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Chair

Ms. Hélène LeBlanc

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● (1530)

[*Translation*]

The Chair (Ms. Hélène LeBlanc (LaSalle—Émard, NDP)): Good afternoon, everyone, and welcome to the 13th meeting of the Standing Committee on the Status of Women. The meeting will exceptionally end at 5:15 p.m., so that the subcommittee can sit for 15 minutes. Joining us today are three groups of witnesses. By finishing at 5:15 p.m. today, we will be able to plan the rest of the study.

In addition, supplementary estimates (C) were sent to the members of the committee on February 13. The committee can study the estimates and report on them or shall be deemed to have reported on the supply for supplementary estimates (C) by March 7, at the latest.

I would now like to welcome our witnesses. Today, we are hearing from Dr. Wendy Spettigue, who is here on behalf of the Canadian Academy of Child and Adolescent Psychiatry. We are also welcoming Dr. Lisa Votta-Bleeker, Deputy Chief Executive Officer and Director of the Science Directorate, as well as Dr. Giorgio A. Tasca, Research Chair in Psychotherapy Research at the University of Ottawa and the Ottawa Hospital. Both of them are representing the Canadian Psychological Association. Also testifying, by videoconference, is Elizabeth Phoenix, Nurse Practitioner from the Canadian Federation of Mental Health Nurses. I would like to welcome her, as well.

Each group of witnesses will have 10 minutes to make a presentation.

Dr. Spettigue will take the floor first.

[*English*]

Dr. Wendy Spettigue (Psychiatrist, Canadian Academy of Child and Adolescent Psychiatry): Thank you for the honour of presenting to you on behalf of the Canadian Academy of Child and Adolescent Psychiatry, and on behalf of clinicians who treat eating disorders in youth.

As you know, eating disorders are devastating illnesses. Research suggests that it takes between two and seven years to recover from an eating disorder, and that only 50% fully recover. Eating disorders have the highest mortality rate of any psychiatric illness due to a combination of medical complications and suicide. For a variety of reasons, eating disorders and risk factors for developing eating disorders are on the rise.

I will begin with the social context.

Rates of body dissatisfaction in women are greater than 87%. Seventy percent of women are currently dieting to lose weight. In a survey of North American women, when offered any three wishes, the majority chose weight loss as their first wish. Ten million women in the U.S. suffer from an eating disorder, more than have breast cancer. I wish I had the equivalent numbers for Canada. We need a national registry for eating disorders. Canada does not know the number of eating disorder sufferers, the average wait times for treatment, or the percentage of patients who get treatment.

Here are more statistics. Forty to fifty per cent of girls aged 11 to 15 years say they need to lose weight, and 61% of Canadian grade 7 and 8 students were trying to lose weight. Researchers in Edmonton studied 700 children in grades 5 to 7. They found that more than 15% were purging or over-exercising, 16% were binge eating, and 19% were restricting to one meal per day or less.

Why is this significant? In a study of 14- to 15-year-old adolescent girls who engaged in strict dieting practices, they were 18 times more likely to develop an eating disorder within six months compared to non-dieters, and had almost a 20% chance of developing an eating disorder within one year.

Not only are eating disorders on the rise, but pediatric mental illness in general is on the rise in Canada and North America. Here are some more statistics. In any given year, one in five people in Canada experiences a mental health illness. Up to 70% of young adults living with mental health problems report that the symptoms started in childhood.

Severe, disabling mental illness has dramatically increased in the United States. In 2011, Marcia Angell reported that mental disorders in children increased by a startling 35 times between 1987 and 2007.

In 1998, Dr. Martin Seligman, then president of the American Psychological Association, presented the results of his research. He reported:

> ...there is now between ten and 20 times as much [depression] as there was 50 years ago. And...it has become a young person's problem. ...thirty years ago...the average age of which the first onset of depression occurred was 29.5. Now the average age is between 14 and 15.

These statistics are valuable because, as a child and adolescent psychiatrist, it is important for me to put eating disorders into context, given that eating disorders are highly associated with other mental illnesses, especially with depression and anxiety.

Happy youngsters don't develop eating disorders. An eating disorder develops when a young person feels not good enough, or literally and figuratively, as though they don't deserve to take up a normal amount of space in this world. Eating disorders arise when a young person feels scared, sad, worried, guilty, angry, stressed, or unworthy to such an extent that starving herself seems like a better alternative, a way to cope with those intolerable feelings and to help her feel good enough. An eating disorder is thus a form of self-treatment akin to drug and alcohol addictions, only in this case, the youth gets addicted to bingeing and purging or to seeing the numbers on the scale go down.

Unfortunately, one side effect of lack of nutrition is increased obsessiveness, so what might start out as a diet or weight loss plan can spiral out of control into an illness similar to obsessive-compulsive disorder, in which the obsessive thought is "I'm eating too much, I'm gaining too much weight", and the patient then feels compelled to decrease the intensity of these obsessive worries through symptoms such as restricting, purging, and exercising.

● (1535)

Associated extreme hunger can then lead to bingeing, although in children, they often just continue to restrict, and lose more and more weight.

Thus, as you can imagine, eating disorders are highly associated with other mental illnesses, including anxiety, depression, obsessive-compulsive disorder, and substance abuse. As those illnesses increase in number so do eating disorders. But other factors are also associated with the rise in eating disorders, including an increase in anxiety about the food we eat and the epidemic of obesity; an increasing emphasis on appearances and celebrity culture; and the huge diet and weight loss industry, all of which lead more and more young females to feel self-conscious and not good enough about their looks.

As mental illnesses and eating disorders have increased the resources and small number of clinicians available to treat these disorders have not been able to keep up with the demand. The number of family doctors trained in the treatment of eating disorders is almost nil. Community mental health agencies lack time or funding for training in eating disorders, and are overwhelmed by mental health referrals in general. There is a terrible shortage of psychiatrists across the country, even fewer child and adolescent psychiatrists, and only a very small handful of us who have specialized training in the treatment of pediatric eating disorders.

So what can we do to improve the situation? Let's examine the various levels of intervention, starting with prevention.

One challenge is that efforts to prevent obesity have actually increased the number of eating disorders. I am frustrated by hearing one story after another of young girls whose eating disorder was triggered by a health class, school project, teacher, coach, or family doctor. We need more research into the causes and risk factors and how to prevent eating disorders, including how to prevent obesity without causing a concomitant increase in eating disorders.

We need to find a message of balance, moderation, size acceptance, and healthy body image that applies to all. We still don't know enough about how to prevent eating disorders. We know that teaching eating disorders in school not only does not help, it actually increases the number of eating disorders. Yet, have we been effective in changing this in the schools? No. It is part of the curriculum and thus difficult to change.

We also need to do a better job of teaching family doctors and medical students, not just about eating disorders but also about the dangers of dieting, that low weight is as unhealthy as overweight, and how to treat obesity without causing eating disorders.

We need to train family doctors to screen for eating disorders and to have the language to talk to girls about nutrition, body image, and eating disorder thoughts, urges, and symptoms.

We need to send more trained mental health nurses into the high schools to help young people who are struggling with depression, anxiety, and eating disorders.

We need more trained community health counsellors who can counsel students who suffer from depression, anxiety, self-injurious behaviour, eating disorders, and addictions.

At the secondary level of care, we find girls with severe anorexia nervosa admitted to smaller community hospitals where the doctors and nurses do not understand eating disorders and are frustrated by the adolescent's stubborn refusal to take nutrition. They resort to behavioural approaches, which often involve sending parents away while the young person stays alone in bed all day until she earns her privileges. This doesn't make sense when you understand that the patient is being controlled by the illness, rather than the other way around.

I also hear horror stories of young girls being sent home from the emergency department at dangerously low weights because their blood work is normal. If only the doctors understood that these girls meet the definition of medically unstable by their low weight alone, despite their body's attempts to compensate for the starvation.

I hear of family doctors who, when faced with teenage girls with obsessive exercising and low heart rates who have lost their menstrual periods, reassure concerned mothers that this is just an effect of being a top athlete.

● (1540)

I often hear my colleagues in child psychiatry say they don't treat eating disorders, or they don't get eating disorders. They can't understand how an underweight teenager can refuse food because she's "too fat". If only they could be helped to understand that this is similar to a person with obsessive-compulsive disorder, who can't stop cleaning their house or washing their hands. It has nothing to do with how clean the house is or how dirty their hands are but instead with the intensity of the obsessions and compulsions.

Many clinicians find it too frustrating to treat an illness in which a young person is extremely medically and psychologically compromised, is angry and depressed, does not want help because she's terrified it will cause weight gain, often resists treatment, and usually takes a very long time and a lot of specialized care to treat. The clinician has to be comfortable working with not just these patients but also their families. Given that most communities have a terrible shortage of child psychiatrists, few of these psychiatrists have enough time to dedicate to these patients or to their distraught, exhausted parents and families.

The Chair: Dr. Spettigue, I thank you very much for your testimony. I know you are not finished, so I am telling the members we will have the whole testimony of Dr. Spettigue translated and distributed to members.

Hopefully, during the question period you will be able to complete your testimony with the rest of your presentation.

Thank you very much.

Now I would like to hear from the Canadian Psychological Association, for 10 minutes, please.

Dr. Giorgio A. Tasca (Research Chair in Psychotherapy Research, University of Ottawa and the Ottawa Hospital, Canadian Psychological Association): Thank you for inviting us today. The Canadian Psychological Association is the national association for psychology in Canada. There are approximately 18,000 psychologists in Canada, making up the largest group of regulated specialized mental health care providers in the country.

Psychologists are committed to evidence-based care—that is, care that is clinically effective and cost-effective. We accomplish this by developing, delivering, and evaluating treatments and programs across a wide range of mental and behavioural health disorders, including eating disorders.

Eating disorders are characterized by severely disturbed eating behaviour, body image, and self-esteem, which typically begin in adolescence or young adulthood. Although boys, men, girls, and women can all be affected by an eating disorder, eating disorders typically affect 10 times more females than males.

Two of the most commonly known eating disorders are anorexia nervosa and bulimia nervosa. Anorexia nervosa is characterized by a refusal to maintain a normal body weight through severe dietary restriction, while bulimia nervosa is characterized by eating an excessive amount of food and losing control during that episode, which is called a binge, followed by purging, usually by vomiting. Binge-eating disorder, which is less well known but is actually the most commonly occurring eating disorder, involves binge eating without purging.

The lifetime prevalence for anorexia nervosa is about 0.9% of the population, for bulimia nervosa it's about 1.5% to 2% of the population, and for binge-eating disorder it's 3.5%. The prevalence of eating disorders, though, is highest among teenage girls and young women.

As Dr. Spettigue mentioned, although we don't have a registry in Canada, if we extrapolate those percentages to the Canadian population we can guess that about 450,000 to 500,000 Canadian women have experienced or will experience an eating disorder during their lifetime. The prevalence rates may actually increase in the coming years, partly for social reasons but also because the diagnostic criteria we use for eating disorders have changed. We're finally recognizing that less extreme levels of disordered eating significantly affect health and functioning.

As was mentioned, eating disorders have a devastating effect on individuals and their families. These disorders often co-occur with other debilitating mental health disorders, such as depression and anxiety. Quality of life, work, education, family, and social functioning are all negatively and significantly affected by an eating disorder. As was previously mentioned, compared with all other mental health disorders, anorexia nervosa has the highest rate of death.

Psychological interventions have the best evidence base for treating eating disorders. Evidence-based psychological treatments are considered by most international treatment guidelines to be the first line of intervention for most eating disorders. Treatments can be provided on an outpatient basis for less severe cases. However, specialist care is required for more severe individuals in both day treatment and in-patient programs for those who are medically compromised.

Successful treatment of eating disorders depends on a comprehensive plan that includes ongoing monitoring of symptoms and stabilizing nutritional status; psychological interventions that include cognitive behavioural therapy, personal psychotherapy, and family counselling; education and nutrition counselling; and in some cases medications.

Often primary care is the first place those suffering with an eating disorder go to for help, so it's critical that family physicians are educated as to the seriousness of eating disorder symptoms, to be able to recognize when there's an eating disorder present and to recognize when the patient requires specialist care.

● (1545)

Dr. Lisa Votta-Bleeker (Deputy Chief Executive Officer and Director, Science Directorate, Canadian Psychological Association): Madam Chair, one of the greatest challenges when it comes to caring for the mental health of Canadians is the significant barriers to accessing mental health services. Only one-third of those in need of mental health services will actually receive the help they need. We have psychological treatments that work and experts who are trained to deliver them. Because these services are not funded by provincial health insurance plans, and because private insurance offered by most plans is frequently too little to allow for meaningful service, Canadians cannot often access the services they need.

The cost of mental illness in Canada is estimated at $51 billion annually. In response to Canada's national mental health strategy, which called for increased access to evidence-based psychotherapies by service providers that are qualified to deliver them, the Canadian Psychological Association commissioned a report to look at how this can be achieved. It is our association's position that psychological assessments and treatments for all mental health problems, including eating disorders, are a necessary basic health service. As concerns eating disorders in particular, several of the models that were recommended in the report we commissioned are especially relevant.

First, Canada needs to integrate psychologists on primary care teams. Various estimates are that 30% to 60% of visits to family physicians and primary care are for, or related to, a mental health problem or disorder. With psychologists working or consulting with primary care, a youth or young adult who presents with an eating disorder will have access to the right care in the right place at the right time.

Patients with eating disorders are often ambivalent about seeking help, so their symptoms can be easily missed in a busy family practice. Having a mental health specialist like a psychologist in primary care settings can reduce these missed patients. Further, girls and women with mild eating disorder symptoms can be cared for by a specialist in a private office. This would reduce the burden on tertiary care centres and provide family physicians with specialists to whom they can refer a patient with an eating disorder.

Second would be to include or maintain psychologists on specialist care teams and secondary and tertiary care facilities for health and mental health conditions. Budget cuts to secondary and tertiary care centres in recent years have reduced the availability of psychological and other services to patients with eating disorders. Given the incidence and prevalence of mental disorders, particularly eating disorders, we need to maintain and augment our mental health resource within publicly funded health care institutions.

Third would be to provide sustained funding for community-based resource and support centres to help those who are recovering from an eating disorder. These centres currently receive little or no public funding and depend on a range of health care providers and services for their success.

Finally, Canada needs to expand private insurance coverage and promote employer support for psychological services. The best mental health return on investment is when services and supports are provided for children and youth. Most mental health disorders begin before young adulthood, and this, as we've heard, is especially true of eating disorders. Children, youth, and families need better access to needed psychological care, whether in a health facility, a primary care setting, or a community-based centre.

It is CPA's mandate and commitment since the commission of our 2013 report to speak with funders of care, and the organizations and agencies that deliver it, to create parity in how Canada takes care of the mental and physical health of its citizens.

Thank you.

● (1550)

The Chair: Thank you very much.

Now, Ms. Phoenix for 10 minutes.

Ms. Elizabeth Phoenix (Nurse Practitioner, Canadian Federation of Mental Health Nurses): Thank you.

As a tertiary care nurse practitioner, I bring 22 years of mental health experience to this consultation session. During my career I have been a part of system and program development in geriatric mental health, adult mood and anxiety. I spent nine years as a pediatric mental health nurse practitioner, and two years as an adult eating disorders nurse practitioner. Along this journey I have been a witness and influencer of implementing evidenced-based mental health treatment. This is a value I hold very strongly as a right for all our mental health patients and families to receive the best of care and the most appropriate level of care. This has lead me to believe that quality research and evidenced-based treatment should inform and guide practice. This evolves from effective training and knowledge dissemination. This body of research should guide policy-makers and decision-makers in the development of programs.

How can this happen? It commences with the collection of research and expert input, such as what we are engaged in today, and it continues with the commitment to excellence in treatment that is the right of all our patients and families.

My additional comments are going to be structured based on the three asks that have been brought forward by previous members consulted before.

Family physicians and nurse practitioners are well positioned as primary care providers to screen and diagnose eating disorders. It is imperative the current and new diagnostic criteria from DSM-5, which was published in May 2013, be taught in education programs and also to practitioners currently in practice. In particular, an existing barrier to timely referral of individuals with eating disorders is the preoccupation by primary care providers with weight and seemingly normal blood work. When weight and blood are within normal limits practitioners, patients, and families can easily think that the individual is still well. Current DSM-5 criteria remove the stringent weight criterion and the amenorrhea, or loss of menstrual cycle, diagnostic measure that previously we had to work with.

Physicians and nurse practitioners need to better understand and communicate to patients that although their blood work can seem normal, their body stores of these elements are significantly depleted and a reflection of their malnutrition. So they may appear to be a healthy and normal weight, but indeed they are not. More telling of their clinical impairment are their thoughts and feelings about their body shape and weight, and their impaired relationship with food. Clinically I have seen this time and again with our patients who are normal weight and have normal blood values.

An 18-year-old I co-treated this past year with our in-patient medical team met this description—

● (1555)

The Chair: Ms. Phoenix, just slow down your delivery a little bit so the translation can keep up. Okay?

Ms. Elizabeth Phoenix: Sure. I'm just mindful of the time.

The Chair: Thank you very much for your collaboration.

Ms. Elizabeth Phoenix: Okay.

Clinically I have seen this time and again with our patients who are normal weight and have normal blood values. An 18-year-old I co-treated with an in-patient medical team last year met this description. However, she had been extremely symptomatic two months prior to hospitalization with bingeing and purging up to eight times per day. She was extremely malnourished as a result; however, her weight was stable and blood work was normal.

While she was in hospital she contracted pertussis, which is whooping cough; she developed Stevens-Johnson syndrome, which is a systemic potentially life-threatening rash; and two pre-arrests were required as result of adult respiratory distress syndrome. It gradually made sense to her treating medical team that she was immunosuppressed and at risk due to her eating disorder symptoms, despite the fact that on paper her weight and blood work appeared quite normal.

I want to draw you a mental picture of what she looked like two weeks into her hospital stay. She was swelling, edematous, from head to toe; she had a rash from head to toe; she was on full isolation —gown, gloves, goggles, masks—and was really unrecognizable by visitors who were coming to see her in hospital. That's how unwell she was.

Integrating 30 nurse practitioners in eating disorders programs in the province of Ontario as an integral part of team structure has been a bold and appropriate step for the province. Nurse practitioners, because of their training and expanded scope of practice, are well positioned to provide efficacious, thorough assessments and treatment of both the mental health and complex physical health needs of individuals with eating disorders.

However, as with physicians, there appears to be inadequate time given in training programs to accurately support screening and identification of individuals who need to be referred on to more specialized services. Further advanced training for nurse practitioners to work with this complex population needs to continue and should serve as a model for other provinces to follow.

Training opportunities could occur through advanced clinical fellowships already offered through the Registered Nurses' Association of Ontario. This process matches experts with novice nurse practitioners to share knowledge through praxis and mentorship. All provinces have professional nurses' associations already to facilitate this framework or model.

Curricula could be developed and followed so that consistency of evidence-based practice is disseminated. In addition to increasing training in medical program curricula and opportunities for clinical training, this would be extremely beneficial.

In addition to increasing training opportunities for eating disorders, it's an important first step to establish Canadian practice guidelines for physicians, nurses, and nurse practitioners in primary care. Practice guidelines have been a reliable method for primary care providers to provide evidenced-based, consistent medical care to their patients over the last several decades. They have become an essential component of evidence-based practice in primary care and could facilitate more consistent screening, early identification, and appropriate referral for specialized treatment of eating disorders in the future.

Good data should inform decisions regarding practice. How do we get good data? As previous presenters have explained, a national registry as requested by previous clinicians would be a process to better understand the scope of eating disorders in our communities in each province. This data should be collected to track the incidence and prevalence of eating disorders, the wait times for assessments and treatment, and the outcomes from the branches of services provided. It should also track dropouts from treatment and the state of wellness achieved by those who receive treatment. Are they relapsing? Are they moving on to develop a quality of life that ensures they are contributing members of society?

Allowing treatment outcomes to be monitored on a federal level would allow us to truly know how well we are doing in the treatment of eating disorders. Further, such tracking would allow us to better assess the impact of training initiatives and efforts to improve access to quality care.

● (1600)

I would like everyone to imagine the following scenario. Two medications exist for a terrible illness. One of the medications has been around for a while and works for 15% of the population. One of the medications is newer and requires training to be able to administer and when properly administered, it works for about 45% of the population.

Would you, the members of this panel, be okay with the following arguments about why we should keep using the first medication? I would love to learn how to administer the new medication, but I don't have time to learn the new technique; or I don't live in a major centre and I can't find someone to train me in using the technique; or the philosophy associated with the new medication does not match my own philosophy. Which of these arguments would alleviate the duty to ensure best practice and best care is delivered? Which of these arguments would work to quell the outrage of the 30% who would have improved had they received the new treatment?

I would suggest that none of these arguments are acceptable and that they're often used in the treatment of eating disorders to rationalize the lack of use of evidence-based practice. Evidence-based practice, as my colleagues have explained, exists for eating disorders and it is important to note that not all treatments for eating disorders are equally effective.

For example, Poulsen and colleagues conducted a randomized control trial comparing cognitive behavioural therapy, CBT, and psychoanalytic psychotherapy for individuals with bulimia nervosa. The psychoanalytic psychotherapy lasted approximately three times longer. At the end of treatment, only 15% of individuals in this group were no longer binge eating compared to 44% of individuals who received CBT.

Clinicians in Calgary were surveyed to explain regular treatment for eating disorders. They found that out of the 52 clinicians who participated, 32.7% used CBT and 1.9% used interpersonal psychotherapy, IPT, as their primary approaches to treatment. Note that 86.5% and 53.8% of clinicians also stated that they used CBT and IPT respectively often or always, although it was unclear whether the treatment carried out by these clinicians was consistent with the manualized treatment approaches that have been studied.

A more recent study surveyed individuals who belonged to one of international eating disorders organizations for whom it might be expected that the use of evidence-based treatments would be higher. Out of the 402 participants surveyed, between 35% and 44% of clinicians exclusively used an evidence-based treatment for individuals with various eating disorders.

These findings further suggest that many therapists do not carry out evidence-based treatments in the manner consistent with treatment manuals. All of this evidence suggests that the treatment we deliver to sufferers does matter and that currently, evidence-based practice is not consistently used. Further, many treatment programs are not asked to prioritize longitudinal program evaluation, which would allow us to examine how effective our treatment programs really are.

I believe that in order to ensure we are most effectively using our health care dollars, there needs to be a national strategy to support the use of evidence-based care in the treatment of eating disorders, as our current efforts are not ensuring that we are giving people the most effective treatment. A significant step towards this goal would be the creation of a national research chair on empirically supported treatment for eating disorders. An important next step would be the creation of a centre of excellence for the treatment of eating disorders where programs that use evidence-based best practices in outpatient, day treatment, and in-patient settings of care would serve as a model and training ground for other programs throughout Canada.

Thank you very much.

● (1605)

The Chair: Thank you very much.

Now for seven minutes, we have Mrs. Truppe.

Mrs. Susan Truppe (London North Centre, CPC): Madam Chair, I'd like to thank our guests who are here in person and by video conference for sharing their expertise with us. We really appreciate that. We always look forward to hearing from the witnesses and learning more about eating disorders.

I'll start with Ms. Phoenix, and maybe, if time permits, I'll have a couple of questions for all of you.

Are nurse practitioners and mental health nurses taught about eating disorders or given training as part of their curriculum? I know you said that 30 were integrated. What about the rest? What about the other practitioners? Do they receive any training on eating disorders?

Ms. Elizabeth Phoenix: You're talking about registered nurses, first of all.

Mrs. Susan Truppe: That's right.

Ms. Elizabeth Phoenix: In undergraduate programs in Ontario there is a mental health component that is part of the curriculum. Eating disorders might get one or two lectures out of that mental health curriculum. It's very minimal.

Mrs. Susan Truppe: Is anyone taught to look for warning signs of eating disorders?

Ms. Elizabeth Phoenix: You're talking about screening? Yes. That would be part of those lectures, but again, it's very brief, and how that gets picked up into clinical practice is really tough to evaluate. I mentioned best practice guidelines used by the RNAO, which in particular in Ontario have been a really efficacious way to disseminate screening and early identification practices in the treatment of other chronic illnesses like asthma and diabetes. That would also be a really good model to follow in the treatment of eating disorders, and it would be good for primary care physicians.

Mrs. Susan Truppe: Do you have any other best practices you would like to mention while I have you here? Is there anything else you think is really great that should be shared with other people or other provinces?

Ms. Elizabeth Phoenix: Do you mean specific to eating disorders? Because there have been many best practice guidelines launched and disseminated across Ontario. I think probably the big red-letter one at the moment is the smoking cessation program, which has been a really great program. The model and framework have been well formatted and developed over the last 15 years through RNAO, so it's a proven model that works.

Mrs. Susan Truppe: Very briefly, can you describe the smoking cessation model you're talking about?

Ms. Elizabeth Phoenix: I haven't been part of that program myself; it's just been implemented in the last decade in Ontario. I think what I'm highlighting is that best practice guidelines through the nursing organization have been effective. For primary care physicians, practice guidelines have been another very effective strategy for screening and early identification, which are essential. Eating disorders are really being missed in lots of folks, and they're not being picked up on by primary care providers.

Mrs. Susan Truppe: Thank you. I've heard that from several witnesses, that they're being misdiagnosed or missed altogether, and therefore bigger problems occur.

Thank you.

My next question is for Dr. Spettigue.

You mentioned at the beginning that it takes two to seven years to recover and that not everybody does recover. What are some of the treatments that help recovery in the two to seven years?

Dr. Wendy Spettigue: I should point out that those are older statistics and that they are for young adults or a study in adults. We think things are starting to get better for young people and for pediatric eating disorders because of the recognition of the need to involve families.

An exciting development you will have probably have heard of is the fact that family-based therapy, also known as Maudsley family therapy, has been studied enough for us to recognize that it is effective in young people and that it is the recommended treatment for restrictive adolescent eating disorders. The exciting thing about it is that it's effective and it's not particularly expensive, compared to in-patient hospitalization. It's an outpatient treatment.

Our problem at CHEO was that we were funded for an in-patient program and a day treatment program, but we never received funding for an outpatient program. The recommended treatment is outpatient family therapy. We've struggled with the fact that we don't have outpatient therapists, but if we just treated patients in hospital who were medically unstable and we discharged them, they wouldn't get better. There are no community resources to do this. Our team ended up doing it and following them. The program evaluation and outcomes are very positive and effective, but as a result we got very backed up with a one-year waiting list and had to close our program and try to figure out what to do about all of this.

● (1610)

Mrs. Susan Truppe: Thank you.

In your opinion, why do you think it works so well with groups and families versus working with the individual directly, getting the families involved? Obviously, it sounds like it's working well, but why is it working well?

Dr. Wendy Spettigue: That's an easy one, but I warn, I can talk a long time about it.

I want you to imagine a patient with severe obsessive-compulsive disorder, who has the constant thought, “There are germs on my hands,” and the only thing that makes it better is if that patient goes and washes their hands, and then the anxiety decreases. But that patient sits down and the thoughts appear again, “There are still hidden germs on your hands. You didn't get them all. They're going to get inside you. They're going to make you sick. They're going to make you die.” You can't stand the agitation, and the only thing that makes it better is washing your hands. Individual treatment would be like trying to get the person to choose not to wash their hands. Even if they're motivated to do that, they probably can't tolerate the severe urges.

Anorexia nervosa in youth is the exact same kind of illness where they can't tolerate the severe anxiety and agitation that goes with the thoughts that have taken over their minds that constantly say, “You're eating too much. You're gaining too much weight.” They feel compelled to restrict or purge, or whatever, to get rid of that. You can't just talk them into not doing it. First of all, they're not motivated because they're afraid of gaining weight. Secondly, even if they were, they can't tolerate it. So we put their renourishment into the hands of parents whose job it is to prevent the opportunity to have symptoms.

The Chair: Thank you very much.

[*Translation*]

Mrs. Sellah, you have seven minutes.

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

I want to begin by thanking our witnesses for joining us and participating by videoconference. I am glad to hear their suggestions to improve diagnoses or treatment plans for people with eating disorders.

My first question is for the representatives of the Canadian Psychological Association.

For the sake of full disclosure, I want to say that I am a health professional and I know that the most used method is the cognitive-behavioural approach. That psychological approach is used the most often to treat those types of disorders. I saw one of your pamphlets released in 2012 that focused on that method. How successful is the approach?

My question is for Dr. Lisa Votta-Bleeker or Dr. Giorgio A. Tasca.

[*English*]

Dr. Giorgio A. Tasca: How effective is it for eating disorders? Cognitive behavioural therapy is the treatment that has the most research behind it. There are other treatments that are variously effective as well, but not as well researched. I would say my reading of the literature is that probably, in terms of bulimia nervosa, about 50% of the patients get better through cognitive behavioural therapy or other treatments that have some evidence base to them. For anorexia nervosa, it's probably around 25% to 30%.

The evidence-based treatments are good, but they're not great in that sense, so there needs to be a lot more done in terms of researching more effective means of getting better outcomes for these patients.

● (1615)

[*Translation*]

Mrs. Djaouida Sellah: Thank you for your answer. That brings me to my next question.

We have received a lot of information since we began our study on eating disorders. One of the things I have learned is that people treated for eating disorders are being discriminated against compared with people receiving general treatment. I know that your association issues guidelines on discrimination in the provision of psychological care. I would like to know whether you have guidelines specifically for the treatment of individuals with eating disorders.

[*English*]

Dr. Lisa Votta-Bleeker: Specific guidelines for...?

Mrs. Djaouida Sellah: Yes.

Dr. Lisa Votta-Bleeker: I'm not sure I understood the question.

Our mantra at the Canadian Psychological Association is that everyone should have access to psychological services regardless of whatever mental health disorder they are suffering from. We want the right provider at the right time, regardless of what their diagnosis is.

I don't know if that's answering the question sufficiently.

Mrs. Djaouida Sellah: I know you have this kind of guideline.

[*Translation*]

I am talking about the psychological approach in a general sense. However, do you have any guidelines that apply specifically to potential discrimination against patients with eating disorders?

[*English*]

Dr. Lisa Votta-Bleeker: Not to my knowledge. We have practice guidelines, yes, but not specific to eating disorders.

[*Translation*]

Mrs. Djaouida Sellah: So that is another shortcoming in the system when it comes to treatment for those kinds of individuals.

Thank you.

[*English*]

Dr. Wendy Spettigue: Again, perhaps I can just clarify. There are practice guidelines for the treatment of child and adolescent eating disorders. There are American practice guidelines, which I helped to develop, and we're in the process of trying to make some Canadian guidelines.

[*Translation*]

Mrs. Djaouida Sellah: If I have understood correctly, we still don't have those guidelines in Canada.

[*English*]

Dr. Wendy Spettigue: They do not entail Canadian guidelines.

[*Translation*]

Mrs. Djaouida Sellah: Thank you for your comment, Dr. Spettigue.

I know that one of the books you wrote contains a chapter titled Pharmacotherapy for eating disorders in children and adolescents. In that chapter, you focused on medical treatments for eating disorders. You think that the best solution for combatting or reducing eating disorders is based on medication. Is that correct?

[*English*]

Dr. Wendy Spettigue: No, I definitely favour evidenced-based treatment for eating disorders, and we lack a lot of evidence. So at this point, for example, there is no evidence whatsoever that there is any medication to treat children and adolescents with anorexia nervosa. Having said that, as I pointed out there is a very high association between eating disorders, depression, and anxiety, and there are medications that are helpful for treating depression and anxiety although they don't work in low-weight patients. We tell them that their food is the medicine they need to start with. We renourish them and then we can treat the depression and anxiety.

Having said that, it's the kind of patient Ms. Phoenix was talking about who is very ill in hospital. I specialize in treating the youth who are so medically unstable and unwell that they require hospitalization at CHEO. For those youth we sometimes get rather desperate in terms of trying to calm them when they become severely agitated or resistant to treatment and to taking nutrition, and they may be trying to kill themselves or to run away, or whatever. We sometimes end up desperately using medications that clinically seem to be helpful in calming their agitation. I'm trying to study a medication that was studied at the Ottawa General Hospital and found to be helpful in adults, but it's taking a long time and it's hard to get enough funding to study these adults and youth with eating disorders.

● (1620)

[*Translation*]

The Chair: Thank you very much.

Mr. Young, go ahead. You have seven minutes.

[*English*]

Mr. Terence Young (Oakville, CPC): Thank you, Chair.

Thank you, everyone, for giving us your time today. It's been extremely interesting and valuable to us.

Dr. Spettigue, what is the minimal level of treatment that girls and women with eating disorders should receive in Canada?

Dr. Wendy Spettigue: It depends on the severity of their illness because I wouldn't want to hospitalize a patient with a mild eating disorder, nor would I want to keep a patient out of hospital who was very severely ill and medically unstable. So it does depend on the level of intervention, and it's important that we match the level of intervention to the severity of the illness.

One of the problems that's happened in Ottawa is that the specialized eating disorder program at CHEO became so overwhelmed by the number of referrals that we had to close and only treat those acutely medically ill patients who required hospitalization. This meant that patients with mild, moderate, or even moderately severe eating disorders in the Ottawa region for the last 20 months have had no specialized eating disorder care, which is atrocious.

Mr. Terence Young: Perhaps you could comment on the components of care at the various levels, depending on severity. That would be helpful. Thanks.

Dr. Wendy Spettigue: The components of care are that you need psychological treatment, medical treatment, and nutritional treatment, and they all need to be combined. For most patients, the recommended treatment is outpatient treatment, where they're followed for their medical issues by a medical doctor and they have nutritional input if that's available, although it's not absolutely necessary. Most important is the outpatient family therapy. A huge issue is that there are very, very few people in Canada who are trained to provide that specialized family therapy for adolescent eating disorders.

Mr. Terence Young: So what percentage of adolescents with eating disorders, when that range of therapy is needed, actually gets it?

Dr. Wendy Spettigue: It would be less than 1%, I would guess, if we looked at the whole country.

Mr. Terence Young: Thank you.

Dr. Votta-Bleeker, do you have anything to add to the components of treatment?

Dr. Lisa Votta-Bleeker: No. She highlighted them.

Mr. Terence Young: Thank you very much.

Dr. Spettigue, is cognitive behavioural therapy the most effective therapy for girls and women with eating disorders?

Dr. Wendy Spettigue: There's a difference between treatment for girls versus that for women, so for adults, yes, but for young people we recommend family-based therapy.

Mr. Terence Young: Thank you.

What are the challenges facing individuals? For a young woman who realizes or has been told by people who love her or by a doctor that she has an eating disorder, what are the challenges in seeking treatment?

Dr. Wendy Spettigue: The number one challenge—and again, I'm only talking about pediatric eating disorders—is that she won't seek treatment because she's terrified that it will mean that she'll have to gain weight. So no matter how much she is suffering, she will not choose to go and get help, because she's terrified. It's usually distraught parents who drag their teenagers to the doctor.

Mr. Terence Young: Thank you.

What seems to be the greatest contributing factor to the development of eating disorders? We've heard a lot about the different factors. What are the greatest contributing factors?

Dr. Wendy Spettigue: That's a very difficult one, because I don't have enough research to answer that question. We desperately need more research into the causes of eating disorders. I might have some opinions, but I don't have facts.

Mr. Terence Young: Okay. That's very helpful. That leads to my next question.

Could you please comment on what gaps there are in research into eating disorders in order to meet the needs of patients? If you had a blank slate and you could commission research, in what areas would you want to see research results?

Dr. Wendy Spettigue: Wow. There are so many gaps that it's hard to know where to begin. There's a huge lack of research. We don't understand the causes of eating disorders. We don't understand how to prevent eating disorders. We don't know how to disseminate the most effective treatments. We don't know how to treat the ones who don't respond to the family-based therapy, which is about 30% of youths. There are huge gaps.

● (1625)

Mr. Terence Young: Would you characterize the treatment that girls and women with eating disorders receive as discriminatory compared to patients with other diseases?

Dr. Wendy Spettigue: Yes, in many ways. Would you like me to elaborate?

Mr. Terence Young: Yes, please. Thanks.

Dr. Wendy Spettigue: For example, in medical school and residency training, there's a definite lack of training and a lack of understanding of eating disorders. Like Ms. Phoenix said for the NPs, for the doctors there would be a mandatory lecture on the symptoms of anorexia nervosa and that kind of thing, but never enough time or depth to really understand and appreciate these patients, what they're going through, and the kind of help they need. Certainly, the poor family doctors are so overwhelmed that they don't have the time to really learn about these illnesses.

Mr. Terence Young: Dr. Blake Woodside talked to us about the fact that virtually every hospital in Canada has a prostate clinic for middle-aged white males, but the services for girls are much sketchier or are unavailable in many locations.

Dr. Wendy Spettigue: There's not one single specialized multidisciplinary pediatric eating disorder program in Saskatchewan, P.E.I., New Brunswick, or the Canadian north. There's one only in all of B.C., Nova Scotia, Quebec, and Newfoundland.

Mr. Terence Young: Thank you.

We heard about how the media affects the way girls view their own body image, etc. Could you please comment on whether there's anything we could do about it, about how the media, movies, and television affect the way young women think about themselves?

Dr. Wendy Spettigue: Yes, but it will take me some time. That's a tough one.

Mr. Terence Young: One minute...you can do it in one minute.

Dr. Wendy Spettigue: I think we need to have a huge campaign to change the huge anxiety around eating and nutrition and helping youth, especially young children. The increase in eating disorders in young children is coming out of the fact that there are a lot of very compliant, self-conscious, perfectionistic, anxious little girls who are trying to be very, very good, and avoiding all the bad foods.

Many of them get to the point where they're hospitalized for medical instability because they're only eating vegetables because they've heard so many messages about the bad foods: the fats, the sodium, and the sugar.

We somehow need to create an atmosphere that's more about moderation and balance that applies to everybody. We also need to figure out how to treat obesity without causing eating disorders because for all of the patients who are getting the messages about the need to diet and watch your eating and all of that, they're creating a whole bunch of young patients who are coming into our hospital terrified of eating, terrified of gaining weight.

Another huge issue is the toxic atmosphere in our high schools across Canada and the emphasis on appearance. I cut some things out of my long talk but one of them was regarding the "hot or not" app that you can get for your iPhone where you post photos of girls and rate them, or the Kate Moss pillow that you can order for $16 on the Internet that has embroidered on it the words "Nothing tastes as good as skinny feels". There are all sorts of things on the Internet—

[*Translation*]

The Chair: Those messages are very....

[*English*]

Dr. Wendy Spettigue: —that are causing eating disorders.

[*Translation*]

The Chair: Thank you very much once again, Dr. Spettigue.

Ms. Duncan, you have seven minutes.

[*English*]

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair, and thank you to all. We appreciate your expertise, and your time and effort today.

I'm going to begin with Dr. Spettigue, and I think this should be an important case study in this report. Could describe as tightly as you can—because I want to ask you all about recommendations for this report—what happened to your clinic, how many people did you treat, the lack of funding, no community resources, the one-year waiting list. What happened, please?

Dr. Wendy Spettigue: That was nice of you, thank you.

For 14 years I served as the psychiatric director of the program at CHEO. Two years ago we were faced with a one-year waiting list, which is completely unacceptable, given the severe medical and psychological complications of eating disorders in young people.

Out of desperation, given that you can't have a one-year waiting list for such sick kids, we just decided to close the program and all those one-year referrals on the waiting list were all sent back to their poor family doctors.

We went through what's called a "lean review" to try to figure out what we were going to cut in order to be more efficient. We're not going to take mild or moderate referrals to our program anymore, even though there's nobody out in the community who will do it. Even though it takes two years for these kids to recover, we're only going to offer them nine months of therapy.

We had to cut all of the therapy groups from our in-patient program in order to try to move some of our in-patient therapists to be able to provide the outpatient family therapy because we didn't have an outpatient team.

● (1630)

Ms. Kirsty Duncan: Dr. Spettigue, how many children did that impact in terms of the closure and in terms of the one-year waiting list, and moving the children and their families around?

Dr. Wendy Spettigue: It's hard to know since I didn't have to see them, but I'm going to say about 200 or so.

Ms. Kirsty Duncan: Two hundred children. I am so sorry.

If you could make a very specific recommendation to this committee, what would have prevented that? What's the recommendation you would make?

Dr. Wendy Spettigue: Well, funding. It's tough because I know that there's not enough funding for a lot of areas in health care, but for sure there's just not enough for eating disorders.

Ms. Kirsty Duncan: So it's about funding.

You listed off which provinces lacked a specialized multidisciplinary centre for childhood eating disorders. What's the recommendation to this committee?

Dr. Wendy Spettigue: We certainly need help at all levels. We certainly need more specialized, multidisciplinary teams like the one at CHEO. They need to be bigger and have more services, and we need more of them, but there's no doubt that we also need more services in the community. As I said, if we're only treating the most severely ill patients, then who's going to treat all the others?

Ms. Kirsty Duncan: Thanks. I'm going to pick that up. It really ties in with what Dr. Votta-Bleeker said.

You mentioned how cuts to secondary and tertiary care have impacted eating disorders. Could you briefly describe that, and then say what the recommendation is, please?

Dr. Lisa Votta-Bleeker: I'm actually going to ask Dr. Tasca to speak to the cuts in a moment. But I can definitely say that for us, from an impact perspective, we're here, we're specialized in the assessment, the diagnosis, and the treatment. We can assist in the research on where the gaps are in terms of what we need to do. We're scientific methodologists; that's what psychologists are trained to be. We're also clinicians, so we can assist in the assessment, the treatment, the diagnosis, the consultation, the education, the service delivery, the program evaluation.

We just want to be integrated into the primary teams, and then funded in that capacity.

Ms. Kirsty Duncan: So should the recommendation of this committee be that psychologists should be considered a basic health care service and part of a multidisciplinary team?

Dr. Lisa Votta-Bleeker: Absolutely.

Ms. Kirsty Duncan: That's a recommendation you want to see in the committee.

Dr. Lisa Votta-Bleeker: Yes, absolutely.

Ms. Kirsty Duncan: Thank you.

Okay, to Dr. Tasca then, regarding the cuts to secondary and tertiary care and their impact on eating disorders....

Dr. Giorgio A. Tasca: I work at the tertiary care centre in the Ottawa Hospital's eating disorders program. I've been there for 17 years.

We've seen cuts over that time. We lost an OT a couple of years ago, an advanced-practice nurse, half of a psychologist position. It's like death by a thousand cuts, constantly being shaved back a little bit at a time with each new budget.

The hospital budget has not increased for the past three years, and we don't see it increasing for the coming years. That actually means a 3% budget cut, because that's the minimum increase in health care costs for a hospital. So I fully anticipate that our eating disorders program is going to be cut again this year, and probably again next year.

That's meant fewer services. That's meant our outpatient program is much smaller than we hoped it would be. Our day hospital is getting thinner—pardon the pun—and the in-patient program is really minimal, from my perspective.

We also don't treat binge-eating disorder. Binge-eating disorder is the most common eating disorder among adults—

Ms. Kirsty Duncan: Then why don't you treat it?

Dr. Giorgio A. Tasca: We don't have the resources.

Ms. Kirsty Duncan: What is the recommendation to this committee, then?

Dr. Giorgio A. Tasca: There should be funded treatment programs for binge-eating disorder. I've run three clinical trials funded by the Canadian Institutes of Health Research and the Ontario Mental Health Foundation. These are research-funded trials, psychotherapy trials for binge-eating disorder.

As soon as we advertise that there is a clinical trial open for binge-eating disorder, we're overwhelmed. We don't spend any of our advertising budget from those trials, because there are just too many people out there who want treatment.

So that's a specific recommendation I would make.

● (1635)

Ms. Kirsty Duncan: Thank you.

The last thing I'm going to ask about, which we have heard over and over as a recommendation, is having a national registry. Dr. Phoenix, you talked about that.

I'm wondering if you could all put your wish list in to this committee about what a national registry would include. If there are things you haven't been able to say today, please know you can send in extra material to the committee.

What would you like in a national registry?

Dr. Wendy Spettigue: For sure I would want a centralized database. I'd want to be able to track eating disorder patients and their progress, their numbers. Separate from that, I agree we need practice guidelines. We need more study of effective treatments, and the dissemination of all of that, tracking the outcome of patients with eating disorders.

The Chair: Thank you.

Did you want to briefly add something on Ms. Duncan's question, Ms. Phoenix?

Ms. Elizabeth Phoenix: I will.

My final comment was about a recommendation for a research chair for eating disorders and a centre of excellence for eating disorders for Canada.

I think that would be a great first step to facilitate a tracking system and a national registry, and oversee a lot of the gaps and the components that all of the speakers have talked about today. We have a lot of catching up to do regarding research into treatments, understanding etiology in a more efficient way, really tracking how our patients who are receiving treatment are doing, and what that full continuum of care could look like—from outpatients to more intensive services—and how best to serve people from B.C. to Newfoundland.

The Chair: Thank you very much.

Mrs. O'Neill Gordon, you have five minutes.

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

Thanks to all of you for being with us this afternoon. We certainly appreciate your time. It is so important for everyone to become more and more informed on this disorder. We are learning this by our study, and certainly valuing every day that we spend studying this.

To Dr. Spettigue, we certainly know what an important role that parents and family play in this. In my experience, however, I have sometimes found that parents have had a very difficult role in dealing with it, and go to the point of maybe even trying to keep it hidden. I'm wondering what help they are offered in the form of counselling and the means of getting to accept this disorder, and how you work with them as well.

Dr. Wendy Spettigue: Every patient at CHEO in our eating disorder program gets family therapy. This means there is a therapist who is mostly with the parents, working very closely with them to educate them and to raise their anxiety about the severity of the illness in their child and the need for very intense intervention, and to try to empower them to take control over the child's nutrition and to not give opportunity for symptoms. Given that it's a combination of an obsessive-compulsive illness and an addiction where the patient is compelled to have symptoms, we really want to then have parents in charge of just not giving opportunity for symptoms.

As you suggested, though, first, it's a lot easier said than done, and second, not all families have the resources for whatever reason. The parents may have mental illness, or they may be single parents and may not be able to get off work or whatever. That's one of our problems. In the best circumstances maybe 70% will respond to FBT, and it may take over a year. But what do we do with the other 30%? We don't even have the research to tell us what to do with them.

Mrs. Tilly O'Neill Gordon: I found that in my acquaintance with one family in particular, even the siblings, the brothers and sisters, were having a very difficult time in dealing with it. Are they included as well?

● (1640)

Dr. Wendy Spettigue: Yes, and they should be. I agree.

Mrs. Tilly O'Neill Gordon: So they also receive some means of counselling as well.

Dr. Wendy Spettigue: Yes.

Mrs. Tilly O'Neill Gordon: Terry kind of asked this question, but I noticed lately in a catalogue that there seemed to be a little more exposure or advertisements of bathing suits with more chunky people in them. I guess it sort of fell into my line of thinking; I thought it was good as well.

Dr. Wendy Spettigue: Do you mean there were more normal-sized models?

Mrs. Tilly O'Neill Gordon: Yes.

Dr. Wendy Spettigue: I agree. I think that's excellent.

Mrs. Tilly O'Neill Gordon: I just think that too is a means of.... The media always goes along with showing the perfect-sized, and we have to try to help them lose that and look at the “normal-sized”, I guess we'd call them.

Dr. Wendy Spettigue: I think that's a huge point. The typical model and celebrity actress has a BMI between 16 and 17, and the average healthy BMI for young females is about 21.

Mrs. Tilly O'Neill Gordon: Now, is there some attempt being made to make them change this unusual story that they give all the time in the media?

Dr. Wendy Spettigue: Are the media part of it? Yes. That's where prevention efforts really need to be targeted, at changing social....

“Weightism” is what it's called—in other words, the attitudes of our society about weight and about, as you said, what's perfect, what's beautiful. We don't want our daughters growing up aiming for an unhealthy BMI. We want to try to change that so that females are accepted at their normal sizes.

Having said that, those of us who work on eating disorder teams are completely overwhelmed by the number of referrals. I always feel like I'm drowning. I work many, many overtime hours, as do all of the people in the same field. We don't have any time to put into prevention efforts.

The Chair: You still have 30 seconds, if you want them.

Mrs. Tilly O'Neill Gordon: Yes.

There's one person I know...and she's doing very well. Is there any chance that any of this in later years will come against her and cause her another form of disorder?

Dr. Wendy Spettigue: It definitely is an illness that can relapse, often in times of stress....

Do you know the rate of relapse? Is it about 30%?

Dr. Giorgio A. Tasca: About 30%, yes.

Mrs. Tilly O'Neill Gordon: This lady herself is working in the psychiatric ward. I often think of her as having so much to offer from what she has gone through herself, but hate to ever think that she could take a step backwards to where she was.

The Chair: Thank you very much.

[*Translation*]

Ms. Freeman, you have five minutes.

Ms. Mylène Freeman (Argenteuil—Papineau—Mirabel, NDP): Thank you, Madam Chair.

[*English*]

I'm not a regular member of this committee, so I have less information than the regular members, but I'm finding it very fascinating to listen to you speak today. I'm going to bounce off my colleagues who have already asked some questions, to maybe delve a little more and make sure we get a complete and accurate picture from all of you.

I don't know if you want to continue, Dr. Spettigue—am I saying that properly? At one point you were starting to talk about what it's like in high schools, basically the image that girls are trying to live up to, the media, normalizing attitudes, etc., around us. What else do you see there? What other milieux are having this? What can we do as legislators to empower our girls?

Dr. Wendy Spettigue: That's an excellent question, and it certainly follows on the last one.

I would describe it as a toxic atmosphere, based on the descriptions that I hear from all the teenage girls that I treat, where they talk about groups of girls that don't eat lunch, that it's just not done, often there isn't even a place to eat lunch; of the comments that boys are making about the girls; and the huge focus on appearance and weight.

[*Pursuant to a motion passed on March 5, 2014, a portion of this testimony has been deleted. See* Minutes of Proceedings]

● (1645)

Ms. Mylène Freeman: Wow. I'm not far enough removed from high school, I guess. I do sort of remember what it was like.

Voices: Oh, oh!

Ms. Mylène Freeman: I know, everyone always laughs.

But, no, it's true, and it is a very toxic atmosphere. As a feminist, I don't think our girls should have to think about how they look in terms of standards that are not appropriate for themselves. I'm going to push you again, though. What is it that we can do?

Dr. Wendy Spettigue: Somebody who has an excellent answer to that question is Dr. Gail McVey. You may have already heard from her. She specializes in the prevention of eating disorders and is trying to change that environment in the school, but there are huge barriers. We need to change the curriculum so that the teachers aren't teaching about eating disorders by describing anorexia nervosa, which then causes girls to go, “Oh, that's a good idea”, which in fact the research shows that it does. We need to teach media literacy. We need to teach about self-esteem and self-care. We need to empower our girls. We need to change the attitudes of the males as well, the teenage boys, and maybe get them together and have them hear from each other. We need more research into all of that and into what is effective and what isn't, the type of research that Dr. Gail McVey specializes in. She's the only one in the entire country who's doing that.

Ms. Mylène Freeman: Okay.

It's been very clear that there is a lack of information. How much do partners, or not partners but *intervenants* working across different fields, how do they work together and share knowledge? What gaps are there?

Dr. Wendy Spettigue: Ontario is probably a good role model for the other provinces, in terms of Gail McVey's work on the Ontario community outreach program for eating disorders, and how she has brought all of the eating disorder programs across the province together as a network. As part of that, our team is trying to lead an initiative to have a shared database amongst the pediatric Ontario eating disorder programs, although, again, we didn't get funding for it, but anyway....

But that's only in Ontario. I would strongly recommend that they use the same model, and apply it to the other provinces, although recognizing that the other provinces don't really have very many programs to get together.

[*Translation*]

The Chair: Thank you very much.

I would like to remind you that Ms. Phoenix is testifying by videoconference. Try to remember to ask her a few questions, if you can.

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

[*English*]

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

[*Translation*]

The Chair: Thank you very much.

[*English*]

Mrs. Stella Ambler: Thank you to all of you for being here today.

Dr. Tasca, I'm wondering if you could tell me, from a research point of view, how much interest there is in the academic community to study eating disorders.

Dr. Giorgio A. Tasca: There's actually a very active group in Canada of eating disorders researchers. The interesting thing about the group is that they're a lot like me, clinicians who are doing research within tertiary care centres. There's a group in Ottawa, our group. There's the group at CHEO. There are SickKids, Toronto General, the Douglas, and St. Paul's in Vancouver. I say it's interesting because they're all in the tertiary care centres, not in the universities.

Mrs. Stella Ambler: Academia per se.

Dr. Giorgio A. Tasca: Yes. I don't know if that's as true in the U.S or if that is unique to Canada.

Do you know?

Dr. Wendy Spettigue: I think they're still connected with the centres, the programs.

Dr. Giorgio A. Tasca: So it's unique, but the good thing about it is that the people doing the research are the ones who are most closely connected to the treatment programs.

● (1650)

Mrs. Stella Ambler: Right, so it's good and bad. Would you say that possibly one of the reasons you find the researchers in practice is because there just aren't that many opportunities for pure research?

Dr. Giorgio A. Tasca: There's not a whole lot of funding to do research on eating disorders in Canada, period. So it's very difficult if you're a young researcher in an academic setting, trying to start a career, to do research in eating disorders. I'm not sure that I'd even recommend it because it's just too difficult.

Mrs. Stella Ambler: Right.

This question would be for either you or Dr. Votta-Bleeker. Among professionals, would you say there is sufficient sharing of knowledge, research data, and promising practices? If not, what could be done to increase that knowledge-sharing.

Dr. Lisa Votta-Bleeker: I think one of the key things, at least among the psychological research, whether it's done in an academic setting or in a clinical setting by a science practitioner, is that knowledge translation. So whether it's done via conferences, whether it's done through journals, or whether it's done through fact sheets, brochures, there's definitely an effort.

Can we be doing more? Absolutely. My argument would be that I'm not sure the knowledge translation needs to be amongst each other, but it needs to hit the different target groups. We've heard about the schools. We've heard about the students. We've heard about the media. We're good at talking to each other. We need to get a little bit better at translating our scientific knowledge to the lay person, to the parent, to whoever can best make use of that information.

Mrs. Stella Ambler: Thank you.

Perhaps I could switch to Dr. Spettigue. You mentioned pharmacological treatments. There was talk of two different ones. One of them was 45% effective. I know it's a big question, but what kinds of pharmacological treatments are available for those suffering from eating disorders? How are they regulated by the Food and Drugs Act? I was a little bit shocked and I wrote down that medications for depression don't work for anorexia. I didn't really know that. Maybe you could explain a little bit for me.

Dr. Wendy Spettigue: Okay. There is no medication that treats anorexia nervosa, nothing that we've discovered. As I said, there was one study at the Ottawa General Hospital in which there was an antipsychotic medication that was found to be helpful for some of the women who took it for treating anorexia nervosa.

Mrs. Stella Ambler: Is that olanzapine?

Dr. Wendy Spettigue: Yes. I've been trying to study olanzapine for youth with anorexia nervosa since 2001. It's one of my major failures because it has taken tonnes of time and tonnes of money, and I just can't get enough subjects to agree to be in it. That's partly because if the parent says yes, the teenager says no, and if the parent says no, the teenager says yes. It's hard to get consent from everybody to be in a research study about a medication when you're not sure about the effects on your child. They just worry about their child being a guinea pig, so it's been very hard to recruit into it.

Mrs. Stella Ambler: Do you already know some of the side effects?

Dr. Wendy Spettigue: The major side effect is weight gain, which is why we're using the medication and sedation. But there's a long list. If you look up every medication in a pharmaceutical book, you get tonnes and tonnes of side effects. When parents read that, they don't want to put their child on it, so it's been hard to study. We just don't know whether it helps or not.

Do you want me to address the depression question?

[*Translation*]

The Chair: Not for the time being, but thank you. Perhaps we could move on to other questions.

Ms. Crockatt, you have five minutes.

[*English*]

Ms. Joan Crockatt (Calgary Centre, CPC): Thank you very much.

I'd like to share a bit of my time with MP Leung, so if you could let me know when I have used three minutes that would be great.

I wanted to ask a bit because I wasn't quite sure what the answer was here. It was about the recommended treatment—Dr. Spettigue, I'll come back to you, thank you—for outpatient family therapy. I'd just like you to expand a little more about why you feel that works. It sounds as if that's a more cost-effective treatment as well, compared to in-patient. Why do you think the family therapy route is the best one, in your experience?

Dr. Wendy Spettigue: For a few reasons. First of all, in the past, in many instances in psychiatry, parents were blamed, and mothers in particular. The good news is that over time that is changing, as it needed to change. Parents used to be blamed for autism, schizophrenia, eating disorders, all things that are not the fault of parents. We now know you can be a very good parent, and of course most of them are, and still have a child with a very severe eating disorder like anorexia nervosa. It's a matter of recognizing that the best support for any ill child is their parents. I work with some of the most wonderful families and parents in the world.

The other thing is, as I said before, it's really that the kids are compelled to have symptoms. A combination of a severe phobia, a delusion, an addiction, and a form of obsessive-compulsive disorder all mixed together would be how I would describe anorexia nervosa. Children can't be expected to be able to just choose to eat and gain weight when they're so terrified and so sick. So we put that into the hands of parents and make it clear that it's their responsibility. I often compare it to a child with diabetes who has a severe needle phobia but needs to get their insulin, and then it's up to the parents to figure out how they're going to do that, and they're wonderful at it.

● (1655)

Ms. Joan Crockatt: Thank you.

I think that's a really important clarification.

You talked about the real difficulty between the messaging of how we're in a society that talks about all the risks of obesity, and then we have kids who are responding to that in a very disastrous way. I just wanted to commend you, because I think you might have given us the solution to the marketing campaign when you said low weight is as dangerous as overweight.

Dr. Wendy Spettigue: It absolutely is.

Ms. Joan Crockatt: I can see that being a campaign slogan that might help to get that message out, so I wanted to thank you for that little nugget.

If I can just go—

Dr. Wendy Spettigue: If I can quickly add, they keep saying healthy weight is a BMI between 18.5 and 25, but they don't point out that not everybody can be healthy at a BMI of 18.5. It has to be the BMI that's healthy for your body, and for some of my patients it's a BMI of 23, which is perfectly healthy.

The Chair: You have two minutes.

Ms. Joan Crockatt: Okay.

I was going to ask Elizabeth Phoenix a question, but I want to share my time, so I'll turn it over to MP Leung.

Mr. Chungsen Leung (Willowdale, CPC): Thank you, Joan.

Thank you, Chair.

I want to address this question from a different angle, a more multicultural dimension. Canada is increasingly a country of immigrants and diversity. Is there a cultural national origin or genetic difference in this eating disorder, especially when we can identify hypertension mostly in the black population, hepatoma in East Asians, and type 2 diabetes in South Asians? In your clinical practice do you see the diversity of Canada or is it a more Canadian culturally induced environment whereby kids are eating a diet that is more dangerous and higher in sugar, salt, and fat?

In the discussion that has gone on, it appears to me that there is a lot of acute care, which is a symptom of our North American medical practice. Isn't the health care dollar better spent in a top-down, directional education process to address this broader issue? Anyone can answer.

Dr. Wendy Spettigue: To that second point, absolutely, that's what was so awful about the fact that our team was closed to all referrals except for those patients who needed hospitalization for the last 20 months. We were so overwhelmed by how many of them there were that nobody was treating mild, moderate, and moderately severe eating disorders. Yet the research shows that earlier intervention has a better prognosis, so for sure, we should be doing the exact opposite of what we're doing and treating the kids earlier.

The Chair: I would ask then, to briefly address the first part of the question about the diversity of the patient, Ms. Phoenix. Could you talk about the cultural diversity of the patients you've encountered or some examples you would like to share with us, maybe for 30 seconds?

● (1700)

Ms. Elizabeth Phoenix: Our program is a newly funded program in London. We are seeing cultural diversity within our program and also very statistically matched male presentation as well within our program.

Can I answer that accurately—is it a function of being in western society that we're seeing these folks present with eating disorders at this present time? We know there are some cultures where eating disorders in country of origin are lower than they are here in North America, but they still do exist and are present. Again, we're always struggling to address the numbers and really understand the data effectively because the numbers are very inconsistent.

I don't know, Dr. Tasca might have those numbers at his fingertips.

The Chair: Do you?

Dr. Giorgio A. Tasca: I don't have the particular numbers, but I know of research that has looked at cultures before Internet and TV was introduced and after Internet and TV was introduced, and the incidence of obesity and eating disorders shot up after the introduction of the media.

The Chair: If you have some documents or links or articles that you feel could complement the answers, please send it to the clerk.

Thank you very much.

Now for five minutes, we have Ms. Duncan.

Ms. Kirsty Duncan: Thank you, Madam Chair.

Again, Dr. Spettigue, you might want to think about writing a case study for inclusion in this report, because I think it's important.

I'm going to ask two questions this time.

Dr. Spettigue, the first one is to you and the Canadian Psychological Association might want to answer as well. It's regarding Gail McVey's work in terms of building this Ontario network in terms of training the doctors. We need to reach these young doctors before they become doctors. We should be talking about this in medical school. If you could give us that Ontario model and again, this might be a brief that's later submitted—

Dr. Wendy Spettigue: Meaning you want me to describe the Ontario model...?

Ms. Kirsty Duncan: If you could, please, so I can ask my second question.

Dr. Wendy Spettigue: The model is just that all of the provincial programs are part of a network where we are in constant communication. We share data and information. We meet at least once a year to have regular conferences where we share data but we also try to make our programs consistent with each other. We have monthly teleconferences where we talk about the treatments we're providing, trying to be consistent about it.

She got all the pediatric programs together in retreats to try to make sure that programs are similar. It was the same for the adult programs and advocating for program evaluation and for prevention. She advocated at the government level to get us the NPs in the programs. There was just so much.

Ms. Kirsty Duncan: Does the federal government kick in funding to support this or is it funded through Ontario?

Dr. Wendy Spettigue: It changed part way there.

Can you answer that one?

Dr. Giorgio A. Tasca: I think it's funded by the Ministry of Health.

Dr. Wendy Spettigue: It's the Ontario Ministry of Health.

Ms. Kirsty Duncan: It's Ontario, okay.

Perhaps, someone could reach out—

Dr. Wendy Spettigue: But it's provincial.

Ms. Kirsty Duncan: Thank you.

Also, in terms of training doctors....

Dr. Wendy Spettigue: That's a tough one, because the problem is that the doctors are all the sons and daughters of us who have grown up with the same attitudes as everybody else, so they also would see a slim, pretty girl and think she looked just fine at a BMI of 18, say. But maybe her healthy BMI is 23 and they can't then recognize the dangers—

Ms. Kirsty Duncan: So it's training the doctors as part of the network.

Dr. Wendy Spettigue: They need training on set point theory, and the dangers of being below your healthy weight, and the importance of regular periods, and things like that, which they don't know about.

Ms. Kirsty Duncan: We really need a brief to this committee about what that model looks like, and the specific recommendations for implementing that—

Dr. Wendy Spettigue: For teaching eating disorders.... Thank you.

Ms. Kirsty Duncan: Thank you.

Dr. Tasca, I believe at the beginning you said only one-third of those who need mental health care receive it. Briefly you mentioned it was because of provincial and private plans. Could you expand on that, and what the recommendation is to this committee, please.

● (1705)

Dr. Giorgio A. Tasca: Dr. Votta-Bleeker, perhaps you could speak to that.

Dr. Lisa Votta-Bleeker: Yes, I can take that one.

We commissioned a number of economists to do our report, so that's how we looked at things from a private and employer perspective. If I even just use employers as an example, Canadian employers could expect to recover $6 billion to $7 billion with attention to prevention, early identification, and treatment of mental health problems. We have upwards of $20 billion in costs when people are going off on medical sick leave, on stress leave, things like that, so the early prevention is key. If you can build that into the insurance programs, whether it's those by employers or whatnot, that's where you're going to see the greatest returns on investment.

Ms. Kirsty Duncan: Okay. You mentioned another recommendation to this committee, which is that psychologists should be part of the primary care team. Is that correct? Do you want to expand on that?

Dr. Lisa Votta-Bleeker: I think as you've heard us all say, including Ms. Phoenix, the multidisciplinary approach is really the most comprehensive way that we're going to address a disorder such —

Ms. Kirsty Duncan: That should be a recommendation—

Dr. Lisa Votta-Bleeker: Absolutely, and it's multidisciplinary. We all have a role to play in this because it needs the nutrition, it needs the education, it needs the family counselling, it needs the psychological interventions, it needs the medication.

Ms. Kirsty Duncan: Is everything you've mentioned part of the recommendation? It's the multidisciplinary team, including everything you've just mentioned.

Dr. Lisa Votta-Bleeker: Yes.

Dr. Wendy Spettigue: If I could just add, when we talk about the fact that the vast majority of girls with eating disorders need outpatient treatment, and there's a lack of that, the problem is that the only available outpatient treatment is expensive private psychologists. That needs to be funded for the families.

Ms. Kirsty Duncan: And the recommendation, then, is...?

Dr. Wendy Spettigue: To have free psychologists available to do the treatment for youth with eating disorders, for sure.

[*Translation*]

The Chair: Thank you very much.

[*English*]

Dr. Lisa Votta-Bleeker: It goes back to making it a basic health service, the provision of psychological care by psychologists.

[*Translation*]

The Chair: Thank you. That is very useful.

Mrs. Truppe, you have the floor for seven minutes.

[*English*]

Mrs. Susan Truppe: Thank you, Madam Chair.

I'm going to share my time with my colleague, Madam Crockatt, since she only had a couple of minutes there at the end.

My first question is for Dr. Spettigue. We had talked about, when our time ran out, working with groups and families versus individuals. Then you just mentioned sharing data at the conferences across Canada, I think it was. I just want to find out what type of data are you sharing? Is there something you found that could be a best practice that could be shared with other health professionals, because it sounds like you're doing conference calls and conferences, so there must be something good coming from there that's maybe being done somewhere else, whether it's here or in other parts of the world? Did you learn anything that we can share with anyone?

Dr. Wendy Spettigue: It's hard to know where to start, but one of the things that we did in our monthly conference call was get all the pediatric in-patient programs together and say, if the evidence is for outpatient family therapy for youths with severe eating disorders who are medically stable, then what should we be doing with our in-patient programs? Do we just medically stabilize, or do we offer group therapy? Is group therapy effective? We really didn't have the answers because the research hasn't been done.

But what we did decide was to go more towards a model where we would have shorter hospital stays. Our program got rid of our group therapy. We just have parents stay by the bedside. We discharge them sooner to outpatient family therapy, and that was based on a provincial decision of all of the programs that they're going to go more towards that model, rather than longer stays where you do lots of group therapy in the hospital.

Mrs. Susan Truppe: That's good, thank you very much.

My next question is for Dr. Tasca. I don't think I heard this yet, so I hope you didn't already talk about it. What we've learned from a lot of the previous witnesses is that a lot of times the only time something is getting looked at is when they, the patients or individuals, are deteriorating so much they then finally get to the hospital. So I was wondering, do you offer some type of outpatient or day programs for those who are not at that danger level yet? Maybe they're just at the beginning of this stage, I'm not sure, but is there something that could be done before they get to that deteriorating stage and they go to the hospital?

Dr. Giorgio A. Tasca: We're a tertiary care centre, so our referrals come from family physicians. By the time the patients get to us, they are already moderately ill in terms of severity. Our program does have an outpatient component to it. We get about 150 to 200 new referrals a year of adults. We triage the referrals in terms of what level of care they require: either in-patient and day hospital or outpatient.

We do provide some outpatient care for some of the individuals who are mildly to moderately severe in terms of eating disorder, but it's fairly limited. Because the more severe individuals require more care, they tend to get bumped to the front of the line. There are many more resources that go to our in-patient and day hospital program as opposed to our outpatient program, and that's just the reality of the current situation.

● (1710)

Mrs. Susan Truppe: That's the way it is.

Dr. Giorgio A. Tasca: Yes.

Mrs. Susan Truppe: Thank you.

My final question before I share my time is for Ms. Phoenix.

In your opinion, if you were only going to pick one, what's the largest obstacle in treating eating disorders?

Ms. Elizabeth Phoenix: Just one, really...?

I was trying to interrupt before to say that I think people are really being clear that, optimally, care is offered by a multidisciplinary team to treat the complex medical, mental health, psychological, and emotional needs, and also the family and partner support needs that are part of an entire system. But that needs to happen in a continuum of care.

I think that's the other piece that's really becoming evident by your questions, in that a continuum of care isn't just an in-patient setting. I think our London program for southwestern Ontario is a good example of a new funding model, where we are an outpatient, day treatment, and residential program with a very exhaustive aftercare program, with that full model. Because you're right, it's not just the sickest of the sick who require treatment. It's those individuals with mild to moderate symptoms who really should be seen, because we know from evidence that those folks who are treated sooner rather than later do best and don't move on to the severe level of symptomatology.

Mrs. Susan Truppe: Thank you.

I'll pass this on to Ms. Crockatt now.

Ms. Joan Crockatt: Thank you very much.

I wanted to go back to you, Dr. Tasca, to one point you were making, just to clarify. You were talking about budget cuts. I wanted to clarify whether you were talking about provincial or federal budget cuts. I'm sure you're probably aware that the federal government has given 6% increases to all of the provinces for health care.

Dr. Giorgio A. Tasca: I'm talking provincial. Technically—

Ms. Joan Crockatt: So what province...? Maybe you can just clarify for us where you were speaking of.

Dr. Giorgio A. Tasca: Well, it's well known that Ontario has not increased funding for hospitals over the past several years and probably won't for another couple of years. That sounds like it's not a budget cut, but it is, because health care costs go up by 3% to 6% a year. That means there are going to be cuts of 3% to 6%.

Ms. Joan Crockatt: Thanks. I just wanted to clarify where you were speaking of. You were speaking of Ontario.

Dr. Giorgio A. Tasca: Yes.

Ms. Joan Crockatt: Maybe I could ask the question that I was going to ask of Ms. Phoenix earlier. It was a bit about talking about how some patients will appear to be a healthy weight when they're not. We've had a bit of discussion here, but it seems to me that diagnosis is probably going to be one of the big things. Could you talk a bit more about what your experience is in how you can diagnose eating disorders? Also, we've heard from other witnesses that dentists often diagnose them. Can you comment?

Ms. Elizabeth Phoenix: I'd be happy to.

I don't think anyone at the table is leaving it up to family physicians to complete the diagnosis. What would be really effective is to have a very consistent method and approach across the country for screening and identifying individuals who are at risk.

In mental health, we diagnose by listening to people's thoughts and feelings and how much that's impairing their day-to-day life when it comes to occupation, schooling, family relationships, and responsibilities. When individuals look at individuals as a possible eating disorder, they are very much distracted by appearance. That really needs to be suspended. We need listen to individuals, to hear what their symptoms are, and to hear the agony of their emotions and thoughts.

Dr. Spettigue has spoken very eloquently today about how obsessive they are and how their urges are so strong and uncomfortable. That's the nature of how we make an accurate diagnosis in mental health, but also in eating disorders. Yes, their weight and other parameters play a role, but that shouldn't be the thing that is the distractor.

● (1715)

[*Translation*]

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

I want to thank the witnesses for coming to meet with us.

Ms. Phoenix, I also want to thank you for testifying by videoconference. You have provided us with much insight on eating disorders.

We will end the meeting so that the subcommittee can sit. Thank you very much.

The meeting is adjourned.