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Chair

Ms. Hélène LeBlanc

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● (1535)

[*Translation*]

The Chair (Ms. Hélène LeBlanc (LaSalle—Émard, NDP)): Good afternoon, and welcome to the eighth meeting of the Standing Committee on the Status of Women. The topic we are considering today concerns eating disorders amongst girls and women.

The meeting will be conducted as follows. Each department or organization will have a maximum of 10 minutes to make its presentation and then we will move on to the questions. I would like to inform you that representatives from Status of Women Canada will be here to answer our questions after the presentations of other witnesses.

I welcome all the witnesses who took the time to meet with us to give us some insight on this very important topic. Today we have the following witnesses: from Status of Women Canada, Sébastien Goupil, Director General, Policy and External Relations, and Linda Savoie, Director General, Women's Program and Regional Operations; from the Department of Health, Hasan Hutchinson, Director General, Office of Nutrition Policy and Promotion, Health Products and Food Branch; and from the Public Health Agency of Canada, Marla Israel, Acting Director General, Centre for Health Promotion, Health Promotion and Chronic Disease Branch. Lastly, via videoconference, I would like to welcome Joy Johnson, from the Canadian Institutes of Health Research, who is Scientific Director for the Institute of Gender and Health.

Ms. Israel, you may begin your presentation. You have 10 minutes.

Ms. Marla Israel (Acting Director General, Centre for Health Promotion, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada): Thank you very much, Madam Chair and members of the committee.

[*English*]

Members of the committee, thank you so much for the opportunity to speak with you today on the subject of eating disorders. My remarks today will focus on the activities of the Public Health Agency of Canada related to this issue.

The Public Health Agency of Canada is committed to improving the health and well-being of Canadians. We do so by administering programs and developing policies that serve to promote the physical and mental health of Canadians and prevent illness. The agency works to reduce risk factors that may contribute to poor health, such as abuse, violence, or neglect, while building such protective factors as resilience, esteem, coping skills, and healthier relationships.

[*Translation*]

Eating disorders involve serious disturbances in eating behaviour. Some disorders, such as anorexia, bulimia and binge eating are mental illnesses that may be associated with stigmatization, isolation and low self-esteem.

Risk factors associated with eating disorders include a combination of biological, psychosocial and social factors as well as developmental factors particularly associated with pressures to be thin, inadequate coping mechanisms, neglect and overprotection.

[*English*]

The release of the 2006 Senate report “Out of the Shadows at Last” brought the issue of mental illness into the mainstream and contributed to the creation of the Mental Health Commission of Canada in 2007. The release of the Mental Health Commission's mental health strategy for Canada identified six strategic directions to improve the continuum of mental health for Canadians. The first strategic direction is to promote the mental well-being of Canadians across the lifespan in homes, schools, and workplaces and prevent mental illness and suicide wherever possible.

Promoting mental health and well-being is about enhancing the capacity of communities and individuals to take control over their lives and improve their mental health. It's about increasing their power and resilience to respond to future adversities. For this reason, our programs focus on populations at highest risk, such as vulnerable children and their families.

[*Translation*]

From a public health perspective, the prevention of eating disorders begins with a solid foundation in terms of mental well-being. I am talking specifically about establishing healthy relationships, fostering sound parenting skills, learning good strategies to overcome adversity, and building positive self-esteem and self-confidence.

We know that initiatives that focus on people's early years and target their environment as a whole are more likely to protect them from poor mental health and mental illness later in life.

● (1540)

[*English*]

To help build this foundation, the Public Health Agency of Canada is supporting programs and activities to maintain and enhance mental well-being. We deliver programs focused on creating a better start in life for vulnerable at-risk children and their families. These programs provide parenting skills and the tools to develop healthy relationships in order to address challenges they may encounter. The agency also plays a key role in surveillance to better understand the factors that influence the physical and mental health of Canadians. These include child abuse and neglect, childhood injuries, self-harm, and mental illness, including eating disorders.

In 2006 we reported that 0.5% of Canadians aged 15 years and over had been diagnosed with an eating disorder in the previous 12 months and that 1.5% of Canadians aged 15 years and older reported symptoms that met the criteria for an eating attitude problem. This information is critical to better understand the rates and prevalence of illness and to better inform the development of policies and programs.

The agency also supports projects that promote healthier behaviours through positive attitudes and physical activity, and we work closely with our colleagues at Health Canada to support healthier eating.

Many factors impact our day-to-day physical and mental health—where we live, where we work, and relationships with our friends, families, and communities. These factors, alone or in combination, have a tremendous impact on how we feel and what we do.

Our goal is to prevent or lessen the impact of mental illness and poor mental health among Canadians. We want to support girls and boys in growing up with a positive sense of self, with feelings of control and self-esteem. This foundation can help protect against developing an eating disorder.

[*Translation*]

The Public Health Agency of Canada is committed to improving the overall health and well-being of all Canadians. Strengthening and maintaining our mental and physical health will help us limit the devastating effects of mental illness, including the impact of eating disorders among young girls, boys, women and men.

Thank you.

Dr. Hasan Hutchinson (Director General, Office of Nutrition Policy and Promotion, Health Products and Food Branch, Department of Health): Thank you, Madam Chair and members of the committee. I am pleased to be here today with my colleagues from the Public Health Agency of Canada, Canadian Institutes of Health Research, and Status of Women Canada.

We recognize that eating disorders are a very worrisome mental health problem. Today I will talk about Health Canada's healthy eating initiatives. While these initiatives do not directly address eating disorders, they are specifically designed and implemented to minimize unforeseen and adverse consequences, such as encouraging poor eating habits.

[*English*]

Healthy eating plays an important role in promoting health and reducing the risk of nutrition-related chronic diseases. Health Canada has a national leadership role to play in supporting healthy eating through the development of nutrition policies and guidelines, enhancing the evidence base to support policy decisions, monitoring and reporting on what Canadians are eating, and providing Canadians with information through awareness and education initiatives that help them make informed and healthy eating decisions.

While developing national nutrition policies and health promotion initiatives, we work to ensure that there are no unintended negative consequences. Every effort is made to provide consumers with positive nutrition messages that focus on health and well-being, and not on weight, as weight preoccupation is a hallmark of eating disorders like anorexia nervosa and bulimia nervosa.

I'll provide a few examples of Health Canada's healthy eating initiatives that put the focus on health and not weight.

“Eating Well with Canada's Food Guide” is likely the most well-known national nutrition resource developed by Health Canada. The food guide promotes a pattern of eating that will meet nutrition needs, promote health, and minimize the risk of nutrition-related chronic diseases. It is designed to help explain to Canadians what healthy eating means. It is an important tool that underpins nutrition and health policies and standards across the country and serves as a basis for a wide variety of nutrition initiatives.

In the development of Canada's food guide, energy balance was of course a key consideration in the development of the food intake pattern, especially in light of the rising rates of obesity among Canadians. Despite this, though, Health Canada did not support a focus on calorie counting in the development of the food guide. Our approach was supported by many other public health stakeholders as well.

In 2011 the FPT Ministers of Health endorsed actions taken and future directions of the framework document “Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights ”. While the framework is a call to reduce childhood obesity, not one of its 10 recommended actions promotes or supports weight-loss diets, calorie counting, or other weight-focused efforts.

Health Canada's healthy eating awareness and education initiative provides clear and consistent healthy eating messages for Canadians. Early phases of the campaign promoted better understanding of nutrition labelling. While the current phase of this healthy eating initiative is aimed at supporting healthy weights, the public messages and media focus encourage healthy eating habits, particularly through the development of food skills. The emphasis on food skills, not body weight, was very intentional.

Let me conclude by stating once again that eating disorders are a serious mental health disorder. Nutrition promotion policies, programs, and messages such as those developed by Health Canada, which focus on health and well-being and not on weight and calories, play an important role in the prevention of disordered eating.

● (1545)

[*Translation*]

So concludes my presentation, Madam Chair. I will gladly answer any questions committee members might have.

The Chair: Thank you, Mr. Hutchinson.

Dr. Johnson, you have 10 minutes for your presentation.

[*English*]

Dr. Joy Johnson (Scientific Director, Institute of Gender and Health, Canadian Institutes of Health Research): Thank you very much, Madam Chair, and honourable members of the committee.

I'd like to thank you for inviting me to discuss the issue of eating disorders among girls and women.

As the scientific director of the Institute of Gender and Health, one of 13 institutes of the Canadian Institutes of Health Research, I'm pleased to have the opportunity to discuss with you how the Government of Canada, through CIHR, is contributing to advancing research knowledge and capacity-building in this area.

Eating disorders are a complex and multi-faceted health challenge. The spectrum of eating disorders varies widely, ranging from mildly abnormal eating habits to life-threatening chronic conditions. Women and girls, particularly young women, are at high risk, and tend to be more affected by eating disorders such as anorexia and bulimia, though an increasing number of boys and men are presenting with these conditions. For example, in one large United States study of children aged 9 to 14, 13.4% of girls and 7.1 % of boys displayed disordered eating behaviours. Young women aged 15 to 19 have the highest incidence rates of anorexia nervosa. The incidence of this condition has increased over time.

The causes of eating disorders are complex and highly gender-specific. They arise from the interactions of environmental context, biology, and developmental features. Risk factors include a family history of eating disorders, obesity, and mood disorders; and a past history of abuse, particularly sexual abuse. Girls who experience early puberty or who are obese are at increased risk for developing eating disorders.

Disordered eating causes medical and psychological challenges. Some of the medical consequences of eating disorders are irreversible or have later repercussions, particularly those affecting the skeleton, the reproductive system, and the brain.

A recent review of the scientific literature on eating disorders noted that anorexia nervosa has the highest mortality rate of all mental disorders. The same study stated that women with anorexia nervosa are 12 times more likely to die than age-matched women without anorexia nervosa in the general population.

Researchers and clinicians are making progress in understanding how to treat eating disorders. Nevertheless, persistent challenges remain in addressing this complex health issue that disproportionately affects Canadian women and girls.

It's the mission of CIHR to support the development and application of the research evidence needed to address challenges such as these. CIHR was established in 2000 by Parliament in recognition that investments in health and the health care system are part of the Canadian vision of being a caring society. CIHR's objectives are to excel, according to internationally accepted standards of scientific excellence, in the creation of new knowledge, and also to translate new knowledge into improved health for Canadians and more effective health services and products.

In 2012-13 the Government of Canada invested close to $1 billion to support the work of CIHR. Approximately 95% of this investment, or $940 million, was used to support more than 13,000 of the best researchers and trainees across the country through research grants and awards.

CIHR integrates research through a unique interdisciplinary structure made up of 13 virtual institutes. Several of these institutes support research related to eating disorders among girls and women.

CIHR's Institute of Neurosciences, Mental Health and Addiction supports research to enhance mental health through prevention strategies, screening, diagnosis, treatment, support, and palliation.

The Institute of Nutrition, Metabolism and Diabetes supports research to enhance health in relation to diet. One of its four research priorities is food and health.

CIHR's Institute of Human Development, Child and Youth Health has as one of its research priorities the development and mental health of children and youth.

And CIHR's Institute of Gender and Health, for which I am scientific director, supports research aimed at advancing our understanding of how gender and sex influence the health of women and men throughout life.

● (1550)

One of CIHR's key signature initiatives is the Strategy for Patient-Oriented Research. The primary objective of this major initiative is to foster evidence-informed health care by bringing innovative diagnostic and therapeutic approaches to the point of care. Through SPOR, CIHR is supporting research networks that are bringing together stakeholders from different sectors to generate evidence and innovations that advance practice and policy changes, leading to transformative and measurable improvements in health care.

The first SPOR network supported by CIHR is in the area of youth and adolescent mental health. It aims to improve the care provided to young Canadians with mental illness by translating promising research findings into practice and policy. This network represents an investment of $25 million over five years, equally shared by CIHR and the Graham Boeckh Foundation, and is aimed at developing clinical solutions to the mental health challenges faced by Canadian young people.

Through strategic investments and its investigator initiated programs, CIHR has directly funded $4.5 million in eating disorders research since 2006. In 2012-13, CIHR also funded $56 million in mental health research and $40 million in research related to nutrition. A few examples: CIHR funded research on the connections between substance abuse and eating disorders, the genetic determinants of low body weight in anorexia nervosa, long-term trends in relapse and recovery of women with anorexia, how relationships with fathers affect the development of eating disorders among young people, and methods for screening eating disorders among children and youth.

CIHR has supported researchers interested in understanding the effectiveness of web-based dissemination of best practice models to clinicians caring for patients with eating disorders and the effectiveness of treatment interventions for women with binge eating disorders. CIHR is proud to support groundbreaking Canadian research on eating disorders. This research holds an important key to addressing the challenge of eating disorders among girls and women.

Thank you very much for your attention.

● (1555)

[*Translation*]

The Chair: Thank you, Dr. Johnson.

We will begin questions with Mrs. Truppe. You have seven minutes.

[*English*]

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

I'd like to thank everyone for being with us today. It's a very important study and we're looking forward to moving on with this. I'm sure we'll all have some good questions.

Dr. Johnson, I have a couple for you. The work we're hearing about today involves partnerships and working across several disciplines and you've expressed there are many facets to tackle with the problem of eating disorders. You said there are some societal factions, genetic issues, and psychological components. Could you tell us about some of the partnership initiatives you support and why you support them?

Dr. Joy Johnson: At CIHR, a number of teams have been supported to specifically investigate eating disorders. For example, at the Douglas Institute in Montreal there's a multidisciplinary team that involves geneticists, psychologists, physicians, all joining together to address the issue of eating disorders. Clearly, this is an interdisciplinary issue. We need many minds coming together on this topic, and that's simply one example.

At the University of Ottawa, there's an excellent program related to eating disorders that's received CIHR funding, again multi-disciplinary in nature, involving medical, psychological, and other health practitioners trying to come up with solutions and implement them in trying to address the issues related to eating disorders.

Mrs. Susan Truppe: Thank you.

What are some of the partnerships you'd like to see or how do you think something else, like another partnership, might be helpful?

Dr. Joy Johnson: In addition to having researchers partnered together, ideally—and we're seeing more of this—the health portfolio is partnering together. We're finding ways that we can link up, join up the programming being offered by Health Canada and the Public Health Agency with researchers who are interested in investigating and understanding the implementation of programming.

We see a similar model, for example, with the Strategy for Patient-Oriented Research. We're partnering with provinces, trying to address a variety of issues related to taking research and moving it into practice, and from that standpoint I think really effectively beginning to address pressing issues related to primary health care, for example.

Mrs. Susan Truppe: Thank you.

You also mentioned that the Government of Canada invested about $1 billion to support the work of CIHR, and 95% of the investment was used for researchers and trainees across the country. What was the other 5% for? Where is that used?

Dr. Joy Johnson: Yes, I can give you more specifics, more details about that, but that's basically the running of the organization, the other 5%.

Mrs. Susan Truppe: I think there was one—

Dr. Joy Johnson: I think the important point here is that the majority of the dollars are going out to researchers to actually address pressing health issues for Canadians.

Mrs. Susan Truppe: That's a lot of money. It's very good that the research is being done.

You also mentioned, I think a little later on, that CIHR had funded $4.5 million in eating disorders research since 2006 and then $56 million in mental health research and $40 million in research related to nutrition. Are any of these projects meant to be preventive, or maybe you can just elaborate a little bit on those ones?

Dr. Joy Johnson: Yes. As you've heard from my colleagues, we hear people talking about the issue of eating disorders in terms of a wide variety of determinants: mental health determinants, obesity as a determinant of eating disorders. We've also heard about, for example, sexual abuse. So, a number of the research initiatives we funded at CIHR have addressed these uphill determinants. We've funded, for example, a lot of work in the area of violence and abuse. We've funded a lot of work in the area of improving mental health of Canadians. From that standpoint, absolutely, research has been funded, and it's been quite promising in terms of addressing some of the important determinants that might lead to disordered eating.

● (1600)

Mrs. Susan Truppe: Great, thank you very much.

My next question is for Ms. Israel. Thank you for your presentation also about public health and the role in helping identify and defeat eating disorders.

You mentioned that the agency's approach is to look at the mental health aspect of eating disorders through the program's at-risk individuals. Could you give us an example of some of the programs that are designed to maintain and increase mental health and well-being?

Ms. Marla Israel: One of the most important things that the agency undertakes is programs for at-risk children and their parents. One of the things that actually struck me when I was preparing for this committee was in looking at levels of income of people who have reported eating disorders. I was really struck that, of those who presented with eating disorders, at least 61% are reporting income in the lowest percentile. I think there's a misnomer that people assume that those who suffer with eating disorders—and I heard it at this committee—are those in the highest income brackets.

Some of the projects we're undertaking are, for example, the community action program for children, aboriginal head start in urban and northern communities, and the Canadian prenatal nutrition program. On an annual basis, those investments are around $115 million. We support community-based projects for ages zero to six and also, in aboriginal head start, ages three to five. We're looking at giving those at-risk children and their parents the greatest start they can get in life, as best as possible. To look at early childhood development, to look at better mental health promotion, to understand anger and aggression, and to foster more positive parenting; those are the focuses of those programs, as well as nutrition and good nutrition practice. Again, the issues around preventing abuse, preventing violence, and preventing anger are things that are very tangible.

I hope that answers your question.

Mrs. Susan Truppe: Thank you.

You had mentioned also—am I done? That was a fast seven minutes.

The Chair: You had 30 seconds. I didn't want to cheat you from your 30 seconds. Thank you very much.

Ms. Ashton, you have seven minutes.

Ms. Niki Ashton (Churchill, NDP): Yes, thank you.

Thank you to all of our witnesses who are here today.

I'd like to start with Health Canada. We're hearing from witnesses that there's no formal place for eating disorders within the federal government. Of course, given that fact, we are extremely concerned because eating disorders have an extremely high mortality rate. Yet it seems they fall into a category where they receive no dedicated support from Health Canada. Using the example of another disease with a very high mortality rate—we heard the example of prostate cancer from a specialist in eating disorders, or even heart disease—I'm wondering if you can describe how Health Canada can direct funds and resources into research and treatment of a specific disease or disorder?

Dr. Hasan Hutchinson: Certainly the mandate we have with respect to healthy eating is more in the sense of making sure that Canadians understand what constitutes a good healthy pattern of eating, helping them make those choices, and helping them develop the skills to get there. The group I'm associated with doesn't have research funding per se that is targeted directly towards especially disease-specific endeavours.

When there are those diseases that have at their basis diet behaviours that are affecting them, we do, however, work very closely, as we mentioned before, across a portfolio with CIHR and with the Public Health Agency to try to make sure that our priorities come together. Dr. Johnson mentioned that we work very closely with the Institute of Nutrition, Metabolism and Diabetes to identify areas of research that have an impact on how Canadians make their decisions about healthy eating patterns.

Ms. Niki Ashton: We've obviously heard from CIHR on their work focused in that area. I know Health Canada is involved in research. Do you think it would be important to have dedicated funding for research under Health Canada when it comes to eating disorders?

● (1605)

Dr. Hasan Hutchinson: Again, the way we're set up is that the dedicated funding for research is delivered through the Canadian Institutes of Health Research, and they're the ones who deliver the research mandate. To reiterate what I said, we work very, very closely with them to make sure that type of research is being done so they can support our policies and our programs as we develop those as well.

Ms. Niki Ashton: There does seem to be, though, a disconnect, because we've clearly heard from CIHR that they've invested a fair amount of money and have come up with some pretty concrete ideas, and yet in your presentations we heard a lot about mental health, we heard a lot about the Canada Food Guide, but we didn't hear a lot about specific actions relating to eating disorders. So there seems to be a gap here between what's coming out of CIHR and what Health Canada is doing.

Dr. Hasan Hutchinson: Our mandate is really to provide guidance. My unit's mandate is to provide guidance to the general population with respect to making good healthy choices. We do work very closely with CIHR.

As a matter of fact, I had talked about an awareness and education campaign that we're doing with respect to healthy weights. That's our "Eat Well" campaign. CIHR has funded a research team from Université Laval and Université de Montréal to evaluate two years of what we are doing, to make sure that we are delivering the program. They are both looking at a process evaluation and making sure we are doing things that are good for the health of Canadians as well. Now, in two years, you're not necessarily going to see any changes in health per se, but what we're hoping to see is that there are changes in intention to change behaviour with respect to healthier eating.

Ms. Niki Ashton: Perhaps we could see more of those connections, and perhaps we as a committee could look at recommending strengthening some of those connections between your two divisions.

Dr. Hasan Hutchinson: I'd add though that when we are putting together these sorts of interventions and these sorts of programs, we of course work very closely with experts across the country.

I know in your last meeting there was reference made to Dr. Leora Pinhas and Dr. Gail McVey. We have had lots and lots of discussions with them as we were developing our education awareness campaign around healthy weights. We talked extensively with them, and also with Dr. Arya Sharma, who is the director of the Canadian Obesity Network, as well as with, of course, our colleagues at CIHR. Behind a lot of our work, we talk with people who work on eating disorders to make sure we don't put forward policies or programs or interventions that are going to create more problems than they resolve.

Ms. Niki Ashton: Fair enough.

My colleagues and I are certainly also concerned about some of the changes that have taken place around cuts to women's research and services around women's health. In 2012 the budget slashed funding for the women's health contribution program. We believe that this choice to abolish funding dedicated to women's health has far-reaching consequences.

I'm wondering if you can explain to the committee some of the services and initiatives that fell under the umbrella of the women's health contribution program, and how they may be connected to some of the factors raised by Ms. Johnson regarding how gender and sex influence the health of women and men, and how that connects with eating disorders.

Dr. Hasan Hutchinson: Certainly that's beyond my particular area of expertise, but perhaps we can do a follow-up and I can make sure that we get the right information from the experts at Health Canada.

Ms. Niki Ashton: I think we'd really appreciate that, specifically how the work of the women's health contribution program related to work around eating disorders. I think, given your understanding of the kinds of connections and perhaps broader approach, I hope that is also applied to the work of the women's health contribution program.

Dr. Johnson, just a logistical question, or a definition question. On page 1, in the second paragraph of your presentation, you make reference to a definition of eating disorders when you say,"The spectrum of eating disorders varies very widely, ranging from mildly abnormal eating habits to life-threatening chronic disease". We've heard some pretty specific examples, whether it's anorexia or bulimia, but you seem to propose a wider spectrum. Is this in the research community or the medical community? Who uses this wider spectrum?

● (1610)

The Chair: Please respond very quickly, Dr. Johnson.

Dr. Joy Johnson: I think we can recognize that some disordered eating, particularly paying close attention to one's food, calorie counting, obsessiveness around calories is potentially a first symptom of disordered eating. I think you heard from the experts that early recognition of disordered eating is important, before it might move forward into more problematic diagnoses such as anorexia or bulimia. So we can think about some of these symptoms being on a continuum, and we can begin to think about prevention and how to intervene early, as these early symptoms appear.

The Chair: Thank you very much.

Now Ms. O'Neill Gordon, you have seven minutes, please.

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

First of all, I want to thank all of you for being with us today. Our committee certainly considers this a very important study as we go forward to learn more and more about it.

You have stressed that healthy eating is the most important aspect, and we certainly go along with that idea. But from my point of view, probably 10 years ago, I had a colleague whose daughter was suffering from this, but they never wanted to speak about it. Friends were baffled as to how they could help. Not only that, I also found that the other children in the family, who were very close in age, were suffering. We certainly know that the person with this disorder is suffering immensely, but at the same time their families are suffering with how to deal with it, how to help them. Is any study being done or are there new methods? What is being done now to help parents and the sisters and brothers in the families?

Ms. Marla Israel: Maybe I can start, if that's okay.

I think you raise really interesting points that are relevant not only to eating disorders but to other types of mental illness as well. That's why I feel it's important to look at this issue in context.

The Mental Health Commission of Canada has launched a campaign around stigma. I think these are some of the things you may be addressing: how parents are very reticent to talk about it among their neighbours, how even a young adolescent may be reluctant to share that kind of information, and they may not understand that their symptoms are being pondered by their friends. So one of the things that the Mental Health Commission of Canada has done is a stigma campaign called Opening Minds.

One of the things they've done with Opening Minds is they've tried to address the plethora of mental illnesses through reducing stigma and discrimination, and to be able to talk about these types of issues very openly, so that as a society we start to get comfortable with understanding that even though we label things as disorders or illnesses, that our mental health and well-being is no different than our physical health and well-being, and nobody should be suffering in silence.

They've approached this issue by speaking with allied health professionals, by addressing issues of stigma within the media, for example. Their interim report just came out in November, and they talk about some of the best practices involved in trying to better de-stigmatize some of these issues around mental illness and disorders.

Mrs. Tilly O'Neill Gordon: Is that meant for the parents?

Ms. Marla Israel: It's for parents, for schools, for media, and it's for health professionals. They pay particular attention to youth ages 15 to 24.

Mrs. Tilly O'Neill Gordon: Yes.

As I watched them go through it, I felt really helpless, that there was nothing I could do. But at the same time, they never spoke about it and kept it all within the walls of their own home.

Today this girl is a nurse in the hospital and doing well, so we have seen her come a long way.

Ms. Marla Israel: That's great.

Mrs. Tilly O'Neill Gordon: You mentioned, as well, that weight preoccupation is a symptom of those suffering from anorexia.

Can you tell us the role that negative messaging about weight can play with those suffering from eating disorders? What are some of the negative messages that we are sending out there?

● (1615)

Ms. Marla Israel: I'll start, and maybe Dr. Johnson can continue.

I think there is no doubt.... One of things that I addressed was psychosocial, social, environmental, and developmental issues affecting weight. Clearly messaging and how it's perceived, how it's shared, and how it's communicated amongst teenagers has the potential to negatively affect people's sense of body image, how they perceive themselves.

One of the things we're looking at in the agency, and that we undertake every four years, is a study with Queen's University called Health Behaviour in School-Aged Children. The latest report focuses on mental health. We have a chapter on eating disorders. You understand the way people communicate, especially young people, and how they perceive themselves as either too thin or too fat. These are people whose BMIs are just right, but their own perception of themselves is not probably where it should be. This is where the concerted effort of society comes into play.

I don't know if Dr. Johnson has something to add.

Dr. Joy Johnson: I think it's a great point, and Marla has addressed it. I think it's really important. You pick up any magazine or watch any movie on television, and young women are getting very specific messages about what their bodies should look like. We also hear in the popular imagination a lot of concern about obesity. Really, there's very little doubt about some of these messages and how they are affecting young girls.

I think it's an important thing for us to bear in mind. We could do everything we might want to do, as parents, as teachers, but there are these other social pressures being brought to bear. They are, as I said, highly gendered, and we need to be thinking about how to prepare girls to counteract, to think about the messages and to realize they are not healthy for them.

That's why I also appreciated what my colleague at Health Canada said, that they're very careful around their healthy eating to not get into this calorie counting thing. Again, that reinforces these notions about weight and shape and how one is to behave in relation to one's food. There can be negative consequences from very well-intended programs.

Mrs. Tilly O'Neill Gordon: How much time do I have?

The Chair: You have 27 seconds.

Mrs. Tilly O'Neill Gordon: That's okay. Thank you.

The Chair: That was very helpful. Thank you both.

Ms. Duncan, for seven minutes.

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

Thank you to everyone for coming.

I want to begin by saying that I strongly support this study, but I think it's being done in the wrong committee and I'm concerned about it. We've heard very clearly today about complex multi-faceted health disorders, serious mental health disorders, life-threatening disorders. We also hear that it's increasing in boys—7%, in one study.

I just want to make sure this is not going to be sidelined—this is a really serious health issue—and that real recommendations come out of this report.

My questions are going to focus on recommendations.

We know the human costs of eating disorders are incalculable. I'm wondering, can anyone tell me what the economic costs of eating disorders are in Canada each year, please?

Dr. Joy Johnson: That's such a good question, and I don't have the numbers at my fingertips. I do want to say that there have been some studies looking at how much money, for example, the diet industry is making in terms of benefiting from marketing weight-loss products, different types of diets, exercise machines, etc. This is a multi-million dollar industry in North America, and clearly somebody is paying for that.

That's just one type of economic cost. I don't have other details at my fingertips, but I think it's a great question, and it's something we need to think more about.

Ms. Kirsty Duncan: Thanks, Dr. Johnson.

I'm wondering if someone can table those numbers in the committee for us. It is a really important issue.

● (1620)

The Chair: There seems to be—

Ms. Kirsty Duncan: Could my time be stopped?

The Chair: If any of the witnesses has figures that would approach an answer to Ms. Duncan's question, please provide them. Send them to the clerk and we will provide them to the members.

Thank you.

Ms. Kirsty Duncan: Thank you, Madam Chair.

The point I'm making is the witnesses are having difficulty finding those numbers and I wanted to make the comparison between what was specifically mandated for eating disorders for CIHR, not the broader picture, not mental health, which was $40 million, but eating disorders, $4.5 million. I would like to show that comparison.

I have another concern. We heard from PHAC and Health Canada that there is a real focus on prevention. We all want prevention, obviously. It's key. My concern is there are Canadians living with eating disorders right now. They're hurting. Their families are hurting, and I'm going to ask you, point-blank, how do we do diagnosis, treatment, and prevention of relapse better? And I would like real recommendations, please, to this committee.

Ms. Marla Israel: There is no doubt that I take your points very seriously with regard to those who are suffering right now. You want to ensure that the health system writ large is able to deal with this issue, that health professionals are acclimatized to this issue. I think the whole issue of healthy eating, quite frankly, has gained greater ground in recent years.

Obviously, for the Public Health Agency of Canada, our mandate is one of prevention, and so that is where the focus of our efforts lies. That said, I do think that within provinces and territories this issue is something that is addressed and that the focus of our work really is one where we try to do the best we can in terms of highlighting issues, including all mental disorders, with a view to greater prevention.

Ms. Kirsty Duncan: Dr. Israel, can I pick up on that?

For my next question, I'm going to ask about wait times. Can the data be provided, or does anyone have it here? What is the wait time for treatment for eating disorders for girls, I'm going to say under 16, if we look at a CHEO or a Sick Kids?

Then over that age, what are the waiting times by province and territory and by eating disorder? Do we have that information?

Ms. Marla Israel: The Public Health Agency of Canada does not collect that kind of information on treatment or in terms of wait times. The wait times to arrive at diagnosis and treatment of eating disorders would be data that is captured, I believe, within provinces or territories—

Ms. Kirsty Duncan: Would that be checked by CIHI as other diseases are tracked?

Ms. Marla Israel: I'm not aware of that.

Ms. Kirsty Duncan: Can anyone find that out for me? Who is tracking wait times for girls and women by province and territory and by eating disorder, and if we don't have those answers, should that be a recommendation?

Then I'll ask Dr. Hutchinson a question, if I may. You were very clear to say, our mandate is around healthy eating. There are Canadians who have disordered eating. Does this need to be addressed?

Dr. Hasan Hutchinson: The way we address that is to make sure that the policies, the programs, and the interventions that we put forward do not have that unintended consequence of creating or going toward disordered eating. We work very closely with experts in the field to make sure that this is built into everything that we put forward.

Ms. Kirsty Duncan: How much time do I have?

The Chair: You have 45 seconds. You just have time to squeeze in a little question.

Ms. Kirsty Duncan: Thanks.

I guess what I'm getting at with the question about CIHI is that, for example, we're going to have an MS monitoring system. We have other systems where we're collecting data by certain conditions. Does this exist for eating disorders? Do we actually know the numbers? Do we know how long people are waiting for diagnosis, how long they are waiting for treatment, time intervals between relapse, how we're doing on preventing relapses?

If that information could be tabled with the committee, I would be grateful.

● (1625)

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

Ms. Bateman, you have five minutes.

Ms. Joyce Bateman (Winnipeg South Centre, CPC): Thank you so much, Madam Chair.

Thank you to all of our witnesses for being here. This is such an important study.

I just want to clarify one of the comments made by you, Dr. Hutchinson, at the very start. A lot of your preamble was focused on health, not on weight. I appreciate you making that distinction, because I think we've all often in the past—I have a 15-year-old daughter—thought about the weight piece. But then in your comments, in response to my colleague Niki Ashton, you said that you've done work on the issue of healthy weights, that you're educating people about their healthy weight.

How do you combine those two issues? If you're not talking about weight, you're talking about health, and then you're saying, “By the way, your healthy weight is *x*.” How do you manage that?

Please don't be too long; I want to move on to the other witnesses as well.

Dr. Hasan Hutchinson: Okay.

For the past few years, as we've been concentrating on the issue of healthy weights, both overweight and obesity, we have tried very hard not to talk about weight per se, or about BMI per se. Having said that, of course you can go to our website and look up BMI measurements and figure out your BMI so that you know what it is.

But where we're trying to go with all of this is to get to the behaviour change that we like to see. We talk about food skills, and about trying to develop good food skills for Canadians, which would apply really across the board, at least from disordered eating over to overweight and to obesity as well.

So when I'm talking about food skills, I'm talking about the basics: understanding nutritional guidelines, understanding the labels, having those planning and shopping skills so that when you're out there, and you're trying to plan your meals—

Ms. Joyce Bateman: I guess I misunderstood your comment about the focus on healthy weights, then.

Dr. Hasan Hutchinson: We take that into consideration as we develop our policies and programs, but what you won't see on our policies and programs is a preoccupation with weight, or with BMI —

Ms. Joyce Bateman: With numbers.

Dr. Hasan Hutchinson: —or with numbers. What we're trying to do is help Canadians make healthier food choices. That would apply across the board.

Ms. Joyce Bateman: That's a great thing.

To the other witnesses, it would appear that there is a mounting body of information regarding the fact that these weight disorders, these food-related disorders, are in fact mental health issues, or are often related to mental health concerns. Is that fair to...?

I'm just curious; is the approach of considering mental health in relation to body image and healthy eating habits, as we have just heard about from Health Canada, relatively new, or have public health agencies long been aware of the link between mental health and eating disorders? I'm really curious about that.

Perhaps we could start with Marla Israel.

Ms. Marla Israel: That's a great question.

I would say that Dr. Johnson is probably a better expert than I to actually come up with the evidence. Just anecdotally in terms of mental health issues writ large, I would argue that there has been a sea change in the country in terms of our understanding, and not only our understanding but also our ability to talk about it publicly.

It's not that long ago that people were reluctant to even talk about mental well-being, even within the agencies. As a public health issue, I would say it's still relatively new. We work with public health nurses and others within the public health community to situate these issues from a public health perspective, from an area of more upstream interventions so that we can prevent the downstream effects, so that we don't have to deal with people in treatment.

Obviously that's not to discount the provincial and territorial roles of the systemic issues that are at play, but when you talk about public health, our interest is in understanding many of these illnesses, or these disorders, as those where, utilizing the right interventions, we can prevent something from happening down the road.

That involves healthy image, that involves self-confidence and self-esteem, that involves prevention of child abuse, prevention of sexual abuse—all of the things that are risk factors, as Dr. Johnson talked about, for the types of disorders that take place later in life.

● (1630)

The Chair: Thank you.

[*Translation*]

Mrs. Sellah, you have the floor. You have five minutes.

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

I want to thank all the witnesses with us here today, even though the people from Status of Women Canada have not yet spoken.

My question has to do with mental health and each one of you is free to answer it.

Dr. Johnson said that there is a wide spectrum of eating disorders, such as anorexia nervosa. These are chronic, complex and multidisciplinary conditions. This is a mental health issue.

[*English*]

Our understanding is that the Mental Health Commission of Canada created a national strategy for Canada two years ago, and that this strategy has yet to be implemented. Is a mental health strategy on track for implementation? If so, how is the progress on that being measured?

[*Translation*]

Ms. Marla Israel: I will begin.

You are right. A year and a half ago, the Mental Health Commission of Canada announced the launch of a mental health strategy. It was very important for the provinces and territories to be part of this strategy. The Commissioner held a number of consultations on this. Some deputy ministers are part of the Commission. The Commission made it clear that the mental health strategy for Canada was not just a government initiative and that it included other sectors.

[*English*]

One of the things that I think the commission is undertaking is a series of initiatives to ensure it follows through with provinces and territories to measure effectively the progress of implementation, because as others have noted, mental health is not only around services that are obviously the responsibilities of the provinces and territories. There are other issues as well that are federal responsibilities.

That is why the Public Health Agency of Canada has taken on strategic direction number one, which is promoting mental health awareness. We look at all the recommendations contained within the strategy, with the view to seeing what we can do in terms of implementation.

[*Translation*]

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

The Chair: You have two minutes remaining.

Mrs. Djaouida Sellah: You said that some ministers withdrew from the board. Did I understand that correctly?

[*English*]

Ms. Marla Israel: There are deputy ministers who form part of the board of directors of the Mental Health Commission of Canada, from the provinces and territories.

[*Translation*]

Mrs. Djaouida Sellah: They are deputy ministers. Is there a problem? Why are people withdrawing from the work of this board? This is a national strategy that, in theory, should affect everyone.

Ms. Marla Israel: Are you asking me who is part of the—

Mrs. Djaouida Sellah: I do not need to know who. I need to know why.

Ms. Marla Israel: Why?

The Chair: Could you repeat your question please?

Mrs. Djaouida Sellah: You said that some deputy ministers had withdrawn from the board. Could you tell us why?

Ms. Marla Israel: I did not say anything about—

Mrs. Djaouida Sellah: That is what I understood from the interpretation.

Ms. Marla Israel: I did not say that people—

● (1635)

Mrs. Djaouida Sellah: Perhaps I misunderstood.

Ms. Marla Israel: I said that they were members—

Mrs. Djaouida Sellah: They withdrew?

Ms. Marla Israel: They did not withdraw. They are still—

Mrs. Djaouida Sellah: They are still members of the board?

Ms. Marla Israel: Yes.

Mrs. Djaouida Sellah: Okay.

Ms. Marla Israel: I am sorry. I misunderstood.

Mrs. Djaouida Sellah: I misunderstood.

Ms. Marla Israel: I, too, misunderstood.

Mrs. Djaouida Sellah: Dr. Hutchinson spoke about a study that was conducted in the United States on eating disorders. I would like to know whether a similar study has been done here in Canada.

The Chair: Dr. Johnson, would you like to answer that question?

[*English*]

Dr. Joy Johnson: I think the question is about rates of anorexia and this notion of how we actually get good data in relation to this.

I think Marla Israel provided data from 2006. We do not have other current data in Canada. Marla Israel might be able to correct me on this, but I think we in Canada are about to collect more data in relation to child and youth health. So hopefully we will have better data in relation to this.

I think this is an important issue for us to bear in mind as we move forward, and that's why I used American data.

Ms. Marla Israel: The latest data available is from 2006, but there will be a report published in 2013 or 2014. I have to confirm that information. It is the next study of the Canadian Community Health Survey. There will be a chapter on mental health. Some of my statistics are just the ones that have been published, but there will be additional updated numbers available next year. I've already heard that the numbers remain the same.

[*Translation*]

The Chair: I am curious about something. The study that Ms. Johnson mentioned also describes how this condition affects young boys and men. Does the Canadian study also look at that?

Ms. Marla Israel: Yes, it does. According to the 2006 report, women were more likely—

[*English*]

—I'll read it in English, if that's okay.

The Chair: It's okay.

Ms. Marla Israel: I can't translate in real time, so I apologize for that.

Women were more likely than men were to report an eating disorder: 0.8% versus 0.2%.

More women than men met the criteria of an eating attitude problem. Among young women, 1.5% reported that they had an eating disorder. Three per cent of women will be affected by an eating disorder in their lifetime.

[*Translation*]

The Chair: Okay.

[*English*]

Ms. Marla Israel: But binge eating affects boys more than girls.

[*Translation*]

The Chair: Thank you for clarifying that.

We now move on to Ms. Ambler, for five minutes.

[*English*]

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

Thank you very much to all of you for being here today.

My question, if I might begin with you, Dr. Johnson, is with regard to your experience as a professor at the school of nursing. This is of interest to me because our witness last week was talking about the fact that at medical schools students are not taught very much, if anything, about this. I was looking for my notes, and I couldn't find them, but if I recall correctly he mentioned that they spend about two hours in total in their three years at medical school learning about eating disorders.

I'm wondering if nurses in training, student nurses, learn any more about it. I would imagine that they're front-line workers as well in diagnosing eating disorders, or at least in triaging them. I'm wondering if that's part of what you do or if you think it's important that that be part of the nursing program in Canada.

Dr. Joy Johnson: I think if we were to go across the country and look at nursing curricula, you'd probably see fairly similar numbers to what was reported in relation to medical curricula. We'd probably see about two hours being spent in the overall curricula. This is one of the problems: no matter what the issue is, there's limited time in the day, and it's very hard to fight for time to actually get particular issues into the curricula.

That being said, I think it is an important issue. People do need to understand the issue. Health professionals, from physicians to nurses to social workers all need to understand the importance of disordered eating.

I would say that on the ground we also need to continue to work with practitioners who are primary care providers as well as others in the system to make sure that we continue their education on the ground. There have been some really good programs that have been developed in terms of providing information about screening, providing information about prevention, etc. That's in some ways why I'm really pleased about the strategy for patient-oriented research. With this network on mental health and youth, we're hoping to actually get best evidence into practice and create a better opportunity, really, for researchers and clinicians to work together to start to change practice.

So I think undergraduate education is important, but education at the practice level is as well. Bringing researchers and practitioners together is also very important.

● (1640)

Mrs. Stella Ambler: In other words, it's not too late. Once they're educated and have become nurses and doctors, it's okay that they don't know everything at that point. There are ways we can train them afterwards to deal with this complicated mental health issue.

Dr. Joy Johnson: It's very important. I would hope that I wouldn't be practising based on what I learnt in 1981. All health professionals are responsible to continue to improve and understand current issues. The science changes, and that's a really important thing for us to bear in mind, that practice needs to change and evolve, and we need to support that.

Mrs. Stella Ambler: Thank you very much.

Dr. Hutchinson, can I ask you specifically if you, as a doctor of naturopathy, think that treatment of eating disorders by physicians in Canada is different from what it would be if a person with an eating disorder went to a doctor of naturopathic medicine? Do you know anything about that? I don't want to put you on the spot, but I thought you might—

Dr. Hasan Hutchinson: I really wouldn't want to venture into that, to be completely honest. I have never really practised as a naturopathic doctor because I came out and started working for the federal government. I wanted to get into public health after medical school.

Mrs. Stella Ambler: Maybe just anecdotally, do you know of any homeopathic or naturopathic treatments for eating disorders that you've come across, working at Health Canada?

Dr. Hasan Hutchinson: No, certainly not since I've been working at Health Canada. I wouldn't venture—

Mrs. Stella Ambler: I was just curious about that. I'm a big supporter of alternative medicine, and I was just wondering if there are different ways of doing things.

Dr. Hasan Hutchinson: Where I think perhaps it comes into line with what we do in the health portfolio is that level of prevention and the basic type of guidance around healthy eating patterns. Certainly that is taught through naturopathic medicine, as it is taught in a very limited way in conventional medical schools.

Mrs. Stella Ambler: Sure, it's wellness and prevention in general, of course.

Dr. Hasan Hutchinson: Prevention in general, yes. Certainly I do like the emphasis that is in some other practices of medicine as well, but that's something we have to make sure is consistent with what we do from a more conventional evidence base. I am also a geneticist, a molecular biologist, and I am trained as a Ph.D. as well. I do like to see that evidence base.

Mrs. Stella Ambler: Sure.

Dr. Hasan Hutchinson: And that's what we—

Mrs. Stella Ambler: When I say doctor, I mean it in both instances.

Dr. Hasan Hutchinson: Really what we try to do at Health Canada is make sure we're working with the best evidence that's out there and then try to turn that into messages that will help to improve eating behaviours. Sometimes that's more of an art than a science, but we always try to make sure we take the best evidence available. Then we work with scientists, say, through CIHR to make sure we're evaluating what it is we're doing so we can correct that and build the evidence base going forward.

The Chair: Thank you very much. It was important to have all the information.

Ms. Ashton, you have five minutes.

Ms. Niki Ashton: Thank you very much. I'd like to engage our guests from Status of Women Canada as well in this discussion. Obviously as the status of women committee, we're keen to make recommendations directed to the minister and the department. I recognize that this discussion today has involved everybody else except for Status of Women, which is something that concerns us. The whole idea here is the disproportionate impact on women.

What programs or initiatives are funded by Status of Women that have a direct relationship to any disorders or diseases or mental health problems that afflict mostly women, as do eating disorders?

● (1645)

Ms. Linda Savoie (Director General, Women's Program and Regional Operations, Status of Women Canada): I would start by saying that it's not really surprising that diseases or issues that affect women in a disproportionate manner are not addressed necessarily by Status of Women. Each department looks at the totality of the Canadian population when it develops its programs and policies. It would not be our role, necessarily, to replace them in this function.

I can't speak to the programs outside Status of Women that would deal with this, and I would have to say that within Status of Women, it hasn't been an area of focus for us. We do not have a program relating to this issue.

Ms. Niki Ashton: I certainly appreciate that answer, and I think the second part is really what gives us some guidance in terms of where the gaps are. I hear your point on looking at the totality of the Canadian population.

We did hear from Dr. Woodside, who's a specialist in this area, last week. He asked whether it is coincidental that it's mostly women who suffer eating disorders and yet there is overall so little attention in terms of a national strategy, in terms of awareness that this is a very important issue. In fact, he equated the number of people who face prostate cancer, obviously men, to the similar numbers of people who experience eating disorders. Yet we have these huge campaigns—Movember. There's research, there's awareness around prostate cancer. Yet we certainly don't see the same when it comes to eating disorders.

For us it really causes one to ask the question around conditions that women face that put them in a position where they're more likely to suffer from an eating disorder—conditions of patriarchy or inequality. Perhaps your team could elaborate how eating disorders or diseases or illnesses that affect women disproportionately intersect with the issue of women's inequality.

Ms. Linda Savoie: I don't think there's much that I could add to this, because I get your point that issues that affect women in a disproportionate manner are a concern. At the agency, we've been focusing particularly on the issues of violence against women, the economic shortcomings in terms of the challenges, and the lack of women's presence in terms of leadership.

We have not been involved in the health sector. I would contrast what you were saying about prostate cancer with breast cancer. There are some really amazing things happening out there when it comes to some very specific women's health issues, and they're being done well by the people who have the lead on this issue. As non-experts in this field, I think it would be somewhat inappropriate for us to start telling people what to do when they're doing it way better than we could.

I think the representatives from the departments here today all have solid gender-based analysis capacity internally, and they would be in a much better position than we would to assess how their policies and programs are or are not meeting the gender analysis test. It goes beyond gender, right? It's the intersectionality: the women in their diversity, the men in their diversity.

It's really not an area of expertise of ours. It's not an area where we've been participating. I would see it as a very significant challenge for us to try to become a player in this field.

Ms. Niki Ashton: Okay. I appreciate that.

How much time do I have?

The Chair: It's perfect right now. Thank you very much.

● (1650)

Ms. Niki Ashton: Thank you.

The Chair: Now we have Mr. Young for five minutes.

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

Madam Israel, you mentioned you had a study done or that you had commissioned a study that had a chapter on eating disorders. Were there any results that came from that project to help patients?

Ms. Marla Israel: I'm sorry. I didn't hear the end of your question.

Mr. Terence Young: You mentioned you had a study done and that there was a chapter on eating disorders. Were there any outcomes from that study that helped the patients?

Ms. Marla Israel: That helped the patients?

Mr. Terence Young: Were there any concrete results?

Ms. Marla Israel: The study itself is one that focuses on mental health writ large in terms of understanding the attitudes and behaviours of kids. That's the purpose of why we gather that information—

Mr. Terence Young: So it's a more general—

Ms. Marla Israel: Yes, it's a general survey, and it's their own self-reporting, which is very, very important.

Mr. Terence Young: Thank you.

Are there any actions your agency has taken that have produced concrete results for patients to date?

Ms. Marla Israel: Well, can you be a little more specific?

Mr. Terence Young: We've heard that patients are underserved, that there are complex diseases, that they're hard...we hear of patients waiting for care. We've heard that family physicians don't know how to deal with them. Is there anything you've been able to do thus far that corrects or improves any of those?

Ms. Marla Israel: Yes, I would venture to say that there are a number of issues and activities on behalf of the Public Health Agency that actually minimize the impact on the health care system. That's the goal of Public Health. It's really to focus on prevention in order to ensure that Canadians don't end up, for example, in the health care system, to added costs in that respect, so....

I can add a specific example where you look at the investments that are being made upstream. There is significant evidence to suggest that those investments upstream have a very positive effect in minimizing the impacts on the health care system.

Mr. Terence Young: “Upstream”? What does that mean?

Ms. Marla Israel: Upstream means that—

Mr. Terence Young: In the hospital?

Ms. Marla Israel: The opposite.

Mr. Terence Young: What's the opposite of the hospital?

Ms. Marla Israel: Staying out of the hospital.

Mr. Terence Young: But where are the investments made?

Ms. Marla Israel: The investments are being made in a variety of community areas dealing with, for example, like I said, children and at-risk parents. You have investments being made in facilities that help ensure that there are education, awareness, tools, and changing behaviours and attitudes. This impacts, for example—

Mr. Terence Young: Okay. Thank you.

Ms. Marla Israel: I'll give you a very tangible example: some of our prenatal nutrition programs. If these programs were not in play, then you'd have a population of mothers, for example, of teenage parents, who would probably end up in hospital with underweight babies and with babies who could suffer multiple birth defects.

Through not a great deal of investment, we have evidence to suggest that for these babies who are served by our programs, their health outcomes are much better than those of the average population after having been exposed to our programs—

Mr. Terence Young: Thank you.

I'm going to try to get a couple more questions in, so I'm going to ask you to end there. Thank you.

I'd like to focus for a second on psychosocial causes. We know that the fashion industry, the clothing industry, is fixated on thin models, models who are artificially thin. Many of them diet severely in a highly competitive profession. Some of them smoke tobacco, or do cocaine, or actually do heroin in order to keep their weight down.

I was shocked to find out about eight years ago that in some of the images in magazines that girls see, the models are made up to look like they're on cocaine or on heroin. That's some kind of style or something.

It was naive of me, I guess, but I discovered—also years ago—that some women's clothing stores don't sell sizes for girls who aren't small. I thought that was pretty mean-spirited. That's kind of reckless, with a disregard for the mental health and the happiness of those who could be their customers. They have these great styles and they have these great labels, but if your BMI is average or higher, you can't buy those clothes.

Do you have any ideas for the fashion industry or the magazine industry, or suggestions that we might make, that they might do cooperatively? Because they have loved ones who might suffer from eating disorders, and they want to help deal with it too. Are there things they might do to reduce this negative influence, this artificial influence on girls with regard to their body image?

Ms. Linda Savoie: We have worked with groups sporadically over the last few years that have brought this to our attention, and we funded a handful of projects over time where groups are trying to get the fashion industry, for instance, to set standards and self-regulate around that.

Mr. Terence Young: Have there been any successes with that?

● (1655)

Ms. Linda Savoie: Very limited, because no one wants to be the first one to do this, because then you're at a disadvantage with your competitors and with other labels. Our projects of course are small scale. We try, in some circumstances, to generate knowledge and identify things that would work.

The Chair: Thank you very much.

Thank you, Mr. Young. That was a very interesting question. Maybe in the further answers we will be able get to the bottom of it.

Ms. Duncan, for five minutes.

Ms. Kirsty Duncan: Thank you, Madam Chair.

Dr. Joy, could you tell us what's the evidence base regarding the challenges in terms of diagnosis, treatment, and preventing relapses here in Canada?

Dr. Joy Johnson: I think that it's an interesting conundrum, because none of us want research to sit on the shelf. I've been guilty of feeling like my work is done when I've published a paper. I think we're all recognizing that we need a new way of doing research, in that we need to bring practitioners and researchers together from the very beginning. In that way we know that practitioners are going to be more likely to take up and utilize research, and to be involved from the very beginning. So that's one thing.

But other decision-makers as well are very important—

Ms. Kirsty Duncan: Sorry, Dr. Johnson, can I just.... That should be a recommendation for the report. We know that in other...you bring the clinicians and the researchers together. So should that be a recommendation of this report?

Dr. Joy Johnson: I think that would be a fabulous recommendation, and I think that in some ways there's a tool there in relation to the strategy for patient-oriented research. I hate to keep beating that drum. But that's what it's about, because we know that's a huge problem right now in Canada, that whole issue.

Ms. Kirsty Duncan: I agree, and I like people-centred and bringing clinicians and the researchers together. So those are two recommendations.

But what are the challenges that you see in diagnosis, treatment, and preventing relapses in this country?

Dr. Joy Johnson: I think we have recognized—and I think the expert you heard from before has said this—that primary care providers are not screening. They don't have the tools and they haven't been well trained.

I think, again, there are materials out there that could be disseminated and utilized, we could do a better job. We could partner, for example, with the Canadian Medical Association and the Canadian Nurses Association, and find ways to disseminate information to on-the-ground practitioners.

At least they ask the questions, have you lost weight in the last year, and has your weight fluctuated?

We could talk to parents about the eating habits of their children. These are all part of some of these guidelines that have been developed and I think are fairly simple and could be used.

Ms. Kirsty Duncan: Okay.

So a third recommendation you would have is dissemination of the guidelines through partnering. Is that correct?

Dr. Joy Johnson: It is one of the best mechanisms to use.

I cannot speak on behalf of those organizations, but they do have a mandate to provide professional materials and best practice guidelines. I think there are some there, and we could find ways to partner with those organizations.

Ms. Kirsty Duncan: I really appreciate that. This is very helpful.

Can I ask about the challenges around treatment and what we can do better? I come back to there being Canadian who are hurting.

Dr. Joy Johnson: The tragedy is that many of us have met those individuals.

I totally agree; it's a dire situation. But as dire as it is in Toronto, try going to Fort McMurray and finding mental health services. We also have an issue around geographic challenges that we need to be thinking about.

I think there has been recognition that mental health services, in general, for children and youth, are not adequate in this country. That's why we need to find better ways to disseminate and provide treatment services.

It might not simply be through very specialized services. We know that some individuals will require that, but we need to think across a variety of areas, from recognition of early symptoms.... We heard about cognitive behavioural therapy being one of the best treatments for some of the eating disorders. We need to train people and make them available. They don't always have to be delivered in a face-to-face way. There are new technologies that can be used. We should be thinking about them, testing them, seeing if they're efficacious, and doing a better job of developing them.

One of the biggest challenges, and we've talked about this a bit, is the federal, provincial, and territorial mandates of health delivery. You have to work with the provinces around this.

● (1700)

Ms. Kirsty Duncan: Sorry, can I jump in? I just want to make sure I'm reflecting your recommendations. We do have a geographic challenge. We do have a youth challenge. You're saying to use new technologies to find different ways of delivering them. You raised the conundrum in health—federal, provincial, territorial.

Do we need a strategy that would allow us to bring the provinces and the territories together with all the stakeholders, to find a way of doing diagnosis, treatment, and prevention better?

The Chair: Very briefly, Dr. Johnson.

Dr. Joy Johnson: I'm not an expert in terms of how to actually shift this policy. I think there are a lot of strategies that have sat on shelves, I guess I would say.

I want to be very careful about any recommendation that I might make in regard to that. I think there are a lot of smaller great initiatives that could be developed that could begin to address this issue in very, very clear ways.

The Chair: I want to thank you very much.

[*Translation*]

I would like to thank all the witnesses. I would also like to take this opportunity to thank the interpreters, the analysts, the support staff, the clerk and all the members of the Standing Committee on the Status of Women.

The next meeting will be held in January. We will inform you of the schedule and of the committee membership.

I wish you a very happy holiday and a healthy and happy 2014.

Thank you very much.

The meeting is adjourned.