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Chair

Mr. Rob Merrifield

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● (1110)

[*English*]

The Chair (Mr. Rob Merrifield (Yellowhead, CPC)): I call the meeting to order. Pursuant to Standing Order 108(2), we are studying the new strategy for the prevention of fetal alcohol spectrum disorder.

We have with us today the chief medical officer of the Public Health Agency of Canada, Dr. David Butler-Jones.

Thank you for coming in. You have some assistants with you. Maybe you would introduce them to us; that would work out well.

Ms. Linda Dabros (Director, Office of Drug Strategy Secretariat and Strategic Policy, Department of Health): Good morning. I'm Linda Dabros from Health Canada.

Ms. Kathy Langlois (Director General, First Nations and Inuit Health Community Programs Directorate, Department of Health): I'm Kathy Langlois, with the first nations and Inuit health branch in Health Canada.

Ms. Kelly Stone (Director, Childhood and Adolescence Division, Centre for Health Promotion, Public Health Agency of Canada): I'm Kelly Stone with the Public Health Agency.

Ms. Barbara Beckett (Assistant Director, Institute of Neurosciences, Mental Health and Addiction, Canadian Institutes of Health Research): I'm Barbara Beckett with the CIHR.

The Chair: Thank you very much for coming in.

I see that you have a presentation you're going to make. We will ask you to introduce that at this time, and then we'll go forward to questioning.

[*Translation*]

Dr. David Butler-Jones (Chief Public Health Officer, Public Health Agency of Canada): Thank you, Mr. Chairman.

[*English*]

It is a pleasure *encore* to be with the committee again, this time on a topic that's very important, and not about pandemics. In the context of many people's experience, this is an increasing challenge in Canada, and it has a potential impact on individuals, families, and communities that we think of in other realms as well.

The former standing committee had requested that we return with a vision document to give the committee an opportunity to discuss further the prevention of FASD. I guess it depends on the perspective, but unfortunately, Parliament dissolved, and we're now back with a new committee.

I really am pleased to discuss a vision with you today.

[*Translation*]

Addressing FASD has been a commitment of the Government of Canada since the mid-nineties. As you know, the term FASD describes a range of lifelong disabilities caused by prenatal exposure to alcohol. It is a leading form of developmental delays in North America and a major cause of preventable birth defects.

● (1115)

[*English*]

The primary disabilities from fetal alcohol create, by the best estimates, somewhere in the neighbourhood of $1.5 million in additional direct costs over the course of an affected individual's lifetime. These costs, we recognize, do not include either the loss of potential of that individual or that of their family or caregivers.

It is in fact a risk for all women of child-bearing age who drink alcohol. Recent studies have shown that drinking even small amounts of alcohol may have a negative impact on the developing fetal brain.

[*Translation*]

Alcohol-related congenital defects have an impact upon public health, health care, education, ability to work, justice, policing, corrections and child and family welfare systems. Therefore, multiple layers of government must be involved as partners.

[*English*]

While many departments across government have programs and projects to address fetal alcohol issues, the health portfolio is currently the only federal department or portfolio with dedicated resources for fetal alcohol syndrome disorder.

[*Translation*]

The Public Health Agency of Canada manages the pan-Canadian FASD Initiative with an emphasis on the federal public health role. The Government of Canada is also responsible for providing community-based health programming in First Nations and Inuit communities.

[*English*]

Many provinces and territories have also identified fetal alcohol syndrome as a serious issue for their governments and have developed strategies along this line. They have called upon the Government of Canada to demonstrate leadership and to develop a federal strategy.

In 2003, following consultations with the provinces and territories, as well as with stakeholders across the country, Health Canada released the framework for action to guide the development and implementation of collaborative efforts.

[*Translation*]

The Framework for Action has become a blueprint for action, and has served as a benchmark for the creation of the Vision. I understand that Committee members have received copies of the Framework document.

[*English*]

The vision is actually based on a three-pronged approach: the promotion of health generally; the prevention of FASD and the reduction of harm by minimizing risk; and thirdly, the early detection and management of FASD and related chronic health and social problems.

Within this approach there are five themes that guide the development of the vision. Under the first theme, the emphasis is on strengthening leadership and coordination to ensure access to tools and knowledge across the country. Stakeholders at all levels are being pressed to work on fetal alcohol problems and related issues as a direct result of growing client needs. Collaboration has let us work more effectively and efficiently and has facilitated joint projects and activities.

The next two themes involve increasing the awareness of the general public and professionals. In 2002 women told us that they felt their health care providers were the most reliable source of information.

[*Translation*]

They also told us that there is inconsistent messaging about the consumption of alcohol during pregnancy. Other research has told us that many health care providers do not feel comfortable dealing with women who drink alcohol during pregnancy.

[*English*]

In recent years, therefore, the Government of Canada has focused much of its efforts on enhancing health care provider awareness, knowledge, and skills, and the provision of tools and resources for use with their clients.

● (1120)

[*Translation*]

Large public awareness campaigns are very expensive and require a great deal of research to segment audiences into various population sub-groups within women of childbearing age so that messages are accurately designed according to, for instance, age, socio-economic status, and risk factors.

[*English*]

The health portfolio has collaborated with provinces and territories in establishing the common messaging that no alcohol could be considered safe during pregnancy. Many of the provinces and territories, in collaboration with their liquor control boards, have conducted effective general public awareness campaigns. Part of the challenge, though, is that with limited funds available, the health portfolio has focused on providing the knowledge base for assessing the learning from effective campaigns, helping to make tools and resources available to communities and groups in order to build their capacity to plan, to manage, and to evaluate effective awareness campaigns, which can then be used as part of general health promotion and prevention work.

This continues to be an important element in addressing fetal alcohol syndrome disorder and is bearing some fruit in the improved general awareness of the harm caused by alcohol used during pregnancy, as can be seen from our most recent public opinion tracking. Environics, during March and April of this year, found that there'd been an improvement, in some 11% of the women surveyed, in knowing that any alcohol consumption during pregnancy can harm the baby.

In addition, diagnosis has been an area of focus in recent years and does represent the fourth theme of the vision. Research has shown us that early identification and diagnosis and effective intervention can in fact improve outcomes for those affected as well as their families and caregivers. Many of the costly secondary effects can be prevented through early and effective management of this lifelong disability.

As a result of this research, the Government of Canada facilitated the work of a national expert advisory committee and a wide range of experts and stakeholders to develop and implement the FASD Canadian guidelines for diagnosis.

[*Translation*]

A common diagnostic approach is critical to being able to move towards national incidence and prevalence data. In the future, an ability to track national incidence and prevalence data will allow us to determine whether FASD awareness and prevention activities are having an impact on reducing alcohol affected births and, consequently, alleviating the individual and societal costs associated with FASD.

[*English*]

This work also appears to be bearing fruit in that the majority of clinics diagnosing in Canada are adopting the new guidelines. This means that we have in fact taken a first step in a common minimum data set on referrals, diagnosis, and common reporting. Central to the vision is the concept that knowledge must be developed and then exchanged to inform and create evidence-based multi-sectoral initiatives.

[*Translation*]

Knowledge development work includes partnership with the Canadian Institutes for Health Research and other such organizations to develop a common research agenda. The long term goal is to build Canadian knowledge and researcher capacity on FASD.

[*English*]

Finally, it's important to help communities to help themselves. And communities, including communities of practice and front-line workers, do need the capacity to deal effectively with these issues.

Local development and exchange of knowledge and evidence will help communities define effective policies, programs, and practices, and this would include sector-specific as well as intersectoral collaborations.

[*Translation*]

Local development and exchange of knowledge and evidence will help communities define effective policies, programs and practices. This would include sector-specific and inter-sectoral collaboration.

[*English*]

It should include social work, child welfare, child care, homeless shelters, and education workers, police, lawyers, judges, parole and corrections officers, employers and employment counsellors, and the community really, at the community and regional level.

I am confident, Mr. Chair, that the vision presented to address FASD provides a cohesive way forward and engages, and continues to engage, multiple partners across various sectors as we move forward. Again, as I've often said, on the issues of pandemic, we're not there yet, but we are making progress. Clearly, the Government of Canada has an important leadership role and must work with key partners and stakeholders to promote the health of Canadians and address this issue. Collectively, I think we're on the right road, but there is still much to be done.

Merci.

The Chair: Okay. I want to thank you for your presentation.

We now move into the question part of our meeting. We'll start with Mr. Szabo; you have 10 minutes.

● (1125)

Mr. Paul Szabo (Mississauga South, Lib.): Thank you. I may be splitting part of that time. It depends if we can get some answers.

Some time ago, Health Canada collaborated with about 18 other organizations, including the CMA, etc., and one of the things it said in its first principle was that fetal alcohol syndrome was the leading known cause of mental retardation in Canada. That's a very ominous statement, and it's absolutely wrong. Fetal alcohol syndrome is not the cause of anything; it is the result. And way back then, and now, it appears that Health Canada still is not prepared to say the maternal consumption of alcohol during pregnancy is the leading known cause of mental retardation in Canada.

I wanted to make that point because it leads to the same point: I've seen this all before. I think I saw this speech 10 years ago. I'm sorry. I'm disappointed. I haven't seen anything new here. I haven't seen any progress. But it says on page 6 of my report—I don't know where it is in the French—that the health portfolio has collaborated with provinces and territories in establishing the common message: no alcohol is safe during pregnancy.

Dr. Butler-Jones, there is enough medical evidence that the risk to the fetus from maternal alcohol consumption occurs from days 15 to 22, when human facial features are established. And in this statement it says no alcohol is safe during pregnancy. It begs the woman to determine, first of all, am I pregnant? If I'm pregnant, then I'm going to make a decision.

This attitude is fatally flawed, and I don't know why the heck Health Canada still cannot bring itself to understand that the message should be—and I want your comments on this—changed immediately to, "If pregnancy is possible, i.e. you are sexually active, not using protection, and are in your birthing years...." That's what the message should be: "You should not use alcohol if pregnancy is possible." Eliminate the risk.

Can Health Canada adopt that as a new saying and get the provinces and territories to adopt it? And can we take one step forward on this file that has taken no steps in the last decade?

Dr. David Butler-Jones: I guess there are a couple of issues there. The first is the suggestion that there's been no progress. In fact there has been progress here. Is it as much as any of us or all of us would have hoped? No. I agree with that. Is there more to be done? Absolutely.

But there's been significant progress in terms of public awareness. There's been significant progress in terms of professional awareness and diagnostic guidelines, etc.

And in terms of the federal role vis-à-vis that of the provinces and territories, that's something for governments to discuss and debate. But within the authorities that we have, we've made significant progress to this point.

On the issue of messaging, the messaging is a complex one, as you can understand, whether it's talking about alcohol and pregnancy or the use of medications during pregnancy or the issue as it relates to other health things and the trade-offs between decisions that people make.

The risk clearly is not uniform throughout the pregnancy. There is risk before women know they are pregnant. That is why the guidance, the public health advice, is different from the common message that all groups are willing to speak to in advertising, etc. What public health speaks to in pre-conception as well as prenatal discussions is that if you think...and this is a general message. I think we can continue to refine what the public messaging is so there is an understanding among the public about the nuance between the issue of dose of alcohol, location of alcohol, and, in this case, pre-conception versus prenatal care and the importance in pre-conception of.... In other words, anybody who has the potential to be pregnant or is thinking about being pregnant should be thinking in the same way as if they are pregnant, not just about alcohol but about the use of over-the-counter medications and other things that may influence the development of that fetus. That is what I was trained in as a physician. That is what public health speaks to. But the message is a bit longer than what you can put on a brochure.

Mr. Paul Szabo: It's interesting that you submitted what you were trained in. The Canadian Medical Association was opposed to telling women about consumption of alcohol during pregnancy because they were afraid it was going to create spontaneous abortions or somehow victimize women. That's why in that joint statement they had that inclusion there, that it was not recommended to tell women. So I have to tell you, I've never been a strong fan of the CMA when it comes down to fetal alcohol syndrome.

The fact that you've actually mentioned in your comments here that there has been inconsistent messaging on the consumption of alcohol during pregnancy tells me that there hasn't been anything going on. We haven't even made progress on the public education standpoint. When you have a social problem, public education is always part of the solution. We still haven't got that right in terms of the basic messaging.

Dr. Butler-Jones, I have to tell you, I am still going to go on the basis...it's not personal, but it is with regard to Health Canada. Back in January 2000 an Environics survey done for Health Canada showed a tremendous amount of information about the knowledge, and it showed that the knowledge of Canadians, particularly Canadian women, was very poor on this subject matter.

One of the things they did was develop a comprehensive strategy on the ways in which you would communicate with the public. They listed the ways, for these provinces, these areas—because they got right down to it—and one of them was that the most prevalent area of access to information at a critical time was in the doctors' offices. That's where women go when they're in their birthing years and they're wondering about contraception or all these other things.

What has Health Canada done to get the medical association, the family physician, the obstetricians, and all the others involved in the education, promotion, and preparation for pregnancy to show leadership in terms of providing the public with information that is consistent across the country? What has Health Canada done?

● (1130)

Dr. David Butler-Jones: I can't speak for Health Canada since it's a separate department from the agency, but in regard to the activities of PHAC that relate to this—and I'll turn it over to the representative from Health Canada after this—in the documents before you is reference to engagement and training of health practitioners in terms of guidelines and advice. So there has been work in that area. To suggest that nothing has gone on is I think really not fair.

I'll ask if Linda or Kathy want to add anything to that.

Ms. Kathy Langlois: What I could add, from a first nations and Inuit health point of view, is that the Canadian Pediatric Society has a first nations and Inuit health committee. They have issued a position statement in their journal on FASD, and we are currently working with them to update that statement. That is the work we've done in FNIHB.

Mr. Paul Szabo: Okay.

I have just one last little question, and I gather there are only a few seconds left. The Canadian Centre on Substance Abuse just put out an enormously excellent report on alcohol, tobacco, and drugs. With regard to the alcohol question, they indicated that the deaths from alcohol misuse had gone up significantly relative to drugs and tobacco.

In their report, they mentioned something that you have not mentioned, and I'm wondering why. It has to do with binge drinking. Binge drinking is the worst kind, the most dangerous kind, of drinking for the unborn child. It is different from any other abuse because it's not a cultural thing, it's not a demographic thing; it in fact crosses all demographics. Binge drinking happens in social life. We have not educated Canadians on this important research finding, which has been there for the last decade.

Why hasn't anybody in the Government of Canada—since you're not Health Canada, I assume—said anything to corroborate or to collaborate in or to initiate some sort of project to tell Canadians what binge drinking is and why it is so dangerous to the unborn child?

Dr. David Butler-Jones: My point about Health Canada is that we are part of the same portfolio in health and we report to the same minister, but I can't speak for Health Canada programs directly. That was just a point of clarification.

We actually are engaged with the group that you speak about. I certainly have spoken to the issue of binge drinking, as have others. It is part of education around alcohol more generally. Again, whether people pick up, the media pick up, and others pick up the messaging is one issue. The fact that we are speaking to this shows that we are doing it.

Is it enough? Are people all hearing it? Are young people hearing it in their schools, in universities? I see in the media frequent references to this under the issues that universities, provinces, and others are taking on, and we speak to that, as do the institutions we support and collaborate with.

● (1135)

The Chair: Our time is gone, but if the committee would allow me to just follow up on that, we have Health Canada, we have CIHR, and we have the vision you've laid out. Do Health Canada and maybe CIHR want to respond to how they fit into that vision, because I think that's really the direction of some of the questioning here?

Ms. Linda Dabros: Health Canada has primary responsibility for Canada's drug strategy and controlled substance program. The responsibilities relating directly to FASD were transferred from Health Canada to the Public Health Agency of Canada when that agency was established a few years ago. We obviously have a lot of links, because part of Canada's drug strategy covers alcohol consumption. We are in the process of leading a national working group to develop a comprehensive Canadian national alcohol strategy, with obvious links with the other partners in the health portfolio, as well as with partners throughout Canada.

So that's the linkage, but in terms of direct responsibility for FASD, Health Canada, except for the first nations and Inuit health branch, doesn't have direct responsibility for that, because they were moved.

I think that might just clarify the responsibilities.

The Chair: Okay, that adds a whole other group of questions.

Can CIHR respond?

Ms. Barbara Beckett: CIHR has several mechanisms for funding research in the area of FASD. One of them, and the area where most of the money has actually gone, is our twice-yearly open competition, through which researchers in any area of interest can submit an application and be funded for an operating grant. The other mechanism is through the CIHR institutes. I represent the Institute of Neurosciences, Mental Health, and Addiction, but other institutes that would have an interest in FASD include the Institute of Human Development, Child and Youth Health; the Institute of Aboriginal Peoples' Health; and the Institute of Gender and Health. Each of these institutes has a strategic plan. I don't believe that FASD is listed as a specific high-priority item for any of our institutes, but some of the requests for applications that we have undertaken—for example, early life events was a recent one—could include applications related to FASD. We have in fact funded a couple of team grants related to FASD, through our initiatives.

In terms of collaboration with the Public Health Agency, Health Canada, and other government departments on the issue of FASD, we have within the last year been actively involved in conversations on a research agenda on a very general level, but we have not, to date, had any specific joint programs with other branches of the government.

The Chair: Thank you.

Madam Gagnon, you have five minutes.

[*Translation*]

Ms. Christiane Gagnon (Québec, BQ): Thank you for being here today. I believe that the issue being raised is one we are aware of.

Bill C-5 respecting the establishment of the Public Health Agency of Canada concerns health in general and your collaboration in establishing initiatives. When we ask questions on an issue under Health Canada's responsibility, the new administrator, Mr. Butler-Jones, says he doesn't have any answers because Health Canada handles it. We don't get the impression these two entities communicate very well, which won't facilitate matters when future initiatives are introduced. Who do we talk to? The new agency or its director, or Health Canada?

Health protection and promotion appear in the preamble of the bill establishing the new agency. If I ask questions on Aboriginal health, for example, I can speak to you and you can give me answers.

Let's take the money that has been invested to fight and prevent fetal alcoholism. In 2001, you invested approximately $25 million, and we don't know what impact that investment has had. Now you want to develop a national plan because, you say, the provinces and territories have asked you to do so.

So it's hard to monitor this new agency and the role it plays in connection with Health Canada and the entire health system in Canada. I don't think Quebec called you in on this issue. For the moment, I won't list all the measures taken by the Government of Quebec to fight fetal alcoholism.

The federal government is responsible for the entire issue of Aboriginal health. And yet, we don't get the impression that a portion of the money invested for Aboriginal health — $17 million at most — was used to fight fetal alcoholism. How much money has been paid to fight this phenomenon? It's quite difficult to see how you will be able to harmonize the strategies put in place by the new agency and by Health Canada management. Who will we talk to? Who will give us the real figures and an accurate picture on changes in alcohol consumption during pregnancy?

● (1140)

Dr. David Butler-Jones: The Public Health Agency of Canada, Health Canada and the CIHR are part of the same portfolio, but some aspects are the responsibility of Health Canada and others of the agency. That's not a problem, but it's up to Health Canada to take a position on health in Canada.

The overall budget of the portfolio is $19 million, $3.3 million of which is allocated to the Public Health Agency of Canada for the purposes of the pan-Canadian strategy. The provinces and territories also have programs.

We want to improve collaboration in the various health-related fields that are the federal government's responsibility, in particular, the health of Aboriginal people on reserves, which is the responsibility of Health Canada.

Now I'll turn the floor over to Kathy.

[*English*]

Ms. Kathy Langlois: I'd be happy to speak to the fact that the first nations and Inuit health branch is a little bit like a province, in that we're responsible for providing those public health promotion services on reserve that a province would provide elsewhere. And we do collaborate with the Public Health Agency; our teams work together, and we ensure that the work we do is consistent with their work. But we also have a special responsibility for community-based programming on reserve. We have developed in that area.

I could speak more on that, Mr. Chair, if you would like me to.

I would say that we are basing all of our programming on evidence that exists in other jurisdictions, and we have in fact based a lot of our mentoring program for women of child-bearing age at risk of consuming alcohol on what's already been done in Manitoba with the Stop FAS program. I could speak at length about our mentoring program.

We're also doing a lot of training in capacity building.

I can tell you that on the awareness piece, we have had significant progress. We have a recent opinion survey that says that 86% of first nations and 75% of Inuit aged 18 to 40 have identified that stopping the use of alcohol is an important factor in having a healthy baby. Similarly, 94% of first nations and 86% of Inuit are aware of FASD, and only a small percentage—less than 10%—think it is okay to consume alcohol during pregnancy.

So we're moving forward in our awareness, but we're also delivering services, which explains why there is a significant level of resources within the first nations and Inuit health branch, because we're actually doing programming on reserve.

● (1145)

The Chair: Okay, thank you. You might be able to comment further on that as the questioning goes on, but the time has now gone.

We'll ask Mr. Fletcher, who has five minutes.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Mr. Chair, I'm going to yield my time to Mr. Dykstra.

The Chair: Okay.

Mr. Rick Dykstra (St. Catharines, CPC): Thank you, Mr. Chair.

Through you, to Ms. Beckett, one of the things that's being pointed out is what you talked about, that from your perspective, priority has not been placed on this. Has the CIHR actually developed a central registry of research relevant to this?

Ms. Barbara Beckett: We have a database, through which we have records of the research that has been funded in the past and that is currently being funded. I have to say there's not a huge amount of capacity in Canada. We currently have five research projects funded. In the past there have been some more, but in the current fiscal year, there's approximately $800,000 going into FASD research.

Sorry, what was the rest of your question?

Mr. Rick Dykstra: Is there a central registry of research?

Ms. Barbara Beckett: The central registry would be our database, really.

Mr. Rick Dykstra: Does that database feed the practical application of education?

Ms. Barbara Beckett: There is not a lot of research going on at CIHR relating to surveillance or evidence about incidents and prevalence. We do have a couple of programs that have been funded in the past, and that are currently funded, dealing with community-based research in aboriginal communities and women's health issues.

I don't have a lot of details about exactly what has been found.

Mr. Rick Dykstra: Okay, thank you.

Dr. David Butler-Jones: If I may, in the last few years there's been about $2.9 million in research and five current projects. They've tended to focus on issues of causation, data, better understanding of how common the issue is, better treatment strategies, and the most cost-effective and appropriate treatment services, etc. So it's building our capacity.

In terms of your question of how that translates, that research, not just in Canada but internationally, then feeds into the development of guidelines and the dissemination of information to assist practitioners in how they actually address these.

Mr. Rick Dykstra: How many GPs do we have in Canada?

Dr. David Butler-Jones: That's a good question.

Mr. Rick Dykstra: Take a wild guess.

Dr. David Butler-Jones: A wild guess would be 20,000. But I really don't know.

● (1150)

Mr. Rick Dykstra: Based on all the research we've done, based on all the money that's been spent over the last number of years, and based on the fact that all of the research since 1996 has never been consistent in terms of how it was completed—but at least, at the end of the day, there's research available—how long would it take for us to develop a general practitioners kit with respect to this issue? How much time would it take to put a kit together?

I know that some folks on the other side of the House aren't happy about five-point plans or five-point priorities, but there are five of them here, in this framework for action. These could help build the strategy and develop for 20,000 practitioners the four- or five-page kit that Mr. Szabo talks about. I think that would actually identify for so many GPs in the country, in a very practical way, how....

When women go in to see their general practitioners, when they're thinking about getting pregnant and asking about the issues related to it, why could we not, in a very practical and meaningful way, based on all of the research that's available, create a kit for each one of those general practitioners in this country?

Dr. David Butler-Jones: Along that line, as a special supplement to the *Canadian Medical Association Journal*, which goes to all doctors related to both provincial and national...there was in fact a supplement on fetal alcohol syndrome with diagnostic guidelines. And other information has already gone out.

Mr. Rick Dykstra: I'm talking about creating one kit for the GP that he or she could actually speak about and hand to the woman who is his or her patient.

Dr. David Butler-Jones: In terms of both pre-conception counselling and advice and prenatal care, there are materials given to women. I won't speak for the fact that every doctor actually uses them, but in a number of resources the issues of fetal alcohol are included.

The suggestion you're making, and it's a good one, looks at whether there's something else that would be useful as a resource. That's part of the follow-up in terms of the ongoing stages of working with the professionals, not just doctors but also nurses working in the community, etc. That includes information for pharmacists, chiropractors—the whole range of professionals out there who are involved in giving advice. What would be most useful next would be to have this process of discussion: what would they find most useful, and what would patients find most useful, to actually have?

Mr. Rick Dykstra: If we could recommend or if we could provide that guidance, would the five of you be receptive to working towards that type of strategy?

Dr. David Butler-Jones: Absolutely. And that's part of the thinking.

One of the challenges, having done this thing for a long time, is that just having pamphlets to give out is not necessarily effective. It's really about an understanding of what it is that women, or their partners, need and what physicians and other health care workers need that would be most useful, and identifying that and the other strategies that would complement that. Having been a family doctor at one time in my life, I know that just having pamphlets on the wall or having something to hand out doesn't necessarily translate into behaviour change.

So it's a key, important element, and I appreciate your raising it.

The Chair: Thank you, Mr. Dykstra. Maybe you can get on in another round.

Ms. Priddy.

Ms. Penny Priddy (Surrey North, NDP): Thank you.

I don't need you to answer my first question verbally. If we could receive your answer at some other time in writing, I'd be happier. These activities were all identified as short-, medium-, and long-term, and I'm not sure what that means. It probably means something different for each area, but I don't know whether short-term means next week, next month, or next year. Many of the issues that I'm concerned about are identified as medium-term issues. I'd appreciate it if at some stage we could have in writing what the timelines for those initiatives are, rather than taking up my question time to have somebody respond to that.

My second point is that this is really—and I agree with the first speaker—a women's health issue. The infant is the victim of it, but it's a women's health issue. We have groups of special needs adoptive parents who are very active in this area around the country. The May 5 *Canadian Medical Association Journal*, which included the uniform diagnosis standards, was to look next at the screening tool—at least I think the committee was.

As for those women at risk, I would want to add—because I haven't heard them mentioned—the people who have any responsibility, and that's often not a lot, for urban aboriginal health, not aboriginal health on reserve.

In my province, British Columbia, one of the largest groups of FASD babies are those from the U.K. That's why under theme one you're talking about international partnerships. In the U.K. they still tell moms it's okay to drink; you can drink only a certain amount, which is actually quite outrageous. You can't smoke, but you can drink a certain amount. So I'm very interested in getting into international partnerships, because we're seeing a larger number of U.K. babies in the province of British Columbia who are FASD or along that line.

My second point—if you have time to respond to it—is that we focus a lot on children, infants, toddlers, etc., but when those people are teens and young adults, we're seeing them in conflict with the law, we're seeing them in the prison system. I have an interest in what work is going on to work with those people so that they don't end up in the prison system or in conflict with the law because they didn't have the attention they needed when they were younger.

● (1155)

Dr. David Butler-Jones: Certainly.

I'll start with the last. Clearly, corrections and justice and others are keenly engaged in these issues and recognize the challenge. They are looking at alternative processes for dealing with those who come into contact with the law. More broadly, though, in terms of prevention and engagement, there are community-based programs, specifically those focused on children, such as Canada's prenatal nutrition program, the action program for children, and Aboriginal Head Start. I'll address those issues as well.

In terms of your first question, short is one to two years, medium is three to five, and long is five-plus years.

Ms. Penny Priddy: So the international partnerships focusing on, for instance, the fact that we're seeing increasing numbers of babies from Commonwealth countries, when we should not be, would not come into effect for five to seven years?

Dr. David Butler-Jones: No, there is actually action now on that. We're actually engaged internationally with WHO to develop an alcohol strategy internationally, one challenge of which, obviously, is fetal alcohol. We constantly share information. We are always looking at what they're doing, and they're looking at what we're doing in terms of how we move forward.

The Chair: Thank you.

Mr. Batters, you have five minutes.

Mr. Dave Batters (Palliser, CPC): Thank you very much, Mr. Chair.

I appreciate all of you coming before this committee today. I'm going to ask a number of questions. If I can have relatively short, succinct answers, then I will be able to get through a lot more questions in my five minutes.

The government and the department have been looking at a variety of strategies and plans for a decade, and I'm going to ask perhaps Dr. Butler-Jones or any of you to comment. Where are the results? Are we seeing concrete, measurable evidence that we are achieving results? I guess what we're looking for—what I'm looking for—is accountability and value for money. I appreciate that all of us want to tackle this very serious problem, and it saddens us greatly that there is such a high level of this problem in Canada, but we need to see some value for the money that's been spent thus far.

That's my question. Where are the results from all the studies we've had, the comprehensive plans, and the flow charts? What can we point to as value for money in terms of results?

Dr. David Butler-Jones: Basically, where we're at now is looking at tracking value in change in terms of diagnostic behaviour; use of guidelines; levels of surveillance; the number of organizations that are engaged; the tracking, the polling that we've done in terms of public awareness. Is there more that could be done? Absolutely. But with the resources, we tend to focus on trying to get the activities based on value for money recognized in terms of practices elsewhere, where studies have been done, and applying them in Canada, as opposed to tracking them here.

Certainly in the future, both through CIHR and some of the things we're doing, looking at returns on investment is obviously key, but given the evidence that exists elsewhere, with limited resources we'll focus it on the activities rather than the other.

Mr. Dave Batters: Your estimates in the brief we were provided from the researchers indicate that we don't really know how many people have FASD in Canada. Estimates range from one to nine live births per thousand individuals. Do we know that the incidence of FASD is on the decline? Do we have any idea of whether or not the rate is going down?

Dr. David Butler-Jones: That we don't know, and the same is true in other countries. What we do have is a series of studies that look.... Part of the issue for the range is that if you look in certain communities the rates are very high and in other communities they're very low. So part of it is the range being taken in.

Mr. Dave Batters: I understand. I want to just back up what Mr. Szabo said. I think changing the wording in some of this literature is essential. With all due respect, Dr. Butler-Jones, it wouldn't take much to put that wording in a pamphlet. You said some things are difficult to word. I'm certain we could do something like that.

I would like to ask Ms. Langlois quickly, in educating first nations and Inuit people on reserves, do you use a pamphlet that gets your message across?

Ms. Kathy Langlois: In the early years of the program there was a poster that I think got significant attention, and we did use it. But to be the most effective, we've allowed communities to develop their own ways of messaging.

Dr. David Butler-Jones: Can I just say very briefly that they have to be targeted and appropriate for the communities. So in public health locally and provincially, there are lots of materials out there. An additional federal one may or may not be useful.

● (1200)

Mr. Dave Batters: But my understanding is that this is a condition—you can correct me if I'm wrong—that is of much higher prevalence in first nations communities than in the general public. I know Mr. Szabo said it crosses all demographics, and we all know that, but I think in terms of incidence, at least speaking from Saskatchewan and our perspective, it's higher among our first nations people.

I just leave you with the thought that perhaps a pamphlet that can be passed out to every individual in their childbearing years could be very beneficial.

Dr. Butler-Jones, you might find this question interesting. I know you made reference the last time you were here to the fact that you're from Saskatchewan. Do we know how many children are estimated to have FASD in Saskatchewan?

Dr. David Butler-Jones: I don't have the answer to that.

Mr. Dave Batters: Does anyone? I certainly don't.

Clearly, this is information that we need to strive to get, with all the research that's been done.

How much money was invested by the previous Liberal government in an FASD strategy?

Ms. Kathy Langlois: I believe the program started in about 1999 with $5 million a year. In the 2002 budget it grew to $19 million to $20 million per year. It has been at that level since then, with $16.7 million with the first nations and Inuit health branch and $3.3 million with the Public Health Agency.

The Chair: It's time to move on.

Ms. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much. I don't want to repeat what Paul Szabo said, but I do reflect a lot of what he says. I really agree with him.

Now everyone talks about it being 10 years. Let me tell you something. Before I became a politician in 1989, I was on a national task force to deal with what was then commonly known as FAS/FAE. I was the Canadian Medical Association representative.

On that we had representatives from the alcohol industry, distillers. We also had parents of children who had FAS/FAE. We set out a beautiful plan to have short-, medium-, and long-term goals. It was all nicely done, and one of the goals had to do with labelling. We looked at some of the things that went on in California that were being shown to be very successful in terms of posters in restaurants, posters in liquor outlets, and of course the labelling of alcohol. I know everyone was shocked—and that was about 17 years ago—to find the alcohol industry in Canada labels its bottles to send to the United States but doesn't label its bottles here; that tells you the bottles can be labelled. It's because we lack the will to do this in this country, and given that this is a very preventable cause of what I consider to be human wastage in terms of generations of people who are born with a syndrome that is fully preventable, it really distresses me that 17 years later we are still hearing things like, "It's going to cost too much. Public awareness campaigns are very expensive."

The cost of the human wastage is very expensive. Nobody has even calculated the lack of productivity of young people with FAS and FAE. Nobody has calculated the cost of people who go to jail who are not really criminals at all, but are actually put into our prisons because of this particular issue. No one has done some of the things we mentioned a long time ago, such as to train corrections officers and police officers to identify the difference between someone who is in fact criminal and someone who has a fetal alcohol spectrum disorder. None of that has been done. We have done absolutely no prevention.

Now, I could talk about the fact that $900,000 to CIHR for this issue is a joke. I can talk about the fact that when the committee on the non-medical use of drugs came up with some recommendations, everyone gave a million dollars over two years, which was a joke.

So we have to ask ourselves—and I know it's a provincial issue—two things. Is the federal government under the new national Public Health Agency going to do certain things that the federal government can do within its jurisdiction? Get a database going. Become a clearinghouse for information. And, thirdly, is the federal government going to be able to pull together the best practices of certain provinces and move on it? This is the role of the federal government, a coordinating role and a leadership role in facilitating certain things. That was identified and it has not been done. I want to know if it's going to be done.

I want to know if training of corrections officers and police is going to be done. I want to know if we're going to talk about putting the appropriate amount of money into research. I want to know if we're going to deal with labelling and prevention. This is preventable. We have to prevent it. I want to know if that's going to happen.

Seventeen years later, I am sitting here as a physician. There were brochures in every physician's office. You should know that. In 1988 the British Columbia Medical Association produced brochures with its own dollars, and it was taken up by the local medical associations in every province. The medical associations came and said they were doing it and would Health Canada assist them with the costs of doing this for a longer period of time. Every patient who came into the office picked it up, read about it, talked to the doctor about it.

That was never done. Why not? Now let me have the answers. I'm just fed up.

● (1205)

The Chair: Now you've got a minute to answer.

Dr. David Butler-Jones: The short answer is we're working within our existing authorities and resources. An effective surveillance system needs appropriate diagnoses. We've taken that step and we're continuing to build on what we can from there.

The Chair: Thank you. Ms. Davidson, five minutes.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you.

I hardly know where to start. As a newcomer to this table and to this topic, I find it very distressing. I hear a huge disconnect about what some members who have previously been here feel should have happened and what obviously hasn't happened.

I guess my questions are more for you, Dr. Butler-Jones. We heard the amounts that you said have been set aside—the $5 million per year in 1999, and then in 2002 that amount being increased from $19 million to $20 million. Is that correct? Did I hear those figures correctly?

Dr. David Butler-Jones: Yes.

Mrs. Patricia Davidson: I guess my question is, what have we received for that money? I'm not seeing a strategy in front of me. If those dollars haven't gone toward a strategy to move forward, what have they gone for?

Secondly, who is responsible for moving it forward? We have three different segments of the health organization here. Is it too fragmented? Is there a lead person? I think this question has been asked, but I guess I missed the answer because I'm not sure who the lead person is.

You just made a statement in response to Ms. Fry's question that you were working within your existing authority and resources. Is that the problem?

Where do we go from here? I am totally confused as to the millions of dollars we've put into this, what we've received, and where we go. I guess that's my basic question: how do we move forward with this very serious issue?

Dr. David Butler-Jones: Currently, the health portfolio is the only federal entity that has dedicated resources. The bulk of those resources is for programs on reserve. A smaller amount in the agency is for the development of the strategy. The work has been ongoing, and that's the point we're at now, the diagnostic guidelines, etc. So that's where we're at with the resources to this point.

Mrs. Patricia Davidson: So what's the plan to move forward? Is there a plan?

Dr. David Butler-Jones: Given issues of cabinet and other things, I'm not the one to speak to that. We continue to plan, and we continue to work with what we have. Future plans will be addressed as a government. I can't speak to that at this point because it's not my role as a deputy.

Mrs. Patricia Davidson: Is there someone within the organization who takes the lead to set the strategy?

Dr. David Butler-Jones: Certainly, the Public Health Agency, within the health portfolio, has the lead in terms of the overall strategy, of which elements are in Health Canada and CIHR. And we partner with other departments of government. That's where we are now.

Mrs. Patricia Davidson: Then perhaps I should be asking Ms. Dabros about the strategy to move forward.

Dr. David Butler-Jones: Are you talking about the alcohol strategy or about FASD? The strategy around FASD is within the agency. Sorry for the confusion.

● (1210)

Mrs. Patricia Davidson: And what is in—

Dr. David Butler-Jones: First nations on reserve therapy as well as the broader drug strategy, the Canada drug strategy.

Mrs. Patricia Davidson: Okay, thank you.

Dr. David Butler-Jones: Just to clarify again, and I hope this isn't redundant, decisions of financing and policy are made by cabinet and Treasury Board and Finance. They're not made by us. That's a longer-term issue.

The Chair: I think the comment was made that this is something that as a committee we may want to address as we perhaps follow this up with a report.

Nonetheless, let's carry on with questioning. I believe it's Madame Demers.

[*Translation*]

Ms. Nicole Demers (Laval, BQ): Thank you, Mr. Chairman.

Dr. Butler-Jones, you usually have answers to all questions, but you're surprising me today. You're confirming the apprehensions we had about a separate public health agency. As a result of the overlap, no one knows anything anymore. I've been watching for a while: a few words here, a few words there. No one is aware of anything whatever. That disappoints me enormously.

Last year, when you came to talk to us about fetal alcohol syndrome, we said that Aboriginals on reserves had major problems. Those problems haven't been solved. I believe the initial problem is poverty. Until that's been solved, we won't solve any other problems. That's not being discussed. In Quebec, for some 10 years now, pamphlets have been issued to all women who go to their doctors, to their obstetricians. Why is it so hard for Health Canada to inquire with Quebec and to ask for a brochure if it doesn't have the necessary money to do research? I don't understand, and I don't see how you can help people by publishing articles in a journal that's only read by doctors instead of doing something that would be read by the people concerned. I don't understand your actions, particularly since this little booklet is so beautiful, so poetic: vision for the future, imagine a world where all Canadians show compassion toward women. But before showing compassion toward women, you have to start by believing at the top, in the department, in the decision-making bodies. It seems to me that all this money has been spent pointlessly and that nothing has been done.

We don't have any actual statistics on the prevalence of fetal alcoholism. We don't know how many children really suffer from it. I don't understand that. How can it be that we don't have any actual data? I don't understand why, after investing so much money in this field, we are still at the dreaming and imagining stage, that we're not yet at the action stage. That really distresses me. As a woman, as a mother, as a grandmother, it distresses me to know that there are pregnant women today who will drink alcohol because they haven't had access to a pamphlet. It greatly saddens me.

Dr. David Butler-Jones: This is a major challenge in the public health field. Over the past decade, the emphasis has solely been placed on treatment, not on public health.

Now the federal and provincial governments are improving their public health activities, but it's impossible to do everything at the same time. They want to develop intervention capability, projects and other activities, all on a collaborative basis. You have concerns about the agency's role, that of the department and that of the other organization. The three are collaborating, and it was decided that the activities of Health Canada, those of the agency and those of the CIHR would be complementary and that there would not be any overlap. That's very important, because no organization can do everything.

● (1215)

Ms. Nicole Demers: But how can you adequately develop a program if you aren't aware of what Health Canada is doing? For some time now, you've been saying that you don't know, because Health Canada or the CIHR handle that. How can you develop an adequate program if you aren't aware?

Dr. David Butler-Jones: Each organization handles its own aspects, but all that is part of a comprehensive approach by the Government of Canada.

[*English*]

The Chair: Thank you.

Mr. Fletcher, and then Ms. Brown.

Mr. Steven Fletcher: I have a quick question, Dr. Jones.

Can you tell us to what extent the vision document is based on stakeholder consultations?

Dr. David Butler-Jones: It was developed collaboratively with stakeholders, with professionals, with PTs, and from looking at activities internationally.

Mr. Steven Fletcher: Okay, thank you.

The Chair: Ms. Brown.

Ms. Bonnie Brown (Oakville, Lib.): Thank you very much, and welcome to our guests.

On page 2 of your remarks, Dr. Butler-Jones, you say that many provinces and territories have identified this issue as one where they want the federal government to take leadership. I might point out that the paragraph would have been more accurate if it included this committee; this committee has been nagging about this subject for years and years and years.

Now on to my questions, Mr. Chairman. I wonder if Ms. Beckett could provide us with a list of the five research projects, the purpose and method of each, what they're actually searching for, and the amount assigned to each.

I don't mean I need it right now, but could you submit it on paper?

Ms. Barbara Beckett: Yes, I could certainly do that.

Ms. Bonnie Brown: Thank you very much.

What is the total amount dedicated to the anti-smoking campaign, the one where we see glorious ads on TV all the time. And who is responsible for that, or is it split as well?

[*Translation*]

Dr. David Butler-Jones: It's the Department of Health.

[*English*]

Ms. Linda Dabros: That is a Health Canada responsibility under the tobacco program.

Ms. Bonnie Brown: What is the total budget?

Ms. Linda Dabros: I don't have that information with me. I can get it for you.

Ms. Bonnie Brown: Could you get that, please, because I would like to do a comparison.

Ms. Linda Dabros: Are you looking for the full program or the moneys around public education only?

Ms. Bonnie Brown: The full program, but with the moneys around public education shown specifically within the full funding. Thank you.

Ms. Langlois suggested that she cooperates with the agency when she delivers essentially the same program to first nations people. I'm wondering if you cooperate to the point where you're actually promoting the same incorrect message, which is that no alcohol is safe during pregnancy.

Ms. Kathy Langlois: Actually, what I pointed out is that we collaborate on a grand level. For example, there are—

Ms. Bonnie Brown: No, I want you to comment on the message. Is your message based on that message, which in my view is incorrect?

Ms. Kathy Langlois: I think our message is more holistic when we work with first nations and Inuit communities. We talk about having health and all the things it takes to be healthy, and—

Ms. Bonnie Brown: You tell young women of child-bearing age that they should not be drinking if they're not using birth control.

Ms. Kathy Langlois: I'm not exactly sure of the specific message, but I can check and get back to you on that. I know we do talk about a healthy lifestyle—

Ms. Bonnie Brown: You're in charge of the program and you don't know what the message is?

Ms. Kathy Langlois: We're talking about a healthy lifestyle; we're talking about women at risk who are already drinking, and we talk to them about the harms it does to their baby. That is the key message in our program.

I also explained that when we did our opinion survey, we asked them if they understood that stopping the use of alcohol was an important factor in increasing the likelihood of healthy babies. That is not—

Ms. Bonnie Brown: And 85% of them said yes.

Ms. Kathy Langlois: Eighty-six percent of first nations said yes and 79% of Inuit said yes.

Ms. Bonnie Brown: Yes, but that could mean that once they think they are pregnant, and the doctor has told them they are pregnant, then they have to stop drinking—but as Mr. Szabo pointed out, between day 15 and 22, before they know they're pregnant, is when the serious damage is done. So that's why I'm asking you this.

Despite the fact this message is agreed upon by provinces, territories, and the Public Health Agency, it would seem to me that you are dealing with an at-risk population and that you should have the correct message. Are you willing to break from that message, which is incorrect, and give the correct message to your clientele?

Ms. Kathy Langlois: In fact, during earlier proceedings, I made a note for myself to go back and ensure we had the accurate message.

Dr. David Butler-Jones: Can I just supplement that very briefly?

At the UN in 2003, the position we took—which is our continuing position, and which I'm sorry wasn't reflected in the remarks clearly—is that if you're thinking about becoming pregnant, or are pregnant, you should have no alcohol. I would extend that to being, if there's a possibility of pregnancy, you should have no alcohol either. That's the message. Now on some liquor bags, in some campaigns that are provincial, or whatever, they may just say that if you're pregnant, no alcohol. But that's not the position we put forward.

On the issue of promotion, etc., the PTs have promotions. They've not asked for federal engagement on that.

● (1220)

Ms. Bonnie Brown: However, they have asked for leadership, and you imply in your remarks that your message is the message they've all agreed to—and that message is incorrect.

We're not as interested in what we said at the UN as we are in what all our people are saying together, so that the basic premise of all the advertising and messaging is the same and that it's correct. Can some work be done to modify the message as it's articulated on page 6?

Dr. David Butler-Jones: Absolutely, because that is the intent of the wording, that if you're thinking about becoming pregnant, or if it's possible that you are pregnant, then you have to be avoiding alcohol.

The Chair: Thank you, Madam Brown. Your time is gone.

Mr. Batters.

Mr. Dave Batters: Thank you very much, Mr. Chair.

I have a couple of quick questions for Dr. Butler-Jones.

Although you work under the minister, as the Chief Public Health Officer in the country you have a dual role in that you can issue reports to Parliament that are tabled in Parliament, that speak to the Canadian people about areas of concern for public health. If the evidence presented today is any indication, this perhaps needs some attention. Would you consider taking up your role as the Chief Public Health Officer, show that leadership, and issue a report as to what you think should be done on this very important subject? There seems to be some hesitancy or some inconsistency as to where we're headed, as I think Ms. Davidson pointed out. Would you consider that?

Dr. David Butler-Jones: Absolutely.

Mr. Dave Batters: Thank you.

I have a quick question. Has the department or agency developed the lifetime costs, up to age 65 years of age, for example, for individual Canadians with FASD? Do we have any costing of this condition?

Dr. David Butler-Jones: The cost estimate that's used in the U.S. and Canada is $1.5 million.

Mr. Dave Batters: Is that the lifetime cost?

Dr. David Butler-Jones: It is the lifetime cost.

Mr. Dave Batters: That's $1.5 million. Thank you.

How does the cost of caring for a child and then later an adult with FASD compare to the amount of money spent on prevention efforts? Could you speak to that?

Dr. David Butler-Jones: Not unusually, the efforts on prevention underestimate the impact they would have.

Mr. Dave Batters: Okay.

Last question, Mr. Chair.

There was some work done in the prairie provinces—I think it was in Manitoba, Alberta, and Saskatchewan—regarding the number of people who are currently incarcerated or have been incarcerated who suffer from FASD. I believe it was something in the neighbourhood of 50% of the people in our prison system.

Do you have research, which you consider correct, on the number of prisoners in our penal institutions that have FASD, obviously at an immense cost in terms of the human cost and the financial cost of crime and then the cost of incarcerating these individuals? Do you have research in that area that you'd like to speak about?

Dr. David Butler-Jones: That figure is one that's often used. It depends on the jurisdiction. We'll have to get back to you through the Correctional Service in terms of their view of the accurate number.

Clearly, one of the challenges of fetal alcohol syndrome is the inability to make the link between actions and consequences and to learn from that. That often leads to the situation where people are in conflict with the law repeatedly as a result.

Mr. Dave Batters: I have one more real quick comment, Mr. Chair.

If that is indeed the case, that 50%, perhaps, of our prisoners in this country suffer from FASD, then we have a massive problem on our hands. If we can address it, and you've indicated that you're willing to show this leadership, Dr. Butler-Jones, then this certainly fits in with the goal of this government and all parliamentarians and all Canadians to reduce crime, as well as to cut down on what Dr. Fry called the human wastage, the terrible potential that's lost as a result of this very preventable condition.

So I look forward to seeing your report at some point, sir.

Thank you very much, Mr. Chair.

● (1225)

The Chair: Just to follow up on that, you said you would be prepared to do a report. Can you tell us how quickly you could make that happen?

Dr. David Butler-Jones: We'll have to look at that in terms of capacity and focus and other activities the government is engaged in.

The Chair: The reason I'm asking is that I'm going to try to encourage the committee to actually do a report on this as well, but it would be valuable for us to have your ideas as part of that.

Dr. David Butler-Jones: Certainly I would be pleased to engage in that conversation to whatever extent is useful for the committee. In terms of a chief medical officer report, that's a timing issue that I can't predict at the moment. I'm sure the committee would like to report probably in advance of when I could do that. So I would be happy to collaborate or cooperate as you see fit.

Mr. Dave Batters: Thank you.

The Chair: Madame Gagnon.

[*Translation*]

Ms. Christiane Gagnon: Mr. Butler-Jones, let's go back to page 4 of your speaking notes. You say that many provinces and territories have identified fetal alcoholism as a serious issue for their governments to address and have developed strategies to address fetal alcoholism and have also called upon the Government of Canada to demonstrate leadership and to develop a federal strategy. Those are your words. I'd like to have a little more explanation on what has raised interest in a national strategy. Tell me what provinces have made these observations and in what order they detected certain problems they were incapable of solving. Why did they have trouble achieving certain objectives? Is it because this is a growing phenomenon? Is it because they don't want to put a strategy in place? I find it hard to imagine Quebec calling on the federal government to develop a national strategy in this area. Have all the provinces called on the federal government? Is it one province or two? Since public education, advertising and awareness campaigns and the enforcement of health regulations fall under provincial jurisdiction, that must be done in the provinces. What is the problem causing the provinces to call upon the federal government?

Dr. David Butler-Jones: The situation differs from province to province. Their capability and approach are very different. For the provinces and territories, the notion of leadership by the federal government includes a process of facilitation and collaboration so that they have assurances that diagnosis and approach will be the same. That can also facilitate their access to international information. They aren't asking the federal government to do programs for the provinces, because that's a responsibility of the provinces and territories. Collaboration between the federal government and the Public Health Agency of Canada improves the program and facilitates collaboration among the parts of the nation.

Ms. Christiane Gagnon: You're talking about developing a federal strategy because that's what you've been asked to do. Tell me clearly and specifically at what level you will act. What problem have you identified? When you ask the federal government to develop a federal strategy, it's because a problem has been identified by a large number of provinces. I'm trying to see where the problem in general is.

In Quebec, there have been regulations and acts. There is Éduc'alcool. We have a way of doing things in Quebec. We've taken action, and an action plan was put in place in 2006. I'd like to know where you're headed. Are you informed enough to prepare a national strategy that responds to a set of problems? The provinces may have adopted different ways of doing things, but that may be producing results. The results of Quebec's strategy may be good. Why is it you're going to contribute to that?

In reading the various files and gathering information, I learned that clienteles are targeted, that certain population segments are at greater risk. Reference is also made to alcoholism. You know how hard it is for an alcoholic to stop drinking: it's a disease. It's often in the family; it's transmitted from generation to generation. So it's very hard. I wonder in what area you'll be taking action.

● (1230)

Dr. David Butler-Jones: It's a joint federal-provincial strategy. That's our contribution. Federal activities are a complement to provincial and territorial activities. Those activities depend on the jurisdiction in question, on capability and on other stakeholders working in the collaborative effort.

Ms. Christiane Gagnon: Didn't the provinces ask you instead for money to assist them in establishing programs? If you develop a federal strategy, funding has to be distributed to the various provinces for that purpose. If you say you're not going to do the programs and that you won't implement them, how are you going to...

[*English*]

The Chair: Okay, your time has actually gone, but I'll ask for a very quick answer to that.

[*Translation*]

Dr. David Butler-Jones: It's a collaborative effort. We allocate funding to federal activities, and the provinces allocate funding to their activities. There isn't a single strategy imposed by one order of government on the other. The various strategies complement each other.

[*English*]

The Chair: Thank you.

Mr. Fletcher.

Mr. Steven Fletcher: Thank you, Mr. Chair.

We're getting a sense of some frustration around the committee; however, now being on the government side, I have been able to witness firsthand the dedication that the bureaucracy and you, Dr. Butler-Jones, have in trying to resolve this issue.

I can understand my colleague Mr. Batters' frustration of 10 years of Liberal inaction, but this government takes this very, very seriously. I'm wondering what we can do, what resources this government can provide you and Health Canada to work to make the best impact possible to help prevent FASD.

Dr. David Butler-Jones: Well, I very much appreciate the offer.

It is, as I reflected earlier, a matter of policy and financing of cabinet and others and their authorities, so I'll defer to them, but certainly we will engage in the conversation that will lead to whatever this government might choose to pursue.

Thank you.

The Chair: Ms. Priddy.

Ms. Penny Priddy: Thank you, Mr. Chair.

I have four points I'd like to make. One of them is, if I were pulling together stakeholders to ask about this, there are moms who will talk about the fact that they binge-drank when they were pregnant and as a result had a baby with FASD. So other than the higher-level people, I would actually ask the people who had engaged in the activity about what kind of information or what kind of mentoring might have prevented that activity.

My second point is, these are lovely. The brochures in the doctor's office are lovely, and often they are, and sometimes people read them, but let's remember a large part of this country is not literate, although you did make the point. We have to get information out in other ways, assuming that not everybody is able to pick up the fancy brochure and read it. By the way, in languages, there is no point in my picking up the English brochure if all I speak is Punjabi. So that's one of the points I'd make.

Let me put my previous minister of health, or minister of education, or minister of labour hat on, or whatever they give you when they can't find the job that would fit for you, and say that without empirical evidence, I have no way, as a minister in a province, of budgeting for what kinds of resources I'm going to need, either in the education system, in the post-secondary system, or in—I hope not—the prison system, but at least in the rehabilitation part of the corrections system. So without any kind of empirical evidence, I can't budget. This becomes one more very large piece when you talk about $1.5 million—although I don't think most people with FASD live to be 65. This is not my understanding, so I think that is an age that probably is further.... Without that information, I can't budget and I'm not going to have enough money to be able to provide the services people need, because it is a reasonably new item, although 20 years old, but reasonably new in budgets.

So those are the things that concern me. If you could comment on those, I'd appreciate it. Thank you.

● (1235)

Dr. David Butler-Jones: Certainly, and I'll pass it over to Kathy in just half a minute.

Certainly the service delivery at the provincial level is challenged by that. We also, in a complementary way with the provinces, fund local projects that work with communities and engage the individuals, as you've talked about. Actually, there are quite a few across the country. But they also develop answers, strategies, etc., that then can be used by other community groups in terms of modules for training in community colleges as well as activities and programs at the community level that we share across the country, for example, children's programs, etc.

So there are a number of activities that are going on in that.

I'll just turn it quickly over to Kathy.

Ms. Kathy Langlois: Yes, just quickly, with regard to engaging women who've engaged in the activity already, that is the basis of our mentoring program. We look for experienced mothers in the community who've walked that road and who have recovered and are prepared to take on the challenge of working with women at risk.

With regard to literacy, that is exactly the reason for working with communities and asking what the best way is to communicate around the issue of FAS. We've had examples where communities have decided to bring women together in a community kitchen environment, where an elder will speak to them about alcohol and the impact it will have on a developing child.

I would just say that with regard to empirical evidence, this is where we are pinning our hopes on the diagnostic work that the Public Health Agency is leading, because as you build the evidence in diagnosis, you will build the evidence base of the prevalence and you will know whether it's going up or down and whether our programs in our communities are having any impact. We look forward to that.

The Chair: Thank you.

Ms. Brown

Ms. Bonnie Brown: Thank you very much. I think it will be pretty instructive when we get the answer to my question about the amount spent on anti-smoking and then we can compare the two. I think you'll find that what is spent on this is absolutely minuscule, comparatively speaking. Look at the success we've had with the anti-smoking campaign and the second-hand smoke and all those kinds of things. If you put in the money, you get the impact.

But I wanted to go back to Dr. Butler-Jones. He kept talking about how resources and allocation of responsibilities are a political decision, a cabinet decision. I think you can hear around the table that we find it pretty frustrating that there's some money here and there's some money there, and different people are in charge of that money. I always find when responsibility is shared, nobody is really responsible.

So I want to ask Dr. Butler-Jones, considering that this has a great deal to do with disease prevention and health promotion, is that the vision he has for the agency? I know the agency's new, it's just growing, and you have to grow at a rate that is manageable. But 20 years from now, do you envisage a public health agency in Canada that is something like the Surgeon General's office in the United States, which is responsible for leading the charge in public education? Even its website is tremendously impressive.

Is that what you see for yourself eventually, that all the prevention-promotion activities will come under the Public Health Agency and your role will be somewhat like that of the Surgeon General?

● (1240)

Dr. David Butler-Jones: The role is somewhat of a combination of the role of the Surgeon General, in terms of its public role, and the head of the Centers for Disease Control.

In terms of the role of the agency itself, there are many players. In public health, it isn't any one. Going back to tobacco control—because I've been around this for a long time—it was the municipalities and local health units. It was provincial, federal, and NGOs and others that actually came together to take different pieces of it to move that agenda forward. But it took 20, 30 years. I'm not sure we have 20 or 30 years in terms of fetal alcohol, so we need to find strategies. But again, we need to respect the jurisdictions, respect the different roles that the players, even within the federal system, play.

The issue of having different points in the system that have different pieces of it does not mean there's no coordination. Your concern is absolutely right that we need to actually come at it as a federal family with a coherent voice, but also with our partners across the voluntary sector and the provinces and territories. So in that sense, I think there really is a desire. Clearly, this committee has expressed its very strong.... “Desire” is too mild a word in terms of forward movement on this. We look forward to continuing in that direction.

Thank you.

Ms. Bonnie Brown: You still didn't tell me if your vision for the agency is that it will be in charge eventually. I don't mean in charge over provincial jurisdiction, but as the main federal voice and receiver of the moneys to dispense on health promotion and disease prevention.

Dr. David Butler-Jones: Quite honestly, at this point, as it's articulated in the legislation, certainly my role is key adviser to governments and of the agency as a key focal point, but to have everything under one I don't think would do it. I think there are elements and expertise that lie outside of the agency, and we need to find ways to ensure that there is a coherent voice. There may be other programs and activities appropriate to the agency that are elsewhere, but that's for future discussion. Anyway, I'm not a kingmaker.

Ms. Bonnie Brown: You're unlike some of your colleagues in the sense that you have no desire to build an empire here.

Dr. David Butler-Jones: Empires usually don't work well.

The Chair: Kings usually get slain; that's the problem.

Madame Demers.

[*Translation*]

Ms. Nicole Demers: Thank you, Mr. Chairman.

Ms. Langlois, I'm pleased that you referred to mentoring. It's an effective method. It's easier for women who have this problem to listen to other women who have experienced it. Can you tell me in how many places this is being done and how many women you can currently count on to do the mentoring?

Ms. Kathy Langlois: With the funding we have, we'll be offering the program in 30 places across the country. We drew on the model developed in Manitoba to set up the program, which serves 20 to 30 women.

Ms. Nicole Demers: I was asking how many women were acting as mentors.

Ms. Kathy Langlois: We have three or four mentors for 15 to 20 women.

Ms. Nicole Demers: Thank you.

[*English*]

The Chair: Thank you.

We have Ms. Fry.

Hon. Hedy Fry: Thanks.

I know you don't want to be a kingmaker, Dr. Butler-Jones, or queenmaker for that matter, but I do think there should be...and I have always felt this, so the fact that I differ on what this Public Health Agency is going to look like is not for lack of trying. I believe the Chief Public Health Officer of Canada should not be restricted by being a bureaucrat. I think he or she should be someone who becomes an advocate for the health status of Canadians, in every single way.

I understood you were going to take over, or this agency would take over, much of the work of the population health agency, or the population health strategies that went on in the Department of Health. I think that while I agree with you that coordination is absolutely important—and obviously provincial jurisdictions and all of that must be taken into consideration—I think you can duplicate a lot at the federal level if you have too many people doing the same things within the same department. I think there has to be one person who has to set the strategy and has to be responsible for it at the end of the day, or if it doesn't happen, unlike a bureaucrat, they must be able to say: this isn't working, I don't think this is appropriate, we should set these kinds of goals, and this is not right. One can't do that if one is trying to wear two hats. So that concerns me.

I would like to see, for instance, the Public Health Agency set measurable goals—10-year goals for achieving health status, for achieving population health, for bringing down FASD. However, how can you do that if you don't even have incidence currently?

I go back to my question: is there a role that the federal government sees itself playing as being the clearinghouse for bringing together evidence from the provinces and putting it in one place, for setting up a national incidence levels...and then using that to set measurable goals for 10 years for bringing down the incidence of FASD in Canada?

The second question I want to ask is to the Department of Health. That is, are you working horizontally with Correctional Service Canada, with the RCMP, and with other agencies that look after criminality, etc., again to train them to understand the different behaviour patterns of people with FASD, as opposed to a criminal?

There is a real difference between the two. A lot of these young people go to jail because they are thought to be criminals when really they are not. There is a certain level of mental competence that they don't possess and a certain level of behavioural problems they have that need to be identified. So you don't criminalize what in effect is a health syndrome. This is a question I want Health Canada to answer: are you working across...?

I'd like Dr. Butler-Jones to answer about whether he sees the federal government having a role and whether he's going to take that role on.

● (1245)

Dr. David Butler-Jones: Our sense and our clear mandate is that we are the lead. The Public Health Agency is the lead on this file and other departments look to us in terms of the overall strategy. As I say, we don't currently have a policy or funding to address some of those elements.

In terms of the role of the Chief Public Health Officer in the legislation, which we discussed the last time we met, the dual role of deputy and to speak independently is actually taken seriously. There is always the risk of conflict between those two roles. But in the debate that led up to the establishment of the agency, it was viewed as more important to have that position as part of government, within government, and the ability to influence development policy, etc., than to have it seen as independent and then risk marginalization as a result of that.

It was a trade-off; it was a debate, and that's where we've ended up. I think it's very important in my role that I do speak to public health issues independently, as need be, but also to actually have the programmatic levers to try to deliver, as an organization, on those issues to the extent that we have the mandate and resources to do so.

In terms of the issue of the criminal justice system, etc., it's absolutely true. Many of these kids, quite honestly, because of the nature of the deficit, don't make the connection. It's not that they want to do bad things, but they don't make the connection. They don't even recognize it when it happens. But that's a larger challenge that we can't deal with directly. I know the criminal justice system is trying alternate ways of dealing with these situations, but it is something that collectively we need to do, and the more we can do to prevent the problem in the first place, a whole lot of kids—adults later on— will be better off.

The Chair: One more quick question.

Hon. Hedy Fry: Prevention is the long-term strategy, but right now we have people in the system who have FASD, and I haven't had my question answered as to whether or not Health Canada is working horizontally. I remember that our government tried to develop horizontal structures within government, so that the health department would work cross-wise with the justice system in order to train police officers, to train corrections officers. Has any of that been done?

Dr. David Butler-Jones: There is an interdepartmental committee, and, yes, there has been training, work with RCMP, police, corrections, lawyers, judges, and people operating homeless shelters. So there are activities that have been ongoing to this point.

On the issue of surveillance, as Kathy referred to earlier, we now have diagnostic guidelines, so we now have a standard upon which we can develop surveillance systems over time, hopefully, and have baseline data in order to be able to track it, as well as recognize and evaluate what works and what doesn't work and in what settings. Again, the settings differ across the country.

● (1250)

The Chair: I think that takes us to the end of the questioning.

I want to thank Dr. David Butler-Jones for coming in. I thank the Canadian Institutes of Health Research as well as the Department of Health for being witnesses here and contributing to the debate. I hope you get a sense, first of all, of the frustration of the committee, and also the passion of the committee to actually get something done with regard to fetal alcohol spectrum disorder. I hope you don't see us as the enemy. I believe we are actually all pushing for the same thing, although there is some frustration in not getting things done as fast as we should. I think that's fair, from all sides of the table, in understanding and discerning that.

I believe we will be issuing a report on this, and that'll likely happen, hopefully, next week, but I want to thank you for coming in and contributing to this.

Thank you.

To the committee, for your information the researchers will have a report ready for us likely by next week. Perhaps we can extend the meeting when the minister is here June 6 from 1 p.m. to 1.30 p.m. to review that report, and hopefully approve it and table it.

Madam Gagnon, I made a commitment to you to make sure that you understood what we were doing before an action item was to take place. Are you okay with that?

Ms. Christiane Gagnon: *Oui*.

The Chair: Fair enough.

This meeting is adjourned.

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