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Chair

Ms. Hélène LeBlanc

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● (1530)

[*Translation*]

The Chair (Ms. Hélène LeBlanc (LaSalle—Émard, NDP)): Good afternoon. Welcome to the 14th meeting of the Standing Committee on the Status of Women.

We have four witnesses on the agenda today. Ms. Cairns should arrive soon, but we can still begin our meeting. We will have to stop at 5 p.m.

[*English*]

Ms. Jadine Cairns (President, Eating Disorders Association of Canada): I'm Jadine Cairns and I'm here.

The Chair: Oh, you are here. I'm sorry about that.

[*Translation*]

We are actually waiting for Bonnie Brayton.

Mr. Young has a point of order.

[*English*]

Mr. Terence Young (Oakville, CPC): Is it possible to get names on the screens so it's a little easier to keep it straight?

The Chair: If we can, we will. If not, I will make sure that I identify them very well.

[*Translation*]

As I was saying, we will end the meeting at 5 p.m., so that we can have enough time to present the subcommittee's report and to make our way to the House for the vote, as the bells will sound at 5:15 p.m..

We are welcoming Arthur Boese, who is in the room. Josée Champagne and Jadine Cairns are also joining us by videoconference. I want to thank them for participating in our meeting.

Without further ado, we will begin with Mr. Boese's testimony. He has 10 minutes.

● (1535)

[*English*]

Mr. Arthur Boese (As an Individual): Thank you for allowing me to put on this presentation. I have two daughters who suffered from eating disorders. When I realized the severity of this disorder, I felt that I had to get involved to help these patients get good care in a timely fashion.

With that in mind, I approached Dr. Paul Garfinkel of CAMH, who was one of the leading authorities in eating disorders in North America back in the early 1980s. Dr. Garfinkel was the president and CEO for the Centre of Addiction and Mental Health. After several meetings he expressed an interest in possibly partnering with my company, Avalon Centers Inc. However, he found that he could do nothing until there was a change in the OHIP policy. With that in mind, I decided to open a pioneering facility, Avalon Centers Inc. Eating Disorder Treatment Center, in the U.S. in hopes of bringing that experience to Canada to help our patients here when the time was right. This was a multidisciplinary approach to the treatment of eating disorders. We had a not-for-profit company called Avalon R and D and a for-profit one called Avalon Centers Inc.

To build a cutting-edge partial hospitalization program, our well-educated clinical team of psychiatrists, psychologists, social workers, nurse practitioners, nurses, and art and yoga therapists needed to build the most up-to-date protocol available. In order to formulate this, we extracted the necessary information from Dr. Garfinkel's vast research. Because of all of the clinicians involved, it was a very expensive process.

After this protocol was completed, I contacted Homewood in Guelph and talked to Dr. Eduardo Perez and April Gates. Over the next few months we had many friendly and informative meetings. When they issued a contract to partner with Avalon, we gave them our confidential protocol. After keeping it for at least four months, they then decided not to go ahead.

We attended many eating disorder meetings and were a member of the Eating Disorders Association of Canada, whose president was Dr. Robbie Campbell. At one such function in Toronto, Dr. Blake Woodside told us that there were probably 100,000 eating disorder patients in Ontario and that 18% of them died. The main treatment available was Homewood in Guelph, which at times had as much as a two-year waiting list.

OHIP did agree to send us patients now and then, depending on who was in charge, but if someone, like MPP Peter Kormos for instance, called, they pushed the patient through the system.

Bellwood, in Toronto, was also very supportive and did occasionally send us a patient.

Once in the U.S. we required a state licence from the Office of Mental Health. We are proud to say we were the first to get a licence as a free-standing facility. This was four and a half years before anyone got a licence in the state of New York. It was quite a feat for us. We established ourselves in three buildings, serving partial hospitalization, outpatient, and a two-shift fully supervised group home, with approximately 30 employees in total in under 4,000 square feet of space. We treated anorexia nervosa, bulimia nervosa, and some obese patients.

In time we worked with Kevin Flynn, who obtained a budget to get OHIP to do an audit on our largest treatment centres in the U.S., ourselves included at the Avalon Centers Inc. Buffalo location. Their audit showed we were as good as the finest centres and better than most in the U.S. and only two hours away from Toronto, but still OHIP was unable to provide us with patients.

We had many meetings with 20 senators and assemblymen to obtain their support in the U.S. I worked closely with Senator Joseph Bruno, majority leader, and Senator George Maziarz of Lockport. They promised us a new 20,000-square-foot centre ready to proceed. We even had fully comprehensive drawings and land picked out. Unfortunately, funds became scarce because of the economic downturn in the U.S.

Since this is a mental disease, and wanting to help patients with their insurance coverage, we went to Washington to help obtain mental health parity with the HMOs. In Washington I ran into a colleague, Kitty Weston, from Minnesota. I told her that I had contacted Senator Hillary Clinton’s office and that she was going to come out to Avalon. But then 9/11 occurred. As it happened, Hillary Clinton was in Washington. My wife and I were fortunate enough to obtain a meeting with her, and she gave us her full support.

● (1540)

We also had an agreement with Dr. Thomas Rosenthal, professor, and chair of the department of family medicine, Buffalo, New York, that all graduating doctors in western New York would be trained by our clinicians in eating disorders, because this is not part of their training.

Through my dedication and personal finances only, we are happy to say we were able to save approximately 1,000 lives in the 11 years that our multidisciplinary partial hospitalization treatment program lasted. Our experience there has shown that the young patients are more receptive to a free-standing facility rather than hospital settings.

Because of my experience, I would be pleased to assist in the process of setting up similar facilities in Canada.

This is respectfully submitted.

The Chair: Thank you very much for your presentation.

Now we'll go to Ms. Brayton for 10 minutes.

Ms. Bonnie L. Brayton (National Executive Director, DisAbled Women's Network of Canada): Thank you.

I've of course discovered on arriving, because I had to print everything and prepare very quickly, that there are some pages missing from my presentation, so I will start with saying, first of all, thank you very much for inviting the DisAbled Women's Network of Canada to come and present before the committee on behalf of our president, the board of directors, our members, and our staff. I also want to begin by acknowledging the Algonquin peoples, upon whose land we are gathered today.

Our remarks today will add the unique perspective of DAWN-RAFH Canada—the DisAbled Women's Network of Canada—that we bring to the table. We aim a disability, feminist, and intersectional lens on eating disorders to add to the discussion and, most importantly, the interventions that will come from these deliberations.

In the Convention on the Rights of Persons with Disabilities, article 6 identifies women and girls with disabilities worldwide as a focus of special concern—

[*Translation*]

The Chair: Ms. Brayton, since you are missing some pages, do you want us to move on to another witness, to give you time to fix the problem?

Ms. Bonnie L. Brayton: Yes, if possible, as I would like to have access to the document in order to print the missing pages.

[*English*]

The Chair: If the other presenters are ready to present, maybe I could ask Ms. Champagne to do so.

[*Translation*]

Ms. Champagne, you have 10 minutes.

Ms. Josée Champagne (Executive Director, Anorexia and bulimia Quebec): I would like to begin by thanking you for having me today, as well. It's truly an honour for me to be here. I also want to thank you for conducting a study on eating disorders. This is a very important issue.

For 14 years, I have been the Executive Director of an organization called Anorexia and bulimia Quebec, or ANEB. This is a not-for-profit organization that provides services to individuals with an eating disorder and their families, across Quebec.

Our organization guarantees free, ad hoc and specialized assistance to individuals suffering from eating disorders, and to their loved ones. We provide a help and referral phone line, prevention activities and professional training. Over the past 14 years, I have seen time and time again how important community resources like ANEB are in the continuum of supportive services for individuals suffering from eating disorders.

Eating disorders are very worrisome public health problems in terms of their rising prevalence, but also in terms of their various manifestations, which are largely unknown and often go unnoticed. Those include anorexia, binge-eating disorder and muscle dysmorphia.

These eating disorders, as you have probably heard from many witnesses who came before me, have numerous psychological and physiological repercussions on the person suffering from them. If left untreated, the disorders may result in death. Unfortunately, these types of situations have occurred in recent years.

Despite this extremely alarming state of affairs, there are very few resources specializing in eating disorders in Quebec. The limited resources that do exist are in the public domain. The number of hospital beds available for individuals with eating disorders is very low—about 10 to 12 beds throughout Quebec.

For adults, it takes a very long time to obtain specialized third-line services for eating disorders. People can wait for months, even a year or sometimes longer, depending on the seriousness of their eating disorders. For people in distress, a few days is a long time. You can imagine what a few months, even a year, can be like. The resources available to people suffering from this disease are clearly insufficient.

Faced with those kinds of wait times, some people decide to turn to private resources for specialized assistance. However, those resources can also have considerably long waiting lists and charge a lot of money for their services. So that is not an option for most people suffering from eating disorders.

When it comes to treatment for eating disorders in Quebec, it may sometimes seem that we have a two-tier health care system. We have the private and the public systems. Currently, in Quebec, a number of public resource professionals are trying to compensate for that shortage in order to meet the demand. However, the sad reality is that few professionals know enough about those disorders to be able to respond effectively.

There is another major issue that should be pointed out. Most of the care available is concentrated in large urban centres. People living in the regions have few resources, and often feel isolated and misunderstood. They also feel like that they are the only ones with these kinds of problems.

We know that the number of individuals with an eating disorder will increase—and they will be younger and younger—and that the physical and psychological consequences are serious. There is an increasingly urgent need for action.

All my years with ANEB have made me see that much of the stigma around the illness has persisted. People still often say that all someone has to do is eat, that their disorder is just a whim, that eating disorders affect only girls, that an individual is not anorexic because they are not thin enough, and I could go on.

● (1545)

This lack of understanding of the disease and the misconceptions about it are sometimes even found among health care professionals who are not trained or informed regarding this issue. Patients are sent home if they are not thin enough because, according to the health care personnel, they are not exhibiting clear physical signs associated with undernutrition. Believe it or not, we are still seeing this in 2014.

In addition to the many persisting prejudices, the illness is still taboo, even in 2014. Those people are ashamed to seek help. They are afraid of being judged. The disease is more taboo among men.

What about loved ones and friends? Family members of affected individuals are often resourceless and powerless in the face of the disease. They feel that they lack information about the illness and about the treatment, and that they have little support in their suffering. They do not feel equipped to help their loved one.

Last year, over 750 family members of individuals with an eating disorder called the ANEB phone help line to seek assistance, and over 300 individuals turned to support groups for accurate information.

Following this reflection, we have a few recommendations for the committee.

It would be important to improve accessibility to specialized support services in the community in order to ensure appropriate and quick assistance for individuals waiting for support, but also after treatment.

It would also be important to consolidate the funding of organizations working with this clientele, so that energy can be invested into developing assistance, instead of into looking for funding. That's often what community organizations have to focus on.

In addition, it would be important to increase the number of awareness and information campaigns targeting the illness. More interest in this issue would go a long way in helping reduce the discrimination and stigma people with an eating disorder experience. It would also be a good idea to find known public figures who have suffered from an eating disorder and who would agree to talk about their experience with the disease.

It would be essential to make training programs more accessible to various professionals, so that they could identify eating disorders more quickly and effectively. That training should target far more professionals, as many of them are likely to deal with such cases. I am not talking about only health care professionals, but also professionals working in schools and sports coaches. That number should be increased as much as possible.

It would also be important to provide professionals with more tools, so that they can respond more effectively and appropriately to clients. This would really help reduce waiting lists for third-line services and provide services in the community.

The use of prevention programs in school should be more prevalent. Those programs would be based on research evidence. In addition, peer helpers should be trained to identify young people in schools.

That concludes my presentation. I hope this information will help you in your study on eating disorders among girls and women.

Thank you for listening.

● (1550)

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

We will now go to Jadine Cairns, from the Eating Disorders Association of Canada. She has 10 minutes.

[*English*]

Ms. Jadine Cairns: Thank you.

Good afternoon. I'm really honoured and excited to be able to present to you as you conduct this study on eating disorders in Canada. As mentioned, I am the 2014 president of Eating Disorders Association of Canada and a registered dietitian by profession. I have worked in the area of eating disorders for 25 years.

I have had the opportunity to review the transcripts of the meetings thus far. I'm very excited the Government of Canada wants to hear about the challenges that eating disorder individuals and their families undergo, something that I've known for the past 25 years. There is a lot of heartache and pain and not enough resources.

I currently work in a tertiary centre. I work in the B.C. Children's Hospital eating disorders day treatment program, and I have a private practice that specializes in eating disorders. In my 25-year tenure I have had the opportunity to participate in setting up in-patient programs, working in outpatient clinics, and setting up residential eating disorder programs. I've even had the opportunity to run an eating disorders camp that we have in B.C. Every year I get a couple of hours to lecture to medical and dental students. I talk on adolescent nutrition. Of course, in my view, the big deal around adolescent nutrition in North America is eating disorders and obesity. I have an interest in obesity also. In fact I took a job in the pediatric obesity program at Children's for a couple of years. I think there's a lot of overlap. I know that other people have presented on this same topic.

Now, about EDAC, the Eating Disorders Association of Canada, it is a very young association. It was incorporated in 2009 when a group of eating disorder professionals saw a need for a uniquely Canadian association. Our mandate is to see how we can best serve the needs of those whose lives are impacted by eating disorders. We are exclusively operated by volunteers. Like me, the volunteers are eating disorder health care professionals. Only last year were we able to hire, on a very part-time basis, some support staff for the association. We felt the need to actually pay a few hours for a webmaster and provide a small amount of administrative support for a different staff member. Until this time last year, these individuals were also volunteers.

The board of directors is quite interesting. They span the country. We have people from coast to coast and across disciplines. I'm a dietitian. We have pediatricians. We have psychologists. We have social workers. We have an elections committee, and we try to emulate the fact that the best practices for treating eating disorders are multidisciplinary. EDAC is unique in that we are trying to be truly multidisciplinary.

As an association, we have four specific objectives. We want to: one, educate each other regarding best practices; two, encourage the sharing of information amongst members on the issue of eating disorders care; three, promote a reflective and responsive approach in the provision of care and amongst providers; and four, stimulate and support research in the area of eating disorders.

Our first president was Dr. Leora Pinhas, whom you've heard from. In fact many of the founding fathers and mothers of EDAC-ATAC are the same visionaries and passionate advocates you've already heard from, including Dr. Woodside and Dr. McVey, just to mention two.

To meet our association mandates at this time, we produce three newsletters a year. We host a national conference every other year. Although not ideal, this is all we can do with the rather limited resources we have. This coming year our national conference is in Vancouver, with the theme of innovation and integration in eating disorders.

As the EDAC-ATAC president, I am also the chair of this conference. Our hope is to provide a forum for many of the eating disorder health care providers from across the country to gather and share information and to invigorate each other as we do our work in our situations. We have arranged for keynote speakers who will go from prevention to treatment. In fact one of our plenaries will be totally devoted to looking at national guidelines for the treatment of eating disorders—all things that I know from past presentations have been a passion for many folks.

I am fortunate enough to be in a province, the province of British Columbia, where we do have a goal of the continuum of care for eating disorders.

● (1555)

It's not perfect. We have lots of holes, and the holes in particular have been addressed by previous witnesses. There's no residential program, and there's a need for it, specifically for young people who are suffering from an eating disorder. For example, right now I have a 13-year-old on our in-patient unit who did not manage to stay in our day treatment unit. She's had five admissions in the past two years. She's only 13. She really does not get the care that she could get provided in the in-patient unit but that's all we have. Ideally a residential program with longer-care commitments would be a better fit.

We also have secondary services in B.C. for children and adolescents. It's really based on family-based therapy, the Maudsley model, and has been well-supported by evidence. It's actually reduced the need for tertiary care of more intensive treatment. We've seen that in real life because when we have people working in those communities doing family-based therapy, we don't get the influx of referrals to the intensive treatment centre. But when we hear that there are budget cuts, there's a lack of program, or the wait-list is a year—for a young person that is ridiculous—we suddenly get a huge influx into the referral system into the intensive programs.

Alisa Harrison, who produced a document for the British Columbia government that was a literature review and environmental scan in 2011, actually cites that in the worldwide literature that she was reviewing. This is a really wonderful, very comprehensive document.

The goal that we work towards in B.C. is trying to look at continuing care for eating disorders services. I just want to highlight those two points as I talk about eating disorders and the role that EDAC is perhaps wanting to look at.

For more information on the state of eating disorders in British Columbia—I could spend another 20 minutes on that—I would refer you to Dr. Connie Coniglio, who is one of our directors at the Children's eating disorder program and she's also from the British Columbia mental health and addictions overall sort of management. So, Alisa Harrison's document is available.

A second document that is quite comprehensive is the clinical practice guidelines for the B.C. eating disorders continuum of service. That's a follow-up document from the continuum of service and it's currently in draft form, and its author is Dr. Josie Geller. I believe that Dr. Geller is on your list of witnesses that you may bring forth. Again, we could spend lots of time talking about the clinical practice guidelines that she's put together. I won't take time to do that, but we can provide it or ask for it for you if you need it.

I also want to take a few minutes to talk about one of the most satisfying things I get to do in my private practice that specializes in eating disorders. Because I've been in the British Columbia eating disorder system for so long, I often get referrals. I get calls from desperate moms and dads who are at a loss as to where to go. Because I know many of the systems, I know where their care might be provided free of charge so they don't have to come to me and pay the private practice price. I love getting them into the right care at the right time. Sometimes I support them while they are on the wait-list to get into the care that's in their local programming.

I was at my doctor's office today. I know there's been a lot of talk about GPs getting the right resources and getting them trained correctly, and I think that's really important. My GP said, “You know, when I see an eating disorder patient I book extra time, but the extra time is 10 minutes and the usual time is seven minutes.” It's almost laughable that they have 10 minutes to support an eating disorder patient and family. He told me, “You know, I see them but then I have to spend a half an hour or hours extra on my own time trying to connect people to the resources.” So, the bottom line is that I want to bring out that navigation piece for the country to coordinate. That would be truly wonderful.

The last part I want to talk about, having reviewed all the transcripts so far, is the health care message. One knows that nutrition and physical activity are very important components of the health care message. For our particular population, especially for those with anorexia nervosa, the health messages are taken in and taken to the extreme.

● (1600)

I'll give you an example. I have a 12-year-old young lady who is in my program right now. She came in at 60% of where her goal weight should be. Her heart rate was in the 30s, she was blue, her heart valve was not working properly and yet when we wanted to provide safe nutrition, provide some nutritional supplements, she was fearful because it had fat in it and it was fat juice. She feared it with her life. In the secrecy of her room she was exercising. The messages that she had absorbed were fat is bad and exercise is always good. Those are the health messages she has taken to the extreme. Of course, at this point in her life and her time fat is good for her and she does not need to exercise and those are actually bad for her.

As we look at the messages that are put out there, I want us to actually be cognizant of perhaps a push for the fear of obesity, obesity prevention, and it really clutters up what the general public is seeing or hearing and even our health professionals and GPs.

The Chair: Thank you very much, Mrs. Cairns, for your testimony.

Maybe you'll have a chance to expand during the question period.

Ms. Brayton for 10 minutes.

Ms. Bonnie L. Brayton: Thank you again for allowing me to get back and get my document correctly printed.

I will say that my president took quite a bit of time to review the previous testimonies and certainly that impacted the way that we chose to prepare for today.

As we already heard from NEDIC, the actual face of an eating disorder is heterogeneous: mostly female, but also male; individuals who identify with their assigned sex and gender, and those who don't; racialized individuals; newcomers to Canada and established Canadians; individuals with physical disabilities; individuals with concurrent medical or psychological disorders, such as, diabetes, substance abuse, depression, PTSD, and so on. Individuals from all socio-economic walks of life have eating disorders.

From a feminist lens, we have long been concerned with the messages women and girls receive about body image, sexuality, and in particular, the sexualization of young girls in the media. Conversely, from a feminist-disability perspective, in the quest to present women as strong and capable, the larger movement does not always reflect the face of women and girls with disabilities. We look everywhere but do not see our faces, and often there is no place for us, no model to follow.

In the intervening time we also see the deadly and devastating impacts of Internet pornography and cyberbullying. Women and girls are being exposed to online sexual harassment and stalking. Sex is a commodity, and your stock rises and falls with your appearance.

No exploration of media and eating disorders would be complete without flagging the issues posed by online groups that are involved in trading ideas about how to binge and purge, further reinforcing deadly practices. Additional impacts also come in the media for our virtual invisibility and the way society views mental illness and invisible disabilities, refining our view to the context of disability.

> People with mental disabilities tend to come at the bottom of the hierarchy of impairments, below those with physical and learning disabilities, because they are constructed as deviant and dangerous...as possessing a spoiled identity and lacking rationality....

I'm quoting from Beresford.

> The media plays a fundamental role in this portrayal focusing on the strange or aggressive behaviour of people categorised as 'mentally ill'. This has real consequences for individuals living with such disabilities because politicians are affected by what is reported and shape policies around mental health accordingly.

Disabled women experience violence and have a unique risk as a result of this.

> Many of us recount our experiences, as young children, of having to display our bodies to groups of male doctors in the guise of "medical treatment" without prior knowledge or consent. We may have been asked to strip, to walk back and forth in front of complete strangers so that they could get a better view of what the physical "problem" is, or to manually manipulate our limbs to determine flexibility and dexterity.
>
> Today, pictures or videos are taken of us and used as educational tools for future doctors, with little thought given to our needs to have control over what happens to our bodies or who sees us. While the medical profession attempts to maintain control over our bodies, some women with disabilities may attempt to regain control through dieting, bingeing or other methods of body mutilation.
>
> It is ableism at play when a doctor asks a woman with a disability to lose weight before she becomes too heavy for her caregivers to lift. And that ableism persists when a woman with a physical disability loses weight, and instead of asking how she did it, congratulates her on her "success."

Though identified as a serious environmental risk factor for eating disorders, every psychiatrist who testified spoke about the active discrimination faced by women and girls with eating disorders. This discrimination is in clear contradiction to the spirit of the Convention on the Rights of Persons with Disabilities, insofar as the right to be assisted in the recovery from injuries posed by their abuse.

DAWN Canada supports the recommendations made by the medical professionals presenting here and those of NEDIC. We offer a discussion of our own.

Recommendation number one. Canada's approach to eating disorders must be strategic and involve all levels of education, practice, and research. We need to ensure that the intersectional, gender, and disability lenses are also trained on the process of research, practice, education, public awareness, and disability inclusion. Public health measures aimed at prevention and early detection must include physician screening; public health nurse screening; school nurse, mental health, and addiction screening; as well as the intervention and recognition that violence against women and girls is a cause, effect, and risk factor for eating disorders. Women and girls need choice and a continuum of referral points.

Caution is also urged in the area of interventions such as neuro-stimulation and magnetic stimulation. There is promise, but have all the risks been taken into account?

Recommendation number two. There are many references to best practices and evidence-based care but there must be room for innovation, new ideas, and also creative care for women and girls with disabilities for whom current evidence-based interventions are not working.

Recommendation number three. We must ensure that women and girls with disabilities are included in discussions of eating disorders and body image. Our voices, perspectives, and indeed our images are necessary in order to move forward effectively.

Recommendation number four. Treatment programs must include women and girls with disabilities and take into account the intersection of gender, violence, and disability.

● (1605)

The services need to be competent in addressing eating disorders, trauma, addictions, and the medical effects of eating disorders and disabilities of women and girls who present for treatment rather than using intersecting disorders as a rationale for exclusion.

Facilities must be developed using the principles of universal access and information must be made available in alternate formats to ensure that all women have the information they need. Treatment must be holistic, multidisciplinary, and offer a range of choices along a continuum of peer support, community treatment, day programs, brief intervention, and long-term treatment. The interventions must take the developmental level of the woman or girl with a disability into account and be appropriately tailored for their needs.

There's a lot of discussion in the presentation about the concurrent addiction but not much discussion on the appropriateness of addiction treatment modalities in helping manage compulsive aspects of eating disorders. More research is needed to help see if addictions modalities could assist eating disorder treatment.

Remove barriers to mothers with disabilities and eating disorders who need to go to treatment. I give Alberta as an example where, under the Child, Youth and Family Enhancement Act, if a child is in care for 200 cumulative days, they move to make the child a permanent guardianship order. If a mother has no other place to care for her children than in temporary foster care, this is a discriminatory measure. We are not sure if this measure is similar in other provinces. In order to provide a structure and framework for therapy, access for determinant of health must be in place.

Justice also has a role to play with mental health diversion and the Elizabeth Fry Society, when people are arrested for stealing to finance binge cycles, as well as ensuring that adequate treatment opportunities exist for women and girls with disabilities.

Women and girls with disabilities must have positive media coverage. Women and girls with disabilities must have access to programming in which they can see their own lives and realities reflected in the Canadian discourse. The CRTC needs to be more active in promoting these measures.

Ever mindful of the slippery slope of assisted suicide—and I bring this forward because it's such an important issue in the Canadian discourse today and such an important issue to people with disabilities—we look at the risk for women with disabilities being valued less for scarce treatment resources because the younger person was perhaps seen as more viable. So she, as a 53-year-old woman, was left for nature to take its course. That's referring to Dr. Woodside's testimony of November 28, 2013.

In countries where euthanasia exists.... The case of Ann G, a 44-year-old woman with anorexia nervosa who died by euthanasia is one in a series of cases that have come out of Belgium, including recent cases, again, as a sidebar, that include the euthanizing of baby girls with spina bifida.

The human family in Canada simply must offer better to all of its citizens, including women and girls with disabilities.

I'm looking forward to preparing a written brief. We had less than a week's notice, so we were not able to prepare it for today, but I wanted to indicate that we would be recommending that the committee also hear from a young woman named Kaley Roosen, who's currently pursuing her Ph.D. at York University. Ms. Roosen's thesis and research is focused on eating disorders and women with physical disabilities. In addition, we will bring some important findings from her research in our written brief.

Thank you.

● (1610)

[*Translation*]

The Chair: Thank you very much. This was quite a marathon. My hat goes off to the interpreters, who managed to keep up with the flow of your ideas.

We will begin the question period.

Ms. Truppe, the floor is yours for seven minutes.

[*English*]

Mrs. Susan Truppe (London North Centre, CPC): Thank you, Madam Chair.

I'd like to thank everyone for being here and sharing your experiences with us.

I have a few questions for almost everybody, but I'd like to start with Madam Champagne.

I just want to commend you. I understand it was maybe 17,000 people who benefited from your services last year. I don't recall hearing from some of the other witnesses, unless I've missed something.... You have support groups, a helpline seven days a week, a confidential online chat forum. I think you also said a referral line.

Who are the people calling? Is it the individuals themselves or the families, supporters, or is it a mixture of people?

[*Translation*]

Ms. Josée Champagne: A variety of individuals call us. We are contacted by individuals suffering from eating disorders, their family members and health care professionals. This is a vital resource, as it enables us not only to provide information, but also to provide support, especially when access to professionals is no longer available. When these individuals find themselves at home at 7 p.m. or 9 p.m. with their suffering, their solitude, they don't know where to turn. This is a point of reference for them, a source of support, a place where someone can listen to them.

[*English*]

Mrs. Susan Truppe: Is the information they're receiving back from you suggestions on places they can go to get help, or is their name left somewhere and then someone calls them back? How are they getting this information? You've obviously done a good job on the awareness program if you are helping that many people. How are you making all these people aware that they know to call you for help if they are sitting at home at seven o'clock at night?

● (1615)

[*Translation*]

Ms. Josée Champagne: It's very interesting. There are very few resources available. We are basically the door that leads to the network. For health professionals, school staff and specialized resources that cannot provide care quickly, it's a matter of getting the word out on the organization as much as possible.

When clients who are trying to get help are told that there is no place for them, that there is a waiting list, they are automatically referred to us. This service is provided across Quebec. Earlier, I was talking about people who live in the regions and have no access to certain services. For them, we are a vital support resource.

Last year, 6,000 people called the help and referral phone line, and over 2,000 of them called after 5 p.m.—between 5 p.m. and 9 p.m. Usually, 50% of people call us because they need support, because they feel a food crisis coming on or because they are in distress. People are increasingly using this service to have someone who would listen to them.

[*English*]

Mrs. Susan Truppe: What would be a best practice that you've experienced that we could share with other people since you seem to be doing so well at this? Have you shared everything you're doing with other teams in other provinces?

[*Translation*]

Ms. Josée Champagne: Yes, we are trying to share this experience more and more. I think that ANEB has a really good service continuum model. We presented our response model to the Eating Disorders Association of Canada two years ago. In addition to the help and referral phone line, we have a good support group model on which more and more research is being done. Very little is being said about the community aspect because it mainly focuses on treatment. That accessible community support really improves the lives of many individuals. It plays an important role during the pre-treatment period and the post-treatment period—once people return home after receiving care. To consolidate the lessons learned, individuals can come to us and obtain support in various ways.

I would also like to add that some of our services are specific to the stage of an individual's journey towards recovery. If someone is not ready to make the call and initiate a treatment process, they can use online services. When providing our services, we really try to determine at what stage of their process the individual is.

[*English*]

Mrs. Susan Truppe: Thank you.

Madam Cairns, I think you mentioned that you have national conferences every other year and four newsletters a year. Do you have a favourite best practice that you've learned from your conferences?

Ms. Jadine Cairns: The best practices seem to be changing all the time. I was at the conference where Madame Champagne presented, and that's part of the excitement, to put together the Canadian.... A lot of really talented people are doing really good work across Canada. One of the things I like to do is look at the continuum of care and fill in the pieces that seem to be missing. I work in tertiary care, so I love it when I hear about prevention in the community, doing something before they need to get to tertiary care. As a therapist for children and teens working on the symptoms of eating disorders, I love the family-based therapy for outpatients in the community. It really does stop the progression.

● (1620)

[*Translation*]

The Chair: Thank you very much.

Ms. Ashton, you have seven minutes.

[*English*]

Ms. Niki Ashton (Churchill, NDP): Thank you very much to all of our witnesses who are joining us here today. I'll be directing my questions from my round to Ms. Brayton and as well to Ms. Cairns.

Ms. Brayton, thank you very much for your presentation and for sharing a very clear focus on the experience of women with disabilities. Early on in your presentation, you commented on the importance of a feminist lens. It's not a lens we've heard much, in this committee, at least explicitly. I think we can argue that many of the witnesses shared critical perspectives. How important is it to apply a feminist lens to dealing with eating disorders?

Ms. Bonnie L. Brayton: I think we should do this given what the statistics show us, which is that while there is certainly, from a gender perspective, a rising issue among men, this is something that is affecting women in mind-boggling numbers. The consequence of this is that the gender analysis and feminist perspective become extremely important around understanding from both an historical perspective.... What's driving this? Again, I made reference to the media and I made reference to a lot of the things that put young women and women of all ages and disability and ability in a position of feeling that they have something to live up to in terms of an image.

I spoke a lot about our concerns around the fact that women with disabilities and deaf women, for example, are not portrayed in the media. The consequence is that they're searching constantly for someone and something against which to measure themselves and they don't find that. Again, I made the other point, which is that the feminist disability lens adds one more dimension to that, which is to understand that often what is a pressure on women with disabilities is to live up to something else, another standard, rather than being accepted and valued for who they are.

Ms. Niki Ashton: Do you have any sense of trends, perhaps, in the media or social media or in public around the portrayal of women and maybe, specifically, women with disabilities?

Ms. Bonnie L. Brayton: The only thing I've ever seen on women with disabilities, for example, would be a show that actually is a bit of a bad example of trying to feature women with disabilities. I think it's called *Push Girls,* a show that was playing on the Life channel last year. I don't know if anyone saw it but again it focused on specifically women in wheelchairs, and again, from a very almost *Sex and The City* perspective, which was really disappointing. I was really happy to see a portrayal of women with disabilities, but it's one that doesn't give a balanced perspective on the reality that most women with disabilities are facing: poverty, unemployment, high rates of violence. These are all things that are much more their reality than what you're seeing. Again, you just don't see us in the media. It's a big problem.

Ms. Niki Ashton: Thank you for sharing that. I have one quick question so I get time to ask Ms. Cairns as well.

An issue, of course, that has come up is the question of bodily sovereignty, I guess the range between voluntary treatment and medical professionals reaching the point that people are forced into treatment. Obviously we know if we apply the disability lens it's a very serious issue we need to look at. I'm wondering if you can comment on that.

Ms. Bonnie L. Brayton: I can. Insofar as forced treatment is a huge issue, particularly for women with a mental health disability, there are so many dimensions to that. We could spend an entire other committee, I'm sure, just on that issue. Electric shock treatment is one of the ones that I think is probably best known to people in terms of forced treatment and that issue for women with mental health problems.

The other thing—and I know you didn't ask about but I wanted to say something on it—is it's really important for people to think about this in the context that you have.... Again, DAWN is a cross-disability organization and what we really hope, and again, what our written brief will reflect, is that these are disabilities already. The mental health disability of these eating disorders exists, in addition to which it's important to understand that there's a whole other perspective that you need to understand from the perspective of women with physical disabilities.

I appreciate very much the question around the treatment issue, Niki, and like I said, it's one issue, but the larger issue is still the attitudinal and physical and all the barriers that women with disabilities are facing in terms of just getting treatment and being recognized as the most high-risk group, in fact, of women for eating disorders.

● (1625)

Ms. Niki Ashton: Thank you very much. We look forward to the written document and thank you for sharing as well the work of the Ph.D. student.

Ms. Bonnie L. Brayton: I hope the committee will call the other woman I mentioned; she would be really important to hear from.

Ms. Niki Ashton: For sure. Thank you, Ms. Brayton.

Ms. Cairns, I quickly wanted to ask about your work and the association's work in identifying the particular challenges that minority populations face in terms of eating disorders and in terms of treatment: aboriginal, immigrant, LGBT communities, people living with disabilities. I'm wondering if you could comment on that.

Ms. Jadine Cairns: Unfortunately, because of the limited time that the association has been active, we haven't got to those particular topics.

One of our visions is to progress to the place where we can address some of those issues. Even this past year, we were talking about having sessions that can perhaps talk about why it is that we don't have as many people of different ethnicities seeking treatment. Actually, a big topic is involuntary treatment, to go back to the questions you were raising before. Involuntary treatment is something that most tertiary care programs really grapple with.

But those are the areas that we would love to have the opportunity to address, and that's why, with your research, we would love to be a part of and support the process as we talk about people with disabilities or people who are of a different ethnicity. Why aren't they coming for treatment? That's something we have noticed, but as an association we have not had the resources or the ability to address it.

Ms. Niki Ashton: Just quickly, Ms. Cairns, I wonder if you would agree with others who have talked about the adverse effects of healthy eating campaigns on people who are living with eating disorders.

Ms. Jadine Cairns: Wholeheartedly, and in fact I was mentioning that I was coming to this meeting and one of my private clients said, “Yes, please tell them that it's really hard on us.” Healthy eating means what? It means that I have to watch my calories, that I have to cut my fat. So wholeheartedly....

I mean, those messages need to get out there—I am a dietician by training—but we need to make sure, as I was mentioning, that we don't just use a broad brush to say that healthy eating is only this: that it's always avoiding fats, that it's always avoiding sugar. What's left? Just protein. It's always exercising....

The health messages need to have this in mind, because our young women and young men are receiving them, and we need to be cognizant of how they may be receiving them and taking them to extreme places.

The Chair: Thank you very much.

[*Translation*]

Mrs. O'Neill Gordon, you have the floor for seven minutes.

[*English*]

Mrs. Tilly O'Neill Gordon (Miramichi, CPC): Thank you, Madam Chair.

I want to say a sincere thank you to all of you for taking the time to be with us today. Our committee has been very focused on this study and has learned much from witnesses like you and others we have had the opportunity to hear. As we all know, it is always great to hear from someone who has worked in this area and has experienced first-hand what eating disorders really are.

My first question is for Mr. Boese. To begin, I want to thank you and congratulate you on seeing the need many years ago and stepping up and doing something about it.

You describe the Avalon Centers making use of a multi-disciplinary approach. How did your team come to create this approach? How can we share this as a model with other organizations in the treatment of eating disorders?

Mr. Arthur Boese: We obtained all the information from Dr. Paul Garfinkel, who was the leading authority back in the early 1980s.

First, I should say that we had two psychiatrists, psychologists, art therapists, and nutritionists, all these people, as part of our program. We had 30 people, so there was a lot of information. They said that it was going to take about three months to get this information to make a partial hospitalization program. At that time, it was a new thing. We're talking about 15 years ago.

I'm hearing a lot of things today that I heard 15 years ago, so not a lot is changing in this whole industry, which absolutely upsets me—I have to hold myself down—because we have to get changes. We can talk about these things. Education is fantastic. I'm told that when Obama got into power he made it law that every doctor had to go through an eating disorder course. So on education, no question.

However, when we got this information from Paul Garfinkel.... In fact, I called him up because my psychiatrist said that it was going to take me three months to pull this stuff together because we had to get it out of the library in Toronto, at the university. Paul Garfinkel said, “Well, what do you need?” I told him and he said, “Oh, that paragraph is in volume 2 on page 27”. He went through the whole thing. Now, he wasn't 100%, but he cut off three months of work. We put it together from that. It probably cost us $200,000 or $300,000 to put a protocol together.

That's what we gave to Homewood in Guelph, which nicely gobbled it up. We had a contract with them. They just took all the information.... It sent us into a bit of turn-spin, because we wanted to open in the U.S. They wanted five things from us. They wanted cutting-edge, which they didn't have. They wanted something that was reproducible, which they didn't have. They wanted something that had a licence, which we thought was a joke. We got the first licence in the State of New York. I could tell you how we got it, but I won't take the time. We really went to the top.

I said that we had a meeting with Hillary Clinton. That was a big feat, too, because we went there to help with mental health parity. I ran into somebody who asked if we had seen Hillary Clinton. When I said no, that she couldn't come out, she took my hand, walked over to a woman and said, “This is Art Boese of Avalon, a friend of mine, and he wants to meet with Hillary Clinton.” Ten minutes later she came back and said, “How about 12:30?” I looked at her and said, “Tomorrow at 12:30?” My wife was with me, I asked her if she thought we could make it, and we had a one-on-one with Hillary Clinton in a room with probably 1,000 people in it. We were in the centre, one-on-one with Hillary Clinton.

I asked that, and she said, “Art, I'm 100% behind you.” I went from there and said that I had two more things. One of them was comprehensive care centres so that patients could move at the rate of the patients' health, not at the whim of the HMOs or the outpatient therapist who keeps them too long.

As I mentioned, we saved 1,000 lives. You hear other things, such as where we've talked to 17,000 people, and that's a wonderful thing, except that we got them when they had failed already from the one-on-one outpatient.... It's important that we have something so that when they do in fact go into.... Normally what happens is that you go from outpatient. Your electrolytes are off and your weight is down. You go into the hospital and they put the weight back on.

The patient thinks, “Wow, did I get help.” But the psychiatrist there checks it off and says, “Oh, Sally was in there.” That's about it. Then she goes back and she fails: now she won't go back into a treatment program.

Somebody called me yesterday before I came out here and said that their daughter had gone to Avalon Hills in Arizona. She had been around for about two years, almost dying everywhere. Anyway, she came out of there feeling great. She went back to her doctor, and her doctor said, “Well, get on the scale and let's have a look.” She went straight back into program. That's all it takes. The education is so important. I always agree that it's important, but we have to do something.

We don't have programs here. We have nothing in Canada, nothing at all. I could scream at the top of my lungs. I work so hard. I work seven days a week. I can tell you that I went through $3 million of my money in this thing, and I see things not moving ahead. I hear the same things that I heard 15 years ago, and I went to a lot of clinical meetings.

I'm sorry to go on like this. Terence, you tell me to keep quiet.

Voices: Oh, oh!

Mr. Arthur Boese: But I went through the clinical stuff. Every week I drove to Buffalo and sat there while they went through an hour and a half with all the staff, because it's multidisciplinary and everybody's going to talk about the patient who's there: the psychiatrist, the psychologist, and the therapist. I got a great education. I'm not a therapist. I was in the valve-and-fitting business. I was not close to this business at all, but I sure learned an awful lot.

But one thing I can do is make things happen. I've had 10 companies in my life. I've made them happen.

● (1630)

I was the first to get the telephone in Canada because they weren't going to do it. I put up the walls on the highways. I was the first one to do that. I went on and on. I can make this happen if you really want it to happen.

We all agree that eating disorders are a problem. There's no question about that. But we can't do anything by talking about this thing and fooling around the outside. You've got to go in and make it happen.

Sorry for that.

Mrs. Tilly O'Neill Gordon: Ms. Champagne, you mentioned, and we all know, that attitudes are a major factor in this disorder. How would you like to see attitudes changed? What are some of the ideas you have to help us to change these attitudes?

● (1635)

[*Translation*]

Ms. Josée Champagne: Over the past few years in Quebec, a movement has emerged out of the Charte québécoise pour une image corporelle saine et diversifiée—Quebec charter for a healthy and diversified body image—which is now called the CHIC. The CHIC was implemented by the provincial ministry of women's affairs. This movement aims to promote a healthy and diversified body image and to encourage the participation of fashion, advertisement, media and health communities. Its goal is to bring together all the partners in order to drive social change and encourage body shape diversity.

This movement is gaining a lot of momentum, and people are increasingly joining in. Leading fashion magazines such as *Clin d'oeil* have decided to sign the charter. Clothing store Jacob also adopted a non-retouching policy. Mobilization is taking place....

The Chair: I have to stop you here, Ms. Champagne. Thank you very much. We have understood and will be able to follow this issue closely.

I now yield the floor to Ms. Duncan, who has seven minutes.

[*English*]

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madame Chair.

Welcome to you all and thank you for being here. I'm going to begin with Ms. Cairns.

Ms. Cairns, I'm going to look for short answers. I'm trying to establish numbers. I'm wondering how many publicly funded outpatient clinics there are in B.C.

Ms. Jadine Cairns: I don't have the numbers at the tip of my fingers, but I can provide them to you.

By region there are at least eight publicly funded outpatient clinics specific to eating disorders.

Ms. Kirsty Duncan: How many publicly funded beds for eating disorders are there in British Columbia?

Ms. Jadine Cairns: There are 14 beds for children and adolescents and six day treatment spaces in the Children's.

In the adult system, I'm not 100% sure. I don't work as closely in that area, but there is an in-patient protocol and Dr. Josie Geller could speak more on that. They use the medical wards.

Ms. Kirsty Duncan: That's okay.

I want to make sure I understand. For all of the province of British Columbia there are 14 pediatric beds for those who are suffering from eating disorders?

Ms. Jadine Cairns: Yes.

There's also a residence that's currently run by the Looking Glass in partnership with B.C. and I think there are 14 beds there. Half of it is private and half of it is provincially funded.

Ms. Kirsty Duncan: Okay, I'm going to come to that in a second. That's very helpful.

So there are 14 publicly funded pediatric beds in B.C. That means if people are from the north of B.C. or from the island, I'm guessing they have to travel. What is the cost for families if you have a young child and they're in long-term care?

Ms. Jadine Cairns: There is a cost to the family. The provincial government helps with the transportation for some of these people from away to attend the day treatment program because we only provide partial hospitalization. They fund them for hotels and to be part of the programming, so it's quite expensive.

As I said, I can get the numbers to you after I talk to the director perhaps, Connie Coniglio, and provide that to you in written form.

Ms. Kirsty Duncan: Yes, Ms. Cairns, if you could provide how many outpatient clinics. All I'm looking at is publicly funded. How many beds in adult versus pediatric, and residential care, and the average distances that families may be travelling? I'd appreciate that.

Now I'm going to go to Ms. Champagne. I'm wondering if you could answer the same questions for Quebec. We'll start with how many outpatient clinics there are, please.

● (1640)

Ms. Josée Champagne: For the outpatient clinics, I would need to get back to you because I don't want to give you false information, but the most specialized clinic is the eating disorder clinic in Montreal, which is headed by Dr. Howard Steiger. Then there's a clinic in Quebec City. Those are the two most organized clinics with outpatient services for eating disorders. What we're seeing is more and more people are getting together to try to develop outpatient clinics—

Ms. Kirsty Duncan: I'm going to interrupt. I'm trying to establish case studies. We have one in B.C. and we have one in Quebec, so it's really numbers I'm looking for.

You mentioned there is help in the public health centres, there's help in urban centres, not in the rural areas, and did I understand there are 10 to 12 beds in Quebec that are publicly funded?

Ms. Josée Champagne: At the Douglas hospital, yes.

Ms. Kirsty Duncan: That's it?

Ms. Josée Champagne: Yes.

Ms. Kirsty Duncan: I really hope this is going to appear as case studies in the report, one from British Columbia, one in Quebec. Thank you.

You mentioned that access is not possible for the majority of people. This is devastating to families. They are forced to go to private care.

Can you talk about the costs of private care, please?

Ms. Josée Champagne: I don't have those numbers, unfortunately. I can try to get them to you. But I know that some people have lost their jobs or have refinanced their homes so that their child or loved one could get services in a private setting.

Ms. Kirsty Duncan: Thank you so much.

Ms. Cairns, if I can go back to you regarding recommendations for...I think you mentioned you would like to stimulate and support research. What is your recommendation to the committee regarding eating disorders in the country, please?

Ms. Jadine Cairns: In our unique circumstance in Canada, with our publicly funded health care and with the different aspects of what we know about eating disorders, we need to start off knowing who our population is by having a database. I think this has been talked about before, having a database of those who are suffering.

Ms. Kirsty Duncan: So you would like a national registry?

Ms. Jadine Cairns: A national registry and then the people who are providing the services.... But overall we need to know what is going to be most effective. We're so in the clouds that we don't know who we are servicing, who's doing the work, what they are doing, and what is efficacious. I know in a very small—

Ms. Kirsty Duncan: Do we need a research chair in eating disorders?

Ms. Jadine Cairns: We absolutely do to coordinate it, to have a vision for Canada to do the best for its population.

Ms. Kirsty Duncan: Thank you.

[*Translation*]

The Chair: Thank you very much.

I will now give the floor to Mr. Young, who has five minutes.

[*English*]

Mr. Terence Young: Thank you, Chair.

And thank you, everyone, for coming to share your expertise with us.

My question is for Mr. Art Boese. Art, I want to go on the record saying that we worked together 10 years ago on this very issue. I was your consultant trying to help with governments and actually failed. So I would like to uncover your unique perspective on this issue.

You operated at a financial loss. Maybe that wasn't your intent, but you didn't make money the whole time you had this program in Buffalo. But you had a non-profit set up as well. You had this excellent program. I think it was about $600 a day, which is a fraction of the cost of Remuda Ranch and some others in the U.S. It was an hour to two hours' drive for hundreds of patients who had bulimia and anorexia nervosa, some of whom faced possibly a fatality from the disease. You had the service available and you basically built it and they didn't come. How is that possible?

● (1645)

Mr. Arthur Boese: I'm not sure, because as I mentioned before, it was depending on who was sitting in the seat. In one case they would send patients through and the next time they would say they've got all kinds of facilities in Ontario—

Mr. Terence Young: So we're talking about the OHIP out-of-country group who said yes or no to them getting care out of country?

Mr. Arthur Boese: That's correct, yes.

We started off where we did have a fair number of patients, and then it changed and there were no more. No matter what we did, no matter how.... I asked if it would make a difference if we lowered our price. We talk about prices; you want to know the cost of these things: $1,900 a day at that time was the Remuda Ranch, which is the highest price. Yesterday, I heard it's $1,500 for Avalon Hills.

We lowered ours to $500, but it didn't matter to OHIP whether it was lower or not, what was important is where the patients wanted to go. That's when I went through the MPP in Oakville and I asked if I could get an audit done. So they went out and saw all of the various facilities—

Sorry, did you want to—

Mr. Terence Young: I have a chance for two more questions, and you have such a great amount of knowledge to share, if you don't mind, I'll get them in. Thank you.

So when an MPP called—you mentioned Peter Kormos—the OHIP out-of-country.... So you're saying this issue was politicized?

Mr. Arthur Boese: Absolutely.

Mr. Terence Young: Okay, thank you very much.

If you could take some time and tell the committee, if you had your dream now.... Well, let's back up a little. First question: why did you go to Buffalo in the first place? Why couldn't you build your centre like the Shouldice Hospital? Why couldn't you build it in the GTA?

Mr. Arthur Boese: Well, that would have been nice, and definitely the Shouldice Hospital is there and it's been accepted for many years. Even Homewood is under somewhat the same kind of program as what Shouldice is under, and I really thought that we could be, but we couldn't, so that's when I went to the U.S.—

Mr. Terence Young: Who told you that you couldn't?

Mr. Arthur Boese: OHIP.

Mr. Terence Young: What did they say?

Mr. Arthur Boese: Well, they just said, “No, we're not covering you.” Really, the interesting thing is that if you were in a hospital setting, then they would cover it. If you were in an individual setting, they won't. But these patients are definitely not going to go into a hospital.

Mr. Terence Young: Okay, let's go back to your dream. If you could redo it now starting tomorrow, what services would you like to provide for girls and women with eating disorders in the GTA? What would you like to do?

Mr. Arthur Boese: I think the important thing is that we save the lives of patients. Because, as Dr. Woodside said when he had that candlelight vigil some years ago, we lost 18,000 patients in a year.

I went to the various people in the hospitals who were there and I asked if they would send patients to the U.S. and they said no, and I asked why: well, because, then OHIP will never cover the patients here. So what in fact they did, they used the patients as pawns to get their own—whatever— agenda. Anyway, we couldn't get them to cover the patients no matter what we did. It was just—

Mr. Terence Young: What would be your dream if you could start fresh tomorrow?

Mr. Arthur Boese: My ideal thing would be that I would set up clinics apart from the hospital, generally out in the woods somewhere. In fact, we have drawings of the ideal building, where they seat how many, who's there, whether it's the psychiatrist or psychologist, and generally there are three or four in the building at one time. I have all of that stuff.

We had plans in the U.S. for all of that stuff. All of that stuff could be done here, and that's why I get a little excited when I wonder if I'm going to hear this thing 15 years—and I won't be alive in 15 years, by the way—this same thing over and over again that we're going to go through. As I say, education is great. You need it, but you have to do both ends of it.

The early intervention is the key to success. You've probably heard that a million times, and that's important, and that's what you're doing, and that's what you're providing. But, then, when the patients get ill, they don't want to send them to the U.S., and they can't do it here and you realize.... But Dr. Paul Garfinkel told me that $4.5 million worth of funds went to the U.S. out of Ontario in one year.

The Chair: Thank you very much for your time and for your answers.

[*Translation*]

Mrs. Sellah, you have five minutes.

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

I must say that I cannot believe this. I want to begin by thanking my colleague Mr. Young for asking Arthur Boese the question.

I want to congratulate you on your initiative. I understand that this is a personal battle for you, since you had two children suffering from that eating disorder. I have a lot of sympathy for you, and I thank you for what you are doing.

My colleague who spoke before me already asked this question. You live in Ontario. You went to the United States to open a centre. I don't understand the government's attitude toward such a serious problem, be it when it comes to the affected individual or their friends and family. Our government did not want to help you with your initiative. Did I understand correctly?

● (1650)

[*English*]

Mr. Arthur Boese: That is absolutely correct.

[*Translation*]

Mrs. Djaouida Sellah: Why do you think that was?

[*English*]

Mr. Arthur Boese: I don't know, because it's so obvious to you, it's obvious to me too.

I really thought that if we went to the U.S. and stayed there for a year, we would be able to come back with all of that information, with all of the latest research in eating disorders, and do it at home. I mean, I want to save our people at home. But they weren't prepared to do anything, no matter what we did. Terence worked with me. We couldn't get them to budge.

[*Translation*]

Mrs. Djaouida Sellah: Is this due to our health care system? Is it due to the successive governments? That's a question mark for me, as for you.

As a member of a committee tasked with studying legislation, I have many questions in my mind. You are not the first or the last to be in this situation. Given all the potential Canadians have to do extraordinary things locally or internationally, I think it's a pity we are letting them leave the country. That's a major concern for me.

I have another question for you. I know that you closed your centres owing to financial problems. You had multidisciplinary teams to provide patients with care. Could you give me the approximate number of relapses during that period and tell me what the cause was?

[*English*]

Mr. Arthur Boese: Well, it's kind of hard; you have to do it over many years. But in terms of our success rate, among the patients who came in and who had failed in a one-on-one, generally the failure rate was about 65%. Those are the people we saw. It wasn't those who came in initially and wanted information.

So we would follow them through, but it was very difficult. The systems didn't allow us to really find out how they were three years later—if they failed, they wouldn't talk to you—but the success rate of the patients who were there was about 85%. That was high. Our treatment centre was as good as any centre out there, as good as the $1,900 that Remuda Ranch was charging.

That's what OHIP told us when I finally got them to do an audit. They went to all the big centres first, because the patients were asking for it, but...anyway.

[*Translation*]

Mrs. Djaouida Sellah: Madam Chair, do I have any time left?

The Chair: You have one minute left.

Mrs. Djaouida Sellah: On a related note, my question is for Ms. Champagne. It's about the ANEB experience in Quebec.

How have you been assessing this program's success since the centre was created? Has the number of calls dropped off? Has there been any positive feedback? Have there been any relapses? Have you assessed the results since your centre was created? And if any results are available, could you please send them to us?

Ms. Josée Champagne: Yes, I can send you some relevant figures. It seems clear to us that more and more people are using our resource for help. Last year, we assisted more than 17,000 individuals, and that number is still growing. All the people who are turning to us are an indication that we are doing something very positive.

Of course, we are a community resource, and not a treatment centre. We do, however, monitor our groups. The questionnaires distributed before and after treatment clearly indicate an improvement in symptoms. However, that all depends on what is being evaluated. The improvement may not always be obvious on the plate, but it can also be noticed in other areas, such as in the person's condition.

● (1655)

Mrs. Djaouida Sellah: Do I have a few seconds left, Madam Chair?

The Chair: You have only five seconds left to thank the witness.

Mrs. Ambler, the floor is yours for five minutes.

[*English*]

Mrs. Stella Ambler (Mississauga South, CPC): Thank you very much, Madam Chair.

Thank you to all of you for being here today and for giving us this fascinating and useful information.

Ms. Cairns, I'd like to ask you as a dietitian about adolescent nutrition. I note that your work as a dietitian has been profiled in high school textbooks. You mentioned that health messages are taken to the extreme. We heard from another witness that sometimes a trigger of eating disorders—not cause, but trigger—is teachers and school projects gone bad.

I'm wondering how we deal with that, with instilling healthy eating habits and attitudes in young people without causing those triggers. I found it alarming that one of the triggers could be from simply trying to teach a young person to not eat too many trans fats, for example, or to stick to eating protein and vegetables or something like that. To have some of them take that to the extreme is frightening.

I guess the question is, what do we do?

Ms. Jadine Cairns: It is frightening, and thank you for asking that excellent question. It's something like what I mentioned. As a dietitian in the eating disorder area, I'm always having to say, “This message is not for you”. It's a message that we put out for the general public, and I'm even skeptical about how we portray that message, as I mentioned, “fat is always bad”, no matter what, and “exercise is always good”. Those messages need to be tailored somewhat, I believe.

In terms of the school curriculum, we certainly see this and hear it. I think it's a question of the education of our coaches, of our educators. It's the whole global campaign that we need to be cognizant of.

One of my recommendations would be to look at a coordinated way to get the messages out. Health Canada does a wonderful job: “These are the top priorities”—for battling, perhaps, obesity or for cardiac issues. It's all very specific. Many people perhaps suffer from cardiac issues, and I know that some previous witnesses have said that there is an obesity epidemic. Is there really, or are we just fearful of it? We need to look at the messages to know how they might be taken in the wrong way. Of course, the eating disorder is the one that's going to take it to the extreme, but we want to always make sure that we not paint it with a broad brush, as I mentioned before, but always be aware of what our messages might translate into.

It starts with the curriculum.

Mrs. Stella Ambler: I'm sure you could expand the point to everyday consumers as well and to the misinformation so many of us have. When people talk about healthy eating.... Even in food labelling, for example, there is talk of putting calorie counts on food labels, or making them more prominent. They are already there for prepared and processed food.

Would you say it would be a dangerous thing to do, to feature calorie counts on food labels?

Ms. Jadine Cairns: It's a huge danger.

I was really happy 20 years ago when I was doing this spiel that people did not have access to the calories and the grams of fat and of carb and of sugar. The more that information is out there and easily accessible, the more our patient population uses it, and because the numbers have this power—the eating disorder drives them—it's a very dangerous thing.

In this case, a little information is dangerous. It's not a good thing.

Mrs. Stella Ambler: It's counterintuitive, isn't it?

Ms. Jadine Cairns: Absolutely. I was trained as a dietitian to think that we need to get information to the public, let them know, let them make the choices. Maybe we don't, because that information can be used in very dangerous ways.

To give you an example, there is a very popular app for iPhone called MyFitnessPal. What a great idea: help people control their calories, help people control their weight and get them healthy. Health is now a synonym for being perhaps skinny, or for something like losing weight.

I have so many young women in the college age group who are addicted to the Fitness Pal numbers. They have to get those numbers into the app. It's an easy way of making them focus on and obsess about the calories in their food. I'm trying to let them back away from this. It's something that's dangerous.

● (1700)

Mrs. Stella Ambler: Thank you very much.

[*Translation*]

The Chair: Thank you very much.

We must now end the public meeting, since we have to plan the rest of our study in camera before we go to the House to vote. That's part of our job.

I would like to thank our witnesses for coming to share their experiences and expertise with us. This will really help us with our study.

[*Proceedings continue in camera*]

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