House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 045 • 3rd SESSION • 40th PARLIAMENT

EVIDENCE

Tuesday, December 14, 2010

Chair

Mrs. Joy Smith

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● (1105)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good morning, everybody. Welcome to the committee today. I am very happy to see you all here.

We will be suspending at 12:30 because we have a half hour of business, so we'll do that in camera.

I want to welcome Mr. Lamoureux to my committee. He's from Winnipeg. I'm very happy to have you here, Mr. Lamoureux.

Pursuant to Standing Order 108(2), we're doing a study on injury prevention in Canada.

We have, from the Canadian Association for Suicide Prevention, Tim Wall.

From Lakehead University, we have Dr. Susan Forbes, adjunct professor. She's with the injury research program. Glad to have you here.

From the Royal College of Physicians and Surgeons of Canada we have Dr. Louis Francescutti. We also have with him Danielle Fréchette, director of health policy. Happy to have you here as well.

From Safe Communities Canada and Passport to Safety, we have Paul Kells, president and founder of that association.

Welcome to all.

We have a lot of very important witnesses today we want to hear from. I'm going to be giving you ten minutes.

I would like to start with Mr. Wall, please.

Mr. Tim Wall (Executive Director, Canadian Association for Suicide Prevention): Thank you.

On behalf of the Canadian Association for Suicide Prevention, our board of directors, and our members across Canada, I want to thank this parliamentary committee for providing us with the opportunity to speak to you today about the intentional injury side of injury prevention.

Over the past two decades, close to 100,000 Canadians have died by suicide. Last year, almost 4,000 Canadians died by suicide, more than the total number of fatalities from all other unintentional injury-related deaths and homicides combined. Death by suicide is the leading cause of death over all other injury-related fatalities. Yet suicide, like injury prevention in general, has been largely ignored by the federal government.

Canada ranks in the top third of countries with the highest suicide rates. Suicide is not the result of a single cause; it is complex. Suicide prevention requires a multi-faceted approach.

Suicide is the result of an interaction of complex biological, psychosocial, and spiritual factors that can include social isolation, trauma, stress, family violence, poverty, poor mental health, and physical and mental illness.

In Canada, suicide prevention is fragmented, disconnected, and lacks a national vision. There is currently nothing under mental health or injury prevention that unifies suicide prevention in Canada.

If one examines the impact that suicide and suicide-related injuries have on our already overburdened health care system, the cost is alarming. It is estimated that in Canada there are in excess of 88,000 visits to emergency departments for suicide-related behaviour.

In 2004 over 7,000 Ontarians were admitted to hospital for suicide-related behaviours. Of this group, permanent partial disabilities were suffered by almost 1,500 people and 76 suffered permanent total disability.

Given the need for hospital and/or rehabilitation services and additional family support following a suicide attempt, the estimated cost of non-fatal suicide-related behaviours ranges anywhere from $33,000 to $308,000. There are many other economic costs associated with intentional injury deaths, but they fade in comparison to the price that is paid by the families of those who died by suicide.

Over three million Canadians, and no doubt some of us in this room today, have known the pain and anguish that comes when someone we love dies by suicide. What adds to this tragedy is knowing that many of these intentional injury deaths were preventable. Sadly, when someone dies by suicide, the pain is not gone. It is merely transferred to their family, their friends, and their community. Their injuries are largely invisible and mostly suffered in silence.

The Canadian Association for Suicide Prevention is made up of a group of dedicated volunteers. Since it began in the 1980s, CASP has conducted its work with no public funding or support from the Government of Canada. CASP and its board have volunteered thousands of hours to promote suicide prevention on a national level, often at great personal sacrifice.

For the past two decades, CASP has done the yeoman's share of the work without support, acknowledgement, or encouragement from federal sources. Up until now, we have only heard silence from Ottawa. The Government of Canada contributes to the stigma and the problem of suicide by its silence, rather than publicly and vigorously declaring its support for suicide prevention. Thank you for helping to break the silence.

While the United Nations, the World Health Organization, every other developed country, and every province and territory recognize suicide as a major public health issue and a priority, the Government of Canada has yet to do so, and has demonstrated little leadership on this intentional injury issue.

Your thoughtful and courageous decision to make the intentional injury of suicide part of this injury prevention discussion gives us hope.

As the UN recognized in 1993, suicide is not the responsibility of a single sector domain. It belongs to public health, mental health, social wellness, and injury prevention. No one can say this is not my problem or responsibility, and yet that has been largely the message we have heard from the Government of Canada.

To date, the federal government's response to our pleas has been that this is a provincial and territorial responsibility and not theirs. Suicide, as a serious intentional injury, is in fact everyone's responsibility. Everyone has a role to play, and that includes the Government of Canada.

● (1110)

Our national government has, in the past, demonstrated leadership and has worked collaboratively with the provinces and territories on numerous public health issues and pandemics, such as H1N1, SARS, and AIDS. It is now time for our national government to get involved, in a meaningful way, in addressing Canada's suicide pandemic. Our national government can no longer ignore the injury prevention issue and simply pass it off as a provincial and territorial issue and walk away.

While our federal government has made important investments in suicide prevention in first nations communities, it has failed to take action beyond this very limited and selective response. It has made no investments in suicide prevention outside of first nations communities.

The good news is that suicide-related injuries are preventable. We know what to do. We can do it, and we must do it together. For the past six years we have been offering the Government of Canada the gift of a national strategy for suicide prevention that was developed by CASP in 2004. I have a couple of copies that I brought with me today. It is a gift that keeps being returned. We invite you today to accept this as our intentional injury prevention gift in the spirit in which we are giving it. Please, let's work together to save lives and comfort those who grieve.

Over 15 years ago the United Nations and the World Health Organization recognized suicide as a major public health issue but didn't confine responsibility to a single domain. In 1992 the United Nations asked Canada to take a lead role in developing international guidelines for suicide prevention, which were later adopted by the UN, in 1996.

The UN guidelines and the subsequent World Health Organization guidelines asked that every country develop both a national suicide prevention strategy and a national coordinating body. Shortly afterwards, countries around the world began developing their strategies. To date, all developed countries have national strategies—all of them, with the exception of Canada. All of these countries overcame obstacles. Why can't Canada? In fact, not only has Canada failed to act on and recognize the UN and WHO guidelines, it has yet to even acknowledge suicide as a national public health issue.

Currently, suicide prevention is no more than a footnote on the Public Health Agency of Canada's website. Once an international leader in suicide prevention, Canada is now not even a follower. We are shamefully out of step with the rest of the world. It is now our turn to learn from other countries and follow their example.

So what can the Government of Canada do? The Government of Canada can do for suicide prevention what it did for mental health, which was to recognize mental health as a priority issue and establish the Mental Health Commission of Canada. When the Mental Health Commission of Canada was established, they were mandated to develop a national mental health strategy.

It is important that we not confuse the Mental Health Commission of Canada's strategy with a suicide prevention strategy. And note that in their excellent report, *Towards Recovery and Well-Being*, only one passing reference is made to suicide prevention.

We are asking that the Government of Canada do the following: formally recognize suicide as a serious public and community health and injury prevention issue and policy priority; appoint and adequately fund a national suicide prevention coordinating body that will serve as a knowledge broker; promote knowledge exchange, best practices, research, and communication; commit to working collaboratively with the national coordinating body, the provinces, and the territories on establishing a national suicide prevention strategy; and mandate and adequately fund the national coordinating body to develop and implement a national suicide awareness and education campaign.

In conclusion, too many lives are being cut short and are being deprived of a future that could be hopeful and fulfilling. Too many people and families are being deprived of loved ones who would have continued to enrich their lives and their communities.

There are hundreds of thousands of people in this nation whose lives have been forever altered by a tragic and needless suicide death. Some of them are your constituents. Some of them are maybe your neighbours, your friends, your families, and even your colleagues here in Parliament.

Suicides are preventable. When asked what you did to help prevent suicides in Canada, how will you answer?

● (1115)

There is hope, and with your support, we can and will save lives, and heal those who grieve.

The Chair: Thank you, Mr. Wall, for your very insightful and heartfelt presentation. We appreciate that.

We'll now go to Dr. Forbes, from the Lakehead University.

Dr. Susan Forbes (Adjunct Professor, Injury Research Program Manager, Play It Cool Injury Prevention Program, Lakehead University): My thanks to the chair and the honourable committee members for the opportunity to come here today and speak with you.

I'd like to focus my comments on three areas: first off, the long-term implications of sport injuries; secondly, where are we at with sport injury prevention; and finally, what are our options.

With respect to the long-term implications for sport injuries, both individually and collectively in terms of their impact on the health care system, these are significant. The 2005 general social survey showed that 7.3 million Canadians, 28% of them 15 years of age and older, were engaged in some form of sport and physical activity. This is approximately 59% of the population. Unfortunately, it also represents a 20% decline in participation rates from 1992. Paralleling that, we are seeing a rise in obesity rates, not just in our youth but across all age groups.

From an economic perspective, the SMARTRISK 2009 “Economic Burden of Injury” report found that sports-related injuries cost the Canadian health care system approximately $188 million in direct and indirect costs. This is simply a snapshot of the scale of these injuries, because these are the ones that are reported at hospitals and actually capture data on a very small category: either you were struck by a piece of sporting equipment, like a puck or a stick or a baseball, or you ran into something, like the boards, a net, or things of that nature. It's not capturing all of the information that we need.

Recent work in the area of sports concussion has also revealed a very strong relationship between multiple concussions—so athletes having two or more concussions throughout their career—and Alzheimer-like symptoms such as cognitive impairment, loss of memory, dizziness, and things of that nature. And we have yet to have been able to calculate what the long-term emotional, personal, and economic impact of those types of injuries will be both for the individuals, their family, and our society.

But even with limited data, the impact of sports-related injury is clear. Furthermore, we don't know the implication sport injuries have on participation rates of children and youth. For example, are kids quitting sports because they're getting hurt, or they fear being injured? Or are they not even bothering to participate because they're afraid of getting hurt, or their parents perceive the sports as being too dangerous, and keeping them out of sport?

That said, we all know that the benefits of physical activity outweigh the risks, but there are risks that are preventable, and we have to find a way not only to prevent them, but at least reduce their incidence where we can. There are several ways we can work to accomplish those goals.

As an academic, I would be remiss if I didn't focus on research. I wouldn't be doing what I get paid for. But from a research perspective, the sport injury research, both domestically and globally, really has exploded in the last two decades, which is a recognition of our area, understanding and pursuing this more deeply.

Many of the research initiatives have entailed injury surveillance as well as efforts to determine the causes of those types of injuries as well as to develop prevention programs. Looking at the research and examining those few research centres—for example, the sport injury prevention research group at the University of Calgary—their focus on sport injury is clear that everybody's counting what's happening: the number of head shots that lead to concussions, the number of knee injuries, and things of that nature. And they're doing a good job of describing what's happening.

As valuable as this information is, they are not exploring or explaining how and why behaviour plays a role in injury, or how external factors influence this type of behaviour—for example, the pressure to win on both players and coaches, the pressure to make it to the next level.

From a government perspective, we are starting to see some recognition of injury and injury prevention as a significant health-related issue. For example, the federal government's throne speech last fall drew attention to the fact that there is a need to address the issue of injury prevention. Even in 2005, the ministers of health document “Creating a Healthier Canada: Making Prevention a Priority” articulates a need to focus on injury prevention. While none of these documents specifically speaks to sport injury, we can certainly imply its presence within their documentation.

What are our options? We can continue to count and describe injuries, but in doing so we need to capture more information in order to understand sport injuries more fully.

● (1120)

More importantly, we need to shift our thinking from merely injury prevention to sports safety, to emphasize that injuries are not inevitable; they are not an inherent part of playing sports. One way we can accomplish that is through skills-based education programs such as Play it Cool, the program in which I am involved.

What is Play it Cool, and how does it differ? It's a safety-oriented intervention program aimed at reducing injuries in minor hockey. The beauty about a program like Play it Cool is it's adaptable to any sport. It provides an online education program that helps coaches learn to teach skills, but with an emphasis on safety.

Going into the initial project we asked kids why they wanted to be good skaters. Overwhelmingly the answer was, from the boys at least, “Well, it means I'll get to go to the NHL”. That is fine and admirable, but the real reason is, “If I get bumped or take a hit, I'm stable, I can absorb it, and I'll be less likely to get hurt”.

We're not changing the game of hockey. We're trying to change the way we think about hockey to give the kids all the skills, in both hockey and all the other sports, to play successfully and for a long period of time. More importantly, we're also trying to help those who are educating these young people to rethink the way they approach teaching skills so the emphasis is on safety, and not simply trying to be the next Wayne Gretzky or Sidney Crosby, or things of that nature.

What would we like to see from a government perspective? Help us understand sports injuries and their implications more thoroughly by enhancing the injury surveillance systems we have in place, as well as helping us to develop new systems and new expanding partnerships.

Help us raise awareness of the seriousness of this type of injury. By elevating sports injuries as a distinct category, such as traffic and suicide, through a national sports-focused safety policy and related infrastructure for coordination, implementation, and support, we can help the public understand that it's not okay for kids to get hurt playing their favourite sports. It's not a normal part of the game.

Help us work toward solutions and best practices. By helping us improve collaborations and partnerships between researchers and injury prevention advocates, both governmental and non-governmental, and lead health and sports agencies, we can come to viable solutions to reduce the incidence of injuries in sports.

Finally, help us shift thinking from prevention to promotion of safety and safe sports.

Thank you.

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

Now I'll go to Mr. Paul Kells.

Mr. Paul Kells (President and Founder, Safe Communities Canada and Passport to Safety): Okay.

The Chair: You sound surprised, Mr. Kells.

Mr. Paul Kells: Absolutely.

I sort of outweigh you on this. My daughter works for the House of Commons, so they put me ahead of you.

The Chair: Mr. Kells, you just ruined it.

Mr. Paul Kells: Now my daughter will be eternally embarrassed, and for that she will not be grateful.

Robin and I experienced a tragedy some 15 years ago, on November 19. Her brother, my son, was killed in a workplace explosion in Brampton, Ontario. He died by fire. You have a graph from Louis that will show you that 2% of fatalities occur from that source. Sean had third-degree burns to 95% of his body in a workplace that had many different violations.

It's a bit discouraging to be here, as much as I relish the opportunity to speak to you. In Nova Scotia last week a verdict was handed down for a young man who died of third-degree burns to 95% of his body handling the same kinds of chemicals in the auto industry, and the fine levied in Nova Scotia was half that of the one issued for the employer of my son 15 years ago.

After spending 15 years trying to work on changing attitudes and culture and workplace safety, and understanding that these things are preventable, and demonstrating across the country—not me, I don't mean I've demonstrated—there has been a radical reduction in workplace injuries, which will go to prove the point that if you focus on this stuff, you can find solutions. But it is sad to see that the attitudes that underlie this, meaning accountability in workplaces and the weight we place on that, are still uneven across the country. It sends a terrible message from Nova Scotia to the rest of Canada. I certainly do hope there will be an appeal of that in the province.

That notwithstanding, what I wanted to talk to you about today is the national.... Well, pick what you'd like: would it be the national injury disparity or the national lifespan gap? Here's the reality. If you live in Ontario and send your child to Saskatchewan or Manitoba—I don't know the numbers exactly—you're one and a half to two times more likely to have your son or daughter die or be permanently disabled at work. The same would be true across other forms of injury where mortality rates and injury rates are higher from province to province across the country.

Provincial jurisdiction, the Confederation model that serves us well in so many ways and on so many fronts, causes some serious gaps or discrepancies.

By now we understand there are some huge best practices. Some interventions work, but they're applied in different provinces in different ways. Where is the national leadership on the issue?

About seven or eight years ago I went to see an assistant deputy minister in the federal labour department, which has some role in workplace injury but not much. I told the fellow at the time that I was trying to figure out what role the federal government might play in impacting workplace safety, at least through bureaucracy. It's such a provincial jurisdiction. It's all regulated by the workers' compensation boards, etc., and there was no money in his department. I understood that. What would it take for a federal government of any political stripe to assume some sort of leadership role in setting a standard for the country as a whole? I said from what I could tell, from what I understood, from what I saw, there was really no leadership on that issue in the federal government. He looked at me—and he knew why I was there, and how I came to be there—and said I was right, there was no leadership at the federal level.

This is in part an appeal. We need to set some national standards. They don't exist. They do exist in other countries. You've heard all sorts of testimony from other people about national strategies, yes. Mental health, suicide threat, yes. So what's the issue, really?

There are lots of technical solutions, and I'm not going to pretend to present them to you because there are people who are far more qualified than I am to do it. But I can tell you that by the end of today there will be 35 more dead Canadians and there will be more than a dozen quadriplegics and that there is no discrimination or political stripe to this—a director of communications for the Liberal Party, the team doctor for the Senators, a quadriplegic from Manitoba who is serving as an MP, the suicide of a son of the Minister of Finance in a Tory government, and on and on—there's no politics around this. We need some unified national leadership.

● (1125)

It is discouraging, I've got to tell you. After 15 years of this, it is discouraging not to have seen this evolve.

It is just great that you're in here talking over these issues and there's an opportunity maybe to achieve some consensus on what is of course a relatively divided country in political terms these days.

There's one thing we all value. Our kids, our moms, our dads, our friends, and human life are meaningful to all of us.

I want to conclude by saying there are really five things that you do need to focus on. Forget the specifics. You need to focus on five things, and they are really general and vague.

First is consistency. You need to get consistent on this. I heard in one province, on the worker safety piece of it, a few years back, Alberta to be specific.... No, they said, we did young workers' safety last year—as though they exposed one generation of kids in one year to a workplace media campaign, and now they're going to be on to road safety this year. No. Consistency is key to this.

In Ontario, for example, where there are 45% fewer severe trauma injuries for young workers than there are anywhere else in the country, by rate, it's because for ten years they have been doing it. They did cut it out this year. They stopped it this year because there's a new financial regime in town, and of course it's a good financial question. Yes, we have a lower workplace injury base than anywhere else in the country, but we spend $90 million a year in Ontario on workplace injury prevention alone. That would be compared to zero dollars, by the way, at the federal level, but $90 million dollars a year.... But could we have done it for $50 million? A good financial question. Now, let's cut that out, and let's cut that out, and in the process this reduction of consistency could potentially cost human lives. Who dies because they weren't aware of it? I don't know. We can't attribute it to that. That is the concern, the consistency that's required.

The other parts are commitment. If you say there should be leadership and you're committed to it, you will make it happen. I expect that of my MP, who is sitting in the room.

● (1130)

The Chair: Who is that, Mr. Kells?

Mr. Paul Kells: Megan Leslie.

The Chair: There we go. I just wondered.

Mr. Paul Kells: She represents Halifax very ably.

Ms. Megan Leslie (Halifax, NDP): Thank you.

Mr. Paul Kells: I say all this non-politically.

Then there's leadership. I'm not going to lecture you. Please bring your leadership abilities and your capacity to this. Please do that.

Yes, you need to bring the resources. If the commitment, the understanding, the passion, the leadership, and the focus are there, the resources will come. There will be people who will be more intelligent than I who would give you advice on how to spend that.

Really, those are the five pieces you need. Put them in any order you want. Please address the national leadership or lifespan gap, the national injury disparity, and the injury problem—all those things that could hurt you. It's actually more than anything else an attitude issue. That you can fix.

Thank you.

The Chair: Thank you very much, Mr. Kells, for your very insightful presentation.

I've chaired this committee for quite a while. One thing I can say about the people on this committee is I've always been very impressed with how, for the most part, they leave it at the door. This committee has elected, as a group, to study this because we all believe, regardless of party preference, that this is of paramount importance to bring to committee and examine it.

Thank you for your very compelling.... My condolences on the death of your son, Mr. Kells.

We will now go to the Royal College of Physicians and Surgeons, Dr. Louis Francescutti.

Dr. Louis Hugo Francescutti (President, Royal College of Physicians and Surgeons of Canada): What I'm going to do is try to build on some of the colleagues' comments that you've heard so far.

[*Translation*]

I will speak French from time to time. I left Quebec 30 years ago and I am out of practice. If there are any questions in French, my colleague Danielle will answer them.

[*English*]

My MP, Mr. Tim Uppal, is in the room as well. The whole point is that I want to try to synthesize what you've heard so that you can actually start practising medicine without a licence, because a group like this one has the power to save more lives than I can ever save as an emergency physician.

I have assumed the role of presidency of the Royal College. The Royal College represents 44,000 international specialists. It's one of the world's most respected specialist organizations. We've recognized that injury is a major problem and we're asking our members—whether they're trauma surgeons, neurosurgeons, orthopedic surgeons, physiatrists, or pediatricians—to get involved in this problem.

Health care spends $194 billion a year, and people are questioning openly what we're getting out of it. Part of the problem is that so many of our patients are there as a result of trauma—suicide attempts, motor vehicle collisions, occupational injuries, sports-related injuries, transportation injuries, injuries around the home, injuries on our farms—and of all the diseases that we treat, this is probably the most preventable.

It's the leading cause of death in the aboriginal community. For our brothers and sisters in our first nations communities, injury is the leading cause of death, exceeding cancer, heart disease, and all others combined. For kids between the ages of one and 19, injuries are the leading cause of death.

If I were to say to you, “pink ribbon”, right away you would focus on that disease and know that it's well mobilized across the country. There is interest, there is research, there are dollars, and the public's really interested in that problem, but you don't understand the injury problem because your constituents don't understand it. To them, they're accidents. When you ask the average Canadian about injuries, they think they're accidents. If they really don't want to assign responsibility, they'll call them freak accidents, but I've never seen anyone in the emergency department clutching their chest and saying ”I'm having a freak heart attack”. However, because the public reports injuries—or so-called accidents—so often, and because they are the leading cause of death among Canadians under the age of 45, what ends up happening is that we become habituated and we think that's the way things are.

About 50 years ago Sweden had a death rate this high compared to Canada. Sweden's death rate was almost twice ours 50 years ago. Sweden now has one of the lowest death rates due to injuries in the world, and Canada has come down modestly.

Australia has shown us how to do it with a national strategy. New Zealand has shown us how to do it. We just came back from Saudi Arabia and Oman, and they're now starting to try to tackle this injury problem at a national level.

If you wanted to go after the low-hanging fruit within the health care system, injury is the only disease you can eliminate overnight through concerted efforts of education, enforcement, engineering, and economic incentives. We know what needs to be done. You could reduce your injury burden almost overnight.

What would that do? It would free up the wait times in the emergency room. I can tell you as an emergency room physician that sometimes 30% to 45% of what we see in emergency is injury-related. It would free up elective surgery time, because our traumas are bumping all of the elective cases. About 12% of all our hospital beds are trauma patients, and what Paul didn't tell you is the impact that injuries have on families in terms of divorce rates, separation rates, and substance abuse down the road. It has devastating impact. It's probably the most under-recognized public health problem facing us today.

That's all bad news, but the good news is that you could do something similar to what was done in the United States in 1985. The Institute of Medicine produced this little red book. That little red book was entitled *Injury in America*, and it laid out what the injury problem was. As a result, a centre for injury control and research was developed within the CDC in Atlanta, Georgia.

We have the Public Health Agency of Canada. I'm sure that Dr. David Butler-Jones, with a little probing, would be able to house a national centre for injury control and research that would encompass all the different diseases of injury.

Injury is caused when the body can't tolerate excess energy that is transferred to it. That's the only way people get injured. The injuries could be intentional or unintentional, or they could be a result of what we do in health care. We injure patients in health care. That's why, several years ago, the federal government and the Royal College established the Canadian Patient Safety Institute. We've taken care of that problem, or we're working on it, but nobody's really tackled the injury problem with the national perspective that's required.

I am aware that health care—other than aboriginal, RCMP, or military health care—is a provincial responsibility, but I think the federal government can play a very meaningful role in health by telling the provinces, “Listen, we're not going to tell you what to do within your provinces, but as a country, this is what we'd like to do. Here's our strategy for injury reduction within the country. This is what we'd like the territories and the provinces to do, and here's how we can help you get there.”

● (1135)

In other words, you can lead without owning, and you can target the provinces that have problems.

[*Translation*]

There is a high rate of suicide in Quebec and Alberta.

[*English*]

In Alberta, more people die from suicide than die in motor vehicle collisions.

If you want to know how many Canadians are dying from injuries every year, it's the equivalent of a fully loaded 737 crashing every five days. Take one of WestJet's 737s, fully loaded, and crash one every five days. By the end of the year, that will be about 14,000 Canadians who die.

Do you think the feds would be doing something if a 737 were crashing every five days? You'd probably shut down the airline industry until you figured out what the problem was. But because these deaths are occurring a few here on our roadways, a few within our homes, a few as a result of suicide—more than a few—a few at work, a few at play, among kids, aboriginals, old people, and young people, we've partitioned it all off. And no one has brought the numbers together.

What we have to do is bring the numbers together and say that enough is enough. Sure, Paul's frustrated. I'm frustrated too. What a glorious opportunity presents itself today, on this day when you can say that we have to do something about this problem.

Every party has to step up to it. Then provide the lead so that the provinces do it as well.

What's the investment we're looking for? A modest number would probably be something in the range of $30 million a year to get started. In Alberta, where we've costed it out, we expected that to get motor vehicle injuries under control within Alberta would probably cost us close to $5 million to $6 million a year, just for that problem. You can bring people in to help you with the figures.

If Santa were to leave something under my tree from this committee, it would be the committee saying, “Wow, we didn't realize that injury was such a problem, because our constituents didn't tell us that it was a problem, because they didn't realize that it was such a problem”. Yet 14,000 Canadians are dying. A quarter of a million are being hospitalized. Our emergency rooms are bursting at the seams.

Other countries have been able to show us that this is a preventable problem with great returns. Australia halved their motor vehicle fatalities, from 733 to 300 or something, within four or five years and maintained that. For every dollar they put into motor vehicle safety, they got a $22 return. The numbers are staggering.

I'm not going to use up my full ten minutes. What I'd like to do is engage in conversation with you to answer the last questions you may have so that when you deliberate you can say that either we were trying to bamboozle you or that this is a problem we've neglected for far too long and have to do something about.

The Royal College, I can tell you, is more than prepared to mobilize 44,000 specialists to see how we can engage municipalities, provincial governments, various levels of departments within those governments, and, more importantly, the Canadian population so that nobody has to suffer what the Kells family went through.

The worst thing I do in emergency is walk from the trauma room to the family room to tell another family that their loved one has died.

I have to tell you that close to 60% of all trauma deaths occur at the scene of the injury. More doctors and nurses and helicopters are not going to solve the problem. We have to prevent the problem. The only cure for trauma is its prevention.

I started by saying that you could be practising medicine without a licence, and I wasn't joking. If you do this and do it properly, you can go back and say to your kids and your family members that you were part of the movement that reduced injuries in Canada.

Things cannot get any worse. Canada is an embarrassment internationally when we take a look at our childhood injury rates. When you take a look at developed countries, we rank among the last. It's really a national embarrassment.

This is a problem that's solvable.

We thank you for the opportunity to come before you today. We look forward to engaging with you.

● (1140)

The Chair: Thank you for your very compelling presentation, doctor. It's very helpful to us.

We're going to go into our round of Q&As, of seven minutes, beginning with Mr. Dosanjh.

Hon. Ujjal Dosanjh (Vancouver South, Lib.): Thank you.

Thank you for your presentations, which were all very moving.

I have two questions. I'm going to ask them both at once, and I would like all of you to answer them, rather than have me wasting your time.

You've made a case, particularly Mr. Wall and Dr. Francescutti, and as well Mr. Kells, that no government has done very much or anything at all, regardless of political stripes, and I agree.

I want to know why you think that has not happened. Why do you think no action has been taken on the suicide file, for instance, federally, or on the sport injury brief mentioned in the speech, or on the issues you and Mr. Kells were talking about?

The second question for all of you is what would federal leadership look like in concrete terms in each of the areas?

● (1145)

The Chair: Who would like to begin with that?

Mr. Wall.

Mr. Tim Wall: When it comes to intentional injuries and suicide, I think there are a number of things that possibly get in the way—the stigma around suicide, the shame.... Suicide is shrouded in secrecy, and I think that's a barrier. Because suicide is so complex and requires a multi-faceted approach, I think the task sometimes feels overwhelming, and people say they're just going to walk away from it. It's not like coming up with a pill or an injection that you can give to prevent something. As Louis was saying, it's very preventable, but it really requires a collaborative approach. I think those are some of the things that get in the way.

To address your second question, there are a lot of wonderful things happening throughout Canada around suicide prevention, and they're making a huge difference. One of the problems, on which we need the federal government to show some leadership, is that one region doesn't know what another region is doing. There are no opportunities to learn from each other and to engage in conversations to find out that something worked here and may work there.

I was on a flight with one of your colleagues recently, and we were having this conversation. The response was that you don't send an electrician to do a plumber's job, meaning that you don't send in the federal government to do the job of the provinces or territories. My response was: that's true; the electrician doesn't tell the plumber what to do, but you need both to build a house, and more importantly, you need a contractor, somebody who can facilitate communication.

We have no knowledge broker, no one who can help synthesize the research and help us put research into practice and into policy. As Louis or Paul was saying about developing best practices, they're there, but we're not sharing them. The role of the federal government is to show some leadership, I believe, in helping us to coordinate—not to tell the provinces or territories what to do, but to help to exchange the information.

The Chair: I think Mr. Dosanjh wants some others to....

Those are very insightful comments. Thank you, Mr. Wall.

Who else would like to make comment?

Dr. Forbes.

Dr. Susan Forbes: I'll keep this very brief.

I think the reason we haven't seen much action is the diverse and multi-faceted nature of injury. It's complex, it's multi-layered, and there are so many different areas of injury.

The question I would have if I were a politician is where do we start? The start, I think, lies—in answer to your second question—around leadership. I like Tim's analogy of the general contractor to oversee everything and to help us coordinate.

I'll admit that as academics we're probably some of the worst people in the world for silo mentalities and not sharing what it is that we do. I frequently tell my colleagues that we need to get over ourselves. And we seriously have to, because there are best practices and initiatives out there that all of us can learn, not just from sport but from a lot of the other injury prevention initiatives hatt we can look at and embrace to try to find out what the best viable solutions are.

I feel that the federal government in particular can help give us that guidance. I like Louis's suggestion about having, either within PHAC or within our own CDC, an area focused on injury. That's as good a place to start as any.

Dr. Louis Hugo Francescutti: On the first question, I've asked politicians in Alberta why this isn't an issue, and it's because their constituents don't think it's an issue. If three kids were to die from meningitis in Ottawa today, you would rest assured that it was an issue, but because 50 kids are going to die from injury.... The point is, we have to get Canadians to understand that this is a priority, and that's where this body could say that it should be a national priority and that you're going to work with the provinces on it.

There's no sense in reinventing the wheel. Let's steal what New Zealand has done and what Australia has done. We know these colleagues; they have told they will share their national strategies with us. In the document that we'll be providing to you—it just wasn't translated—we call for the establishment of a Canadian injury prevention network that would do exactly what you're describing, bringing together the people who are out there.

The trouble with the people who are out there is that they are getting frustrated. As Paul said, they have been struggling for 15 years to try to make this happen, and it's a revolving door. There's not enough “stick power” in it, because they see that our provincial and federal counterparts really don't have an interest in the problem.

Injury in America, from the Institute of Medicine, is the stage you're at. You create that document with some seed dollars and then look towards the creation within the Public Health Agency of Canada—which is, I think, where it should reside—of a focus on injury. I can tell you that the Royal College of Physicians and Surgeons will be there to work with you on it.

Does that answer your question?

● (1150)

Hon. Ujjal Dosanjh: Yes.

Mr. Paul Kells: I agree absolutely with Louis's recommendations. The only other thing I would say is that in the vacuum of standards, which is really what we're talking about, best practices arise in places where they apply different levels of money and resources. The Passport to Safety program that I created happened when I got 50 volunteers from across the country, subject experts, and asked them not to represent their organizations or their provinces or their governments but to tell me as a person—as an employer, or labour person, or a physician, or whatever they were—what the minimum is that any kid needs to know before they go to work. It was really a simple question.

If we ask some simple questions, set some standards—as you do in so many other things—and then ask people to perform to those standards, that would be a great start. I think going through the kind of structure that Louis is talking about, and even the process, would be a terrific step forward.

Hon. Ujjal Dosanjh: Thank you.

The Chair: You have another minute, Mr. Dosanjh.

Hon. Ujjal Dosanjh: Let me use that minute just to briefly say that I actually disagree with those who say that we have no jurisdiction in what provinces do. When we give them money, we have the right to make arrangements, which they should live up to. I think the federal government needs to have a more assertive role in health care, not just as an ATM, not just as a banker. I think the federal government has a larger influence than sometimes we give ourselves credit for.

I don't want to use my time. You can give it to somebody else. I think the points have been made.

The Chair: Thank you, Mr. Dosanjh.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Madam Chair.

I want to thank the witnesses for their presentation. I do not have any questions for them at this time.

[*English*]

The Chair: Thank you, Monsieur Malo.

Ms. Leslie.

Ms. Megan Leslie: Thank you, Madam Chair.

And thank you to all of you for your testimony today. I felt like standing up and applauding afterwards; it was incredibly compelling.

The Chair: Well, you do have seven minutes, you know.

Some hon. members: Oh, oh!

Ms. Megan Leslie: But I have questions, Madam Chair, that I'd like to spend this time asking. I'll start with Ms. Forbes.

I really appreciated your presentation. I'm with the NDP, and we have a sport critic, Mr. Glenn Thibeault. He asked a question in the House a few weeks ago of the Minister of State for Sport about injury in sport, particularly with amateur athletes. I have the answer here somewhere. I just want to read you part of the answer, because he talked about Hockey Canada and he talked about helmets:

> Children wear helmets in Canada. [...] We support Hockey Canada in its efforts. However, I do not think this is a place for the government to step in and regulate.

I think it's clear that we are not just talking about helmets when we talk about injury in amateur sport, but I wanted to ask you: what do you think about the fact that the minister is saying that this is not a place for government to step in and regulate?

Dr. Susan Forbes: That's a good question. Thank you for asking it.

I will build on Mr. Dosanjh's comment. As a funder of Sport Canada and Hockey Canada, you absolutely have a say in where your moneys go and how they are spent. The fact that you have a minister of state responsible for sport clearly indicates that the government has a role in sport. Otherwise the thing wouldn't exist. In fairness, it has been a nebulous body, because it has been its own stand-alone ministry for years and then has gone back and forth.

That said, if you're going to be investing money in amateur sport in this country, then you should have control over some of what goes on. While you don't want to be heavy-handed and micromanage, clearly when initiatives are tied to the broader health of Canadians, both in dealing with pressures on our health care system and the health and well-being of our youth and adults there needs to be a much more evident role. I think you have the moral and legal authority to assume that role.

● (1155)

Ms. Megan Leslie: Mr. Wall, you and I have worked together, as you know. I have a bill for a suicide prevention strategy, and CASP has been wonderful in helping us out with information and putting it together. You and I have spoken before about the Mental Health Commission and its role in suicide prevention. As you pointed out here in your testimony, there was just one passing reference to suicide prevention in the last report of the commission.

A few weeks ago we had officials here from Health Canada and the Public Health Agency, and I specifically asked about suicide prevention. We were told that the Mental Health Commission was working on a comprehensive national suicide strategy. Do you know anything about this? Are you able to fill me in on what's going on?

Mr. Tim Wall: To the best of my knowledge, that's not happening at the Mental Health Commission. I think we have to be clear that the mental health strategy, which is an incredible document, is not a suicide prevention strategy. At this point we are not aware that they are working on including a national suicide prevention strategy within their framework.

Ms. Megan Leslie: Their framework does talk about suicide.

Mr. Tim Wall: In "Toward Recovery" there's one sentence about suicide. In our conversations with them to date, they've been very clear that's not their priority.

Ms. Megan Leslie: Do you think there needs to be a separate suicide prevention strategy, versus just enveloping it into the Mental Health Commission?

Mr. Tim Wall: I think you can do either. If you look at Scotland, they developed their national suicide prevention strategy as a component of their mental health strategy. They complement each other. It is a stand-alone document within the larger mental health strategy.

Ms. Megan Leslie: So the point is that it needs to happen.

Mr. Tim Wall: I think there's a lot to learn from Scotland.

Ms. Megan Leslie: Thank you.

Dr. Francescutti, because you spoke about intentional and unintentional injury, I'm assuming that when you call for a national injury prevention and safety promotion strategy in your recommendations that would include suicide.

Dr. Louis Hugo Francescutti: Absolutely.

Ms. Megan Leslie: In your recommendations you don't actually mention the Public Health Agency of Canada. What do you see as the role of this agency, and do you think the Public Health Agency is currently filling a role in injury prevention?

Dr. Louis Hugo Francescutti: I don't think they are. If they were, we wouldn't have this big problem. That was a suggestion as the most logical place for it, if I had to put it somewhere. It could be free-standing as well. I always believe in minimizing bureaucracy, so if existing organizations lend themselves to that, it would probably be wiser to put it within them.

A lot of dollars could be brought in from industry to support a centre like this. Industry watches the bottom line, and at the end of the day they understand that if they can get people to be healthier from a mental or an injury perspective—even a sports-on-the-weekend perspective—they'll make more money at the end of the day. So there are plenty of industries that would love to be partners in this as well.

Where it ends up at the end of the day, it really doesn't matter. The Public Health Agency could be one place, but it could have its own free-standing centre as well.

Ms. Megan Leslie: Thank you.

Ms. Forbes, I know that helmets do a good job and we should make sure kids wear helmets. That's not the only thing. Skating was a very good example.

How can we have tangible results when it comes to reducing injury in sport? Is it just mandating "Hey kids, wear helmets; hey kids, take skating"? What are some of the things we actually need to put in place?

Dr. Susan Forbes: Thanks for the question, Megan.

I'd like to start to answer that by saying when we look at the mandating of helmets in ice hockey, we have to recognize two things. Kids are still getting concussions. Helmets were actually designed to prevent what we refer to as focal injuries, which are pinpoint injuries that can lead to skull fractures and things like that. While they can lessen trauma to the head and minimize concussions to a certain point, they cannot prevent concussions because of the way the brain sits inside of the skull. Louis is probably much more articulate at describing that than I am.

That said, the question I always ask when I look at this data is why is this stuff happening in the first place? Why is it a kid takes a shot to the head? What is happening behind the scenes that's leading to that type of action? Can education prevent that? It can't necessarily, because once athletes get on the playing field, stuff happens. We can do our best to try to prevent that, and education is probably a critical piece.

I think by going back to the fundamental question, why these things are happening, which Paul has asked, and understanding that more fully, then either we can develop new best practices or we can work with the existing best practices. The outcome is changing the behaviour that leads to injury. That's true of anything. We've seen that around seat-belt use. We've seen that around drunk driving. If we start to change people's behaviours, we can see a reduction in injuries. The outcome is fewer visits to the emergency room.

The other piece that quite frankly frequently gets lost in issues around youth and sports, especially with head trauma, is that we're not just talking about kids getting hurt playing a game of hockey. We're talking about kids who are also students getting hurt playing a game of hockey. What are the consequences in terms of their academic capabilities or advancement? If their brain injury is sufficient, do we lose them—

● (1200)

The Chair: Dr. Forbes, could you wrap up, please?

Dr. Susan Forbes: Sorry.

Do we lose them out of the education system? Are they now an additional burden on society?

The Chair: Thank you, Doctor.

Now we'll go to Dr. Carrie.

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

I want to thank all the witnesses for being here.

I don't think this has really been looked at the way we're starting to look at it now. I do appreciate your comments, and I also appreciate that you're going to recommend things to us as a committee.

I have three little kids, and I encourage them to get out and exercise as much as possible. We've had a broken arm at a playground, and a certain number of things that have happened—some of the rites, I guess, of growing up when you're active as a small child.

I was listening, Dr. Forbes, as you talked about your program, Play it Cool. You talked a little bit about communication, and it's really focused on coaches learning to teach skills. You also commented about changing behaviours. I was wondering if you could comment to us around the table here, if we look at it from the point of view of parents. From your experience, what would you say parents need to know, and what can parents do to help decrease injuries, starting around the house and what we do with our kids?

Dr. Susan Forbes: First of all, I suggest you let them go out and play. Let them learn how to use their bodies and move. Don't just immediately strap them into hockey skates or soccer cleats or something and have a singular focus.

There's not a lot of research on this, but the research that's out there suggests that kids who engage in a variety of activities at a level that's enjoyable for them develop better body awareness and have stronger capabilities to deal with bumps and falls and things like that, which can help minimize and potentially prevent injuries. That broader experience is huge.

So as parents, just let them get out, enjoy life, and play. But also help them understand that there's a right way and a wrong way to do things, so that they are equipped with the skills they need to engage in these activities.

Parents can take a role with that but also can ensure that coaches have the opportunity to understand how to take that approach as well.

I think almost all of us to a person have said that awareness of all the potential factors associated with injury needs to be first and foremost in our minds. Raising awareness is another piece I would recommend.

Mr. Colin Carrie: Does your program Play it Cool focus mostly on coaches, or does it go directly to the...?

Dr. Susan Forbes: The initial part is with the coaches and helping them understand how they can teach the game of hockey differently from a safety perspective, but we also are engaged in raising awareness, particularly concussion, because two of our partners are the Canadian Spinal Research Organization and the Ontario Neurotrauma Foundation, and we raise awareness among athletes as well as parents as to the symptoms of concussions, for example.

We have a community partner, which is supported by the CSRO, that goes out and does community awareness days and has a website. The whole idea is to elevate awareness around what the risks are, what the factors are that contribute to injuries, and what you should do if you even suspect that your child has any type of an injury.

● (1205)

Mr. Colin Carrie: My next question is for Dr. Francescutti. You did mention that this topic is really all-encompassing. There are a lot of different factors involved.

What have been some of the successful injury prevention initiatives? You mentioned Australia and New Zealand. You said "Why bother reinventing the wheel?" You also mentioned different statistics in different silos.

It's kind of a two-part question. What have been some successful injury-prevention initiatives, but also, are there statistics out there? How many of these are motor vehicle? How many are sports injuries? How many of these are "injuries", slips and falls, and things like that? Could you enlighten me on those two questions?

Dr. Louis Hugo Francescutti: Yes, that is not a problem.

If you take a look at unintentional injuries, 38% of those injuries are falls. And those are not just falls of seniors. Those are falls of kids, occupational falls, all over the place. About 25% are motor vehicle-related, 5% are poisoning, 2% are fire burns, 1% is blows in sports, and 1% is drowning. You could pretty well say motor vehicle-related, suicide, and falls are the leading causes.

There is a new area I'm getting more interested in. The third leading cause of death in Alberta is so-called accidental poisonings. These are overdoses; they are not accidental poisonings. They are related to substance abuse within individuals of both prescription and non-prescription medication.

It's a new area that's rapidly growing as one of the problem areas, but we do know where the problems are. As a matter of fact, every medical examiner or coroner, by law, has to be told about every sudden, unexpected death. The trouble is that nobody is keeping track of the score. We have all these injuries and they're all being parcelled out, but there is no one central agency that actually looks at the numbers.

If you look at the numbers, as I said, it translates to a fully loaded 767 crashing every five days. It is a major problem. Remember, those are the ones who die. The ones who don't die are even more costly to the health care system: the spinal cord injuries and the brain injuries.

In the past, these people used to die. They're not dying now and so there are many long-term care facilities in any community for people who have serious brain injuries from which they are never going to recover, or serious spinal cord injuries as well.

Mr. Colin Carrie: Do you have some examples? The second part of my question was what have been some of the successful injury-prevention initiatives? You mentioned Australia and New Zealand.

Dr. Louis Hugo Francescutti: That's probably the one that everyone talks about. Australia has been able to reduce carnage on their roadways through aggressive enforcement. The enforcement on their roadways is 24/7 and they are constantly looking for speeders. They are constantly looking for people talking on cellphones.

Let me just give you a good example. In Canada, provinces are passing legislation banning hand-held phones. While all the evidence in the world.... There are only 600 studies that tell us that it doesn't matter whether it's hand-held or hands-free, it's the conversation that's the distraction. That's why all these provinces passing hand-held legislation is going to have no impact whatsoever, because they're just going to hands-free, which is just as dangerous. It's the conversation.

That is because there is a lack of unity across the country and there is no repository house for people who are passionate about injury. We've been diluted, and they're competing against each other, actually. They have to come under one roof.

Paul Kells has been a leader trying to get some of those NGOs in injury to come under one roof.

Mr. Paul Kells: It's quite odd. On the hand-held, there is actually some emerging evidence that it is actually more dangerous. What people are doing is it's now going down here instead of holding the thing up, so they can't be detected. In fact, their eyes are going off the road.

Dr. Louis Hugo Francescutti: Just to give you an example, 7% of all fatalities in France on roadways are directly related to cellphone use, so that's how big a problem it is.

● (1210)

Mr. Colin Carrie: Well, I've actually seen the videos that Australia put out for driving. I have a 17-year-old. I thought the new media, you know, the Facebook, the YouTube, stuff like that, was very impressive, so I got him to watch that. I think that's made him—

Dr. Louis Hugo Francescutti: Just go to YouTube and Google "25th anniversary TAC", Transport Accident Commission, and there's a five-minute video that pulls 25 years of commercials together. You'll see how it's done.

That's why I'm saying Canada could leap-start ahead by just asking people who know what's happened around the world successfully, and let's just steal that and use it. The first target group I would go for is our aboriginal community, because this is truly an epidemic within that community.

The Chair: Thank you, Dr. Francescutti. Thank you, Dr. Carrie.

We'll now go to Dr. Duncan.

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

Thank you to the witnesses.

The Chair: She's been doing sign language all morning.

Ms. Kirsty Duncan: I would like to address suicide, particularly in the military. I am very concerned about the suicide rate among Canada's soldiers. Based on military police records, the average suicide rate among Canadian Forces military, both regular and reserve, between 1994 and 2000 was found to be about 16 per year. The number of suicides among members of the military rose to 20 in 2006, and then jumped to 36 in 2007, or double the rate of the previous year. The 2007 numbers put the military's suicide rate at triple that of the Canadian population.

And just this month we now have another study. This is a new study. It's the first time they've looked at suicide among female military veterans, and this is from the United States. What they found is the suicide rate among this group is nearly three times higher than that for civilian women.

I'm wondering if you have done any work in this area.

Mr. Tim Wall: The short answer is no. We don't have the resources to do that. What you're sharing with the committee is not new to CASP. I would simply say that in the U.S., the two primary partners in suicide prevention on the national level are their Department of Health and their Department of Defense, or the military. The U.S. acknowledged that suicide within the military was an enormous problem years ago.

I can only say I'm glad that in Canada we're now beginning to recognize that within the military it's a huge issue, which is also very much related to the issue of trauma, post-traumatic stress. I think those are two big challenges for the military today.

Thank you.

Ms. Kirsty Duncan: Thank you.

You've raised PTSD, and I wholeheartedly agree. There is concern that the rise is linked to the intensification of Canada's mission in Afghanistan.

Are you aware of measures being undertaken in other countries to reduce suicide? Are there any recommendations you would like to make here?

Mr. Tim Wall: Within the military specifically?

Ms. Kirsty Duncan: Yes.

Mr. Tim Wall: I don't know the specifics. Again, all I can point to is I think the U.S. is a real leader in that regard. They've had a national strategy now for over ten years, and they're just in the process of reviewing it and updating it. Part of the impetus around the new investments that the U.S. is making in suicide prevention is coming from the military, so I think the U.S. has been doing a lot of research. I don't have that handy, but I would certainly look to them for examples as to what they've done and what they've learned.

Ms. Kirsty Duncan: Thank you.

Could you comment on the direct link between neurological conditions and suicide, particularly for young people with ADD or ADHD, fetal alcohol syndrome, FASD, mood disorders, or brain injuries? Then I want to make sure my colleague has time. Maybe I should turn it over here.

● (1215)

Mr. Tim Wall: That's not my area of expertise.

Perhaps Louis might be able to comment on that.

I would quickly say, though, that when it comes to suicide there is a misunderstanding that suicides are always about mental illness. In fact, the majority of people who die by suicide did not have a mental illness. People like myself and Louis and Paul are in the highest-risk group. It's men and older men. As our population ages, the problem is only going to get worse. I'll just throw that in.

Maybe Louis can comment.

Dr. Louis Hugo Francescutti: There is definitely a link between brain injury and fetal alcohol syndrome and suicide. Once you start teasing apart what happens to an injured individual, a lot of them are not able to reintegrate back into society. A lot of them we see start falling into substance abuse and then you get a vicious circle. When they end up in substance abuse, either the criminal system has to deal with them or they get injured. And then it's a vicious circle.

The Chair: Thank you very much, Doctor.

We will now go to Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

Thank you to all the witnesses.

Hopefully I'll have time to focus on three areas.

First, a number of years ago now I was working in a rural emergency department, where of course we saw everything. At the same time I ended up getting involved in local municipal politics. It was through that connection that we would frequently see a number of children come into our emergency facility with injuries from our dock. It was a little lake. Only because I was involved in municipal politics were we able to quickly say this dock is creating a lot of injuries and we need to fix it.

Do we not need to, to some degree, empower our hospitals to be analyzing what's happening in their communities around accidents and injuries and actually create that connection at that level? We have huge opportunities, a community base in injury prevention.

I just wanted to throw that out. We talk a lot about a national perspective. I always like to believe in the power of community.

Dr. Louis Hugo Francescutti: There's an actual program that Canada developed under the directorship of Dr. Barry Pless called CHIRP, the Canadian hospital injury reporting program. It doesn't exist in every hospital, but in the ones that do have it—primarily children's hospitals—they do collect the data. Once again, they're under-resourced to be able to take that information, package it, and give it with some prevention strategies to the people who can make the difference. You're absolutely correct. Other countries that have done this successfully have very robust surveillance systems. In Iceland, what they actually do is assign a bar code to every injury, and everything related to that injury is assigned to that bar code so they can actually quantify the costs of it. Your thinking is absolutely correct: a robust surveillance system. What's missing now is that information needs to be analyzed and then fed back to the community.

Ideally, if we had Paul Kells in every community, it would save communities, and that would be the group that would receive that information, do something, and then the surveillance group could measure if it's having any impact.

Mr. Paul Kells: We do that. There are 16 designated safe communities in Canada, and we have an authenticated community injury-priority-setting session. The data is so much better now, but it's still not close to being good enough. Within four hours we can build consensus. We can put 250 people in Winnipeg around the table and they'll have a unified consensus on what injury issues are the major ones, what are the interventions that are required, and what's already going on that could do it. There are actually tools in place to make that happen. It's just limited in terms of its expansion and scope.

I would also say, finally, there are a lot of things going on at the local level in terms of investment that the federal government makes: economic development, infrastructure support, sports funding. You issue contracts and workplaces have to deal with this. You could begin picking through each one of those, setting standards for what you could tie your investments to and the conditions under which you'll give that money in terms of safe practices.

In the skate park that you helped build in Halifax, across from the CBC, no kids are wearing helmets because the cops don't go by. You could tie a condition to the development or the funding of that to say we'll do this providing it's operated safely. There are literally hundreds of things that can impact people locally at the community level, and communities are willing to help you do that if you organize them.

● (1220)

Mrs. Cathy McLeod: The second thing is some sort of discussion around what is ultimately achievable. You gave an very powerful example of WestJet and every five days, and now as I reflect, I think yes, we can certainly reduce morbidity and mortality. What are the best countries in the world doing? Is their WestJet comparably every 10 days or every 15 days? It's probably a hard question to answer, but—

Dr. Louis Hugo Francescutti: No, that's a simple question.

Mrs. Cathy McLeod: Okay.

Dr. Louis Hugo Francescutti: It's Sweden. Canada has this many deaths per 100,000 and Sweden has that many deaths per 100,000. It's a rarity when a child is traumatized in Sweden. Sweden, nationally, set as their objective.... In Sweden, their parliament actually passed an act that said “We want zero injuries on Swedish roadways”. That's zero injuries on Swedish roadways. And we have plenty of examples of people who are far more sophisticated than we are.

Mrs. Cathy McLeod: In any time I have left, I'd love to hear international examples.

The Chair: You only have about 25 seconds.

Dr. Louis Hugo Francescutti: We can do that offline.

The Chair: What do you want to hear?

Dr. Louis Hugo Francescutti: That's what it looks like, by the way. We have a graph.

The Chair: We can see a picture.

Dr. Louis Hugo Francescutti: You can pass it to the vice-chair.

The Chair: Thank you very much, Doctor.

Thank you, Ms. McLeod.

Monsieur Malo, excuse me. I understand the Bloc does not want to ask any questions. This is your opportunity.

[*Translation*]

Mr. Luc Malo: Madam Chair, I do not have any questions. Thank you.

[*English*]

The Chair: Monsieur Dufour, you're the same...?

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Same for me.

[*English*]

The Chair: You're going to chill out today. Okay.

We'll go to Mr. Uppal.

Mr. Tim Uppal (Edmonton—Sherwood Park, CPC): Thank you, Madam Chair.

Thank you for coming.

I just want to start off from more or less a personal experience. My daughter is almost three years old. We have been thinking about the winter and talking about skating and skiing for her. We've gone to a few different department and sporting goods stores, and we're getting different answers from everybody about when is the right time to start and what types of skates are good starting skates with regard to the different models.

Is there a way to educate the people who are actually giving out the information? I've been to a few websites, and they're giving out different information on what direction to head down when children should start into the sports. Anyone?

Dr. Susan Forbes: Sure. Why not? I don't mean to be flippant about that, because I'm one of those odd Canadians who really doesn't skate well.

I think the most important thing to recognize is that every kid develops differently, so I think some of the most intelligent people around that are the parents. It's intuitive around what your child is capable of doing and not capable of doing, so let common sense prevail. If the kid is always falling down, now is not necessarily a good time to introduce him to sports where falling down is going to be an issue.

As far as equipment goes, everybody has a vested interest. Can we educate people in retail? It's really hard, because it's sort of a McDonald's mentality, and the turnover rate is astronomical.

With regard to websites, absolutely, we could do that. Play it Cool has some information around hockey helmets in particular, but certainly there are other sources out there. I would suggest to look for the ones that are non-profit organizations interested in kids' participation, and to stay away from the manufacturers, because obviously they have a vested interest.

Mr. Paul Kells: If you had a centre for disease control in Canada that was actually a source of independent advice, then maybe you'd be able to find that kind of information if indeed that was a priority. The problem is in the vacuum that exists when the leadership is not there or the resource isn't there. Then you'll get all sorts of people from the marketplace, understandably—no pointing of any fingers at that—but they'll fill the void with their own cases and arguments. If you really want that to be a priority in terms of developing guides for consumers and Canadians, then you'll need to help create that.

Dr. Louis Hugo Francescutti: The other thing you can do is work with your family doctor, pediatrician, and public health units, because they should be the ones who are giving you that information. So every time a child sees a health care provider.... I always tell my patients who have ear infections that the only reason God gave them ear infections is so I can give them the lecture on injury prevention.

Voices: Oh, oh!

Dr. Louis Hugo Francescutti: That's the time you use because that's what's going to kill them. The ear infection is not going to kill them.

We need to do risk assessments for kids when we interact with them, and as they grow that's going to change.

Mr. Tim Uppal: In a sport, what's the timeline from the time a injury is identified as a problem? Let's say it's in ice hockey. When I was younger and playing ice hockey, we didn't have the stop sign on the back of the jerseys saying not to hit from behind. At the time, it was obviously an offence, but it wasn't as much of an issue. But now all these young kids I know in our area have that little stop sign on their backs, which probably helps them in many ways.

How long does it take before you can identify a problem and you get it to the coaching level, to the organization level, and it gets further?

● (1225)

Dr. Louis Hugo Francescutti: Let me give you the best example. Alcan, which is a company that makes aluminum, has hundreds of thousands of employees around the world. They solved the problem within the organization by having an online reporting system for occupational injuries. From synthesizing that information and having it out in less than 24 hours to their worldwide operation, they had one of the lowest injury rates in the world.

With the technology that exists today, you should be able to be on that problem within minutes, because those injuries can be reported with either an iPhone or an iPad and then analyzed. The appropriate guidelines can then be disseminated by text back to the parents as they're watching their kids playing.

The technology is there. We're just not using it.

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

Now we will go to Mr. Lamoureux.

Mr. Kevin Lamoureux (Winnipeg North, Lib.): Thank you.

I enjoyed the presentations very much.

One of the things I was reflecting on was that for years inside the Manitoba legislature I would introduce a bill to make bicycle helmets mandatory. What I found was that throughout Canada, there's a great deal of discrepancy with respect to minimum ages, maximum ages, the amounts of fines, and you name it. There's a lot of discrepancy. Alberta probably has one of the better laws.

I'm interested in knowing what you feel the role of a federal government could be in addressing an issue of that nature. What sort of advice would you give?

The Chair: Who would like to tackle that one?

Go ahead, Dr. Forbes.

Dr. Susan Forbes: Why don't you start?

Dr. Louis Hugo Francescutti: The best example I can give you is the H1N1 disaster we just went through. We had no fewer than 14 ways to immunize people against H1N1. How ridiculous. There's really only one way to immunize people properly.

That's the trouble we have right now. Each province is helter-skelter introducing its own legislation. I don't know what the hell it's based on, but it's sure not based on science.

Even if the feds had a repository of what the evidence says should be done that governments can go to, whether they choose to do that is up to them. That's why we end up with 14 different strategies for doing things there should be only one way to do, and it should be based on evidence.

Mr. Paul Kells: Once you've set a national standard—I'll come back to that—you can encourage the different groups to conform to it.

My question to the folks who ask what, as a parent, they can do, is whether they are wearing helmets when they're on a bike. Are they wearing helmets when they're coaching on a hockey rink?

Those are examples of best practices. Introducing those things through sports associations, provincially and federally, and through procurement policies are all the pieces that can be put in place.

The Chair: Ms. Fréchette.

Ms. Danielle Fréchette (Director, Health Policy, Royal College of Physicians and Surgeons of Canada): Another example you can think of is the guidance of this government on extreme heat events. Working with the Public Health Agency, they developed some standards for alerts and interventions and advice for the population, and disseminated it at the municipal level.

There are many examples of how we can tap into modern technology, as Louis was saying. Use of public awareness as one of the greatest ways to change the culture.

Dr. Susan Forbes: The answer is public awareness. You can legislate helmets all you want. But I see kids all the time in hockey and on bicycles and in other sports not wearing them properly. It doesn't matter if you have a helmet on. If it's not on properly, it's not going to do the job it's designed to do. How do you get them to do that? You educate people on the consequences of not engaging in safe behaviour.

The Chair: Mr. Kells, do you have a comment?

Mr. Paul Kells: I have just one final comment on all this. I would just say that there's an army of people at the community level who would be willing to step forward and help. I actually personally intend to spend the rest of my time working on this and bringing victims and families to the forefront.

We have 14,000 people a year. With a couple of parents, in most cases, grandfathers, kids, brothers, and sisters, there are probably 75,000, 80,000, or 100,000 new people a year in that club. Most of these people, because of the trauma that's happened, are shell-shocked. They lack counselling, unlike for cancer or other things. They're left, all of a sudden, with a departed son. For all of these other health issues that happen or occur after the fact, there's actually no support in our health care systems anywhere to help.

You can actually encourage, mobilize, and peer-support people to come forward and actually support you in your efforts across the country if we can only tap into those kinds of volunteer activities, as we have with AIDS, cancer, and others.

● (1230)

The Chair: Thank you very much. Our time is up now.

I want to thank the witnesses so much. This has been one of the most beneficial meetings we've had, I think. There's lots of new information. We will be looking to you in the future for your expertise. I know that.

I want to especially thank you for coming today and for giving us your insightful comments and your expertise.

Having said that, I am going to suspend this committee briefly and then we're going into committee business.

Thank you.

[*Proceedings continue in camera*]

● (1230)

(Pause)

● (1235)

[*Public proceedings resume*]

The Chair: Okay, we're in public session now.

We'll start with Dr. Duncan.

Let's start with your first motion, which has been outstanding for a long time, the year of the brain. Can you speak to that, please?

Ms. Kirsty Duncan: Thanks, Madam Chair.

For the committee, we've heard repeatedly in our subcommittee that we need a galvanizing effort. So the motion as was passed by the subcommittee would be that the committee recommends that the Government of Canada declare 2013 as the year of the brain.

I'll give you some background as to why that would be a good thing to do. The EU has named 2013 year of the brain in Europe. As you all know, our first national population health study of neurological conditions concludes at that time. The EU has funded a similar study. The World Parkinson Congress will be held in Canada that year. It brings 4,000 people together. It's the largest conference. The World Congress on Conductive Education will also occur in Canada. That's for children and adults who have motor disorders with neurological origins. We'll have the conclusion of the Canadian Dementia Knowledge Translation Network project, which is funded by CHR. The neurological health charities of Canada would be willing to work with the community to leverage planned events into significant year-of-the-brain occasions. They would be keen to coordinate a knowledge exchange event between the Canadian and European population health studies.

It's a timely target to work toward improving the quality of life for more than eleven million Canadians who live with a neurological or psychiatric condition.

I just want to finish by saying that in the 1970s we took real action on smoking, and on the heart in the 1970s and 1980s. We made a real difference. We have an opportunity with 2013 and Canada doing so much to use this as a galvanizing effort.

● (1240)

The Chair: Thank you.

Discussion?

Dr. Carrie.

Mr. Colin Carrie: I did want to take a moment. I want to commend my colleague for her interest in and commitment to the issue, because it is a commitment that the government does share. We've invested $120 million for neurological diseases. We launched a four-year national population health study of neurological conditions. As well, we've signed international MOUs with France, Germany, and the U.K. for Alzheimer's research.

We took a quick glance at the items tabled for private members' business, and it reveals a long list of designated days, weeks, and months. We're probably all very aware of that. One example I've been involved with is Bill S-211, which I think is coming up in the House on Wednesday or Thursday this week. The bill brought up by the member's colleague, Senator Jim Munson, would designate April 2 as Autism Awareness Day. I very much share his passion for this particular private member's bill.

My concern with this motion is I feel it is disrespectful to our fellow parliamentarians. I know the intent is very good but they have chosen to go through the approved process with a private member's bill and for this reason I will be abstaining from the vote, Madam Chair.

The Chair: Thank you, Dr. Carrie.

Any further discussion?

Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Thank you very much Madam Chair.

I would just like to understand what harm there is in using a private members' bill when it is a normal process for this type of recognition. We are talking about nothing more than a recommendation here. In fact, the committee has no authority for imposing this. If the government wants to proceed with this proclamation for 2013, it will have to do so through a bill that will debated in the House.

I am simply trying to understand how this might be contradictory. If the committee's objective is to ask the government to introduce a bill to be debated by the House to proclaim 2013 the year of the brain, how is that different than other types of processes where hon. members introduce bills in the House to designate a day, a month or a year commemorating a certain disease or event that they consider important?

Wherein lies the problem?

● (1245)

[*English*]

The Chair: Dr. Carrie.

Mr. Colin Carrie: Thank you very much to my colleague for his question.

Basically, he's given himself the answer to his question. There is a process to go through. As you said, this is just a recommendation. Why bother doing it if there is already a process in place to go forward?

As I said, I do actually respect what the member is trying to do, but I think I've put my reasons on the table for why I will be abstaining from it. But thank you very much for the question.

The Chair: I'll call the question.

(Motion agreed to)

The Chair: We'll go to your next one, by Dr. Duncan: that the committee recommend that the minister announce a new set of picture warnings—

Hon. Ujjal Dosanjh: No, that's mine, actually.

The Chair: It's submitted by Dr. Duncan.

Hon. Ujjal Dosanjh: No, the next one is the longer motion.

The Chair: Well, I'm going to do Dr. Duncan's first.

Hon. Ujjal Dosanjh: No, you're not, because this came first in time.

The Chair: Well, in the spirit of cooperation, Mr. Dosanjh, I will remember you're not cooperating.

Hon. Ujjal Dosanjh: We're going to accommodate both. I was just joking there.

We're going to accommodate both.

The Chair: It's not a joke. I'm going to do Dr. Duncan's first.

Hon. Ujjal Dosanjh: No, you can't.

The Chair: Well, I know I can get through this in 30 seconds, if you don't—

Hon. Ujjal Dosanjh: No, we're going to accommodate her motion in mine. We'll combine the two.

The Chair: You're going to combine the two?

Hon. Ujjal Dosanjh: Yes, there's an amendment coming.

The Chair: Let's have this open for discussion then.

Hon. Ujjal Dosanjh: I don't want to waste time, I just want to get the motion.

The Chair: No, let's waste time.

Hon. Ujjal Dosanjh: Oh....

That's fine.

The Chair: Dr. Duncan, are you going to have an amendment to add to Mr. Dosanjh's?

Ms. Kirsty Duncan: Can I make a friendly amendment? I think there's a way to combine the two.

The Chair: Okay.

Ms. Kirsty Duncan: If people are comfortable with that, the motion is that the committee recommend that the minister announce a new set of picture warnings for cigarette packaging on or before Monday, January 17, 2011, to mark national non-smoking week.

I think if we could insert it at top of Mr. Dosanjh's motion, that would be my recommendation.

The Chair: Okay, good, that's your recommendation.

Mr. Dosanjh, do you want to speak to that?

Hon. Ujjal Dosanjh: I'd be happy to have that amendment.

There's another part of my motion that needs to be amended, and that's paragraph (e). Rather than saying "every four years", just say "regularly". So whenever the government believes it's appropriate to do a report, it will do so, rather than saying a report should be done every four years.

Do you want to move that?

Ms. Kirsty Duncan: Yes, I move the amendment.

Hon. Ujjal Dosanjh: So my colleague, Ms. Duncan, has moved that.

The Chair: Do you mind if I just try to clarify this to make sure everyone's clear on it?

Basically, under Mr. Dosanjh's motion, Dr. Duncan has recommended that she puts hers first:

> That the committee recommend that the minister announce a new set of picture warnings for cigarette packaging on or before Monday, January 17, 2011, to mark national non-smoking week; and that, in the opinion of the committee, the government should amend the Tobacco Products Information Regulations forthwith to require that:

—and the rest would read the same until we get to paragraph (e), right, Mr. Dosanjh?—

Hon. Ujjal Dosanjh: That's fine.

The Chair: —where the amended paragraph would read:

> health warning messages be reviewed regularly to ensure that the labels stay current and that the committee report this motion to the House.

Hon. Ujjal Dosanjh: Yes.

The Chair: Okay, now we're open for discussion.

Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Madam Chair.

We're prepared to deal with these two motions separately today. I agree with you that if we deal with Madam Duncan's, we can probably get that over with in about 30 seconds; but I do have some issues with Mr. Dosanjh's motion, which might require some further discussion.

So I think if we just do it the way all of us originally thought we would, we could expedite the process, but it's up to the opposition what they would like to do today.

The Chair: Dr. Duncan.

Ms. Kirsty Duncan: We'll disentangle it and do the one, and then —

Hon. Ujjal Dosanjh: We'll do one in 30 seconds and then we'll come to mine.

The Chair: Very good, "in 30 seconds". Is that a quote, Mr. Dosanjh?

Hon. Ujjal Dosanjh: Yes, it is.

The Chair: Dr. Duncan, can you read it through?

Ms. Kirsty Duncan: Thank you all.

The motion is that the committee recommend that the minister announce a new set of picture warnings for cigarette packaging on or before Monday, January 17, 2011, to mark national non-smoking week, and that this motion be reported to the House.

An hon. member: I like it.

● (1250)

The Chair: Dr. Carrie.

Mr. Colin Carrie: I just have a quick comment.

As we heard from the minister last week, she is willing to move forward with an announcement soon. So I think we will be able to support this motion.

The Chair: Can we go to the question now?

(Motion agreed to) [See *Minutes of Proceedings*]

The Chair: Now, Mr. Dosanjh, it's your turn.

Hon. Ujjal Dosanjh: I move my original motion.

It doesn't require any discussion, at least from my perspective. I think we went through a day of hearings on this very issue and the motion is quite self-explanatory as it stands.

The Chair: But you do want the word "regularly" in there instead of "every four years".

Hon. Ujjal Dosanjh: Yes, I would want that amendment, if you will allow that.

The Chair: Dr. Carrie, we're going to talk to the amendment first, changing the words "every four years" to "regularly".

Dr. Carrie.

Mr. Colin Carrie: That's fine. It doesn't matter to me.

The Chair: Is everyone in agreement with that amendment then?

The amendment is that health warning messages be reviewed "regularly"—

Mr. Ron Cannan (Kelowna—Lake Country, CPC): Every day, I think.

Hon. Ujjal Dosanjh: Oh, oh!

The Chair: Mr. Cannan, I don't think Mr. Dosanjh meant every day.

I will give you the benefit of the doubt, Mr. Dosanjh.

Is everyone in favour of the amendment?

(Amendment agreed to)

The Chair: Now, all in favour of Mr. Dosanjh's motion?

I'm sorry, Monsieur Malo, I stand to be corrected. Go ahead.

[*Translation*]

Mr. Luc Malo: Thank you very much Madam Chair.

Item (c) of Mr. Dosanjh's motion talks about a "national toll-free quitline". You know that in Quebec we have toll-free IQUITNOW help line. I wonder whether I could get Mr. Dosanjh's permission to add to the end of item (c) the following words: "and in Quebec that number is 1-866-527-7383".

[*English*]

The Chair: All right, we have another amendment now.

Monsieur Malo, can you please read again exactly what you want at the end of paragraph (c)?

[*Translation*]

Mr. Luc Malo: Yes, I would like the following words to be added: "and in Quebec that number is 1-866-527-7383".

[*English*]

The Chair: Ms. McLeod.

Mrs. Cathy McLeod: Madam Chair, I know that in British Columbia we have a very comfortable, recognized number, the QuitNow number: 1-877-455-2233.

I think that if we head down this path we're going to have a cigarette package with 14 separate numbers. So I would argue that is not appropriate.

The Chair: Thank you.

Is there any other discussion?

Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour: Thank you Madam Chair.

Contrary to what Ms. McLeod just said, in the last committee meeting we saw that MacDonald cigarette packages in Quebec have the fleur-de-lys on them, while in the rest of Canada they have the maple leaf. I do not see why a package of cigarettes in British Columbia could not have the appropriate phone number on it and why in Quebec we could not have the number 1-866-527-7383 on our packages. All 7 million Quebeckers know about that number. Since health is still a provincial jurisdiction I do not see how this would be contradictory.

[*English*]

The Chair: Is there any further discussion?

I'm going to ask the clerk to read out (c) to make sure that we're very, very clear on what we have as an amendment.

Can you read it for me?

[*Translation*]

The Clerk of the Committee (Ms. Christine Holke David): "(c) a national toll-free quitline telephone number be included as part of the warning messages on every package and that in Quebec that number is 1-866-527-7383;"

[*English*]

The Chair: Does everyone understand the amendment?

Some hon. members: Yes.

The Chair: We're voting on the amendment now.

Mr. Colin Carrie: We're voting on the Bloc's amendment?

The Chair: We are voting on the amendment to item (c), which came from the Bloc, yes.

(Amendment agreed to) [See *Minutes of Proceedings*]

The Chair: Don't get too excited yet, it's 12:55 and this motion isn't passed yet.

We've dealt with the two motions—and emotions—but we are now going to go to the whole motion.

Dr. Carrie.

● (1255)

Mr. Colin Carrie: I have some discussion on the overall motion.

It would be premature for the committee to endorse this motion. We heard from the Minister of Health here in committee a couple of weeks ago and last week that the project overall has not been taken off the table; they are going through further analysis.

The minister also mentioned that the department does not consider that hard-hitting health warning messages on the dangers of tobacco should be a stand-alone initiative.

The social environment has changed significantly since health warning messages were introduced ten years ago. It's a good time to refocus our efforts to ensure that the warnings reach the largest number of smokers possible while remaining effective and cost-efficient.

Health Canada is examining innovative ways to complement existing strategies by strengthening its Internet presence and extending its presence using social media tools, such as Twitter, Facebook, etc., to reach more Canadians.

It's important to remember that there's no single solution to further reduce tobacco use in Canada. Canada has been successful in lowering the smoking rates because we have implemented a strong and comprehensive tobacco-controlled environment that includes multiple policy levers all working together—for example, second-hand smoke, bans on advertising, bans on high taxes, restrictions on marketing to youth, etc.

Given the information provided by the health minister, I cannot support this motion. It would be premature for the committee to report this motion to the House. I suggest that the committee allow the department time to continue its good work, which thus far has led to Canada having one of the lowest smoking rates in the world.

The Chair: Dr. Duncan.

Ms. Kirsty Duncan: Is it possible to call the vote?

The Chair: Yes, I just want to make sure everybody knows. We'll get that done before one o'clock. I'm mindful of the time.

Is there any other debate?

The motion reads:

> That, in the opinion of the Committee, the Government should amend the Tobacco Products Information Regulations forthwith to require that:
>
> (a) new refreshed picture-based health warning messages appear on the two major surfaces of all packages of tobacco products;
>
> (b) health warning messages cover at least 75% of the major surfaces of cigarette packages;

—and this is the amendment—

> (c) a national toll-free quitline telephone number be included as part of the warning messages on every package; and in Quebec the number is 1-866-JARRETE;
>
> (d) new warning and information messages be included on the inside of cigarette packages;
>
> (e) health warning messages be reviewed regularly to ensure that the labels stay current and that the committee report this motion to the House; and
>
> That the Committee report this motion to the House.

(Motion as amended agreed to)

The Chair: Ladies and gentlemen, we have done the deed.

The committee is dismissed.