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**EVIDENCE**

## Monday, April 4, 2005

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## Chair

**Ms. Bonnie Brown**

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● (1535)

[*English*]

**The Chair (Ms. Bonnie Brown (Oakville, Lib.)):** Good afternoon, ladies and gentlemen. It's my pleasure to welcome you to the 29th meeting of the Standing Committee on Health. Once again we are working pursuant to an order of reference of Wednesday, February 9, on Bill C-206, an Act to amend the Food and Drugs Act (warning labels regarding the consumption of alcohol).

We will move directly to the testimony of our witnesses. Just before we do, I'd like to caution the members that we will have a little bit of committee business at the end of this meeting, so I'd like to save about six or seven minutes for that.

Welcome to our witnesses. The first speaker will be Dr. Gideon Koren, director of the Motherisk program at the Hospital for Sick Children.

**Dr. Gideon Koren (Director, Motherisk Program, Hospital for Sick Children):** Thank you very much.

I want to thank the committee for allowing me to come from Toronto. What I hope to do in the next couple of minutes is share with you the Motherisk program experience with the issue of fetal alcohol syndrome, give you a Canadian perspective, and discuss the issue of labeling, of course.

I'm a pediatrician in my training, and I'm a clinical pharmacologist–toxicologist, so my career is really dedicated to the issues of medications and chemicals in pregnancy and during childhood and what they will do to the child along his or her life. I'm also a professor at the University of Toronto, and the Ivey chair of molecular toxicology at the University of Western Ontario in London.

We established Motherisk in 1985 to provide counselling for Canadian women from coast to coast on what would happen if they took a medication, were exposed to chemicals, or used alcohol during pregnancy or during lactation. Motherisk is supported by the Ontario Ministry of Health, as well as by many agencies both private and public, such as the CIHR, the NIH, and others. Over the last twenty years we have counselled over one million women, both from Canada and from other countries, and from China to any other part of the world.

What we deal with is exposure to medicines, to chemicals, to herbals. Women need to work with chemicals in the workplace, and they're afraid to do that because of the potential risks to the baby. We have published over 250 scientific papers and 10 medical books on this area.

Just before we go into the area of alcohol, to give you an example, it was Motherisk that published several papers that led women throughout the world to be able to use antidepressants in pregnancy without being afraid that they would affect the baby, because we showed that they do not affect the baby negatively. As a result, hundreds of thousands of women now receive the medications they need with that support. In parallel, we do a lot of work on the perceptions of women, how they perceive their risk, and how they behave about that risk, which is very important if we are going to change women's behaviour to more health-oriented behaviour.

As Motherisk was established, we became painfully aware of the risk of alcohol in pregnancy, recognizing that it's the number one reason known today for mental retardation among Canadian kids. A lot of our work is on alcohol in pregnancy. Out of the 70-strong team of mothers, about 25 people work on fetal alcohol syndrome in one way or another. I'll just give you one or two examples.

Animal studies show that if you give a mom antioxidants —“mom” meaning the animal mom—you can abolish the effects of alcohol with vitamin C and vitamin E. With the support of CIHR, the Canadian Institutes of Health Research, we are now conducting the first study on alcoholic women who are pregnant, trying to mitigate the effects of alcohol by giving them vitamin C and vitamin E. We still do not know if it works, but this is the first study worldwide to do so.

As you might have heard several months ago, we discovered a new way to know if the baby was exposed to significant alcohol. You need to collect the first stool of the baby, which is called meconium. You can find metabolites in there, or byproducts of alcohol. This test is now used on thousands of Canadian kids by physicians, by children's aid societies, by hospitals, and by other people. It's used now in other countries too. We did a large study in Barcelona and we did a large study in South America. We just completed the first ever prevalent study in any country by using this test in the Grey–Bruce area, and we showed high prevalence of alcohol exposure in babies, with much more than you would have assumed from just talking to moms. Of course, that's not surprising.

On the clinical front, we established the first clinic to diagnose fetal alcohol syndrome in Ontario—now there are more clinics—where a multidisciplinary team of physicians, toxicologists, and psychologists diagnose kids. We have a second clinic now in Breaking the Cycle, a downtown Toronto clinic and program for addicted mothers and their children. It's also the only clinic where we can diagnose the mother, if she has fetal alcohol syndrome herself because her mother was drinking.

Motherisk also operates the only national toll-free alcohol and substance abuse helpline for pregnant women. This free line is called upon, coast to coast, by women who drink alcohol or use drugs of abuse, or by their health professionals, about what is the risk, what to do, how to deal with this. Women are counselled, on average, for up to an hour or an hour and a half by specialized counsellors. We refer them to services in their areas. We have a large map of what's available in our country. If they are in an area close to other members of our network—which I'll talk about in a minute—we will refer them to local expertise in their areas.

We believe the helpline has helped thousands of Canadian women and their children. The helpline is supported by the Hospital for Sick Children and by the Brewers Association of Canada. It's a free clinical service available to any Canadian, and, for that matter, anyone who wants to call us from other places too.

In 2000 we established the FACE network. FACE stands for fetal alcohol Canadian expertise. It's the only forum where all people who do research on fetal alcohol syndrome come together. We have two meetings a year, one on September 9, which is FAS Day every year, and one during the American meeting, which occurs in June of every year, on fetal alcohol. That's the only way we'll move forward, by us collaborating our research.

Lastly, we established two years ago the first scientific journal for FAS, called the *Journal of FAS International*, copies of which I gave to the clerk of the committee. It's free, so no one has to pay for it, and you can get it online. It's meant not just for researchers, but for anyone who is interested in the area. It is in this journal that we publish, we believe, the only paper on “To Label or Not to Label”.

I'm not going to cover all the paper, because it's too lengthy, but it's available to you. This is a complex question, and I know you've heard a lot about it in your meetings.

The point I want to stress is that most scientists agree today that alcohol labelling is not effective in changing the behaviour of problem drinkers. Problem drinkers are women who give birth to children with FASD. “Problem drinkers” means addiction, chemical dependence. So while there are studies to show that you can change the habits of women who are not problem drinkers, the studies fail to show effect on problem drinkers, on the women who will give birth to FASD children. For that reason, many people believe that while the labelling may have other impacts, it cannot impact the number of kids with FASD because it's not changing the behaviours of their mothers.

Just to give you a large example—the largest laboratory you can think of—south of our border there's a democratic country with 300 million people. They established labelling 15 years ago. The United States of America has the CDC, the Centers for Disease Control and Prevention, which is the pre-eminent epidemiology group worldwide, in Atlanta, Georgia. In 1999, they wanted to see what changes there were in drinking in pregnancy, and they conducted a very large survey. What they found is very alarming.

In 1991, 0.7% of American women binge drank in pregnancy—0.7%. Four years later, in 1995, it was 2.9%; fourfold more women binged in pregnancy.

In context, binging means five or more drinks per sitting. This is the kind of behaviour that leads to fetal alcohol spectrum disorder. These numbers do not suggest that labelling changed problem drinking. So in a way, on a huge scale, it suggests that the small studies are on line; namely, that we cannot change those behaviours. It's sad, but that's a fact.

● (1540)

Our paper also includes a large part in favour of labelling. I shall read to you one small portion.

> Studies have claimed that the alcohol warning label is ineffective in changing drinking behaviours. However, even if the warning label is not directly effective in changing the pattern of problem drinkers, they are effective in changing the culture of drinking, similar to the change in attitudes toward drinking and driving or smoking.

But again, on a scientific level, I want to ensure that you understand that the science today does not indicate that that will change the number of FASD kids—because it cannot change, and that's not surprising medically. Women who are addicted to alcohol cannot change their behaviour because something is written. They have an addiction. People with addictions are chemically dependent. It takes much more, and labelling does not do it, not just for alcohol but in other areas too. It's sad, but that's reality. Addiction is the most difficult condition in the medical book. We do awfully bad with addictions. By “we”, I mean we in the medical community and we as a society. We do not do much about it at the present time.

● (1545)

**The Chair:** Dr. Koren, you're over your time now. So if you have a couple of points you'd like to make, I would ask you to make them quickly.

**Dr. Gideon Koren:** I want to finish by saying thank you for having me.

I also want to thank Health Canada for establishing the guidelines for the diagnosis of fetal alcohol syndrome, which is very important—it brought together 13 of our programs to establish the diagnosis—and for the CAP-C program, which is a front-line program dealing with high-risk women.

I believe we need to use this opportunity, by your having this discussion, to come up with a consensus on how to most effectively approach the issue of FASD. It's not an easy one. There are many approaches to it. We should use this energy to affect it positively in the future.

Thank you.

**The Chair:** Thank you very much, Dr. Koren.

We'll now move to the Department of Justice.

Ms. Weiser.

**Ms. Irit Weiser (Director and Senior General Counsel, Health, Department of Justice):** I want to start by thanking you for inviting my colleague, Elisabeth Eid, who is the head of the human rights law section at the Department of Justice, and me. I head up legal services at Health Canada. Thank you for inviting us to speak to this committee today.

As legal counsel for the Government of Canada, we provide advice exclusively to the government of the day, and that includes on proposed government bills. It would therefore be inappropriate for me to provide legal advice to this committee, particularly on a private member's bill. However, I would be pleased to offer some information on charter issues generally that you may wish to contemplate when examining Bill C-206.

As you are aware, Bill C-206 would prohibit the sale of any alcoholic beverage that is not clearly labelled with a specified warning message relating to the ill effects of alcohol. Because the bill would oblige manufacturers to place specific messages on their containers, it engages the guarantee of free expression in paragraph 2 (b) of the charter. The Supreme Court of Canada has interpreted freedom of expression very broadly to cover virtually any communication or activity that conveys or attempts to convey a meaning, regardless of the content of that meaning. Specifically, the court has established that the guarantee of free expression extends to commercial speech. According to the Supreme Court justices, commercial speech serves two purposes: it protects the expression rights of commercial entities as well as the rights of consumers to receive information.

The protection guaranteed by paragraph 2(b) of the charter also includes the right to say nothing and the right to choose what not to express. When persons or entities are compelled to make statements that are not necessarily theirs, or which they do not necessarily believe, then according to the jurisprudence, freedom of expression is typically infringed. However, that's not the end of the story.

A restriction on freedom of expression can be justified as a reasonable limit under section 1 of the charter. To succeed in this regard, a court will have to be persuaded of a number of things: first, that the mandated health message pursues a sufficiently pressing and substantial objective; second, that the labelling requirement is rationally connected to the objective; third, that the labelling requirement impairs the industry's freedom of expression no more than is necessary; and finally, that the beneficial effects of the mandatory labels, in achieving the government's objective, outweigh the negative effects of mandatory labelling.

I understand that during your deliberations some comparisons have been drawn with government legislation mandating health warnings on tobacco packages. For this reason I thought it might be useful to outline very briefly the Supreme Court's decision in RJR-Macdonald. In that case, two tobacco manufacturers challenged the validity of the Tobacco Products Control Act, in part because it required that unattributed warnings of the dangers of tobacco use be placed prominently on tobacco packaging. The tobacco companies argued that the legislation violated the charter's guarantee of free expression in a manner that could not be justified under section 1. A majority of the Supreme Court agreed. Their conclusions were based in part on the fact that under the Tobacco Products Control Act the health warning messages were not to be attributed back to the government, and as well, there were concerns about the adequacy of the evidence.

As a result of RJR-Macdonald, Health Canada commissioned studies, conducted consultations, and collected evidence culminating in new regulations on mandatory labelling of tobacco products in 2000. These regulations have again been challenged by the tobacco industry, and we're currently awaiting a decision on the constitutionality of the regulations from the Quebec Court of Appeal.

I'd like to conclude by noting that prior to the introduction of a government bill, Department of Justice lawyers typically vet that bill for compliance with the Canadian Charter of Rights and Freedoms. Usually this also involves an assessment of the availability of evidence to support the proposed legislation in the event of a legal challenge.

Bill C-206, being a private member's bill, poses a somewhat unique situation. It does not engage the government's responsibility to review the legislation for charter consistency and sufficiency of evidence. Consequently, the record of this committee may be highly significant should the bill become law and should a challenge be brought under the charter.

● (1550)

I will conclude by thanking you for the opportunity to speak. Ms. Eid and I are available for questions at the appropriate time.

**The Chair:** Thank you, Ms. Weiser.

We'll now move to the Department of Health. We have Ms. Fletcher, Ms. Langlois, and Ms. Dalpé.

I'm not sure which of you is going to make the presentation, but whoever it is has the floor.

**Ms. Susan Fletcher (Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, Department of Health):** I'm Susan Fletcher. Thank you very much, Madam President. I will make the presentation.

As you noted, Kathy Langlois is with me. She is with the first nations and Inuit health branch of the department.

We have Claudette Dalpé, who is with the health products and food branch; and Kelly Stone and Mary Johnston, who are with the Public Health Agency of Canada and are responsible for the FASD program.

A brief statement has been submitted, and my presentation will very much follow that, but at a very high level.

Our remarks are centred on three issues: first of all, the context of alcohol abuse; secondly, ongoing activities within the health portfolio to address alcohol abuse; and thirdly, to conclude, some general remarks regarding the use of warning labels.

[*Translation*]

First, I'll speak about the problems associated with alcohol abuse.

[*English*]

The 2004 Canadian addiction survey indicates that the majority of Canadians drink responsibly and with moderation.

[*Translation*]

However, approximately 4.6 million Canadians—14 percent of the population—do engage in high-risk drinking; that's mainly young people 18 to 24 years of age.

[*English*]

In 1996, the Canadian Centre on Substance Abuse estimated that alcohol consumption produces more than $7.5 billion in costs. This includes costs for lost productivity due to illness andpremature death of around $4 billion annually; the costs for law enforcement, of about $1.5 billion; and in direct health care costs, another $1.5 billion. So it's very costly.

In 1995 there were an estimated 6,500 alcohol-related deaths in Canada and 80,000 Canadians were hospitalized due to alcohol abuse. The deaths, in order of priority, were related to motor vehicle accidents, cirrhosis, andsuicide, while the hospitalizations were related to falls, alcohol dependency, and again, motor vehicle accidents.

You will note also that alcohol-related deaths among aboriginal people are twice the rate of the general population, with aboriginal youth being at higher risk. Fetal alcohol syndrome disorder is the leading cause of developmental delays in North America and, as we've heard from others, a major cause of preventable birth defects. There's evidence that FASD is also more frequent in first nations and Inuit populations. The estimate we have is that there are around 3,000 births annually of people with FASD. Right now, around 250,000 people in Canada are affected by it.

Finally, from a statistical point of view, I want to conclude with a recent article in the British medical journal, *The Lancet*, that found that 4% of the global burden of disease worldwide can be attributed to alcohol.

● (1555)

[*Translation*]

Now I'm going to talk about what Health Canada is doing in this area.

The federal Department of Health has taken a number of initiatives to address alcohol abuse.

[*English*]

We actually spend around $100 million across the health portfolio, of which the vast majority is with the first nations and Inuit health branch. We have a number of programs, and in our statement you'll find each of them listed with a brief description of what we do. They include Canada's drug strategy; the national native alcohol and drug abuse program; the national fetal alcohol spectrum disorder initiative; the first nations and Inuit fetal alcohol spectrum disorder program; grants and contributions through the alcohol and drug treatment program; the drug strategy community initiatives fund; development of best practices documents on prevention, treatment, and rehabilitation; and the development of a youth website on substance abuse that includes alcohol.

[*Translation*]

Other federal departments and agencies also play an important role in addressing alcohol abuse.

[*English*]

Notably, for example, in the Criminal Code, there is work on—I have French here—

[*Translation*]

the fight against impaired driving.

[*English*]

Many provinces have also begun developing drug and alcohol abuse strategies. In fact, in consultations we did across Canada in late 2004 with the Canadian Centre on Substance Abuse—and I believe you've already heard from them about these consultations—one of the clear messages that we heard was that alcohol abuse is a major problem that we need to be dealing with. This was confirmed by an expert round table on alcohol policy that was chaired by the CCSA and sponsored by us at the end of the fall.

[*Translation*]

In addition, the World Health Organization has renewed its commitment to work with member states in developing and implementing alcohol abuse action plans.

[*English*]

Now I will pass to warning labels.

A recent public opinion poll shows that most Canadians view alcohol warning labels in a positive light. Fully 66% said they would support warning labels. However, less than half the respondents believe alcohol warning labels would not effectively inform about the related harms. However, learning from our experience of addressing tobacco use, we found a greater reduction in smoking prevalence once warning labels were combined with related initiatives such as awareness campaigns. I think this is another message that you've heard over and over. As Mr. Koren said, labels in and of themselves don't seem to have any success, but what we've found with tobacco is that when you combine labelling with other program elements, other awareness elements, and other community initiatives, and when you work with all partners, you start to have more success.

Questions have been raised, though, about using alcohol warning labels. One is the impact of using labels alone. The second is the charter issues that you've heard about from the Department of Justice. There are also trade issues. If warning labels are to be implemented, we have to do it in the context of our trade obligations as a country. There is the feasibility to implement them, especially for smaller enterprises, and also the feasibility for our provincial and territorial colleagues who are part of the enforcement exercise. And finally there are international best practices and awareness measures.

● (1600)

[*Translation*]

Now I'll make a few comments on the present wording of the bill. They're based on what we've learned from our experience with the use of warnings against tobacco and in addressing tobacco abuse.

There is, of course, a difference between health programs involving tobacco and those addressing alcohol, but what we've learned is very useful to us.

[*English*]

You will see that there are six issues listed here.

First, as the bill currently reads, the intent is to warn consumers about the health effects of alcohol and to change their behaviour. Based on our experience with tobacco, labels are, rather, intended to inform.

Second, the bill contains certain requirements that labels be affixed to a beverage rather than a container. This would mean that drinks sold by the glass or pitcher would require a label. This would be very difficult to implement and must involve the compliance of a variety of hospitality industries.

Third, case law for tobacco labelling legislation requires that manufacturers have the option to attribute the message to a government body.

Fourth, it doesn't allow for flexibility to craft appropriate and efficient messages as we learn more.

Fifth, once enacted, the bill does not allow industry the time to redesign and implement the labelling requirements, causing alcohol beverages already on the market to be in violation.

Sixth, there is no flexibility for small businesses to have time to comply.

And finally, there's a conflict—this is a small one—between the English and French wording of the bill.

So as we've looked at this particular bill in the department, these are things we've noted that cause some worry.

[*Translation*]

Those are my comments. I'm ready to answer your questions.

Thank you.

[*English*]

**The Chair:** Thank you very much.

We'll move on to the Public Health Agency of Canada, and Ms. Stone, the director, and Ms. Johnston, the manager of the fetal alcohol syndrome team.

**Ms. Susan Fletcher:** Madam Chair, my presentation covered the Public Health Agency, so unless there's a specific question....

**The Chair:** I see. My agenda shows them as having their own presentation. Thank you.

Our next witness will be one of our colleagues, Mr. Jim Gouk, who is an MP from British Columbia.

**Mr. Jim Gouk (British Columbia Southern Interior, CPC):** Thank you, Madam Chair.

When I asked to appear before the committee, I had no idea that it was somewhat unprecedented. I thought it was very natural, given that I am the representative of a riding that has a very significant region of wineries that have a very strong economic and social infrastructure important to our area.

I believe this bill is very well intended. I know the author and I have a lot of respect for the author, but I believe it is misdirected. It takes the approach, I believe, that anything is better than doing nothing and that we must be seen to be doing something. I do not agree with that for a variety of reasons. There has been no substantive evidence that I have been able to find that shows there is a benefit to labelling, despite the fact that there have been years of their use in other areas, and we've heard testimony to that effect.

I don't know the exact costs. We heard $100 million mentioned by the Department of Health. Specifically within the area of focus, FASD, I believe it is a substantially smaller amount. There's going to be a lot of cost involved in the enforcement of this regulation should it come into force, and I would question whether we're better off spending money enforcing labels on bottles or taking that money and spending it on actually going in and helping, particularly given the overwhelming amount of testimony that we've heard that those labels do very little good in terms of dealing with FASD.

There's a cost to wineries. I've talked to different members in the House and on this committee who have said the cost is negligible. Well, Madam Chair, I would suggest to you that the cost is not negligible. It may be for a huge corporate entity that is a winery, but it is not to a small cottage industry, of which a lot of the wine industry is made up. That is certainly the case in my riding.

These wineries are often husband-and-wife operations that hire additional people as necessary and may have the joint use, with a couple of other wineries, of a person responsible for the actual blending of the wine and putting it out. They hire throughout the year, and they work very hard in this industry to make a simple, decent living. Any cost whatsoever that comes out of this doesn't come out of corporate profits or some other area; it comes out of their pockets.

There is no agricultural sector, wineries and the entire infrastructure involved in them included, that is known to be a wealthy industry. The cost to wineries is in part a matter of economy of scale. The bigger wineries may be able to shrug this off and eat those costs, but I can assure you that it's a different case for people running these small types of operations.

As has also been said, FASD drinkers do not read labels. I understand that there have been quotations from the author of this bill that we have to make the labels bigger and that we have to put graphic warnings on the bottle. Well, Madam Chair, we have a growing sideline from simple operations of wineries in my riding, and that is in agri-tourism development. This is something that is growing throughout North America, and indeed throughout the world. It's a type of tour that people go on, and it draws people to the area for the economy of the entire region. We're now taking something that we're trying to develop and we're going to put a label on bottles, with perhaps a graphic warning as well, saying, "This could be dangerous to your health." Well, that's a wonderful way to get something going.

If someone could show quantitative evidence that this was actually going to do a significant amount of good, then we'd have to say that's the cost of this kind of benefit. But there has been no evidence of that whatsoever, so it concerns me greatly that we would move into this area. The brewery industry, as an example, has started many initiatives on its own to address things like responsible drinking and warning people about drinking and driving. This is something that industry has done voluntarily.

There has been talk that this is going to be part of a much bigger, more comprehensive package. Well, why are we looking at this piecemeal? Why are we looking at doing something that, at best, has a minimal amount of impact, if indeed any, and is going to be part of a bigger package when that bigger package isn't there? I would suggest that if the bigger package is the approach of this committee, then they need to come and address that package. If they decide in their deliberations that labelling needs to be a part of that bigger package, then that's the time to address it, not as a stand-alone jump out ahead of the pack.

● (1605)

Voting against this bill is not ignoring the problem of FAS; it is quite the contrary. We have a risk with doing something like this. Just as people say at one end that doing something is better than doing nothing—we must be seen to be doing something—the risk of proceeding with something like this is that there's a tendency for people to say, even if only subconsciously, there, now we have done something. And there's a tendency to back off and not follow up and not do that comprehensive package and put attention in other areas. If this is really a concern for people, this is something they need to address as a package, not as a stand-alone.

The only thing I'd like to say in conclusion is some people made comparisons between this and the tobacco industry, and I would suggest that is not in any way valid whatsoever. I know of no redeeming quality or benefit whatsoever from smoking a cigarette, but there is substantive evidence—a body of evidence by medical doctors, by researchers—that a glass of wine, in moderation, is actually beneficial. There are even many who suggest that a glass or two a week of wine, particularly red wine, even during pregnancy is not detrimental, and indeed could be beneficial.

So I think it is wrong to take this type of approach. I think we are creating a big stir that may be a concern. What happens to a woman who takes an occasional glass of wine with her dinner and discovers 30 days later that she's been pregnant for 30 days? What anxieties does that bring up with her if she reads that the very drinks she's been taking may produce birth defects in the baby she just found out started 30 days before?

There's a tremendous amount of concern. I think we're doing this and proceeding for the right ideas, but I think it's the wrong thing to do. I urge you to reconsider this. If you want to address this issue, and well you should, then do it from the comprehensive point of view, not from the piecemeal point of view. Thank you.

**The Chair:** Thank you, Mr. Gouk. You might be interested to know that it is rather unusual for a member of Parliament to be allowed to come and present. However, there were so many members of Parliament who had small wineries and small breweries in their ridings that we decided that since you asked most directly to come, you could come and represent them pretty well. From the comprehensiveness of your presentation, I think you covered most of the points that those various MPs have been taking each of us aside to tell us about. So thank you very much for doing that for us.

We'll now move to the question and answer session. I think we're in good time.

Mr. Merrifield. Are you splitting your time, Mr. Merrifield?

● (1610)

**Mr. Rob Merrifield (Yellowhead, CPC):** No, I'm not.

First of all, I'd like to ask a question to Mr. Koren. The vitamin C and E is an intriguing concept. On the vitamin C and vitamin E that you shared in your testimony, can you tell us how long it will be before studies are conclusive on that? What timeline might we be looking at?

**Dr. Gideon Koren:** For about ten years people have been asking why alcohol damages the baby. You've probably heard in other areas of medicine about oxidative damage. We hear a lot about antioxidants these days. I won't go through the biochemistry of it, just because you will probably all fall asleep.

But by now, 15 experimental studies in animals and in tissue—no human—show that if you expose them to enough alcohol you cause fetal damage. If you give antioxidants, you can minimize it or sometimes even inhibit it. In medicine there comes a stage when you ask, when are you going to give the benefit to humans? We are, I believe, the first group to say it's the right time. We applied for funding, we will do the study across Canada, and we don't know yet if it works. I can tell you, though—-

**Mr. Rob Merrifield:** What's the timeline on the study, though?

**Dr. Gideon Koren:** The study will take years because we need to give it in pregnancy, to see the baby born, and have the baby develop enough for us to do the physiological testing and all the other testing.

**Mr. Rob Merrifield:** That's fine. Is there a genetic link from the fetal alcohol syndrome mother having a child? Is there any genetic carryover from that?

**Dr. Gideon Koren:** That's an excellent question. It does not occur randomly. A mom who had a child with fetal alcohol syndrome has a very high chance that her next child will also have it. However, the same mom who drank a lot but did not have a child with fetal alcohol syndrome has a much lower chance. So genetics is involved. We call it pharmacogenetics. We don't know what does it yet, but there are a lot of theories.

**Mr. Rob Merrifield:** I have one question for Justice. I'm just trying to get a handle on exactly what you were saying. What I think you said is that if we put labels on bottles, it could be subject to a court challenge under the charter. Is that what you were saying?

**Ms. Irit Weiser:** Any legislation could be subject to a challenge.

**Mr. Rob Merrifield:** Yes, but I believe you used the case of cigarettes. If we enacted Bill C-206 and it was challenged in a court, is there a likelihood of that case being successful? What would be the chances of it being successful or not? I guess that would be the question.

**Ms. Irit Weiser:** I wouldn't speculate on that. What I was trying to say was that with freedom of expression, the courts have interpreted that freedom very broadly, so you quickly get to the justification stage. At that point, the government has to present the evidence that would justify an infringement. Whether or not this bill would be successful in a court challenge would really depend on the evidence.

My colleague may wish to add to that.

**Ms. Elisabeth Eid (Director and General Counsel, Human Rights Law Section, Department of Justice):** Did you have a follow-up question to that?

**Mr. Rob Merrifield:** No, I didn't. The only follow-up would be that you had mentioned the court case with the cigarettes and that it didn't hold up. Is that what you were saying?

**Ms. Elisabeth Eid:** Yes. With respect to the RJR-Macdonald case, the court found that there was a violation of freedom of expression and it was not justified by the Government of Canada. So there is a risk when you're engaged in labelling requirements in terms of constitutionality.

**Mr. Rob Merrifield:** Would it be a fair statement to say that if cigarettes lost, the alcohol...?

**Ms. Elisabeth Eid:** It's a different case and it's a different situation. There would be different evidentiary issues.

**Ms. Irit Weiser:** If I could just add to that, I agree that each case is very much fact-specific. In addition, one of the difficulties the Supreme Court had in RJR-Macdonald was that the health messages were not attributed to the government. That remains an issue.

The other thing they said was that the evidence the government presented at that time was insufficient. We then put together new regulations, but we commissioned a number of studies beforehand. We put together a very careful evidence base. Before the Quebec Superior Court, the government was successful. It was challenged on appeal by the industry to the Quebec Court of Appeal, and we're awaiting a decision from them.

● (1615)

**Mr. Rob Merrifield:** Thank you. That clears up what I was concerned about with your testimony. I'm even more concerned now, in that even the evidence from the panel here suggests that labelling may not have the effect that we really want it to have.

Given that, I have a question for the department before my time runs out. The Canadian Centre on Substance Abuse actually had a collective strategy to come together to deal with fetal alcohol syndrome. It includes more than just labelling, but I want to know what part labelling would have in those discussions, when the report would be coming forward, and how the progress is going with regard to that.

**Ms. Susan Fletcher:** We have been working with the Canadian Centre on Substance Abuse for about the last year now, as part of the work we're doing under Canada's drug strategy to look at some of the key issues we should be dealing with as a country. As I mentioned in my presentation, we've had consultations across the country. We've had round tables on several important issues that have come up, one of which was alcohol abuse.

Moving into the future, we expect to continue to bring stakeholders together. One of the messages we got loud and clear was that alcohol abuse was an issue that needed to be dealt with. Whether we were talking to provincial and territorial stakeholders, industry stakeholders, or others, everybody agreed that one of the ways to be successful was to work together and to have something that is integrated and comprehensive. Over the course of the next year, we will continue to work toward that.

**Mr. Rob Merrifield:** Yes, I think that's my problem. “Over the next year, we will continue to work toward that.” That's just too fuzzy a talk for actually getting to where we need to go.

Can you tell me what your timelines might be if you were pushed on this issue? I say that because the minister, in a speech to the same group on February 7, actually talked about a national advisory committee that's working on this. If they're actually working on this, what kinds of timelines would they have, and what could we do as a committee to accelerate that progress?

**Ms. Susan Fletcher:** Obviously, as you can imagine, there's a crossover between preparatory work that the department would do with others and decisions that are taken by the government to move forward. But our minister has asked us to do our work and come up with some ideas later this spring or summer.

**Mr. Rob Merrifield:** Would it be fair to say there will be a report by the stakeholder groups by this summer?

**Ms. Susan Fletcher:** Groups like the Canadian Centre for Substance Abuse will be making public reports along the way, that's true.

**Mr. Rob Merrifield:** All right.

Would it be fair then if the committee asked for a decisive, final report on recommendations to a comprehensive program on fetal alcohol syndrome sometime this summer? Would that be a fair timeline?

**Ms. Susan Fletcher:** So you're more interested in fetal alcohol syndrome? We've been doing some specific work around that, and with the chair's permission, I'd ask Kelly Stone to talk about what we're doing around FASD in particular. I was talking about alcohol abuse more generally.

**Mr. Rob Merrifield:** I think the committee is wanting to deal with this bill that's before us, Bill C-206, talking about fetal alcohol syndrome specifically and a comprehensive plan and how labelling would flow into that. I think we need some timelines, and I think the committee would be very interested in knowing what you're doing up to this point.

**Ms. Susan Fletcher:** I'll just set the stage. We are doing work on alcohol abuse. Fetal alcohol syndrome is part of that. The minister has asked for ideas.

As for the work we're doing on fetal alcohol syndrome, we're actually much further ahead on that than alcohol abuse generally, because we've had an initiative in place in the department for some time. Kelly can speak to that issue.

**Mr. Rob Merrifield:** So we might have a report sooner than that?

**Ms. Kelly Stone (Director, Childhood and Adolescence Division, Centre for Healthy Human Development, Public Health Agency of Canada):** Thank you.

The Public Health Agency has been very involved in the last few years in developing a national approach to fetal alcohol syndrome through the national FASD initiative and working with partners, including provinces, territories, health providers, health professionals, and others across the country to bring together the best ideas, common agenda, a set of priorities.

In 2003 we published a national framework on FASD that laid out those priorities, and from the federal perspective, again in conjunction with our partners, such as Mr. Koren, we are working on diagnostic guidelines. A national set of guidelines was first promulgated at the beginning of March through a special supplement in the *Canadian Medical Association Journal*. These guidelines are the first baseline set of guidelines for diagnosis of FASD that can be used across the country, and the next session is to promulgate them.

● (1620)

**Mr. Rob Merrifield:** Are you talking about how to diagnose fetal alcohol syndrome?

**Ms. Kelly Stone:** Yes.

**Mr. Rob Merrifield:** I'm looking for a report on a prevention of fetal alcohol syndrome. I believe the minister talked about a national advisory committee on fetal alcohol syndrome to deal with what I would assume would be the prevention, not the diagnosis. The prevention would be a comprehensive program that would fall right into Mr. Szabo's bill. Part of it, I would imagine, would be looking at the idea of labelling.

**Ms. Kelly Stone:** There's an FASD advisory committee for the minister actually, but that committee doesn't produce a fulsome report. It produces a small report on its activities, and I actually co-chair that advisory committee. But there isn't a fulsome report on prevention that is to be produced by that committee.

**Mr. Rob Merrifield:** So no report is coming.

**Ms. Kelly Stone:** I'm sorry, I'm not sure what it was the minister was referring to. I'm happy to tell you about the activities that are going on, and there are a lot of them, but I'm not sure about the report.

**The Chair:** Ms. Stone, from what you've said, it all seems to be stuck within the medical model, that is, diagnosing and then treating, as opposed to trying to figure out how to motivate people to avoid it.

Is there any work that the Public Health Agency is doing that is about educating the public to avoid having this phenomenon occur at all as opposed to the medical model, which is diagnosing the pathology and then trying to fix it?

**Ms. Kelly Stone:** I guess we're going at this in a couple of different directions. Certainly, one of them is the diagnosis, which in turn will lead eventually to surveillance. The other side of that is the public and professional awareness that has to go on. So it's a two-pronged approach.

**The Chair:** How far are you on the second prong?

**Ms. Kelly Stone:** On public awareness, we've just done environmental scans. Public awareness is a very big piece. We have been focusing more at this stage, because of the publications and the guidelines, on professional awareness and the education of physicians.

**The Chair:** Thank you.

Madam Demers is next.

[*Translation*]

**Ms. Nicole Demers (Laval, BQ):** Thank you, Madam Chair.

Ms. Fletcher, you said that various measures have been taken by Health Canada and its partners. Among other things, you mentioned roundtables.

Have the strategies contemplated under these measures ever included labelling as such?

[*English*]

**Ms. Susan Fletcher:** The issue of labelling, I understand, did come up at the round tables. Basically, my understanding is that people were looking for evidence and talked about how we could get evidence, what evidence we currently had, what evidence existed in other jurisdictions, and what that could tell us about whether or not labelling should be part of it.

From the point of view of alcohol, in and of itself, as you've heard over and over, we don't have that evidence yet. Our experience with tobacco tells us that if you do get the evidence and you can make labelling part of a comprehensive strategy, it can be helpful. When we were doing labelling alone on tobacco, without all the awareness, advertising, community development, and so on, we weren't having nearly the success in reducing the amount of smoking in Canada. In 2001, when we brought together a fair amount of resources, when the government made a fair investment, when we had lots of advertising on TV, which you will have seen, and we developed a fairly large community program so that people in the communities could get out and raise awareness among people who were smoking or among people who were permitting smoking, we started to see a very fast decline in the number of smokers in Canada.

So from our experience in tobacco, our sense is that labelling as part of a comprehensive program can work. The difficulty is labelling in and of itself.

● (1625)

[*Translation*]

**Ms. Nicole Demers:** Thank you.

Would you have any data on the decline in the number of newborns suffering from SARS in the Yukon and the Northwest Territories, where a mandatory labelling law was enacted in 1992?

[*English*]

**Ms. Susan Fletcher:** I don't have any data that tells us that. In fact, I don't think there have been any evaluations of the labelling that is in the territories at this time. So we don't, in the department, have any such data.

[*Translation*]

**Ms. Nicole Demers:** Ms. Weiser, do you believe labelling would pose problems in the context of the agreements that we have with other countries, NAFTA, for example?

[*English*]

**Ms. Irit Weiser:** Again, I can offer some general principles on our international trade obligations, but I won't apply them specifically to Bill C-206. As you're probably aware, we do have trade obligations under both NAFTA and the World Trade Organization. First, Canada has an obligation to ensure that any technical regulation does not discriminate between domestically produced products and imported products or among imports from different countries. Second, Canada must ensure that any technical regulation is not more trade restrictive than necessary to fulfill a legitimate objective. Legitimate objectives can include the protection of human health and safety.

[*Translation*]

**Ms. Nicole Demers:** Mr. Koren, is the Brewers Association of Canada your only partner in terms of financing?

[*English*]

**Dr. Gideon Koren:** No, the Brewers of Canada are one of our funders. We are very grateful that that happened. They also fund the Canadian Centre on Substance Abuse and some other very important programs. But we are funded by about 20 different funders across the country, some private and some medication companies, the Canadian Institutes of Health Research, the Ontario Ministry of Health. A big funder is the Hospital for Sick Children in Toronto, which funds a lot of the infrastructure we are working with.

[*Translation*]

**Ms. Nicole Demers:** Did the Brewers Association of Canada put pressure on you to appear before this committee and testify against labelling?

[*English*]

**Dr. Gideon Koren:** No, in fact, my involvement on the national front of alcohol brought me to want to appear here. I wrote the only paper on the topic. The Brewers Association had nothing to do with this. I funded my own way here. Even with Motherisk, the Brewers Association does not fund our research, and the clinical service is at arm's length. They have no right to tell us what to do. It's part of the agreement, as with many other third-party payers that help academic institutions. We are at arm's length from them, and there is no interference or influence in any direct or indirect manner.

[*Translation*]

**Ms. Nicole Demers:** Thank you very much.

[*English*]

**The Chair:** Thank you, Madame Demers.

Mrs. Chamberlain.

**Hon. Brenda Chamberlain (Guelph, Lib.):** One of the crutches to this issue seems to be that if, for instance, these organizations that are already voluntarily funding programs or partially funding programs like Motherisk have to—I'm going to become very personal now. Sleeman Breweries is in my riding and it's going to cost them $1 million a year to be able to implement this. If they go that direction and it affects their bottom line, and they and many other microbreweries, etc., have to withdraw funding to these voluntary programs, what does that mean? Do you have any sense of that? How would that affect you? How bad would that be for you?

**Dr. Gideon Koren:** It's an important question. I must say working with the brewers now for six or seven years, I hope and believe that they will not withdraw. I may sound over-optimistic, but I do not believe it. I feel their real commitment to prevent alcohol syndrome, and they believe, as we do, that counselling women at risk and counselling their physicians on what to do is a very effective matter. If that came to be, it would be devastating, because the brewers, as other organizations, are now investing in very important operations toward these issues. I certainly do not believe that would be the case, whatever way the law goes, but if it happens it would be a very sad moment, because they are now very effective investments.

● (1630)

**Hon. Brenda Chamberlain:** Does anybody else wish to address that question at all?

**The Chair:** Everybody else is on the government's payroll.

**Hon. Brenda Chamberlain:** That brings me to my next question, Madam Chair.

If that were to happen with the brewers and they withdrew, Dr. Koren, is it your belief then that the government should step in and start to fund all these programs if the Brewers Association couldn't? Should the government replace that funding then?

**Dr. Gideon Koren:** I personally believe that governments at all levels in Canada should be doing much more for the most common problem among our kids. The fact that the brewers stepped forward in the late 1990s to do it I think is a very strong element to show that they're good citizens of this country. I would hope the government would do more.

Clearly, in many countries, governments fund what the brewers are doing here. These are services that governments should fund. We in the academic world try to find money wherever we can to push the agenda of Canadian kids and their parents.

**Mr. Jim Gouk:** Could I address that as well?

**Hon. Brenda Chamberlain:** Certainly.

**Mr. Jim Gouk:** I did touch on that in what I presented. There is a cost to the department for enforcement of the labels. What I suggested—and perhaps Dr. Koren can say how effective it would be, given his testimony, and he is an expert in this field—is the money they are spending now is much more effective than labelling can ever be, and if we took the money that the department will be using for enforcement and put that into the things that are already proven to be effective, we would get much more bang for our buck.

**Hon. Brenda Chamberlain:** Do we have any figures, Mr. Gouk, on the enforcement at all? Do you have any idea?

**Mr. Jim Gouk:** I've heard figures. I don't know if they're accurate or not, but I've heard the figure of $27.5 million a year mentioned.

**Hon. Brenda Chamberlain:** Thank you.

To the Health Canada people, you talked about tobacco labelling and alcohol labelling being very different. I wonder if you could tell me how, in your estimation, they're different.

**Ms. Elisabeth Eid:** Yes. Basically, as Irit stated earlier, if there were a constitutional challenge to the bill, each case would have to deal with the facts of that case. For instance, with respect to tobacco, there was evidence of the significant harm that tobacco produces. That was laid before the court, and at least there was a lot of evidence with respect to harm caused by the product.

The reason we have been drawing an analogy with the tobacco case is that it's similar in the sense that the court dealt with the issue of an unattributed warning on labelling. That's why we've been using the case as an example of how the court would look at a similar labelling requirement, the considerations it would look at, and the evidence it would require.

**Hon. Brenda Chamberlain:** Thank you.

**The Chair:** Mr. Fletcher.

**Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC):** Thank you, Madam Chair.

My question is for Health Canada. It's a two-parter and will only require a yes or no answer. Is there a comprehensive plan being put together for drinking and driving? Is there a comprehensive plan being put together on FAS?

**Ms. Susan Fletcher:** We are currently working with partners to identify the key areas of alcohol abuse that need to be addressed, and we're looking at what each of the stakeholders, if you will, can do to address it. So, yes, we're looking at vulnerable populations. We're looking at first nations and what their vulnerabilities to alcohol abuse are. We're looking at FASD. We're looking at youths. Youths seem to be particularly vulnerable. There are high levels of drinking among youths between 18 and 24 years old. What can we be doing there?

Then we're looking at what the levers are, if you will, or the tools that the federal government can bring to bear to try to make a reduction. What are the tools that perhaps the provincial and territorial governments have that they can use?

● (1635)

**Mr. Steven Fletcher:** I'm getting the picture. You can look until the cows come home, but what is the timeline? Is there a timeline? One of the arguments is that we can't go forward in a piecemeal manner, but if there isn't a big, comprehensive plan imminent, maybe piecemeal is the only way we can go about it.

**Ms. Susan Fletcher:** What I can tell you is that our minister has asked us to work on it, and we will work on it. Then there is the whole policy process that has to take place in the federal government.

**Mr. Steven Fletcher:** That was under this minister, but presumably under other ministers this has come up. With all due respect, it just seems that this has been dragged out and will last in perpetuity, with nothing actually happening. This is like an episode of *Yes, Minister*.

**Ms. Susan Fletcher:** To tell you the honest truth, I think alcohol abuse has come to the forefront now for a whole variety of reasons. Obviously, the private member put the pill on the table, but around the world we're seeing that, all of a sudden, the World Health Organization has alcohol abuse on its table this year.

**Mr. Steven Fletcher:** But I'm concerned about what's happening in Canada and what we can do right now, ASAP, to prevent FAS and to prevent drinking and driving. I'm not hearing that this is coming from Health Canada.

**Ms. Susan Fletcher:** Sorry. Indeed, what I tried to say when I talked about it was that we actually already have a number of initiatives in place by which we try to do that. We have a community initiatives fund, for example, now under Canada's drug strategy, and one of the key issues is going to be alcohol abuse. That will allow communities to find ways to address alcohol abuse and do some of the kinds of prevention activities that we heard about. We already have an FASD program, both in the agency and in the first nations and Inuit health branch. So there are things that we are doing.

In terms of what we're not doing right now, we don't have a comprehensive, integrated program in which it's not only what we can do as the federal government or as the Health portfolio, but in which it's integrated with what the criminal justice system can do, it's integrated with what Corrections can do, and it's integrated with what the provinces and territories and other stakeholders can do. That's what we're trying to work toward.

**Mr. Steven Fletcher:** Since I like your name, I'm going to give you a break.

**Voices:** Oh, oh!

**Mr. Steven Fletcher:** I wanted to ask something of the Public Health Agency of Canada. I was concerned, as the chair pointed out, that you kept on talking about the medical model, but I didn't hear the word “prevention”. As most people would agree, prevention is the best way to avoid the system. Are any of your initiatives preventative, Ms. Stone?

**Ms. Kelly Stone:** Thank you.

To answer your question generally, including the first part, I mentioned briefly that we did produce with our partners a framework for action that includes prevention. Each level of government had their piece, which they then had to take away and get working on; indeed, I have a compendium of some of the interesting things that provinces and territories are doing on their part, including on the prevention side.

On the federal side, certainly a comprehensive strategy on FASD is the next logical step. There's no doubt about that, and we have various pieces we're working on now.

**Mr. Steven Fletcher:** So they're pieces, not a comprehensive strategy. So the argument that we need a comprehensive strategy to move forward before we do.... Maybe labelling is a part of it; maybe it's not, but we don't know because there is no comprehensive strategy. I guess that's a broader question.

Would that be a correct assumption?

**Ms. Susan Fletcher:** That's a correct assumption. There's no policy approval yet for a broader strategy, but there has been a request for us to work towards that.

**Mr. Steven Fletcher:** For a point of information, when I get potato chips or whatever, there are labels telling you what's in any food product. Why is that not the case with alcohol?

**Ms. Susan Fletcher:** In fact, it is. There's the percentage of alcohol in the bottle.

But I'm going to ask the health products and food branch to respond specifically.

● (1640)

**Mr. Steven Fletcher:** But what about ingredients other than alcohol? Is it just alcohol and water? Is that it?

**Ms. Claudette Dalpé (Associate Director, Food Regulatory Programs and Access to Information, Bureau of Food Regulatory, International and Interagency Affairs, Food Directorate, Health Products and Food Branch, Department of Health):** Under the food and drug regulations, as you know, alcohol beverages aren't foods. What is happening is that certain labelling requirements apply to alcoholic beverages. These labelling requirements apply to the percentage of alcohol.

You're talking about the list of ingredients, of course. Alcoholic beverages subject to standards under the food and drug regulations, the ones described in division 2 of the regulations, are exempt from carrying a list of ingredients. This has been the case since the establishment of these regulations in 1964.

We have to consider that alcoholic beverages are not like a potato chip, though I don't want to excuse them. A potato chip is a potato, the oil you use to make it, and whatever you add to flavour it. Alcoholic beverages are quite different. When the ingredients are finalized, they begin to produce the beverages; therefore, the list of ingredients permitted in these standardized products would be tremendously long and would not be informative to consumers, because you will not find the ingredients that are listed in the final product.

**The Chair:** Excuse me, could you not analyze the ingredients once the process is finished and require those ingredients of the finished and fermented product to be on the label?

**Ms. Claudette Dalpé:** The fermentation process is really destroying the original ingredients of the alcoholic beverages. You can't measure—

**The Chair:** Yes, but what about the final ingredients? Can you not actually analyze at the final stage what the new ingredients are after the chemical process has taken place?

**Ms. Claudette Dalpé:** Of course, you can analyze it for the polyalcohols and the flavonoids that are produced as a result of the production and manufacturing.

**The Chair:** But they are exempted from that, you're saying?

**Ms. Claudette Dalpé:** They're exempted.

**The Chair:** Thank you.

I have just one more point of clarification. I should say that previous witnesses have made it clear to us that we are not only talking about addicts and alcohol abuse, but also, according to certain witnesses, the fact that FASD effects on people can come with what some people might call responsible drinking. It turns out not to be responsible. But we're talking about alcohol use, not abuse, and we're not talking about addicts necessarily, because all these things, of course, are on a spectrum.

The next speaker is Mr. Savage.

**Mr. Michael Savage (Dartmouth—Cole Harbour, Lib.):** Thank you, Madam Chair.

My first question is going to follow up on what you said. I listened with interest to a colleague from the House, Mr. Gouk, and a couple of comments you made caught my attention. One was the distinction between the alcohol industry and the cigarette industry, which I think is a very good point. In my view, there are huge differences in terms of the responsibility of the alcohol industry versus the tobacco industry.

But the second comment you made indicated that a glass or two of wine a week by a pregnant woman might not harm the fetus. Is that what you said?

**Mr. Jim Gouk:** That is what I have read in medical journals, particularly from Britain, where studies have been done. There are going to be conflicts of opinion on that, as there are on many things, but that is something that has been presented by the medical fraternity in certain areas.

**Mr. Michael Savage:** That's new to me. I wonder if anybody else would have a thought on that.

**Dr. Gideon Koren:** The Motherisk program is part of our mandate to review all existing literature and synthesize it. And we publish it. We published two of those that answer your question now.

We tell women not to drink any drink in pregnancy. This should be the rule. Yet, as one of the members mentioned, 50% of Canadian women do not plan pregnancy, so they become pregnant unknowingly. Fifty per cent of Canadian women drink socially, and 50% times 50% is 25%. So one-quarter of all women will have some alcohol seen by the fetus.

So the question becomes very important. At present there is no evidence of damage to the baby from rare, non-addictive use of alcohol. We meta-analyzed it. It's published in the literature. This does not mean there is no damage. It means no one has measured it yet. So clearly, Canadian and other women should not drink during pregnancy.

On the question of whether one drink before you conceive could cause damage to the baby, to the best available data now, no one has shown that to be the case. Is this a reason for us to say that the women should drink? Absolutely not.

● (1645)

**Mr. Michael Savage:** Right.

Ms. Fletcher.

**Ms. Susan Fletcher:** On behalf of the department and the Public Health Agency, our current advice is exactly that. If you're pregnant or think you might become pregnant, you should not drink. It's based on the best available evidence we have at this time.

**Mr. Michael Savage:** That was my understanding. I think that makes sense.

I have a second question, Ms. Fletcher. Under warning labels, you indicated some advice. The first point indicated that as the bill currently reads, the intent is to warn consumers about the health effects of alcohol and to change their behaviour. You say based on your experience with tobacco, labels are rather intended to inform consumers about the health effects.

Can one imply, then, that you don't believe they would change their behaviour?

**Ms. Susan Fletcher:** It's based on our understanding of the case law and how the judicial system would assess the evidence we currently have. So as you've heard from Justice, we currently don't have the evidence to say that it changes behaviour. We do have some information that would suggest that by providing information to people, they might make choices that are different. So unless and until we have a stronger evidentiary base, it's better to look at informing as opposed to warning.

Again, I would suggest if you want more clarification on that, Justice can help.

**Mr. Michael Savage:** I wasn't interested in the legal opinion, I was interested more in trying to get at the issue here for me, which is what is the evidence that warning labels work? You indicated with tobacco our experience was that by themselves, they didn't do very much. When we had a PR campaign about the effects of smoking, it caught hold.

I read with great interest a piece that Mr. Szabo sent me on Friday, which I assume he sent to other members of the committee. I gave it some great attention. He listed a number of countries that had warning labels.

This is a bit of a repeat, and I wasn't here for Dr. Koren's presentation. Unfortunately, I hit a lot of provinces on my way to Ottawa today because of the weather back east. My question is whether there is evidence from any jurisdictions that we can reasonably use to indicate that warning labels work.

**Ms. Susan Fletcher:** We had a consultant pull together every study that he could find worldwide on the evidentiary base. At this point in time, we do not seem to have it, no.

**The Chair:** That particular person is coming here on Thursday.

**Mr. Michael Savage:** Who's coming, your expert?

**Ms. Susan Fletcher:** Yes, the expert we used is coming, I believe, to answer questions.

**Mr. Michael Savage:** Dr. Koren, did you have something?

**Dr. Gideon Koren:** I will be brief.

From the evidence today, mostly from the largest country that has evidence, which is the United States, I quoted that despite the labelling—and one can argue it's their labelling, it's not necessarily what we want to do—in 1989, 1990.... The CDC in 1991 looked at how many women were problem drinkers in pregnancy, repeated it in 1995, and found fourfold more women were problem drinkers.

So clearly, if anything, it suggested there was no measurable effect. That's the best evidence available today on an ecosystem, on a large population—not just a small study.

**Mr. Michael Savage:** A number of other countries, though, do have warning labels. Mr. Szabo's piece indicated Guatemala, Ecuador—it seemed like a number of Central American countries. Is there no evidence from those countries, any studies that have been done on them?

**Dr. Gideon Koren:** I'm not aware as of today—this morning—of studies coming from these jurisdictions. This does not mean it does not work for them, but it has not been shown.

**Mr. Michael Savage:** This seems to me to be a bit of a gap in the study of this issue right now. There are jurisdictions that have the warning labels, and have had them for a reasonable period of time, but we don't have evidence as to their impact.

**Dr. Gideon Koren:** With respect, the only reason the American data should be looked at very carefully is that the study was done by the CDC, the Centers for Disease Control and Prevention, which is the pre-eminent epidemiology group in the world. These are the people who know how to do studies, and they do not show effects. I cannot attest that other labelling or other combinations with other things will not work. For the present time, my scientific answer to you is that there is no evidence that it works on the problem drinkers.

● (1650)

**Mr. Michael Savage:** Thank you.

**The Chair:** Thank you, Mr. Savage.

We all agree on the CDC being the pre-eminent place to do these analyses, but we're also aware, because of samples we've seen, that the labels they were examining had possibly the worst, most obfuscated messages that could possibly be designed for any product. You could hardly read the warning.

Dr. Lunney.

**Mr. James Lunney (Nanaimo—Alberni, CPC):** Thank you, Madam Chair.

Well, we're having another interesting session on this subject.

The first questions are for Dr. Koren—and we're very pleased to have all of our witnesses here as usual. But, Dr. Koren, your experience with Motherisk is unique. It's a program I'm sure all committee members found very interesting. I have just a few questions for you because of your strong scientific background and credibility in this subject.

Can you confirm the time in fetal development where the fetus is at greatest risk? Is it very early in pregnancy?

**Dr. Gideon Koren:** During the first 12 weeks of pregnancy, all body organs are developed. The brain is the only organ in the human pregnancy that develops throughout pregnancy. As a result, damage can happen even later. As you realize—and I know you know it—in pregnancy, a problem drinker does not start drinking in the second trimester, so we don't have laboratory evidence.

But in primates, in monkeys, where we can give them alcohol when we want—not that it's nice, but it's the way we do research—you can show that even second trimester will cause damage to the brain. It's a different type of damage.

So in answer, any time in pregnancy that a woman drinks can cause damage to the brain of the developing fetus.

**Mr. James Lunney:** Okay—and we're talking about binge drinking there. But is there any greater risk, as far as the binge drinking goes, in the very early stages versus later? Does there seem to be more resistance later? The characteristic changes are in the very early stages, aren't they?

**Dr. Gideon Koren:** Yes. There's no question that the first trimester, because of everything we've said, is the most sensitive area—no question about it. But I just want to ensure that no one says, oh, after the first trimester it's okay.

As you know, for medicinal drugs, sometimes after the first trimester you can take a drug. Lithium and other drugs that can cause malformation cannot do so after 12 weeks, when the heart is produced, but that's not true for the brain.

**Mr. James Lunney:** Okay. Are you aware of any research about the age of mothers? Again, does it affect mothers at all ages, from early teens through to their forties, or is it more the young mothers who are really at risk here in terms of numbers?

**Dr. Gideon Koren:** That's a very important question. Research from Seattle and other jurisdictions shows—and our research confirms this—that the older the mom, the higher the risk.

First we thought it was because when you become more addicted, you drink more, but we corrected for that. I believe now that it's to do with liver damage. As the damage to the liver of the mother increases, her ability to deal with alcohol decreases.

But there's no question that for moms who drink chronically, the chances for the fifth or sixth child are much higher than for those born earlier, which again for prevention is very important. If we identify her early and we can do something to prevent either the pregnancy, by contraception, or the addiction, hopefully, we can prevent this occurrence. But clearly the risk increases with age.

**Mr. James Lunney:** Excellent.

We're very interested in what you were saying about the studies with antioxidants. Could you give us an idea of the level of antioxidants—vitamin C, for example—being used? Are you talking about 500 milligrams or a gram a day or multiple grams?

**Dr. Gideon Koren:** Yes. Of course, we all consume antioxidants in our foods and many Canadians take vitamins, but it's not enough to take small amounts. You need large doses.

We use vitamin C at 800 milligrams, which is a high dose, and vitamin E at 400 international units. Why? Because studies of pregnant women with pre-eclampsia with hypertension in Britain used those doses and could reverse oxidant damage, and they even measured oxidant measures, biochemical measures.

So clearly, as you realize, in pregnancy the ethicality of doing studies is a very sensitive issue, so for that reason we chose a dose that was shown in another context to work in humans and to be safe, of course.

**Mr. James Lunney:** Excellent. Well, at 800 milligrams—you're talking daily here now?

● (1655)

**Dr. Gideon Koren:** That's right.

**Mr. James Lunney:** It's certainly not a huge dose, and it's very readily available and not expensive. The same with 400 international units of vitamin E, which has been shown to reduce the risk of multiple sclerosis, for example.

**Dr. Gideon Koren:** Absolutely.

**Mr. James Lunney:** I have a final question, and I'm going to ask you to speculate on something. If we're talking about a program here with labelling that might cost millions for Health Canada to enforce and for industry to apply, we might apply some millions to making antioxidant vitamins available and promoting that on speculation, even though the results aren't final here. There is no downside to women taking antioxidant vitamins at an early age as a preventative measure even if it turns out later we find definitively.... There is no downside, is there? Would you speculate that this might be a good investment for government to pursue?

**Dr. Gideon Koren:** It's a very, very good question. Thank you. I visited with you, and I know the thoughtfulness of the work you do on both sides.

However, as you may know now, medical people told everyone, "You can use vitamin E as an antioxidant". Now studies have begun that show cardiovascular damage caused by hyper vitamin E use. The problem is, when you change an ecosystem it always looks positive at the beginning; only later on it picks up the flack. So I just want to be extremely cautious. When we take a lot of a good thing, we may do some bad things too.

So if this would work, clearly this would be an example of where you could even add the vitamins to alcohol, for example. You asked me to be kind of thinking.... Why not add them so people who drink alcohol would get the vitamins? But of course, we still have years before we can say that, so it's totally speculative.

**Mr. James Lunney:** I'm just surprised—

**The Chair:** Mr. Lunney, your time is up.

Mr. Szabo, go ahead, please.

**Mr. Paul Szabo (Mississauga South, Lib.):** Thank you.

Dr. Koren, if a woman didn't drink at all during her entire life except for going to a social function and having five drinks—defined as a binge—could she produce an FASD child?

**Dr. Gideon Koren:** If I understand, it's a one-time binge. Motherisk published this year, in the *Journal of Women's Health*, the first study to address your question, so it's an excellent question, because we have such women.

They call us hysterically. They had one binge. They didn't know they had conceived. None of the kids—

**Mr. Paul Szabo:** I know, but it can happen.

**Dr. Gideon Koren:** Oh, it does happen.

**Mr. Paul Szabo:** Okay. Let me read something to you here. This is from a paper. It says, and I quote:

> In the unlikely event that at the end, alcohol warning labels are proven to have no affect whatsoever, this is still a non-expensive means that has no risk or downside to it. In the implementation of the alcohol warning label, nothing can be lost; only gained.

Do you recognize that?

**Dr. Gideon Koren:** Yes, I'm sure—

**Mr. Paul Szabo:** You co-authored this paper in March of 2004, which totally contradicts what you've said here today.

**Dr. Gideon Koren:** No, no. I want to put it into context, Mr. Szabo. Our paper brought together all the pros and cons, as you can read. It's not me saying what I believe. We thought that for scientific discussion we needed both sides, and I'm not necessarily saying today that the label is detrimental. I'm not saying that.

I am saying—

**Mr. Paul Szabo:** Okay. Could I ask another question then? Have you ever seen the U.S. warning labels?

**Dr. Gideon Koren:** Yes.

**Mr. Paul Szabo:** And would you characterize them as readable and noticeable?

**Dr. Gideon Koren:** No. As Madam Chair said, this is not the way to do it.

**Mr. Paul Szabo:** And the information we've all heard—and I think what you're relying on now—is someone's research on the effectiveness of the U.S. warning label because it's the one that's been around the longest, and there are so many places to do it.

Answer this question: if a label is unreadable and unnoticeable, why would anyone in their right mind do a research study to determine its effectiveness?

**Dr. Gideon Koren:** First of all, if they implemented it, they should research it. The readability of the American label is questioned, and as you said, rightly so. The question of whether other labels will be more effective is to be answered too.

**Mr. Paul Szabo:** Absolutely.

**Dr. Gideon Koren:** You do not know that another will work.

**Mr. Paul Szabo:** I want to ask Health Canada a couple of questions. First of all, I have to tell you I feel badly that nobody has really talked about the magnitude or the scope of FASD. We've had testimony, and it's about 1% of live births—anywhere from 3,000 to 5,000 children each year—and health, social program, and criminal justice costs are probably well in excess of about $15 billion a year.

Let me tell you, Ms. Fletcher, what the alcohol industry did in 2002, according to Library of Parliament research. Sales were $14.5 billion. They spent $660 million on advertising and promoting their product. They spent $5 million on responsible-use programming and they had a profit of $700 million.

Why is it, Ms. Fletcher, that Canadians have to absorb the cost of the adverse and tragic consequences of alcohol misuse of some $15 billion a year or more, and we don't even want to make a move to say there ought to be a better balance here because in fact the alcohol industry is spending negligible amounts on responsible-use messaging? Why hasn't Health Canada seized this thing? Why is it that beverage alcohol is the only consumer product that can harm you if misused that it doesn't warn you of the fact? It can hurt you. Why hasn't Health Canada done this?

● (1700)

**Ms. Susan Fletcher:** There are two things. I'd like to come back to the data on FASD, because you're absolutely right, it's a very big problem and it's one that we're obviously concerned about. While I had a few statistics in my opening remarks, I can ask Kelly to give more to this table.

I believe Health Canada is doing work. When it comes to the whole issue, though, of labelling and what to put on labelling, this committee has heard from us today some of the dilemmas we face as a government in trying to put forward labelling.

**Mr. Paul Szabo:** Okay, one last question then. In the House of Commons, Minister Ujjal Dosanjh, in a response to a question I made about the health warning labels and my bill, responded that he's supporting the bill, that he encourages members in the House to support that bill, and that Health Canada was already working on a comprehensive strategy in support of that bill.

Can you tell me why the minister said that in the House and you have totally contradicted him today?

**Ms. Susan Fletcher:** I cannot tell you why he said that in the House and I hope I have not contradicted him today.

**The Chair:** Thank you, Mr. Szabo.

Mr. Ménard is next, then Mr. Thibault.

[*Translation*]

**Mr. Réal Ménard (Hochelaga, BQ):** I apologize for leaving the committee; I had to go and make a speech as part of a debate on a motion on Hepatitis C.

I have two questions for the representatives of the Department of Health and one for those from the Department of Justice. You of course can't answer on behalf of the minister; we understand that.

Have you made a positive recommendation to the minister? As officials, as an advisory service, do you support the bill? From your brief, I believe we can understand that you don't support it or that you have major reservations. I'm not asking for a political answer—we'll put that kind of question to the minister—but, from the standpoint of an advisory service, as a department, am I correct in saying you don't support the bill?

Second, our researchers have given us a note that states that there was a labelling pilot project at Health Canada in 1995. Can you tell us about that?

Third, are we to understand that no study has been conducted, contrary to what was done in the case of tobacco? You filed some studies with the committee, of which I was a member. For labelling, does Health Canada have no studies on the decisive and conclusive nature of a bill such as this one?

[*English*]

**Ms. Susan Fletcher:** Basically we provided the minister with the factual information that I've tried to provide the committee with today. The rest is a policy question, which as a public servant I can't answer.

From the point of view of the study that we did in the late nineties, basically at that time what the study found is that there was not sufficient evidentiary information for us to move forward on labelling. So it would be the same kind of thing, and in fact—-

[*Translation*]

**Mr. Réal Ménard:** Have you filed that study? Can you file it with our clerk, so that we can have...?

[*English*]

**Ms. Susan Fletcher:** What we did agree to is...more recently, with this bill in the House, we also did another study, and as the chair has just indicated, you will be having the researcher who did that study, and the study he provided us with, coming to your committee, so you will have that information.

[*Translation*]

**Mr. Réal Ménard:** All right.

Now I turn to the Justice Department representatives. I checked with the Société des alcools du Québec, which, together with Éduc'alcool, belongs to a coalition that does not support the bill.

Do you fear there will be any constitutional challenges regarding the division of powers and freedom of expression, since the Irwin Toy decision was the subject of a three-question test that was administered in an exam at the Ottawa law faculties? Do you fear there will be constitutional challenges regarding the division of powers and paragraph 2(b) of the Canadian Charter of Rights and Freedoms, which concerns freedom of expression?

● (1705)

**Mme Elisabeth Eid:** I think I'll let Irit answer your question. I don't think any companies have threatened a challenge to date. We don't assess the risk of challenges; where there's any doubt, we assume there may be some.

**Mr. Réal Ménard:** The Minister of Justice must always state in a brief to Cabinet that the bill is consistent with the Charter.

**Mme Elisabeth Eid:** That's true in the case of government bills. In the case of a government bill, we usually conduct a Charter study. We don't do a study to see whether there is a risk of challenges as such, but rather, if there is a challenge, whether it will be considered constitutional or not.

**Mr. Réal Ménard:** Do you think so in this case?

**Mme Elisabeth Eid:** The process isn't the same because this is a private member's bill. We aren't here to give you a legal opinion.

**Mr. Réal Ménard:** But what's your assessment? I asked to have representatives appear from the Department of Justice because I wanted to take advantage of your expertise and to know your opinion. Until someone files a lawsuit, we can't know, but do you anticipate any? Do you find the bill constitutional on a prima facie basis, at first glance?

[*English*]

**Ms. Irit Weiser:** As I indicated at the outset of my presentation, we are counsel exclusively to the government of the day, and we cannot, without entering into a conflict of interest, advise the committee. What we can do is outline the governing principles, the general—

[*Translation*]

**Mr. Réal Ménard:** This is a statutory measure, and we're parliamentarians. Whether it originates with the Crown or with members, it seems to me you should have an opinion on the subject. Otherwise, with all due respect, your testimony is completely [*Editor's Note: Inaudible*]. I'm not asking you for a political answer; the minister will handle that.

Do you think, at first glance, that there is the potential for a challenge? Someone at the department must have studied this from the standpoint of the division of powers or the Charter. Otherwise, your presence here is purely academic.

**Mme Elisabeth Eid:** With regard to freedom of expression, Irit has already described some of the considerations the court would have. It's been said that labelling is a kind of forced expression. Obviously, paragraph 2(b) of the Charter is concerned by this bill. The question is whether that can be justified with respect to section 1 of the Charter. The burden of proof is on the government. Even in the case of a private member's bill, the government has to justify legislation. There has to be proof for each stage of the analysis under section 1.

As to the division of powers, I don't know whether Irit has any comments.

**Ms. Irit Weiser:** Yes. I explained that there were only general principles.

[*English*]

Health is a matter that can fall within either federal or provincial jurisdiction, depending on the nature of the legislation. The courts have long recognized that the protection of public health and safety are valid uses of the federal government's criminal law power. That was recently confirmed by the Supreme Court of Canada in RJR-Macdonald, when the court concluded that the Tobacco Products Control Act, although unconstitutional on charter grounds, was validly enacted under the federal government's criminal law power.

The sole restriction on criminal legislation dealing with health is that there be a prohibition and a penalty and that it cannot represent a colourable intrusion on provincial jurisdiction. Tobacco as well as food and drugs are examples of current statutes that are enacted under the federal government's criminal law power.

[*Translation*]

**Mr. Réal Ménard:** Madam Chair, do I have a little time left?

[*English*]

Do I have time to ask another question?

● (1710)

**The Chair:** Time's up. Sorry.

Mr. Thibault, and then Mr. Carrie.

**Hon. Robert Thibault (West Nova, Lib.):** Merci, madam la présidente.

Thank you very much.

I noticed that our chairman was exceptionally busy getting advice from our clerk on procedure.

Prior to a question I have for Mr. Koren, I just want to point out, relevant to Mr. Szabo's question, that it's my memory that when the minister was speaking about his support for the bill and a comprehensive strategy, he was talking about the comprehensive strategy on substance abuse or alcohol abuse, and not specifically on the implementation of this bill. But our memory can be refreshed by finding copies of the speech to make sure we understand exactly what the minister said.

The question I would ask you, Dr. Koren, without getting into the financial aspects of it, because I understand that you haven't necessarily done that study, is that we've had some suggestions at the committee that the implementation of this bill as a stand-alone thing, outside a comprehensive strategy, might have some negative sides to it, and I find that a little difficult to comprehend.

Would that be your understanding, that it would be perhaps detrimental to do it as a stand alone, rather than waiting to do it, should it be decided, as part of a comprehensive strategy, as we have with cigarette labelling, where we do it with an information campaign and other ways of informing the public of the dangers of cigarettes?

**Dr. Gideon Koren:** Thank you. I'm not a health economist, so clearly it's outside my field. We did conduct the first study in Canada on the cost of fetal alcohol syndrome. My PhD student, Brenda Stade, interviewed 140 families across the country. And Mr. Szabo is correct. The cost per family up to age 65 is about $1 million. If we have 4,000 such children every year, it's $4 billion. So the cost is immense.

I cannot attest to the cost of implementing the program. One member of the committee asked whether, because of that, existing programs would not be supported. That would be detrimental. But that's not my.... I'm not an economist. So I have to pardon myself and not answer it. I do not know what the cost of implementing the bill would be.

**Hon. Robert Thibault:** In your experience, in your capacity, in your expertise, in your profession, what level of understanding do you find people have, generally, who get into trouble because of the use of alcohol, or who have medical ill effects or bad effects? What level do you find would not know of the possible ill effects of these products?

**Dr. Gideon Koren:** On that question, sir, there are many studies, and people quote different numbers. Most Canadian women know that alcohol is not good for you. The point I was making was that addicted women, those who give birth to children with fetal alcohol syndrome, even when they know—and we talk to them, we counsel them every day, and they come to my clinics—they cannot stop drinking because they are chemically dependent on it. You cannot stop chemical dependence.

Smokers who are nicotine dependent do not stop smoking because of advertising, because they are chemically dependent. They need a much stronger investment, interventions, medical models, other models, social.... Addiction is a terrible illness that is not resolved by labelling. That does not address the culture issue and developing a culture in which drinking is not acceptable. That's another question. But to your question, we do a lot of research on women's perception of risk, and the women who are addicted cannot change their behaviours. They tell you. They know it's not good for them. I see them in my clinics. They know, but they cannot do anything about it. Even if they know they will lose the children, they don't stop the behaviour because they cannot stop it. It's a very sad situation.

**Hon. Robert Thibault:** Would the same be true of teenage girls who are not necessarily thinking of becoming pregnant? Would they be aware of the potential ill effects of alcohol?

**Dr. Gideon Koren:** Teenage girls are a very high-risk group. When they become sexually active, if alcohol is involved...most sex acts are done without protection, unplanned, and often using alcohol—all reasons for becoming pregnant unknowingly, because it was not planned. So this is a high-risk group.

Most teenage girls know that alcohol and pregnancy don't go together, but do they act upon it? They do not plan the pregnancy, so they cannot act upon it. I don't think a label can prevent them from being sexually active and drinking, because teenagers are drinking.

● (1715)

**The Chair:** Thank you, Mr. Thibeault.

Mr. Carrie.

**Mr. Colin Carrie (Oshawa, CPC):** Thank you very much, Madam Chair.

I have so many questions to get through. I'm going to try to be as quick as I can getting them out.

My first question is for Health Canada. I think you mentioned the number of $100 million. Is that how much the government spends on combating fetal alcohol syndrome and drinking and driving each year?

Is that what you said the amount of money was?

**Ms. Susan Fletcher:** Yes, the figure I used of $100 million is what we're currently spending on alcohol abuse generally. The largest proportion of that was with first nations and Inuit health, about $75 million. Then there's a portion of the $75 million and a portion of the remaining $25 million that would be on FASD.

Can I just ask, Kelly, how much that would be?

**Ms. Kelly Stone:** Our portion is actually rather small, $3.3 million, back from 1999, which we get on an annual basis, and an additional $1 million over just two years—we're just starting our second year—from Canada's drug strategy. So it's quite small in our case.

**Mr. Colin Carrie:** I believe Mr. Gouk was saying if we're going to be doing labelling, it's going to cost an extra $27.5 million to enforce it.

Is that a true number? Have you heard that?

**Ms. Susan Fletcher:** Yes, I've heard that. It's a number that represents our best understanding of what it would cost in Health Canada and the Canadian Food Inspection Agency—because if we were to enforce this bill, it would involve both of us—to develop and implement an enforcement program for the regulation.

**Mr. Colin Carrie:** Would that be additional money, or do they plan on just capping you at $100 million and you'll have to make do?

**Ms. Susan Fletcher:** No, the $100 million is money we're currently spending. The $27 million would be over five years. So it would be about $5-million-and-change per year in the first five years. It would go down a bit in future years, once we got the regulatory program in place.

**Mr. Colin Carrie:** The programs you spoke about—there were nine listed in your presentation—I was wondering how effective they are and how you measure the success of the programs you already have.

**Ms. Susan Fletcher:** The programs under the Canada drug strategy are just new programs. We just got the money for Canada's drug strategy about two years ago. So, for example, the community initiatives fund is only rolling out. This is the first year we will actually be delivering it. In fact, for the first nations and Inuit health programs there is a number in place, and I'll turn to them.

One of the other programs we have is the program where we transfer around $15 million every year to the provinces to do alcohol and drug treatment programs at the provincial level. The alcohol and drug treatment program we have has been evaluated. It was a program...because it's been in place for about 15 years now—

**Mr. Colin Carrie:** How effective is that?

**Ms. Susan Fletcher:** We evaluated it from the point of view of meeting its original intent, which was to produce new and emerging ways to fund alcohol treatment programs in the provinces, as opposed to it being part of their A base. There is some difficulty with the money, because once the province gets the money they kind of start thinking of it as part of their normal programming. So we're going to be working with the provinces this year to make it more of an innovation program again, which was its original intent. It was not meant to be ongoing, everyday funding for their existing programs.

**Mr. Colin Carrie:** What I'm curious to know, though, is if we're spending $100 million and we have $75 million for the first nations, how do we know how effective it's going to be?

Do you have things set up to know how effective it is and how you're going to measure it?

**Ms. Susan Fletcher:** Can I ask Kathy Langlois?

**Ms. Kathy Langlois (Director General, Community Programs Directorate, First Nations and Inuit Health Branch, Department of Health):** Good afternoon.

In regard to the two areas we're spending the $75 million on, we're spending about $17 million annually on our FASD program, and we're spending the remaining $58 million on the national native alcohol and drug abuse program. I'll talk quickly about both of them.

In terms of the fetal alcohol spectrum disorder program, we're looking at preventing FASD births and at improving the quality of life for those affected by FASD. In terms of prevention, we provide education and training in order to increase awareness, but also to increase community readiness to deal with FASD. As you can appreciate, this is first nations on-reserve and Inuit in Inuit communities, and alcoholism and addiction is a community issue, so we need to work at a community level.

We also have targeted interventions for those at risk of having an FASD birth. In there, I would talk about our mentoring programs with pregnant women at risk or women who are at risk of having an FASD birth. As Dr. Koren said, those tend to be women who've already had an FASD birth. So we have a mentoring program we've started to put in place.

● (1720)

**Mr. Colin Carrie:** How are you going to measure the results, though? I understand you have the programs. There are nine listed here. Is there any idea of how you're going to measure them? As parliamentarians we want to find out if we're going to get the best bang for the buck. Have you considered how you're going to measure the effectiveness of the program?

**Ms. Kathy Langlois:** You're absolutely right. But these are social programs, very difficult to measure. What we are relying on in the example of the mentoring program is that we're also working with the Indian health services in the United States, who've identified mentoring as a best practice. We're working together to build the evidence base to move forward. But that mentoring program has been identified as the best practice.

We also have multidisciplinary teams that we're looking at putting in place. For example, we have one at the Lakeland Centre for FASD in Cold Lake, Alberta. Again, we have demonstrated this in some of our baseline work. Multidisciplinary teams have looked at the issue of a child who has FASD, and have determined that connecting children to the services to mitigate the impacts is a best practice. So we're working on the basis of best practices and looking at putting baseline measures in as much as we can.

**The Chair:** Thank you very much, Dr. Carrie.

I have a few questions. Dr. Koren, what percentage of your working time is spent with Motherisk?

**Dr. Gideon Koren:** I am a full-time employee of the Hospital for Sick Children. I'm a senior scientist at the Canadian Institutes of Health Research. It's 100% of my time, but it's many more hours than 100%. I'm working many hours a day.

**The Chair:** But does the program Motherisk have a separate accounting system, or is it just done through the hospital?

**Dr. Gideon Koren:** It is part of the division of clinical pharmacology and toxicology at the department of pediatrics of the Hospital for Sick Children and it's part of the faculty of medicine of the University of Toronto. So I'm full-time, together with another three physicians. All of us are funded by the Hospital for Sick Children.

**The Chair:** What percentage of Motherisk's budget is funded by the brewers, or any part of the alcohol industry?

**Dr. Gideon Koren:** Three to five percent.

**The Chair:** Good. Thank you.

You seemed to agree with me earlier that the American warning labels were a sham. You couldn't find them, you couldn't read them. You had to be hunting for them to see them. If you agree with that idea, then why in heaven's name would you use the results of a study examining their effectiveness to promote your idea that labels are ineffective? I mean, anybody could look at that label and say, “You know what, this label's ineffective”.

So the CDC did a study to prove that it was ineffective, and then you quote that as your major reason for saying that warning labels are ineffective. I can't understand a scientist doing that.

**Dr. Gideon Koren:** No, actually you misquote me, unfortunately. What I said is that presently there's no proof that labelling works. If you want to prove that labelling works, you must invent labels that work. You must look at it in the context of a study and prove that it works. Then put labels. You are jumping a step, not me.

**The Chair:** I understood that we didn't have proof that it was effective, but you seem to be saying that it's essentially ineffective because of a study that was done in the United States on labels that were ineffective.

**Dr. Gideon Koren:** No, again you do not read right. My paper does not include the study from the CDC as the main point. It's a point that I make now in my speech. The paper itself is a pro and con—

**The Chair:** I'm on page 3, where you say “...conducted by the Centers for Disease Control and Prevention...”, etc. You make several points.

**Dr. Gideon Koren:** That's not in that context, though. Our paper, as I said to Mr. Szabo, was to bring out all the pros and cons, as you should do in a scientific paper. I do not claim that the label will not work. I'm saying that presently there's no proof that it works.

**The Chair:** I'm not talking about your paper with the pros and cons. I'm talking about your presentation today, which is a different paper. It's pretty clear that you're against this. That's why I wondered how tied you were to the alcohol industry. You seem to be pretty clear about the fact that you're not impressed with the idea of labels.

● (1725)

**Dr. Gideon Koren:** No, it's not correct that I'm not impressed. I never said that. If you ask me as a scientist how I will move this idea forward...I'll ask Mr. Szabo, yourself, or any other good Canadian to come up with the right label, do the study to show that it works, and then make it law. But we are jumping three pages now.

**The Chair:** I see. Thank you.

I'm wondering if the assistant deputy minister who spoke for both Health Canada and the separate department known as the Public Health Agency knew there was really not empirical evidence in the tobacco case. We've had scientists here telling us that there was never clear evidence that they could present, which is why the government lost in the RJR-Macdonald case. Did you know that?

**Ms. Susan Fletcher:** We were aware there were problems with our evidence very early on, and we had been working to try to collect the best evidentiary base that we could. We learned—

**The Chair:** But it didn't stop you from trying to have tobacco labels even though you knew there were problems with the evidence. Isn't that right?

**Ms. Susan Fletcher:** That is correct.

**The Chair:** Did you know the warning labels preceded the comprehensive strategy that you now have referred to, such as ads on TV, etc.?

**Ms. Susan Fletcher:** Yes, I did. We started—

**The Chair:** So do you think it might work that way with alcohol? You start with warning labels, and somehow or other that puts a burr under the saddle of everybody in the field and they start pulling together a comprehensive strategy, as happened with tobacco.

**Ms. Susan Fletcher:** The one thing I would like to make clear is that even with tobacco, before we did warning labels, we had what we thought was a sufficient evidentiary base, even in the first instance. Even though we subsequently found it wasn't sufficient, now we know that we need even more.

**The Chair:** Okay.

We're very aware here that this is a health committee, and we're very aware that certain things we try to do will be subverted by those parliamentarians and bureaucrats dedicated to things like industry. There's a Department of Industry, there's a committee on industry, etc. Justice also often doesn't want to take any risks, as we heard here today. Heavens, they might have to go to court. Wouldn't that be awful?

Anyway, I'm wondering why you would say something like this as an assistant deputy minister in the health department, something about how it could cost the industry some money or something like that. Where is that?

**Ms. Susan Fletcher:** Was it where I was talking about the feasibility of implementation?

**The Chair:** Yes. You say “feasibility of implementation by industry - particularly for small and medium-sized enterprises”. Is it part of your responsibility as an ADM for health to worry about the feasibility of the industry coping? Or is your main thrust not supposed to be protecting the health of Canadians while letting the industry department worry about that other thing?

**Ms. Susan Fletcher:** That would be true, but when we're providing facts to our minister in order for him to understand what some of the issues might be that might cause us difficulty in regulating, for example, he needs to be aware of that as he takes decisions and as he works with his colleagues in government.

**The Chair:** I see that.

Well, I just wondered who you were actually working for after I read these four problems you raised about it. It seemed to me that you were very critical: “there is no flexibility to allow for the crafting of appropriate and efficient messages”. In fact, we've been told by others that the bill is sufficiently vague and short that the crafting of messages would be done later by regulations and could be changed any time we wanted.

**Ms. Susan Fletcher:** My understanding is—and I stand to be corrected—that if the bill continues to be worded that way, it will create an issue around whether we could change by regulation the messages in the longer term. It's a question of the wording in the bill.

**Mr. Paul Szabo:** Madam Chair, the bill says that the details are referred to order in council, which is Health Canada. There is no label in the bill. You mentioned something about the object of the bill being to change behaviour, but the word “behaviour” is not in there. It says “warrant”. I don't know why you're putting words in that aren't there.

● (1730)

**The Chair:** Every possible thing that you could find, that you could nitpick at, is in your list of something like eleven reasons why, yet we can't support the health of Canadians as a committee unless the bureaucrats from Health Canada themselves help us to do it. In other words, if there's something wrong, you say this wouldn't work this way, but you could do it that way. No, this is just a critique.

**Ms. Susan Fletcher:** You're absolutely right, that's what it is. It's tabled before you so you can take it and use it as you think would help you—

**The Chair:** We are not crafting a bill today. We have a bill before us, which some of us are against—like my colleague across the table from me, for serious reasons from his riding—and some of us are for, not because we think it's the be-all and end-all, but because we see it as perhaps a launching pad for the comprehensive strategy we witnessed not that long ago with tobacco.

**Ms. Susan Fletcher:** Can I just say that this list was tabled to say that if in its wisdom this committee would like to have an act that could be reasonably implemented, these are things that would need to be addressed. It was not meant to be anything more than that.

**Mr. Jim Gouk:** Madam Chair, could I just address your comment on that?

We could design an automobile right now that would reduce if not end traffic fatalities, but nobody could afford to drive it. So it is germane that if the health committee or any other committee wishes to do something, they have to consider all the aspects. They can't come out with well-meaning legislation or bills, or pass something and say, “To hell with the consequences anywhere else, we are only focusing on this”. That would not be responsible, and I believe this is a responsible committee. So the information provided is germane to making sure that the recommendations and the amendments, if appropriate, are right so they would fit together properly and not be one-sided.

**The Chair:** I agree with you, but sometimes we don't expect the proponents from the health department to do that. You did that very efficiently for us today. We have other witnesses who pointed it out. Members themselves have brought those points forward in their testimony. But it's a little disconcerting to see the people from the Department of Health bringing forward those kinds of legal, trade, and economic issues.

Anyway, I've said too much today.

On behalf of the committee, I want to thank all of you for coming and presenting your views, even though everybody didn't get a chance to present their views. For that I'm sorry. Hopefully we will come to some conclusion on this and you can follow our progress.

Thank you very much.

I want to remind members of the committee that the deadline for submission of amendments to this bill is Tuesday, April 5, at 5 p.m. The final witnesses will be on Thursday. We'll have the one I referred to earlier, Dr. Tim Stockwell, and we'll have Mr. Szabo with his concluding remarks. I believe he has a full statement for Thursday.

**Mr. Paul Szabo:** I have one if you want it.

**The Chair:** We'll begin clause-by-clause on Thursday after the presentations.

There's a statement from me that the clerk has prepared on process. I will ask her to pass it out so you can read it, as opposed to me taking your time now.

Thank you very much, ladies and gentlemen.

This meeting is adjourned.

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