graduates with little training and less experience, filled by pediatricians, or left vacant. This has occurred in some fashion in all but one of the seven provinces that currently have tertiary or specialized intensive programs to treat adolescents with eating disorders.

Would we accept this situation for any other life-threatening illness? What if all the senior pediatric cardiologists left? Would this not be a crisis? Would it be okay if the cardiology programs were just hiring new graduates to run their programs even if they had little or no training? Would it be okay if they just hired an adult cardiologist who had no training in working with children? Maybe they could hire a pediatric thoracic surgeon to run the cardiology units. After all, the heart is in the chest cavity, right? Close enough; it should be okay, right?

When families seek help in a specialized program, they assume they are being treated by experts with both training and experience. Why are children and adolescents with eating disorders not equally entitled?

I have only one answer for you: discrimination. It's discrimination that we find within the health care and mental health care system, rather than in the community. It's my colleagues in research, in academia, and in clinical care who simply do not like patients with eating disorders and who dismiss people like me as just bothersome.

Raise the issue of lack of training and get ready to be told that we should be glad eating disorders are even mentioned in training. Express the need for more services and get told there are enough already in place and that, after all, it's a rare disorder. Submit for research funding and, even if it's a study that's the first of its kind in looking at the long-term medical consequences of eating disorders, get pigeonholed off into a nutrition category, and then get rejected because there's no dietician as a co-investigator on the study.

Like many of my colleagues, I have just given up, not on eating disorder patients, but rather on the medical institutions that care little for our patients. We do what we can with what little we have. We advocate whenever we get the chance. Our institutions become interested only if and when we get some funding, but no matter the need or the funding, eating disorders rarely become identified in an institution as a priority program.

I'm here because I'm seeing patients become chronically ill because they have no access to respectful and appropriate services in a timely fashion. I'm tired of watching parents tolerate humiliation and discrimination in the hopes that their child might receive adequate care. Nobody should have to take their child home and watch her slowly starve to death because she's too sick for outpatient or residential care but is refused admission to hospital because they just simply don't like dealing with eating disorder patients and don't feel like admitting her.

This is the standard here in Canada, and it's not good enough.

What can the federal government do?

First, we need a national eating disorder registry so that we can track what happens to patients with eating disorders. At this point, there is no database that consistently tells us enough about what's happening, and if we don't measure the problem, it's as if the problem does not exist.

We need a nationally funded research strategy. The current funding strategies ensure that our colleagues will not share... [*Technical Difficulty—Editor*]...the pie with us. Crumbs are simply no longer enough. We need infrastructure funding to ensure that training and knowledge translation occur across the country and at all levels of training.

Evidence-based interventions exist that result in recovery rates of 60% to 70% in adolescents with severe eating disorders, yet there is nowhere in this country where families can consistently find these services in a timely fashion. In fact, in most of the country, these services are unavailable, meaning that these unlucky adolescents are sentenced to chronic illness and a shortened lifespan.

We need to act now as a nation.

Don't let this cycle of neglect repeat itself another time. Let this time be the last.

Thank you.

● (1540)

[*Translation*]

The Chair: Thank you very much for your fascinating testimony, Dr. Pinhas.

I will now give the floor to Dr. Gail McVey, who has 10 minutes at her disposal.

[*English*]

Dr. Gail McVey (Community Health Systems Resource Group, Ontario Community Outreach Program for Eating Disorders, The Hospital for Sick Children): Thank you very much for the invitation to speak.

I am speaking on behalf of two of my roles. One is as a senior associate scientist at The Hospital for Sick Children, where I've carried out a 17-year program of research in the prevention of eating disorders. The other is as a psychologist and director of a provincial training program in the treatment of eating disorders that is funded by the Ministry of Health and Long-Term Care in Ontario.

My prevention research takes a lifespan approach and is heavily anchored in mental health promotion designed to foster healthy coping skills to fend off stressors that lead to eating disorders.

My early-to-mid research career has been supported by funding from the Ontario Mental Health Foundation, the Ontario Women's Health Council, CIHR knowledge translation and exchange, and a mid-career award from CIHR from the Institute of Gender and Health.

I have identified normative stressors of early adolescents that trigger eating problems in young females. This led to the development, implementation, and evaluation of prevention, trying to prevent symptoms that lead up to eating disorders in young females.

I subsequently trained local public health practitioners to facilitate prevention and conducted research on that. I'm the first to develop and research a school-based ecological prevention program designed to prevent eating disorders by involving male and female students, parents, teachers, school personnel, and public health.

In recognition of the late adolescent risk transition for eating disorders, I partnered with university-based practitioners from student health services to develop, implement, and evaluate a prevention program for university students using peer health educators as agents of change. I have translated the evidence-based strategies into an online curriculum for teachers and public health and I've matched them to the ministry of education's learning objectives to foster uptake by teachers in Ontario, Nova Scotia, and British Columbia.

Coordination of my prevention research and knowledge translation activities has been made possible by my active and volunteer membership on various coalitions, including the Ontario Healthy Schools Coalition, the Body Image Coalition of Peel, and the Canadian Association for School Health, and through my delivery of face-to-face community-based prevention workshops across the province of Ontario.

What is unique and innovative about the prevention research that I've been conducting is that it has been shown to enhance protective factors and decrease risk factors that are associated with both eating disorders and obesity. The prevention strategies also promote a sense of belonging and connectedness among the youth, which is protective against a myriad of mental health concerns and risky behaviours.

Since 2007, I have broadened my program of research in two ways: one, by bridging the field of eating disorders and obesity prevention to seek common ground to promote health; and two, by broadening the scope of my partnerships Canada-wide. I'm currently leading an innovative professional development training model geared towards front-line health promoters to help integrate mental health promotion into healthy weight messaging, as well as leading a knowledge mobilization strategy across Canada, entitled the national prevention strategy group on the prevention of obesity and eating disorders. All of this has been done on pilot funding from CIHR in the amount of $68,000.

The stop and go nature of this research funding has brought the program of research to a halt. The competing demands on public health practitioners and educators, whom I have trained, have drowned out the need for eating disorder prevention and early intervention.

Within the eating disorder prevention research field, targeted prevention, which is defined as interventions designed for high school students that are aimed at preventing early onset symptoms from escalating into eating disorders, has produced in the research field the largest intervention effects. That means they are the most effective, yet there is a total absence of targeted prevention for Canadian adolescents.

This gap in service, or death valley, coincides with the highest period of risk for the development of eating disorder symptoms and their associated mental health concerns. Up to 25% of Canadian children and youth experience significant mental health issues, and 50% of these problems appear before the age of 14 years. Eating disorders are no exception. They fall into the same category of prevalence and onset.

● (1545)

A third of youth at risk for substance abuse, most of whom are female, also report experiencing concurrent eating disorder symptoms. Yet we don't have any concurrent substance abuse and eating disorder programming in Canada, with the exception of Rideauwood Addiction and Family Services in Ottawa, who are reaching out to our field of eating disorders to learn how to treat eating disorders, so that small agency can jump-start the first-of-its-kind concurrent treatment and prevention of eating disorders and substance abuse.

It would appear that across Canada we have resources and policies in place that focus on upstream health promotion for the whole population. Attention is also being given to maternal health and early childhood well-being for the zero to six years age group, and there is attention being focused on adults. There is a large gap in intervention research and resources available, however, for the 6 to 19 year age group, or the 6 to 24 year age group.

In my role with the Ontario Community Outreach Program for Eating Disorders, with the generous support of the Ministry of Health and Long-Term Care in Ontario, my colleagues and I have created a provincial training program. The lifespan approach delivers training and supervision and evidence-based eating disorder treatment, and works to bridge partnerships across sectors.

With a small investment in 1994 in the amount of $100,000, we travelled the province of Ontario and identified champions who, with our support, showed an interest in specializing in the treatment of eating disorders and educating health care practitioners and educators to help out with identification and early intervention, where possible.

With further investment from the Ministry of Health in Ontario, we developed a first-of-its-kind provincial network of specialized eating disorder service providers.

Despite our best attempts, we can't keep up with the heavy demand for specialized treatment, and the increasing complexity and comorbid conditions that accompany eating disorders, including anxiety, depression, and substance abuse, to name a few. We need help from the mental health and addiction field.

My recommendations for your report are that we need a tracking system for eating disorders at the national level, including a registry. We need guidelines for the treatment and prevention of eating disorders, with subsections for child and adolescent eating disorders, adult eating disorders, and young adult transition-aged youth with eating disorders. With that we need a mechanism for knowledge translation of these guidelines across multiple disciplines and faculties.

We need a research chair in the prevention of eating disorders, and we need a research chair in the treatment of eating disorders, one for adults, and one for children and youth.

We need a strategy to reach out to primary care practitioners, including family doctors, who are the first point of contact for the public, yet they are the least knowledgeable and skilled to recognize eating disorders and offer timely early intervention.

Last, as a field, we need to leverage the trains in motion that are under way at the federal, provincial and territorial levels in the area of mental health, so that eating disorders are part of round table discussions on topics of stigma reduction, knowledge translation and capacity building, youth councils, caregiver guidelines, speaker training, and tool kits.

In short, we want to put a stop to the discrimination experienced by the field of eating disorders so that we can meet the needs of individuals and their families who are so desperate for our care.

Thank you.

● (1550)

[*Translation*]

The Chair: Thank you very much, Dr. McVey.

We will now go to questions.

Ms. Truppe, you have seven minutes.

[*English*]

Mrs. Susan Truppe (London North Centre, CPC): Thank you, Dr. McVey and Dr. Pinhas, for being here today and taking time out of your busy schedules.

Dr. Pinhas, it's nice to see you again today. I had the honour and pleasure of meeting with you last week to learn a lot more about eating disorders. That was very informative. Thank you for doing that and meeting with some of the MPs.

Obviously there are different approaches to treating eating disorders, as there are for other diseases, mainly because it's a psychological disease as much as anything else. That we're learning.

Within the context of eating disorders, could you tell us how working with younger people differs from working with adults?

You mentioned that during your conversation with me in my office. You said that there were special challenges in dealing with younger kids due to the psychological makeup.

What works? What works when dealing with younger kids? What would be the best practice that you've seen?

Dr. Leora Pinhas: First, there is a real deficit of research when it comes to children specifically. We know we have to take a developmental approach and not try to treat kids like little adults, or even like miniature teenagers.

Right now a child as young as six or seven who shows up with an eating disorder can end up being in an in-patient unit where they are treated with 17-year-olds. This is really problematic. Most of us don't want our seven-year-olds hanging out with teenagers who may be talking about all kinds of things that are beyond a seven-year-old's ability to process. Working with their parents and helping their parents problem solve around how to get their child to eat again, supporting the parents in family therapy seems to work, although we don't have adequate research.

Again, we have evidence-based treatments that work for adolescents. We have some research to support this, but again, not as much as we would like. It is very different from treating adults who are independent and who don't have the same kind of relationships with their parents.

To answer your question about needing a variety of treatments, the problem is that even for an adult with other kinds of disorders, we have a variety of treatment options. With kidney failure, you might have a kidney transplant; you might have dialysis. For depression, there are all kinds of different therapy. Somehow with eating disorders, we've decided that if there is one program in the city, that's enough, and if you don't respond to that treatment it's too bad. Your only choice is to try again or to stay sick.

Mrs. Susan Truppe: You've also spoken out about some of the eating and nutritional programs that are taught in middle school in Canada and some of the unfortunate consequences that go along with it.

Can you tell us a little more about these programs and what your concerns were?

Dr. Leora Pinhas: Sure. I think we've implemented in the curriculum all these healthy lifestyle programs that start in kindergarten and find their way not just into health class but into math and English. Kids are inundated with all this information, sometimes too much information, that they can't really understand or process and that they're not in charge of managing anyway. To keep telling kids that what they're eating is wrong, or that they need to change it when they don't buy their food, don't make their lunches.... It's the one area in education where instead of giving kids age-appropriate tasks where they can practise a skill, we tell them what they're supposed to do and then leave them to figure it out.

If we really want kids to have healthy, nutritious lunches, we need to have a lunch program. We can't tell kids what a healthy lunch is and then expect them to somehow figure out how to do that for themselves. We end up undermining parental authority, interfering with normal development, and we see kids who develop eating disorders because of that.

● (1555)

Mrs. Susan Truppe: Dr. McVey, I read your biography, and it explains that you host the international symposium on integration of practices that prevent eating disorders. Whom do you invite to that? What type of professional people? Whom do you invite from across Canada or internationally? I'm assuming it's worldwide.

Dr. Gail McVey: This is across Canada. I've reached out to stakeholders from each province, some of the provinces that reach out to territories, as well as three of our federal agencies. The goal here was to be strategic. We wanted to try to bridge the field of eating disorders, so we reached out to people from these areas who specialized in the prevention of eating disorders. Then we invited people who were either at a policy, research, or practice level involved in healthy weight messaging and obesity prevention. These were multiple disciplines, so there was no exclusion according to discipline. This was more in terms of expertise in each of these two categories.

We wanted to leverage the research findings from both fields and look at opportunities to have lessons learned from success stories from each of these fields and try to look at an integrated approach to the prevention of a broad spectrum of weight-related disorders.

Mrs. Susan Truppe: You just mentioned success stories and lessons learned. Do you have a good success story, a best practice or something that you really like which you think might work, or did work, that you've learned from hosting this?

Dr. Gail McVey: One of the things I did when I brought everybody together was share with them a background paper that I put together, which I would be very happy to share with the committee. It looked at research literature supporting why it is we would like to integrate both of these approaches up until a certain age group. We know from the literature that there are risk factors and protective factors common to both eating disorders and obesity. We have had some prevention research be successful in modifying those risk factors and boosting those protective factors, but they've been supported by funding in the eating disorder literature and have yet to be crossed over to the area of obesity prevention.

Mrs. Susan Truppe: How often do you host these conferences? Are they annual?

Dr. Gail McVey: This started off with a CIHR planning and dissemination grant that I received in the amount of $20,000. It was a two-day in-person meeting that we hosted in 2011. It was met with such success that the participants requested that I continue to chair these meetings. Usually once every two months is what we've been doing up until now.

Mrs. Susan Truppe: Thank you.

The Chair: Ms. Ashton, for seven minutes, please.

Ms. Niki Ashton (Churchill, NDP): Thank you very much, Dr. Pinhas and Dr. McVey, for joining us today and sharing your very important work and your research.

Dr. Pinhas, I'm very interested in your book, “Developing a feminist-informed model for decision making in the treatment of adolescent eating disorders”.

People with anorexia will sometimes refuse treatment by doctors. I'm wondering if you believe it is ethical to intervene against their will. What kind of ramifications does this have on a larger feminist framework which values informed consent? I'm wondering how your book addresses this tension.

Dr. Leora Pinhas: It wasn't a book; it was a paper, just to be clear.

What we were arguing for is that patients with eating disorders are like other mental health patients, and sometimes, because of the illness, they're not capable of consenting to treatment, particularly when they're really young. In the case of voluntarily allowing a 12-year-old to refuse treatment, we have to really...[*Technical Difficulty —Editor*]...whether she really understands the ramifications of what she's doing.

The feminist perspective was to talk not just about this idea of informed consent and having the freedom to make decisions, but it was also about responsibility and what families owed each other in terms of taking care of each other. Most people live in families and make their decisions independent of their family.

Sometimes people refuse treatment because they can't afford child care. I have seen someone delay their treatment for an eating disorder because they didn't have enough child care over the Christmas holidays. They couldn't do the treatment because they had to be home for their children.

This paper was arguing not necessarily that treatment should always be forced, but that people live in families, and it's about doing no harm and making sure that families can keep their family members safe.

As with other mental health disorders, when they are no longer able to make rational decisions for themselves, we have to step in the same way we do for other disorders. It was done as a direct response to not stepping in when it was clear that people were so starved they were not thinking clearly and had at previous times chosen therapy or would have likely chosen treatment had they had all their capacities intact.

We should not allow those people to make decisions that end their life. We don't do that in schizophrenia. We don't do that in depression. We should not do that in eating disorders. I have colleagues who can't step in because there's nowhere to treat patients. There is no one that will take them into a locked unit. They don't have the same rights.

I would argue that I don't think 10-year-olds or 12-year-olds have the capacity to decide to die from an eating disorder. I take those things very seriously.

● (1600)

Ms. Niki Ashton: Absolutely.

Do you think that applying a feminist lens when we're talking about eating disorders is important?

Dr. Leora Pinhas: Absolutely.

Ms. Niki Ashton: We're hearing from stakeholders such as yourselves and doctors that there's not enough access to treatment for people with eating disorders. Often it requires hospitalization for a person to receive a spot in a treatment program and there isn't enough treatment of the upstream causes of eating disorders or follow-through after a patient is released from a treatment program.

I notice your work with Sheena's Place, which tries to provide support to people through their life cycle. We find this work very commendable. I'm wondering if you could speak to the funding model for Sheena's Place and how similar centres can be established. More importantly, given our committee's work, could the federal government support such initiatives?

Dr. Leora Pinhas: I think the federal government could support such initiatives.

Sheena's Place is funded right now through donations. They don't currently have much access to government funding. What they do provide are groups. They do provide the funding for the therapists who provide the groups. They provide a safe place for patients who have had negative experiences and are afraid to return to hospital.

In fact, sometimes, even people who work in the hospitals, like me, will meet a patient at Sheena's Place because it feels safer for them. I would strongly endorse the work done by Sheena's Place and similar organizations like Hope's Garden and Danielle's Place. We need more services, but we also need to help them provide more services.

I know that Sheena's Place often worries about whether they'll have enough funding. Sometimes they have to cut back. They really do live month to month.

Dr. Gail McVey: I'd like to add a comment, please.

One way to look at it is that often in severe cases of eating disorder, medical stabilization and psychiatric stabilization are warranted. We very much rely on our colleagues working in tertiary care hospitals to deliver that expert care, but all too often, with the limited funding and resources that we have, there are very few dollars left over to help people with that. The medical and psychiatric stabilization just helps a person maximize the use of outpatient treatment, if you will, and some of the issues to look at the root causes of the eating disorder, or how to overcome the eating disorder, and we often don't have very much funding left over for those outpatient services.

I would agree with some of the other witnesses in their statements that we are lacking in terms of the pre-hospitalization, the follow-up to hospitalization, and as I mentioned in my presentation, targeted prevention, which is really catching young women and men at the onset of their symptoms and trying to actually prevent them from developing into eating disorders in the first place.

Ms. Niki Ashton: It's very surprising to hear that you run simply on donations. It really does seem that the federal government could play a role in terms of funding in the case of this work. We are concerned by the lack of funding this government has put toward eating disorders. We're also concerned by the lack of funding put toward eating disorders from all levels of government.

Last week we heard compelling testimony from Merryl Bear of NEDIC, the National Eating Disorder Information Centre. She talked about how sparse and unsustainable the funding model is for places like Sheena's Place and for her organization. She puts the lack of funding inside a cultural context that doesn't value women's health care sufficiently. She talked about the government cutting funding to the women's health contribution program and other pockets of money that supported work in women's health.

Would you agree with Merryl Bear on this point? How could better funding contribute to helping those with eating disorders?

● (1605)

The Chair: Very briefly, please.

Dr. Gail McVey: The one comment I would like to make to support the comments that Merryl Bear at NEDIC made is that certainly in my area, as a person who specializes in prevention research, toward the early and mid part of my career, I had funding from women's...[*Inaudible—Editor*]...funding agencies. When those funding bodies were depleted or no longer existed, my eating disorder research funding fell by the wayside as well.

I very much benefited from those funding sources. I really think there's a misunderstanding about eating disorders. This is not just a women's health issue. Eating disorders affect all of us. We need to be under the tent of mental health and addiction, and we need to be under the tent of other health initiatives that are being discussed across the federal level.

The Chair: Thank you very much, Dr. McVey.

[*Translation*]

Mr. Terence Young, you have seven minutes.

[*English*]

Mr. Terence Young (Oakville, CPC): Dr. Pinhas, I want to know if you have any concerns about the obesity interventions that some health care professionals bring forward and that are amplified by the media, which can create anxiety in the minds of young people, young girls, for example, leaving the impression that all sugar is bad and you should never touch sugar, or that all young girls should have the same body mass index as every other young girl.

Do you have concerns that all those messages are planting the seeds of eating disorders in children?

Dr. Leora Pinhas: Absolutely.

I think we've been overtaken by this panic around obesity. There is apparently an obesity epidemic. As far as I can tell, though, the rate of obesity in children is essentially a flat line. In fact, recent data from the United States suggests that in the younger groups of people, it's actually going down, not up. We keep acting like we have to do something to make sure kids aren't fat, but in our rush to do that, we are transmitting a kind of panic. What happens is that kids start to think that fat is bad, that being fat is bad.

You know, there are studies that show that kids would rather have a parent die of cancer, they'd rather lose an arm, they'd rather be hit by a truck, than be fat. Being fat is one of the most common reasons kids get bullied. Other kids feel justified when they hear from their teachers, their doctors, and their parents that obesity is such a horrible thing. They misunderstand that. We need to slow down and think about what we are actually transmitting.

I want to commend Hasan Hutchinson, who presented earlier on, for his public health work that has really worked to try to move the focus away from weight to healthy lifestyles. You can be healthy and fat. You can be unhealthy and thin. You cannot tell what someone's health status is just by one number, and yet that seems to be what we're transmitting. Recently there's been a push to look at physical education and physical literacy, but I have also heard suggestions that we should include people's BMI in their marks in gym class, as if kids have any control over that.

Mr. Terence Young: That's bad news. Thank you for a fulsome answer.

Dr. Pinhas, what should be the minimum standard of care for girls and women with eating disorders?

Dr. Leora Pinhas: That's a big question. I guess what I would say is that girls and women with eating disorders are entitled to the same standards of care they would be entitled to if they had any other mental health disorder. There should be guidelines in place. There should be treatment options across all spectrums of treatment, and treatment should be available across this country. That is the minimum standard of care. We have evidence-based research in some areas, and where we don't we need to be doing that research. That's the minimum standard of care, I would say.

I could go into detail about the specific kinds of things we need. Sure we need in-patient programs, and yes, we need residential programs, but a lot of what we need is outpatient programs. We need intensive community programs and people who are trained to work with families where they live and provide them the supports they're entitled to in the way they do for any other mental health disorder.

Our kids often are excluded from those services in general mental health units. If a child had depression, you could send the child to the local outpatient mental health program. When they hear that these kids have eating disorders, we're often told that there's no place for them. In Toronto, all the acute adolescent mental health beds exclude patients who have a primary diagnosis of an eating disorder, even if they have other reasons to be admitted, such as suicidality.

I've had some of my colleagues in psychiatry approach me and tell me that they would want to admit some of these girls, but they're not allowed because girls with eating disorders aren't entitled to those beds.

● (1610)

Mr. Terence Young: Thank you.

Is this lack of consistent and effective services for our children with eating disorders about money?

Dr. Leora Pinhas: It's twofold. Sure, it's about money, but it's also about discrimination. When there is money that is sent to child and adolescent mental health, whether that's federal or provincial, we always look.... Eating disorders are always listed, but when the money gets to the mental health care centres, somehow nothing ever gets developed, not only specialized to treat eating disorders, but even to just incorporate patients who have comorbid eating disorders into the other programs.

It's twofold. One is about how much needs to be put into place, but the other is about ensuring accountability, so that when that money is allocated, eating disorders are invited to the table, as Dr. McVey suggested.

Mr. Terence Young: Thank you.

If a doctor or a parent of a child with an eating disorder wanted to find out the cost burden of seeking treatment for their child, which would include transportation, day care, time off work, etc., is there anywhere they could find this information?

Dr. Leora Pinhas: Not...[*Technical Difficulty—Editor*] We don't track that. There's no research to look into that, and it's almost impossible to figure out a way to get funded for that kind of research.

Mr. Terence Young: If you wanted to find out how many women and girls have died of an eating disorder in Canada, is there a resource to do so?

Dr. Leora Pinhas: No, there is not.

Mr. Terence Young: Would a death registry be helpful?

Dr. Leora Pinhas: A registry that tracked patients identified with eating disorders, for an unfortunate death, or recovery, or any kind of data that a registry, say, like the cancer registry, could track, but for eating disorders, would immediately improve the state of affairs.

Mr. Terence Young: Some of the patients who are treated as in-patients in hospital programs—I'm talking about girls and women—leave and sometimes slip back into their old patterns of purging, etc. What could we do? What could be done or should be done with regard to their care to make their improvements more permanent?

The Chair: Very briefly, please.

Dr. Leora Pinhas: First of all, it would be great if we even had outpatient programming for them. Many of these women leave in-patient intensive services and go to nothing, so anything we could do, even weekly visits, would be better. Certainly, we could do other things, such as working with them in the community, like they do with addictions or in some other child models, but anything would be better than what we have now, which is nothing.

Dr. Gail McVey: Schools are actually reaching out and asking how they can help them re-enter the school system when they are still in recovery or have recently recovered from the eating disorder.

The Chair: Thank you, Mr. Young.

[*Translation*]

Ms. Duncan, you have seven minutes.

[*English*]

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Dr. Pinhas and Dr. McVey. Welcome to committee.

First, I don't mean to harp on this, but I note that I am waiting for information that I asked for from officials on December 10.

Dr. McVey, I'm wondering if you could tell the committee how many psychiatrists there are in Canada who work with Canadians with eating disorders, please.

Dr. Gail McVey: Yes. We have approximately 40,000 to 41,000 psychiatrists in Canada in total. Based on anecdotally looking at our colleagues across Canada, we have approximately 12 psychiatrists who work in the area of eating disorders. That is split between those who specialize in adult eating disorders versus those who specialize in child and adolescent eating disorders.

Ms. Kirsty Duncan: That's shocking. Are there provinces where there is not a.... If there's one psychiatrist, the distance people are going to have to travel is shocking.

If you could make a recommendation to this committee regarding psychiatrists who look at eating disorders, what would that very specific recommendation be, please?

● (1615)

Dr. Gail McVey: For me, the recommendation would be around opportunities for training and mentoring of psychiatry residents, and a succession plan. One of the things we're worried about is if the existing 12 psychiatrists who specialize in eating disorders retire or turn to another field, we're left with succession planning. There is a real and urgent need for training in this area.

Dr. Leora Pinhas: I would like to add as a psychiatrist that it's impossible to graduate as a psychiatrist and not have treated someone with schizophrenia or a mood disorder. It's certainly possible to graduate today as a psychiatrist and never have treated an eating disorder. It's possible to be a child psychiatrist and never have treated an eating disorder.

We have to treat eating disorders and training like we treat the other major axis I diagnoses.

Ms. Kirsty Duncan: Thank you, Dr. Pinhas.

I'm going to jump in here. You're giving us a very specific recommendation that you'd like to see in the report, and that's regarding training and succession planning.

Dr. McVey, could I ask you to table with the committee a very specific recommendation? In terms of training, what kind of training do you want? When? What's the funding that's required? Be as specific as you can, please.

Dr. McVey, if people need long-term treatment, how many centres are there in Canada, please?

Dr. Gail McVey: I believe seven provinces offer some form of eating disorder treatment, but for the full scale of eating disorder treatment that's required in terms of the minimal level of service, which would include a combination of outpatient day treatment and in-patient residential care, Ontario is probably the lead province in this area. That has been an output of the investments made by the Ministry of Health and Long-Term Care in Ontario, primarily by a group of people who wanted to champion this as an issue. It started off with a training program that allowed us to meet with people from different disciplines and try to coax them and look at ways we could engage them in the treatment of eating disorders.

Ms. Kirsty Duncan: Only seven provinces offer help in eating disorders.

Dr. Gail McVey: Not all of them offer it to its full capacity.

Ms. Kirsty Duncan: Okay, thank you.

How many long-term treatment centres are there in Canada?

Dr. Gail McVey: That are funded, do you mean?

Ms. Kirsty Duncan: Yes, where people don't have to pay out of their pocket.

Dr. Gail McVey: At this point it's zero.

Dr. Leora Pinhas: Yes, there aren't any really. There are two beds in Homewood.

Dr. Gail McVey: Yes. In terms of long-term residential care, we don't have any funded programs in Canada. Homewood does have one funded bed in a residential care program that has a wait list of three to seven years.

Ms. Kirsty Duncan: Are there no publicly funded long-term care centres in Canada?

Dr. Gail McVey: Correct.

Ms. Kirsty Duncan: People who have eating disorders can't wait. You said they're waiting three to seven years. If they can't wait, they go out of country. Can you share what are the costs to families?

Dr. Gail McVey: We haven't assessed across Canada the complete costs to families.

Those of us who work in the health care system have tried to look at the cost of running an in-patient bed in a province here in Canada versus one day of treatment in the U.S. and the comparison is quite striking. We're often paying more for out-of-country care. What we're not assured of is whether this is evidence-based treatment. Also, when clients return to us here in Canada, they often require follow-up care. They've already developed an alliance with the team in another country and they end up sitting on wait lists and they sometimes return. It's a bit of a revolving door. They might have multiple visits out of country as a result.

Ms. Kirsty Duncan: If I could pick up on that, I believe in Ontario they cover the cost of out-of-country treatment. You've raised the issue of follow-up care, which I hope my colleagues will pick up on in further questions. If you could make a very specific recommendation to this committee regarding long-term treatment, what would it be?

● (1620)

The Chair: Very briefly please.

Dr. Leora Pinhas: I think what we would say is that we need long-term residential treatment programs across the country, not just in Ontario. We need them for adolescents and we need them for adults. They need to be treated in the same way as we treat long-term residential or sheltered living accommodations for other mental health disorders. There needs to be a variety of options. They also need to be funded.

Certainly the Government of Ontario has looked to repatriating some of those services, but they are the first who are in the process of doing that. We need it across the country.

The Chair: Thank you very much.

Madam O'Neill Gordon, you have five minutes.

Mrs. Tilly O'Neill Gordon (Miramichi, CPC): Thank you, Doctors, for your very informative presentation this afternoon.

The more we hear about eating disorders, the more we realize that more people out there need to hear this. The need for public awareness is very important. We certainly have quite a variety of audiences out there, such as schools, community groups, professional, medical, laity, as well as professional medical bodies.

How can public awareness campaigns effectively deliver this message to the many different audiences that are out there? They need to hear your message as well.

Dr. Gail McVey: We have some solutions that perhaps don't necessarily require funding. I would really like to see eating disorders be considered under the tent of mental health and addiction in terms of the excellent work that's being done by the Mental Health Commission of Canada, Health Canada, the Public Health Agency of Canada and CIHR. What we're asking for is that when we talk about mental health and addiction, we're educating both professionals and the public that eating disorders are a mental health issue, a mental health disorder, and deserve to be considered in those public awareness campaigns.

Mrs. Tilly O'Neill Gordon: The more we hear, the more we know that this message has to get out. It is a disease. It's something that has to be dealt with the same as all other treatment.

We know as well that there would be many challenges in detecting an eating disorder. What are some of the challenges that medical professionals face in detecting and diagnosing eating disorders, particularly with girls and women?

Dr. Leora Pinhas: I think one of the challenges is even considering that it might be an eating disorder. There is this misperception that it happens to white upper middle-class teenage girls, and it's actually an equal opportunity illness. It can happen to new immigrants. It can happen in all races and ethnicities. Often if you don't look like the typical case, people don't even think about it as a possibility. That's related to a lack of training and myths that revolve around eating disorders.

We also have to deal with the shame and stigma issue. It's still a very stigmatized illness. Patients often are ashamed. It's also an illness where, particularly in kids, they want to keep it a secret because they want to keep doing it. The patients in children and adolescent programs often come unwillingly as it is their parents who are concerned.

The first step I think is recognizing it's an equal opportunity illness and training people to look at what the signs are.

The other issue is knowing when you need to get more help. The idea that it's just a phase, or that we'll just watch it or, “Come here next week and I want to see that you've gained weight”, and doing that for months and months without actually providing adequate mental health treatment, because it exists, really just leads to chronicity. There's an interesting study that came out of the U.K. which shows that if you get a child into specialized mental health care quickly, you can really prevent the beginnings of an eating disorder from turning into something more chronic. The longer a child is sick, the more difficult the illness is to treat.

● (1625)

Mrs. Tilly O'Neill Gordon: Am I okay for time?

[*Translation*]

The Chair: You have a minute and a half left.

[*English*]

Mrs. Tilly O'Neill Gordon: I'm also wondering how perceptions have changed. What influences, positive or negative, have these perceptions had on the fight against eating disorders? Are more doctors aware of eating disorders? Is there more training going into this?

Dr. Gail McVey: We've had a similar story here in Ontario with investment from the Ontario Ministry of Health and Long-Term Care.

We have a training program that has allowed us to fund and have available resources. Experts in the area of eating disorders will travel to different communities and try to do training with front-line workers. We would certainly like to see that replicated in other provinces across Canada. We would like to look at opportunities. It's been going now for about 20 years, so we have an opportunity to look at what has worked well and what some of the challenges are. We would appreciate having the opportunity to share that across Canada.

Mrs. Tilly O'Neill Gordon: Thank you.

The Chair: Thank you very much.

[*Translation*]

Mrs. Sellah, you have time for one question, if you wish.

Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP): Yes, Madam Chair.

First, I would like to thank Dr. Pinhas and Dr. McVey for their testimony. Listening to them, I understand that, unfortunately, the situation regarding care for eating disorders is dire. With regard to professional resources, we know that only two out of all psychiatrists treat these disorders. There is a lack of infrastructure; only one or two centres deal with these disorders. There is also a lack of databases and funded research. We got the message loud and clear.

Dr. Pinhas, when you began your presentation, you said that there is no access to emergency care in Canada, with the exception of one province. Could you tell us in which province people have access to this emergency care?

I would also like to come back to the work you do. I know that you studied the programs in public schools that promote a healthy lifestyle. What is surprising is that you show that these programs have had impacts that are contrary to the objectives targeted. You explained that children who follow these programs had a tendency to lose weight and suffer from eating disorders. How do you explain the harmful consequences of these types of programs? Is it because the teachers do not have the knowledge or because the disorders that these programs can cause are not well known?

[*English*]

Dr. Leora Pinhas: First of all, I'm confused about the question regarding emergency services. I don't recall saying that in my introduction.

Dr. Gail McVey: It was 12 psychiatrists.

Dr. Leora Pinhas: It was 12 psychiatrists in the country, not two psychiatrists, as well. There's a correction there.

[*Translation*]

Dr. Gail McVey: We are talking about 12 psychiatrists.

Mrs. Djaouida Sellah: Yes, I meant 12 out of 40 psychiatrists.

[*English*]

Dr. Gail McVey: I would like to answer the question regarding raising awareness around healthy weights and healthy life-style issues. I want to applaud the initiatives at the FPT level. We certainly share with our colleagues the need to look at sedentary behaviours and the need for healthy eating among our children and youth in Canada.

I want to take this opportunity to applaud Health Canada, in particular, Hasan Hutchinson's department and initiatives. He has played a big leadership role across Canada in looking at how we integrate obesity and eating disorders so when we're doing healthy weight messaging we're trying not to do harm.

Where I think there is room for improvement in our schools and in our different levels of community is that professionals and adult influencers in general need to be sensitized about their own weight bias and their own attitudes around weight and shape. They need to understand that sometimes it can be transmitted to children in a negative way. I've certainly moved my prevention research from working with children to working with the adults themselves, because there's a lot of room for improvement in terms of sensitivity training with the adults so they can learn how in an objective way to help children develop healthy lifestyles.

● (1630)

[*Translation*]

The Chair: Thank you very much.

Dr. McVey and Dr. Pinhas, thank you very much for your testimony. It was very enlightening.

We will now suspend the meeting to prepare for our second hour.

[*English*]

Ms. Joan Crockatt (Calgary Centre, CPC): May I just say thank you as well to both doctors. I hope that you haven't lost heart and that you will be encouraged by the fact that we're doing this study and attempting to shine a light on the subject.

I also want to commend the only male on our panel. Terence Young, the MP for Oakville, was the one who suggested that we do this study.

I'm happy that we're here and that we had an opportunity to hear you.

Dr. Gail McVey: Thank you.

[*Translation*]

The Chair: Thank you very much, Ms. Crockatt.

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(Pause)

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The Chair: We will now resume the meeting.

We now welcome Ms. Jarrah Hodge.

I would ask you to give a 10-minute presentation.

[*English*]

Ms. Jarrah Hodge (Women, Action and the Media): Thank you to the committee for inviting me to appear today.

My name is Jarrah Hodge and I'm a feminist blogger and activist from Vancouver. I run a multi-author feminist blog called Gender Focus.

One of our main goals is to analyze the ways in which women are represented in media. Through that I've been involved with Women, Action and the Media, Vancouver. WAM is a group of media makers, activists, academics and supporters working collaboratively to advance women's media participation and improve representation. Several people in that group shared their experiences and helped guide my research for today, so I have to send a big thanks to them.

I'm sure that you've heard from other witnesses about the serious issues we're discussing today and statistics such as eating disorders are among the 10 leading causes of disability among young women. We know that girls as young as five to women in their senior years experience eating disorders.

The situation women and girls are facing should not lead us to marginalize or forget about male patients; that can only lead to greater barriers for them to access treatment. The gender difference points to a real need for research and analysis that takes gender into account. I'm glad to see this committee taking on some of that work.

It is widely known that eating disorders arise from a complex interaction of biological, genetic, psychological, behavioural, and social factors.

One of the key social factors, and my focus for today, is the influence of media and advertising.

It's not hard to see that in popular media, thinness is rewarded while fatness is hidden, or when it is shown, deeply shamed. Today's thin ideal is thinner than past generations. It's thinner also than the general population today.

From a very young age girls learn that their body is for attracting instead of acting, which makes achieving the beauty ideal a crucial and lifelong project.

Research last year out of Pepperdine University examined girls ages three to five and found they had already internalized weight-based stereotypes. Girls were more likely to characterize the thinner figures as nice, smart, cute, neat, and quiet, while heavier figures were characterized as mean, stupid, friendless, sloppy, ugly, and loud. It's not a leap to see how these attitudes can turn inwards.

The Canadian Mental Health Association states that media glamourization of so-called ideal bodies coupled with the view that dieting is a normal activity can obscure a person's eating problems.

Over the past few decades, several studies have investigated the links between media images, women's body image, and eating disorders. in a meta-analysis of these studies, Shelly Grabe and her colleagues noted, "Research from prospective and longitudinal designs has identified body dissatisfaction as one of the most consistent and robust risk factors for eating disorders such as bulimia."

Grabe looked at 77 studies, including experimental studies in labs and correlational studies that compare women's real media consumption with their body image over time. They found an overall relationship between the amount of media consumed and higher eating disorder symptomatology, as well as other body image issues.

The evidence is compelling and points to some actions that can be taken. Before I get to that, I have to acknowledge three significant gaps in the research and in the way we talk and think about eating disorders generally.

The first is that only focusing on the thin ideal can prevent us from thinking about how the shame and policing of fatness plays in. Kalamity Hildebrandt of Fat Panic! Vancouver says that troubled eating behaviours aren't just about wanting the carrot of the thin ideal. She says there's also a stick in our culture and perpetuated in our media that polices against fatness. It says, “Look at what we do to fat people every day.”

Going back to the Pepperdine study, the fact that fat equalled friendless, ugly, mean, stupid, and loud is just as important as what thin means to girls. The study author, Jennifer Harriger, said, “A lot of the three-year-olds said to me, 'I hate her; she's fat.' Or, 'Her stomach is big; I don't want to be her.' That was really concerning to me, that children so young already had such strong beliefs about what it is to be overweight.”

When it comes to disordered eating, assumptions around weight and fatness can be devastating. Many hospital-based programs will refuse to admit patients based on their not being thin enough. There are hospitals that are forced to tell people that they have to get sicker before they can get treatment. Having weight as a deciding criterion shows an appallingly simplistic understanding of the physical effects of different eating disorders and how different factors factor in for different individuals.

● (1635)

We need to make sure we aren't reinforcing a society where behaviours considered disordered in thin people, such as extreme dieting and purging, are accepted and even encouraged in fat people.

Another gap I have to note here is Grabe's observation that there has been extreme neglect of women of colour in this research area. Moving forward that's something that needs to change. We need more and better research on how women of colour and first nations women experience eating disorders, how that relates to media messages, and to what extent there is or isn't access to culturally competent treatment in Canada.

Finally, we need more consideration of how LGBT people's experiences with eating disorders are shaped by their identities. For LGBT people, experiences of violence, bullying, and fear of rejection may be greater and can play into the risk for disordered eating. We also need to ask whether they face any additional barriers to treatment that straight or cis people may not.

One thing we do know from the research that has been done is that there are places we can start acting now. Most importantly, in terms of the areas that I'm looking at today, we need to introduce new, and expand existing, media literacy programs in our schools. Groesz, Levine and Martin define media literacy as education that raises awareness of media use, includes analysis of content and intentions, and promotes participant action in the form of media advocacy or activism.

I want to turn briefly to another meta-analysis, this time of the efficacy of media literacy programs. Szabo reviewed studies of programs from across Europe and North America and found that media literacy programs proved to be effective with the potential to reduce general and specific risk factors for eating disorders.

However, it's likely not enough to set aside a short period of time in a classroom one afternoon to deliver one-way information.

The same meta-study found that the most effective media literacy prevention programs were complex programs which contained elements that focused not solely on body image and problems related to eating habits, but also put emphasis on combatting social pressure and improved critical thinking in relation to societal standards and media messages. Yager and O'Dea confirm this finding. When done right, they found that programs with media literacy components were among the most successful at helping youth deal with body image and eating disorders.

I have more information on some specific programs that have been researched and shown to be effective, but I'm not going to have time to go into that right now. Maybe we can get into that in questions.

To conclude, I've only addressed one factor in eating disorders and their effect on girls and women, that being the influence of the media and culture on body image, but it is a significant factor and one that should not be left out of this study.

Although I suggested areas where we need more study, and focused on recommendations around media literacy education that would be aimed primarily at prevention, I also want to echo what has been said by many organizations and advocates working on eating disorder issues in Canada, which is that urgent changes are needed now.

As we saw in Nova Scotia last week, there are opportunities to make sure health care professionals are more sensitively trained to help people with eating disorders. Fundamentally, there are simply not enough in-patient spaces when and where people need them. Residential spaces are too costly for many. Financial means and geography should not be barriers to accessing treatment, nor should one-size-fits-all assessments like ruling people out based on weighing too much. We also need to address the serious lack of continuing care options available.

Thank you again to the committee for your time today. I look forward to your questions.

● (1640)

The Chair: Thank you very much.

[*Translation*]

Ms. Preskow, the floor is yours. You have 10 minutes.

[*English*]

Ms. Wendy Preskow (Founder and Chief Advocate, National Initiative for Eating Disorders): Hello everybody.

As the founder of NIED, the National Initiative for Eating Disorders, I would like to thank the committee for taking on this study of eating disorders among girls and women. I am here today to speak on behalf of hundreds and thousands of moms and dads, caregivers, and families just like ours.

As parents of a 28-year-old who has been suffering with anorexia and bulimia for over 13 years, my husband Len and I have done everything possible emotionally, physically, and financially to provide and help our daughter Amy, and it is never enough.

Our experiences of helplessness, frustration, and ultimately anger fuelled me to want to create awareness and take action regarding the bizarre and unforgiving world of eating disorders. The pain for sufferers and their families is insurmountable. The stress and strain on families is extreme, horrendous, and devastating.

There is no system in place to help our child. Yes, at 28, she is a child not only with an eating disorder, but she is also on a provincial disability support program because she cannot work. She is so paralyzed with anxiety and depression, and still expected to navigate the so-called system for help because of her age.

As parents we have been down the roughest, most horrid road ever imaginable, including using tough love at its worst and still knowing we have unconditional love for our daughter.

Siblings, grandparents, cousins, aunts, uncles, and friends are all affected by the suffering of our daughter. Fortunately, Len and I have held and supported each other through thick and thin. Living with this can and does kill relationships and marriages. It splits and isolates families, even forcing them into bankruptcy.

Eating disorders kill. They have the highest mortality rate of any mental disease. Yet, unlike depression, schizophrenia, anxiety, and mood disorders, eating disorders have no profile.

Yes, eating disorders are recognized as a mental disease, but they are seldom mentioned or acknowledged under the umbrella of mental illnesses.

We hear, read, and see all about mental health per se, but eating disorders are not on the mental health radar, programs, campaigns, or agendas.

In mid-July last year, Amy spent a week in a symptom interruption bed in Toronto to help stop the starving binge and purge behaviour. To give you an example, for her this could be both bingeing and purging 15 to 20 times a day and going out in the dead of winter in the middle of the night for binge food in a physical condition where she could have dropped dead at any time. She was consuming quantities of food beyond anyone's imagination.

When I was on the Hill in Ottawa in November last year, she let me know that she had spent $450 on food to eat and purge over three days. Multiple binges include 36 to 48 muffins, 6 to 10 large pizzas, slab cakes, litres of ice cream, mounds of chocolate, and I'm sure there was more to add to this. This happened daily for three days.

You can see how in this state she has resorted to shoplifting to feed her addiction. Unfortunately, when she had been caught in previous occasions and the police were called, she was handled unprofessionally, negligently, ridiculed, and almost thrown into an ambulance. These episodes led to a full-blown panic attack.

She is not a criminal. She is sick and there is nowhere to go for help. How is it possible for someone so sick to be turned away from treatment or not have access to treatment within a reasonable timeframe?

Back to the symptom interruption bed, it worked for her for a week, with Len and I sharing time during the day to be with her. Bullying and gossip arose from other patients, making her so uncomfortable that she left. Leaving a program midstream is extremely common with thousands like her.

Prior to hospitalization, Amy was living in a bachelor apartment with an eating disorder killing her on a daily basis. After she left the hospital, she was so vulnerable that we brought her back to live at home. This became permanent in October.

Like so many other mothers in this country, one of which was with us last week on the Hill, I have been running a 24/7 do-it-yourself treatment centre for her. There is nowhere for her to be or go other than to receive my full-time support.

I know and she knows that she should not have to deal with anxiety, binges, depression, mood fluctuations, while trying desperately and so hard every single minute to not give into the loud, noisy, forceful voices in her head that could lead to more binge behaviour.

If that's not enough, there are times when Len has had to take off work or leave work early to take over from me.

● (1645)

As you can see the impact extends far beyond the sufferer, and affects those directly involved and indirectly the greater community.

I started NIED two years ago, and have been operating on zero funding, to create awareness of eating disorder sufferers and their families, and to ultimately change and improve the system across Canada. I am extremely fortunate and grateful for the volunteers who have supported me, and especially the doctors who, despite facing their own challenges within the eating disorder system, have gone above and beyond to support NIED. These include Dr. Blake Woodside, Dr. Gail McVey, Dr. Leora Pinhas, Dr. Mark Norris, Dr. Chuck Emmrys, as well as the numerous MPs and MPPs who have helped to get NIED to where we are today to start the wheels of change.

I totally support the recommendations—

The Chair: Mrs. Preskow, please slow down a little bit to make sure the translators get all your very good recommendations. I'll let you continue, but just slow down your speech. Thank you.

Ms. Wendy Preskow: Okay.

We totally support the recommendations put forward by the doctors. As parents we want access to treatment by properly trained professionals in a timely manner.

Creation of group homes, places of safety the same as provided for substance abuse, alcoholism, and drug abuse; there is absolutely nothing like this for eating disorder sufferers.

When it comes to coverage of treatment, medical insurance companies need to step up to the plate and start covering expenses necessary to help all these sufferers and their families. How can $500 on an employee's benefit plan cover anything? Two sessions with a psychologist and it is done. It's almost better to not even start rather than opening a can of worms and leaving it to fester.

Coverage for treatment by psychotherapists, nurse practitioners, and nutritionists who have been helping and working with eating disorder sufferers and whose services are not covered by, in Ontario, OHIP or private insurance companies.

Doctors, GPs, pediatricians, social workers, teachers, police, court staff, any profession dealing on the front lines needs mandatory courses specially focused on eating disorders included in their training.

In closing, allow me to share Amy's words with you. She sent this to my phone on Saturday night:

“You keep saying this time last year I was dying, and although I'm not in the same immediate danger, my head is as ever, if not more, in the deepest darkest rabbit hole. I feel impending doom, the same impending doom I felt when I was alone at my lowest weight and bingeing purging 24/7. It's the sense of profound fear that I'm not going to make it out of this eating disorder. I'm not going to be the one-third that recovers. I may even be in the 20% that die.

“You are changing the ED world in Canada, and perhaps the only reason I ever existed was for you to create colossal change, but what about me now? It will be years before any such dream treatment facility will be brought to fruition in Canada. We all know the system here is heartless and virtually useless. They can check on my weight, and send me back into this world, and then I'm right back where I started as a little girl, scared of life and equally scared of death, scared of the unknown, and aging, and loss, and abandonment.

“There is nowhere to treat chronic eating disorders. There is nowhere to go in the emergency. There are so few who understand. I still wake up dreading the day. How will I get through it? What will I eat or not eat? How will I control myself from eating trigger foods? I can't focus on anything. I can barely read, or write, or find joy in anything because I'm constantly paralyzed with fear and anxiety, consumed with indecision and yearning to be numb.”

As a mom, here I am on behalf of NIED, advocating to make changes and bring public awareness for eating disorders, just as Terry Fox and his mom did for cancer.

Thank you.

● (1650)

[*Translation*]

The Chair: Ms. Preskow, thank you very much for your testimony.

I will now give the floor to Ms. Ambler for seven minutes.

[*English*]

Mrs. Stella Ambler (Mississauga South, CPC): Thank you both for being here today.

Wendy, we met last week. It's nice to see you again. Thank you for coming back to speak to us.

I think we all heard about your frustration and your anger and how helpless you felt. We thank you for telling us about it.

I'd like to know how you navigated the system at the beginning and over the past 12 years for your daughter on her behalf. What roadblocks did you encounter and what recommendations would you make to fix those problems?

Ms. Wendy Preskow: In the very beginning, we only found out that Amy was actually throwing away her school lunch when a friend came to tell us. She was 16. I guess at that point she was on the cusp of being admitted into hospital or not.

I think initially we were so completely naive and green and completely shocked. We have two other children as well. I remember my husband and me lying in bed just crying on each other's shoulders and asking, what did we do wrong? What went wrong? Here are two other kids who are fine and what happened to Amy? What went wrong with her?

I remember taking her to her pediatrician. We were just thrown into the deep end and we were numbed ourselves. We were completely shocked. I remember my husband also charging downtown, actually to where Merryl Bear works, to NEDIC. He googled—13 years ago, I suppose, Google was something new—and he found NEDIC. He came home with pages and pages and pages of stuff. We just sat on the bed and didn't know where to begin. I remember taking her to the pediatrician and writing him notes before we got there so that when he examined her, he knew where we were coming from as parents. I think it took a while for him to actually say to Amy that she had an eating disorder. It even took Amy about four years until she could actually say the word “anorexia”, because she started off with anorexia.

After that, it was about getting a referral. I remember getting a referral to North York General Hospital. I have no idea how long it took to get the actual appointment. I can't remember that, but I know she was really on the edge. She would keep herself so on the edge of not being hospitalized that we never had to get her in at 16 or 18. It happened much later on in her life.

I think the roadblocks are around the help and where to go, looking up people's names and psychologists, and you have to wait and you have to pay. You know, after two sessions we had reached the maximum level at my husband's office benefits anyway. There's also the fact that Amy is 28 and she's not covered under any benefits from my husband's office, because she's over the age of 25 and she's not a student. On her Ontario disability support program, she doesn't have enough money even for monthly living. We're supporting her like crazy.

As far as the roadblocks are concerned, I think it was about just not getting enough help, not having access to the help, and the whole process of a doctor having to refer you and then you wait for the assessment. The assessment comes months after the appointment. It's months before you get into the hospital program. If you get a call to come into the hospital...Amy had such a panic and anxiety attack about it. She couldn't accept the time when the phone calls came. You have to decide literally on the phone, while talking to the secretary. You either accept during the phone call or you don't come and it will go on to the next person on the waiting list.

● (1655)

Mrs. Stella Ambler: Thank you very much.

The Chair: You've got two minutes.

Mrs. Stella Ambler: Oh, good.

What would you say some of the most common misconceptions are that you and your daughter have come up against with regard to her eating disorder?

Ms. Wendy Preskow: Honestly, I think it's understanding from the majority. I think people over the years, even my close family—I hate to say that, but it's true—just aren't aware. They get fed up or they've had enough or they don't want to hear me talking about it anymore, so I just let it be. We have wonderful friends and other support systems in place.

I don't think people realize the depth of the complication and complexity, the anxiety, the social phobia, and her fears of something that you and I just take for granted or don't think is such a big issue. For somebody like Amy, it's absolutely enormous. Even for a family meal, just the other day she even said to me she's fine eating her fruit and vegetables in front of my husband and me, but for instance she can't even have an omelette in front of us because she doesn't know how to. I honestly think she's lived in such a bad way for the past six or seven years especially, that for her to relearn normal social skills is absolutely enormous.

Mrs. Stella Ambler: Thank you very much. We really appreciate your forthrightness and honesty.

The Chair: You have one minute left if you want.

Mrs. Stella Ambler: Do I? That's great.

Last week when we got together we talked about the article in *Canadian Living*. I mentioned that the mother of the teenage boy in the article who had an eating disorder blamed herself and asked herself questions about the kinds of messages she imparted to her son as a youngster, telling him that he shouldn't have a second helping because he would get fat. She felt very guilty.

I'm wondering if there's any message we can give parents. I want to tell them it's not their fault. Did you have those feelings? Did you go through that stage. Is there any advice you can give to parents of children suffering from an eating disorder?

● (1700)

Ms. Wendy Preskow: Yes, initially my husband and I totally had those guilt feelings: what did we do wrong; what did we say?

I think the best advice I can give to any parent is that if your child does not want help, you need the help. This is not something the parents have done or not done. I'm not saying in all circumstances, but certainly from the knowledge that I have gained over the years, it was absolutely not something my husband and I did. Every one of them has their unique story, and my best advice for any parent is the parents themselves need to go for help.

Mrs. Stella Ambler: That's great advice. Thank you.

The Chair: Thank you very much.

We'll move on to Ms. Ashton for seven minutes.

Ms. Niki Ashton: Thank you very much, Ms. Hodge and Ms. Preskow, for joining us today.

Ms. Preskow, I want to thank you for sharing your private story, your family story, your powerful testimony. We've heard from witnesses that one of the major barriers is the silence that people living with eating disorders and their families face. You are certainly breaking that silence by speaking out on behalf of so many families who normally wouldn't be able to join us in this committee.

Ms. Hodge, to follow up on your presentation, you talked quite a bit about existing research but also about gaps that exist in research with respect to this issue. I am wondering if you can elaborate on how underfunding can impact the quality of research conducted on eating disorders as well as the quality of care women receive.

Ms. Jarrah Hodge: There has been a real lack of any kind of research in Canada on eating disorders over the last little while. The most recent detailed calculation done by Statistics Canada of how many people we're looking at in Canada was done in 1993. That's part of the reason you see huge variations in estimates of what the needs are. You end up with a bit of a vicious cycle happening for the non-profits, the community organizations, and the health care providers that want to be able to offer programs. To offer programs they need to show hard statistics, but they need funding and the ability to do pilots to collect that data. I think there has been a really big gap.

Another issue of what research it would help to have from the government would be an analysis of the full financial impact of eating disorders on Canada. Countries like Germany have looked into that. It needs to take into account not just the cost to the health care system, but also the burden placed on caregivers, the indirect costs that are caused by people not being able to work. I think all that information would be beneficial for us to figure out how we can address the needs that are there and to show that, as they have in Germany, not addressing these issues is ethically but also financially irresponsible in the long term.

Ms. Niki Ashton: That's interesting.

You spoke very passionately about the need for media literacy. It's interesting, our first witness in this study, Dr. Woodside, whose long career has been committed to the issue of eating disorders, and Ms. Preskow mentioned him as well, talked about how the root causes are connected to issues that you can break down medically, whether it's mental disorders or related issues, but the trigger is often social issues. You spoke about the images girls and women are exposed to. You referred to the increased pressures, perhaps most recently—and I think we all know from our own experience; I, myself, as a young woman do—the kinds of images that my generation have been faced with, and continue to be faced with, which are also shifting images, right? We see different trends when it comes to the image of what women should look or act like.

Given the need, as you know, for media literacy initiatives, particularly in a school setting, I'm wondering what a general awareness campaign initiative could look like to actually reach out to the public in an effective way.

● (1705)

Ms. Jarrah Hodge: Yes, I think there needs to be general awareness, as well as school-based programs. Some things that this can look like is more government recognition, and supporting the activists, advocates, and non-profits working on these issues. In terms of what school-based programs or education could look like, the research shows that media literacy interventions need to be long term. They need to start early, and they need to focus on critical thinking, questioning and discussions. It's not just, like I said, delivering one-way information or showing a video.

In the U.K., a program is being run called Happy Being Me, which is a school-based program targeting kids 10 and 11 years of age. It targets both girls and boys and looks at known risk factors for negative body image. It promotes self-esteem. Researchers have assessed participants pre, post, and three months after the program. They found that girls had significant positive change in body satisfaction, appearance-related conversation and comparison, eating behaviours, and knowledge of the topics that they were talking about. Boys also showed positive outcomes from that program.

There's also a program called Go Girls! that operated in the United States and which was studied in five states. It included 12 group meetings of an hour each, either in class or after school. The evaluation also found really promising results. Girls were reducing their internalizing thin ideals, had a reduced desire to be thin, and had increased self-acceptance and empowerment.

Ms. Niki Ashton: Thank you very much, Ms. Hodge.

In your presentation you mentioned that you wanted to elaborate on a couple of points. I'm wondering if you'd still like to do that in the remaining minute that you have left.

Ms. Jarrah Hodge: Sure.

That's sort of what I was getting into with those two programs. Again, as I said, just to reinforce that successful programs aren't one-offs.... They involve discussion. The message is reinforced over time. In addition to the treatment, there are things that we desperately need to improve now and looking down the road. We need to address the education side to make things better in the future and help build up resistance to some of those social triggers.

Ms. Niki Ashton: Thank you.

The Chair: Thank you very much, Ms. Hodge.

[*Translation*]

We will now go to Ms. Crockatt, who has seven minutes.

[*English*]

Ms. Joan Crockatt: I'd like to start with Jarrah, please.

Thank you both very much for being here. Every witness that we have heard provides us with more compelling testimony. Some of us might wonder why we didn't get to this beforehand, but I'm very glad we have you here today.

Jarrah, I want to talk a bit about the media image, coming from the media myself. It sounds like you've put a lot of thought and study into this, and I appreciate it.

Can you talk to us about where you think the message is best directed? Sometimes we think there's a component of this that requires us to have a lot of communication to change attitudes, etc., but for this age group, I'm wondering where you think that can be properly targeted.

Ms. Jarrah Hodge: Fundamentally, it needs to start in schools, but you're right: it is a big problem. That's part of the reason studies have shown that one-off interventions don't work. When you watch a short video, you're still bombarded with these messages all the time on billboards, on TV. You have the *The Biggest Loser* on reality TV, and things like that. You need to build up the skills starting at a younger age, of course, being age appropriate, and reinforce them over time. It's not just saying that this is bad, but it's helping kids develop the skills that help them understand advertising tactics. The way things have changed over time, like Ms. Ashton mentioned, in terms of what the beauty ideal was, say, six years ago to today shows that these ideas aren't fixed.

The other big problem with the media image is the fact that it creates even more barriers for people who aren't white. Some of the early evidence we've seen in studies that have been done on women of colour with eating disorders is that because the image of the ideal beautiful woman is presented as a white woman, it can create additional complications. There still may be susceptibility to this same issue, so we need to explore race in there as well.

● (1710)

Ms. Joan Crockatt: Perhaps we can think out of the box in terms of what influences kids. If kids as young as three....

We heard today of very negative stereotypes toward fat people. Are we looking at something where this needs to be part of parenting early on? Do we need to do cartoons for kids? How do you grapple with such an overwhelming stereotype that to be thin is sexy and desirable when it's on cereal boxes, it's seen every time you turn on the TV, it's in movies, it's in everything?

Ms. Jarrah Hodge: Absolutely parents have a very important role to play. If elements of that can be built into parenting programs or parent and kid programs in communities, that would be fantastic. It's something that you can't rely on happening, but it should be encouraged, absolutely.

Also, in terms of things like cereal boxes and other advertisements that kids are exposed to on a daily basis, it's worth exploring, trying to get creative, I guess. It has been suggested in Norway, England, and France, for example, that they might want to look at having warning labels on advertisements to denote when they have been Photoshopped, or at least making it easier. The American Medical Association wants to make it easier for people in the United States to have complaints addressed when the women and images are retouched to such an extent that the advertising is no longer honest.

Ms. Joan Crockatt: Are you familiar with the modelling company that uses normal-sized models? I'm not sure where they're from, but I think they're from Barrie, Ontario. Dove, the soap company, has used them, as well as some others. Are you familiar with them? Do you think that has an impact?

Ms. Jarrah Hodge: I'm not familiar with them specifically, but laboratory studies on body image often involve showing women. They evaluate women's attitudes about their bodies and then show them images and then evaluate them again afterwards. It has been reinforced that women who view so-called average-size women or plus-size models in advertisements feel less bad about their body at the end of those experiments, so I think it does have an impact.

Italy, Israel, and India have all looked at banning models who are underweight. I don't know if that would have an incredible impact because we're getting a lot of our media from the United States, but I think encouraging health and working to break down the idea that beauty is one size would be helpful.

Ms. Joan Crockatt: Ms. Preskow, I'm sorry I'm not going to get to you. It's not out of any desire, but I have one more question, and I think that's all the time that I have for Jarrah.

You mentioned the LGBT community. I realize you're not an expert on causality of eating disorders, but you do write a blog, and you have people who write into you. What anecdotally do you know about the risks and causality of eating disorders just from what you've heard? We know a lot of people will express themselves more openly on social media than in a lot of other places. Could you comment?

Ms. Jarrah Hodge: Yes, I've heard and read in a National Institutes of Health study on LGBT people and eating disorders that initially the assumption was you would see more eating disorders in gay men because there is more pressure to conform to a beauty ideal, and that you would see less in lesbian women, but the second part of that was shown in the study to not be the case, that lesbian women and bisexual women would experience eating disorders at roughly the same rate. There definitely needs to be more study done.

Any time you're telling people there is one way to be beautiful and that your main goal has to be to attract someone using this beauty, you're going to have issues, and that is not just a message that goes to straight people.

● (1715)

Ms. Joan Crockatt: Thank you so much.

[*Translation*]

The Chair: Thank you very much.

Ms. Duncan, you have the floor for seven minutes.

[*English*]

Ms. Kirsty Duncan: Ms. Preskow, thank you for your powerful testimony, for your courage and your strength. We keep your family with us.

I'm wondering if you can share with the committee what the costs are that a family might have to incur, whether for psychiatrists or nutritionists. What are those costs? What might they be for a year, for example?

Ms. Wendy Preskow: Amy is on Ontario disability and obviously, that is a limited amount. Even though she actually does get a bit more because she has an eating disorder, with the kind of money that she's given, unless she's living in a hole, honestly, she would not have any money to come out on. Even when she was not living with us, and that's only been for the last six months, we were supplementing her rent and her food on a daily basis. We were actually doing what our therapist was helping us with, which was helping her to not steal. We were supplementing her, giving her extra food and buying her extra food, and a cellphone, which is $70-odd a month. Because she is so riddled with anxiety, using the subway and public transportation right now for her is very hard, almost impossible, so I really have to take her everywhere, to the doctor, shopping for food, for clothes, buying her clothes.

When she wasn't living with us, there was clothing, food, TV cable, shelter, all the basic necessities of life. Fortunately, her psychologist—and I can really thank her publicly—has been seeing her pro bono for the last couple of years because she realized it just wasn't something Amy could pay for and it was getting absolutely beyond us. If you're talking about between $200 and $250 a week every single week, the dollars add up in no time at all.

Because Amy feels so guilty about everything.... Honestly, I would give her the clothes off my back and run a bath for her and we would do without because the pain for her is incredible. She feels so guilty and so bad about everything. She feels like she's a burden. I'm always trying to tell her it's not her fault.

I actually have said to her that Canada has let her down, that she should be somewhere nice and warm and fuzzy, that is not a 24/7 place, but is somewhere she could have access to. It would not necessarily be a residential place, just a place of safety where she could go, something warm and fuzzy that was not and is not an institution. I've said to her many times that what is happening to her should not be happening to her, that it's not her fault, and I'm sorry that her country has let her down. I've said that to her.

Ms. Kirsty Duncan: Those are very powerful words. Could you be very specific and say what would have made Amy's life easier from the time she was diagnosed right through every step?

As you said earlier, you have to learn this brand new world on your own. There is no help.

Very specifically, what recommendations would you make to this committee so that lives could be easier going forward?

Ms. Wendy Preskow: What I've been trying to do with awareness.... If families were more aware of what goes on.... A lot of the time, and it certainly happened to us as well, in the beginning, it's such a secretive disease. We didn't keep it a secret, but we did not want Amy to be labelled. I didn't want anybody to look at her any differently as being, “Oh Amy, she has an eating disorder.” If people were more aware of it, and the families were more aware of it....

As well, one of the things I would also say to moms especially is to never say in front of their children, “I need to lose five kilos because I'm going to a wedding and I need to get into a special outfit.”

I never brought the word “diet” into our home. Never. It was never something that she ever heard from me. We're not an overweight family to begin with, so it was never something I ever spoke about. Parents' own attitude and their own acceptance of themselves probably has a role to play with their children. If children see how their parents are looking at themselves constantly in the mirror or saying , “I shouldn't be eating this”, it's going to have an effect on their children.

Other specific things—

● (1720)

Ms. Kirsty Duncan: Ms. Preskow, perhaps I could jump in.

As a recommendation to this committee, you would like an awareness and education campaign—I'm guessing; I don't want to put words in your mouth so you'll have to correct me if I'm wrong—and something that also targets reducing the stigma. Is that correct?

Ms. Wendy Preskow: Yes.

There needs to be an awareness campaign that is visible, that is not hidden. Eating disorders are hidden. Especially, unfortunately for somebody like Amy was in the beginning, with anorexia, you can see somebody who looks anorexic by the physical look of their bodies, but with bulimia, you don't know who has bulimia. You have no idea how many of your colleagues sitting around that table could have bulimia.

Campaigns and advertising need to be done in such a way so people know that it should come out. Where we are with eating disorders, I feel, is where AIDS was 30 years ago. Eating disorders are in the same place where AIDS was 30 years ago. All the outcome of AIDS and talking about it and bringing it out into the open has made the whole world embrace and help those suffering with AIDS. I think eating disorders are a full 50 years behind.

The Chair: Thank you very much.

[*Translation*]

Ms. Young, you have the floor for five minutes.

[*English*]

Ms. Wai Young (Vancouver South, CPC): Thank you again to both of you for coming today.

I want to really thank you, Ms. Preskow, for your final couple of comments. You've sort of encapsulated my questioning.

Obviously we are decades behind here. We heard in earlier testimony by Dr. Katzman that the prevalence of eating disorders in Canada is about 1.5% of our population, which therefore means we are looking at 525,000 people in Canada. She was saying that 10,000 people have cancer, 25,000 people have diabetes, and as you know, there's a greater awareness and obviously services and programs and all of the things we've been discussing and heard from previous witnesses about.

Some 25 or 26 years ago, Canada was the first country to stand up and enact legislation about second-hand smoke. That has made a huge difference, because right now in television programs, etc., there's not as much prevalence of smoking.

I want to direct my questions to Jarrah Hodge, because I want to look at the greater societal picture, and I'm also a sociologist from UBC.

Given your experience in blogging and what you hear anecdotally from people, what cultural or legislative changes—and you did touch upon that at the tail-end of your testimony—do you think would cause such a change as we have seen, such as in the awareness that we have of cancer now, the reduction of actors smoking on TV, in all kinds of areas? How can we get to that point from where we are now? We are obviously not yet there with eating disorders.

Ms. Jarrah Hodge: I think that's an excellent question.

The first thing is it has to be clear that this is a health issue. We have to use some of the techniques that were used in terms of second-hand smoke, such as public safety advertising, potentially looking at warning labels, or at least increasing the accountability on advertisers. Those are things that can be dealt with. I think they would have an effect across the system. We definitely need to be doing the teaching in schools. To counter some of the power of those overwhelming media messages, it would also help to have reinforced in the media and in public that those lessons about how distorted those images are, that is not real and that is not ideal.

Education, health-related awareness campaigns would be amazing. I think research is really needed in specifically addressing those gaps that I mentioned, but also just overall, figuring out where the gaps are, and in terms of the costs. That would also be very helpful for programs.

● (1725)

Ms. Wai Young: Ms. Hodge, I'm sorry, but may I just interrupt for a second. I have very limited time and I want very dearly to have you and Ms. Preskow submit any additional information that you have for us. I would like to address these questions to you, and please feel free to write to the committee, because we will include that testimony.

I want to spend my time, just because we have very little of it, asking some additional questions, if that's okay with you. I absolutely agree with you that we need to do more with the media, etc., but that's such a vague notion. I think the reason we are successful with cigarette smoking is that we had cigarette companies to work with and to target, etc. The media is this big vague thing out there.

Ms. Preskow, you said you do not come from an obese family, so you never talked about dieting. You have to ask, where did Amy get these concepts? How did that turn into her eating disorder? What is the link between media and our society? How then did it become a disorder for her?

I think that given how huge this issue is, 500,000 people, and the fact that it's so hidden, we have to ask ourselves these bigger questions. Obviously, it has a huge impact not just on families such as yours, Ms. Preskow, but also on society in that we've lost so much from these people who can contribute.

Please give us those answers.

Thank you very much.

The Chair: Ms. Hodge and Ms. Preskow, you have the questions from Ms. Young. The clerk will send in those questions, and if you could answer them in writing, or if you want to provide any information that you feel would be useful to the committee, points that you haven't had the chance to expand upon, other things, feel free to communicate with the clerk of the committee, and that will continue to enrich our study on this very important subject.

I want to thank you again for taking the time to meet with us, and I wish you a very good evening.

Our next meeting will be Wednesday, February 12, at 3:30 p.m. in the same room.

The meeting is adjourned.

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