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Chair

Mr. Mike Wallace

Standing Committee on Justice and Human Rights

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● (1530)

[*English*]

The Chair (Mr. Mike Wallace (Burlington, CPC)): I'm going to call this meeting to order. This is the Standing Committee on Justice and Human Rights, meeting number 67. According to the orders of the day we're dealing with the order of reference of Wednesday, November 26, 2014. The subject matter is Bill C-583, an act to amend the Criminal Code, regarding fetal alcohol spectrum disorder.

We have a number of witnesses today. I'm going to do a little housekeeping first if you don't mind, committee. We did invite everybody back who was at the last meeting, at which we were interrupted with numerous votes. One person is joining us in the second hour and a half who had given their presentation but we didn't give an opportunity to ask questions. Three of the witnesses in the second hour are on video conference, so it will take a few minutes to get that set up, and we have a fourth witness who will be here with us in the room.

We have two witnesses with us today, but let me start with this. Technically the committee is to report back to the House on Thursday. There is no way that we're going to have a report by Thursday. My recommendation to the committee is that we ask for an extension of 45 days. We'll do it within 45 days, but that's the maximum we can ask for. We'll get a motion here and it will go to the House. It will get voted on, I guess. I could ask for unanimous consent to see if we could get it done that way. It's one less voting round for us. I need a motion to that effect. If we pass it today I would bring it to the House tomorrow, and we would have it passed before Thursday.

Mr. Bob Dechert (Mississauga—Erindale, CPC): I so move.

(Motion agreed to)

The Chair: Thank you very much.

The other thing I wanted to let you know is that we have four meetings in this section before there's another constituency week. The mover of the motion that we postpone Bill C-587, increasing parole ineligibility, has come back to me and asked that we do clause-by-clause on it, which is fair. We were about to do it but he asked to look at the bill, and he wants it done now. I have scheduled next Monday to do clause-by-clause on Bill C-587, the parole ineligibility act.

Next Wednesday after that I think we should have a subcommittee on agenda. I can't get the minister here. I thought I could get the minister here to start Bill C-35, Quanto's law, but I can't get him here because he's not available that day. What I thought we would do is get together as a subcommittee, figure out the schedule for the last eight weeks, and I'll do my best to find out when the minister is available for mains and for Quanto's Law, and all that. That is the schedule unless you have any questions.

We're dealing with this today. We're dealing with it on Wednesday with more witnesses, then clause-by-clause on Bill C-587, and then a subcommittee on agenda in these two weeks. Okay, thank you very much. Thank you for your patience on that.

Our witnesses today for the first hour are from the Office of the Correctional Investigator. Mr. Sapers is the correctional investigator and Mr. Zinger is the executive director and general counsel. The floor is yours for 10 minutes or longer, if you need it.

The floor is yours.

Mr. Howard Sapers (Correctional Investigator, Office of the Correctional Investigator): Thank you very much, Mr. Chair. I appreciate it.

Thank you, committee, for the invitation to appear before you this afternoon in the context of your study of Bill C-583.

I'll speak about some of what it is that we know about the prevalence of fetal alcohol spectrum disorder, and as important, some of what it is that we don't know about the disorder in corrections, and the specific outcomes for federally sentenced offenders affected by fetal alcohol spectrum disorder. I'll comment on the capacity of the Correctional Service of Canada to meet rising mental health care demands in federal prisons, and conclude with some considerations that I believe are relevant to your study of this proposed legislation.

With respect to the prevalence of FAS disorders amongst individuals involved in the criminal justice system, there is no one conclusive or confident dataset, though it is an area that has attracted more research and attention in recent years. Estimates for FAS-disordered individuals amongst correctional populations vary significantly, with numbers typically ranging from about one in 10 to nearly one in four.

It is difficult to reliably establish prevalence rates in correctional settings as there is considerable variation in methods of diagnosis, testing, and case identification. It is complicated by the need for some diagnoses to confirm a history of maternal drinking in a population who were often the victims of abuse, neglect, or subject to intervention by child protection authorities. The impact and interplay of socio-economic factors and criminal justice system involvement in disadvantaged settings suggests that FASD is a substantial problem among youth and adult correctional populations. FASD is a lifelong, clinically recognized disability; an afflicted person does not outgrow their brain injury.

The research to date suggests that individuals with FASD are at increased risk of coming into contact with the criminal justice system due to neuropsychological deficits in judgment, difficulty understanding consequences of behaviour, inability to make connections between cause and effect, impulsivity, drug or alcohol misuse, and a failure to learn from past mistakes. The range of cognitive deficits that characterize FASD have important legal and practical implications for the criminal justice system.

As a group these individuals challenge some of the underlying premises of sentencing, namely that defendants understand the relationship between actions, outcomes, guilt, culpability, and punishment. The response of the criminal justice system may, in fact, exacerbate individual difficulties associated with fetal alcohol spectrum disorder. For example, sending an FASD-affected person to jail to "learn a lesson" may be an exercise in futility. A sentence founded on specific or general deterrence is not likely to be meaningful for an FASD person.

In 2011 the Correctional Service of Canada conducted one of its first comprehensive research studies of FASD prevalence in federal corrections. It found that amongst a sample of newly admitted adult male offenders aged 30 and under, 10% of the participants met the criteria for a diagnosis of FASD. Another 15% of the sample met some of the diagnostic criteria, but were missing information critical to making or ruling out a positive diagnosis. The rate of FASD amongst this sample is 10 times higher than the current general Canadian incidence estimate, which according to Health Canada is about nine in 1,000.

The research also demonstrates that those diagnosed with FASD had a higher risk and needs rating compared to other offenders. FASD-affected offenders had severe neuropsychological deficits in attention, executive functioning, and adaptive behaviour. They were much more likely to have had multiple convictions and previous periods of incarceration as both youth and adults. Offenders with FASD have more problems adjusting while incarcerated. They are less likely to have completed school, and more likely to have dropped out at an earlier age than other offenders. They are more likely to report a personal and family history of abuse, substance abuse, and delinquency.

Research confirms another important finding that goes to stigma and perception, which is that the level of violence used during the commission of their crimes was not markedly different from non-FASD affected offenders.

● (1535)

Significantly, none of the offenders diagnosed in this research study had been previously identified as being FASD-affected. As the research concludes:

> There is a population...within Correctional Service Canada who are affected by FASD who are currently not being recognized upon intake, and are not being offered the types of services or programs that meet their unique needs.... Screening to identify those at risk for an FASD is necessary and has been demonstrated as feasible in a correctional context.

Four years later, Corrections Canada still does not routinely screen for FAS disorder among newly admitted, federally sentenced offenders. This is a vulnerable population with significant mental health and behavioural needs. More recent CSC research confirms that those with FASD exhibit deficits that impact their ability to adjust to an institutional setting. As such, they are more likely to be involved in institutional incidents, both as instigators and as victims, and to incur institutional charges. They complete their correctional programs at much lower rates and they typically spend more of their sentence incarcerated before their first release. Offenders with FASD are more likely to be returned to the community on statutory release.

The unfortunate reality is that most FASD-affected offenders come into prison undiagnosed and untreated, and they remain that way. There is very little programming for affected adults in the community and there are no correctional programs specifically for offenders with FASD. CSC can and does adapt interventions to accommodate needs. There is evidence to suggest that individuals with FASD can benefit from programs that are structured, highly repetitive, and that use multiple delivery modalities.

I will conclude my remarks with a cautionary note. Bill C-583 contemplates an amendment to the Criminal Code that would require the courts to consider as a mitigating factor in sentencing a determination that the accused suffers from FASD. It is a proposed change to sentencing principles that is similar in intent to paragraph 718.2(e) of the Criminal Code, which was enacted in 1996 and which expresses the need for judges to consider all other sentencing alternatives before sending an offender to prison, with particular consideration for the circumstances of aboriginal people. The seminal Supreme Court of Canada decision in R. v. Gladue, 1999, interpreted this provision as a remedial measure aimed at combatting the overrepresentation of aboriginal peoples in Canadian prisons. Though the intent of paragraph 718.2(e) was to show restraint in the use of incarceration, the outcome of this measure has not lived up to the optimism about it.

When the Criminal Code was amended in 1996, aboriginal people represented 15% of the total offender population. Today, almost 25% of the federal inmate population is of aboriginal ancestry. These trends are accelerating. In fact, the incarcerated aboriginal population has increased by more than 50% in the last 10 years. If there has been judicial restraint, it has not translated into an actual decrease in the number of aboriginal people being sent to Canadian jails and prisons.

A correctional system that relies on obeying orders and rules that incentivize appropriate conduct and requires an offender to demonstrate behavioural progress is not particularly accommodating to persons afflicted with FASD. Similarly, a parole and pardon system that is predicated on the need and capacity to express remorse and learn from past mistakes is also not well-suited to FASD-affected persons.

I have suggested that the challenges faced by FASD-disordered individuals are largely at odds with the purposes of sentencing and incarceration. It is one thing to shed light on the causal factors that may have brought an FASD-afflicted person before the courts. It is quite another to have in place upstream diversion and treatment programs, services and supports in the community that could provide the courts with an appropriate disposition other than incarceration. Sentencing is a back-end measure. There is a need for screening and diagnostic services to be made available to FASD-afflicted persons at first contact with the criminal justice system. Prevention and diversion should be front-end considerations. By the time a case makes it to sentencing, options other than incarceration have become considerably restricted.

● (1540)

Notwithstanding these concerns, it may well be time to consider broadening the definition of mitigating factors at sentencing to include all forms of mental illness and disability, not just FASD. Such consideration, while late, would certainly be better than never.

Thank you very much for your attention. I look forward to your questions.

The Chair: Thank you for that presentation.

We are going to questions now. Our first questioner is Madam Boivin from the New Democratic Party.

[*Translation*]

Ms. Françoise Boivin (Gatineau, NDP): Thank you, Mr. Chair.

Thank you, Mr. Sapers.

That was extremely interesting, albeit a little discouraging too. You reviewed the implications of the Gladue case very well. The reality does not seem to correspond to what was anticipated at the time. We are now studying Bill C-583, An Act to amend the Criminal Code (fetal alcohol spectrum disorder). We are just studying it in broad terms.

You are aware of the recommendations that the Canadian Bar Association has made, starting in 2010, about fetal alcohol spectrum disorder (FASD). The association came back to the issue in 2013 with five very specific recommendations dealing with what correctional services must do. You say that definition perhaps should be broader, and I understand that, but we have to start somewhere because the situation just seems to be becoming more tragic.

Before you made your presentation, you were surely aware of the bill Mr. Leef has introduced, Bill C-583.

Do you think that the bill could help to improve the situation?

● (1545)

Dr. Ivan Zinger (Executive Director and General Counsel, Office of the Correctional Investigator): I think that our office's position is simply expressed by noting that we are a little concerned by the situation. I have to say that an amendment of that kind may well fail to produce the desired results and I compare that with the previous provisions for Aboriginal people, which did not produce the desired results either—

Ms. Françoise Boivin: But how do you explain that? As I understand it, you do not think that Bill C-583 will change a thing. As the Aboriginal prison population has increased, it seems that the principles of the Gladue case have not borne fruit. That is what I understand from Mr. Sapers' presentation.

Has there been any analysis of the reasons why it has not worked? Is it because it has not been talked about during the trials, because the courts have not considered it? Do we have any data, or do we take it for granted that, notwithstanding the Gladue case, courts just send people to prison? Does that suggest that, even with FASD, the principles of Bill C-583 would not change anything at all? It seems to me that the statements of principles in the bill are pretty solid.

Dr. Ivan Zinger: We certainly do not wish to dismiss everything out of hand and pretend that nothing in it is going to work. We just want to tell you that we must not see it as the only solution. The problem is that, in it, we are trying to intervene at the end of the process, at sentencing. All kinds of things could be done beforehand. We are actually just trying to point out that, if we worked more proactively, we would not be in the situation we now find ourselves in.

Ms. Françoise Boivin: I understand that.

Dr. Ivan Zinger: We cannot ask correctional services to try to solve a problem that should have been settled in the community, with more adequate screening services.

Ms. Françoise Boivin: But, Mr. Zinger, Bill C-583 provides for that proactive work, not just the punishment aspect of the sentence. It is also a matter of what aspects the judges see. Bill C-583 goes further; it is much more complete. The matter of the syndrome can be included and put before the court, which will then adapt the sentence.

Is that not a new way of working proactively?

Dr. Ivan Zinger: As Mr. Sapers clearly said, there is some value in it and it could even be expanded to include mental health problems or cognitive deficits. There are a lot of them. For example, a study by Correctional Service Canada suggests that 45% of federally sentenced offenders have neurological conditions.

So this is a little late; the process is well advanced. Clearly, it will make a small difference. However, if we compare that with what happened with the treatment of the Aboriginal people, it perhaps slowed the process down, but it certainly did not succeed in reaching the ultimate goal of reducing their incarceration rate, which is much higher that one might expect when compared to the general population.

● (1550)

Ms. Françoise Boivin: So let me come back to the parallel I was drawing with the Canadian Bar Association's five recommendations. They urged the federal government to amend the Criminal Code based on five principles: that legislation should define FASD (that is in Bill C-583); that courts should be authorized to order assessments (that is also in Bill C-583); that FASD should be a mitigating factor in sentencing: that courts should be authorized to make orders for external support plans for those with FASD; and that Correctional Service Canada should be required to accommodate those with FASD receiving sentences of two years and more.

That background seems well reflected in Mr. Leef's bill. It seems to include it all, in an overall way, starting from the time when a person enters the legal system because they are charged with something.

Dr. Ivan Zinger: You are right.

However, we have to consider what happens prior to that, before the person is faced with the correctional services. Of course, they could do a lot better and provide many more services to a population with fetal alcohol syndrome disorders.

But, as I have already told you, it is really late, the process is already well advanced.

Ms. Françoise Boivin: So you would like to become involved before a crime is committed. However, that is not a matter for this committee because we are discussing offences and the Criminal Code. Nevertheless, I understand your point of view. You would like offenders not to get to the point of committing an offence that causes the justice system to become responsible for them.

Dr. Ivan Zinger: Yes, or that much more should be done to try to steer them into a system other than the criminal justice system.

[*English*]

The Chair: Thank you for those questions and answers.

Our next questioner, from the Conservative Party, is Monsieur Goguen.

Mr. Robert Goguen (Moncton—Riverview—Dieppe, CPC): Thank you, Mr. Chair.

Thank you to the witnesses for coming and giving us their testimony today.

Mr. Sapers, I heard you say that there is no particular program in the federal system for people who are identified with FASD. That's what I understood.

I suspect that some offenders, before going into the federal system, would go through the provincial system of justice and incarceration. Are there any provinces that have any programs? Is there anything out there?

Mr. Howard Sapers: Thank you for your question.

I'm not familiar with the range of programs offered by all of the provinces and territories. I do know, though, that their system has some of the same challenges that the federal system has, and that is in utilizing screening tools that are appropriate for a correctional environment. That's why about four years ago, the Correctional Service of Canada conducted the pilot project to see whether a simple checklist approach could work to help identify the at-risk population. There are community-based initiatives for dealing with fetal alcohol spectrum-disordered individuals, but there are very few tailored correctional interventions.

The Correctional Service of Canada has actually put together a very good guide for staff, to provide them with advice and tips on how to deal with an FAS-affected individual. As I say, there has been some tailoring of more general programs. These are changes in the way the program is delivered so the programs are more easily integrated by the FASD individual. But there is not a "built from the bottom up" comprehensive array of interventions that have been designed for corrections and for people with FAS disorder.

Mr. Robert Goguen: Beyond some sort of program with some tips, is there any kind of formal training for corrections officers, police officers, judges, prosecutors, ambulance attendants?

Mr. Howard Sapers: I wish I had a more comprehensive knowledge. I don't know what happens for ambulance attendants or police officers, but I can tell you that in corrections there is general training in terms of mental health issues. The Correctional Service of Canada is doing a better job of delivering that training. Again, there are materials that are available as resources to staff, but there is not comprehensive or intensive training in terms of dealing with this population.

Mr. Robert Goguen: There's no curriculum on mental health, whether it be FASD or—

Mr. Howard Sapers: There is a curriculum on mental health. As I said, the Correctional Service of Canada has developed better training and is delivering that training increasingly, both in the initial training and also in refresher training, classroom-based and online, but it's about mental health and mental wellness more generally, not specifically about FASD.

● (1555)

Mr. Robert Goguen: I wasn't trying to throw you for a loop with the ambulance attendants. It's just that there are so many people out there who are afflicted with this, and there are so many occasions for different participants in society to interact with them. Knowing how to deal with the symptoms would definitely come as a benefit to most, right?

Mr. Howard Sapers: Absolutely, and I actually take your question to heart. It is related to the earlier question as well. Where do you intervene and where would we get the most value for an early intervention? Typically, prior to somebody coming into negative contact with the criminal justice system would be the place to do that. Often, people like ambulance attendants and police constables are the first contact for people. If there were resources that were available to them, other than arrest and charging, that would probably make a huge difference.

Mr. Robert Goguen: Even the social workers apprehending children of parents who have FASD would have to struggle with that, but enough said.

What kinds of impacts do you think more adequate training would have on the criminal justice system? Do you anticipate that it would have a significant impact in actually dealing with the rehabilitation of offenders struck with this?

Mr. Howard Sapers: If you'll permit me to speculate with you for just a minute, when I think this through, this is what occurs to me. We have a population of individuals whose lack of judgment and behaviour has brought them into conflict with the law. It's landed them in a federal penitentiary. That same behaviour that's linked to the disadvantage they have as a result of being FAS-disordered follows them into the institution, so that same lack of judgment, the same behavioural challenges, follows them into the institutional environment.

Prisons are really based on people being able to obey rules, follow instructions, and if you don't, you again bring negative attention to yourself. These are the individuals who are constantly running afoul of institutional rules and regulations, being charged with both minor and major infractions of institutional rules, perhaps receiving punitive sanctions inside because they've been charged with a major infraction where they've had to appear before an independent chairperson. These are folks who don't fare well in front of parole boards. They tend to spend longer time in higher security levels, and they tend to attract segregation placements, etc., so their correctional outcomes are compromised. That's a burden on the system, as well as being a burden on them. They're also more difficult to manage and more expensive for the system.

Mr. Robert Goguen: Your suggestion is that this type of a system wouldn't bring very good results in rehabilitating them.

Mr. Howard Sapers: I think that the ability for rehabilitative programming diminishes based on the ability of the individuals to successfully participate in the programs. What we do know from the little bit of research that's been done is that those people who we know are FAS-disordered have a lower participation and completion rate in those correctional programs.

Mr. Robert Goguen: When you suggest that FASD should be a factor in mitigation, would you go so far as to say that perhaps rehabilitation should be favoured in all instances with these people? Their sense of culpability really isn't there, not because they want it to be or don't want it to be but because they're afflicted.

Mr. Howard Sapers: I want to make sure that I understand your question. In terms of the emphasis on rehabilitation, I think that both aspects of the Correctional Service of Canada's dual mandate of safe custody and preparation for release start on the first day of the sentence, so engaging somebody in the array of programs and opportunities that will prepare them for safe release back to the community is very important. I think that the service will have to do that regardless of the neuropsychological health of the individual. But it's a matter of preparing that offender realistically and also providing programs that they're going to be able to benefit from based on their own intellectual abilities.

I think my colleague wanted to add something.

Dr. Ivan Zinger: With respect to correctional programs, the Correctional Service of Canada basically delivers cognitive behavioural treatment to many offenders. The treatments are based on three principles.

The first one is a risk principle, which states that more intensive treatment should be given to higher-risk offenders. The second one is the needs principle, which suggests that you should target criminogenic needs—areas that are linked with reoffending. The third is the one we're concerned with here. It is called the responsivity principle. It suggests that the style and mode of learning should be taken into account when delivering a program. When that is done, people with FASD can go through treatment successfully and make some gains and lower their recidivism rate.

The service is required to look at responsivity. That means, for example, that if there is a cultural element, it should deliver the program in cognizance of that different culture. But it also comprises the notion that any sort of cognitive impairment should also be taken into account. That might mean providing more repetition, being clearer and simpler in the delivery of the program, or focusing more on reinforcement.

You can have some good outcomes, but that result is predicated on the notion that you are screening people systemically to see what types of impairments they have and that you have the ability to adapt the programs. As Mr. Sapers said, there's no such thing as a program specifically for FASD currently in the system.

● (1600)

The Chair: Okay.

Thank you very much for those questions and answers.

The next questioner, from the Liberal Party, is Mr. Casey.

Mr. Sean Casey (Charlottetown, Lib.): Thank you, Mr. Chair.

Madam Boivin asked you about the recommendations of the Canadian Bar Association from a couple of years ago. I'd like to focus on one of those recommendations, because it is directed right to Corrections Canada and also because it wasn't in the piece of legislation that was withdrawn; Bill C-583 does not contain any reference to it.

Let me read to you the recommendation from the Canadian Bar Association of August 2013:

> The Corrections and Conditional Release Act should be amended to expressly require the Correctional Service of Canada to accommodate FASD as a disability when providing correctional services to inmates who have or likely have FASD.

Could I hear from you concerning your thoughts, recommendations, opportunities, limitations, or the advisability of including that recommendation in legislation—whatever comments you have with respect to that recommendation from the CBA, please?

Mr. Howard Sapers: Thank you.

It's a tall challenge for the Correctional Service of Canada. Over the years, we've made many recommendations that the Correctional Service of Canada tailor programs for individuals who face a variety of difficulties and challenges, whether they be age related, deficits that have resulted in some intellectual impairment or some physical impairment, or for people with different cultural backgrounds, etc.

The Correctional Service of Canada tries to accommodate all the needs that are identified but is also very focused on doing individual case management and case assessments. Every offender who comes into the system is screened and assessed. Criminogenic needs are identified and the kind of program plan that Dr. Zinger was talking about is developed based on the RNR model of program delivery. Programs are made available throughout an offender's sentence, and again, hopefully to prepare them for safe release.

The difficulty in accommodating the array of individual needs is that it becomes very time-consuming. It becomes very intensive from a human resources standpoint. The correctional system only has the ability to intervene for that period of time, for the sentence, and if it includes a health-focused treatment delivered by a health professional, then of course you have issues of consent in order to get involved.

The service is left with trying to accommodate the entire range of individual needs that can be identified at the same time as administering the sentence according to the order of the court. It's a very difficult balance to achieve. That's not to say that there's an excuse for the Correctional Service not to accommodate individual needs. Certainly, the service has to accommodate physical disabilities. The service has to accommodate a whole range of issues right now. Increasingly, the service is recognizing the need to accommodate mental health issues, and we've certainly made a number of recommendations about how the service can increase its responsiveness to mental health needs in corrections.

● (1605)

Mr. Sean Casey: So a major part of the problem is resources. Would that be one conclusion that I could draw from your response?

Dr. Ivan Zinger: Resources of course may be part of the answer. I think the challenge is the complexity with regard to the offender population and the profile of that inmate population. What we've seen over the years is that now we have over 60% of the inmate population requiring psychological or psychiatric services.

On average, the educational attainment of offenders is a grade 8 education. We have 75% of the offenders coming into the system with substance abuse issues. About two-thirds of them were intoxicated at the time of their index offence. Then you add the 30% who have hepatitis C and the almost 5% who have HIV. Almost a quarter of the inmate population is aboriginal. Almost 10% of them are black offenders. It becomes very difficult for the Correctional Service of Canada to try to address the employment needs, the mental health needs, and the vocational needs. It's a really big challenge, and I would certainly say that resources absolutely sometimes can be a part of the challenge here.

But again, this is done at the last stage of the criminal justice system, in corrections, and we should really think about trying to divert these individuals and consider that perhaps incarceration is not the way to go. There must be other programs and alternatives to incarceration, and better services upstream.

Mr. Sean Casey: Thank you for raising again the issue of upstream treatment, upstream options. What are the gold standards? What are the best examples out there of upstream, effective options?

Mr. Howard Sapers: Particularly in dealing with offenders who have mental health issues, where we see the best success is where there are integrated approaches that involve how the police respond, and community action teams that are in place in different municipalities across this country where there is good and open information sharing between the health and justice sectors.

We see successes through the operations of specialty courts such as mental health courts that bring a specific focus to styles of interventions and supports that are available to people who are suffering from mental health issues but are also in conflict with the law. We also see successes where there is emphasis and focus on building communities of support during all of those transitions between court and corrections, between corrections and back into the community.

We know that building responses and supports around safe and affordable housing is very important to this population. We know that repeated contact with those individuals who are part of that support team is very important, and for many we know that efforts aimed at compliance with medication is very important and key to community success as well.

It's those components that make positive differences.

● (1610)

Mr. Sean Casey: I'm interested that none of the items you just spoke to included amendment of legislation, but I appreciate and understand that all too often resource allocation is the answer as opposed to legislative amendment.

I would like a further comment on the bill that's been withdrawn. If that bill was to be reintroduced and improvements could be made, what improvements if any would you recommend?

Mr. Howard Sapers: I'm not giving up hope on legislative leadership in this area. My key message would be that there are a number of people involved with neuropsychological deficits who are involved with the criminal justice system. FASD is a huge component and very important, but it's not the only source of those deficits, so I would broaden the scope of the bill to include other mental health issues in terms of mitigating factors.

The Chair: Thank you for those questions and answers.

Our next questioner is from the Conservative Party, Mr. Wilks.

Mr. David Wilks (Kootenay—Columbia, CPC): Thank you, Mr. Chair. Thank you, Mr. Sapers and Mr. Zinger.

Let's continue on down that road with regard to what you said about including all forms of mental illness and disability.

I wonder if you could give us some idea of where the door would close, because at some point in time regardless of who sits in this room or any courtroom, you have to close the door and say, I'm sorry but you're being incarcerated for X even though we recognize there is a mental issue that needs to be dealt with. He or she still needs to move on.

Maybe talk about that just for a little bit.

Mr. Howard Sapers: Sure.

The sentencing provisions of the Criminal Code are based on a principle, to some extent, of restraint and that incarceration should be used as a last resort. Then it's a matter of sorting out when that last resort has been reached. The recent experience has been growth in the prevalence of individuals in the correctional system that have a diagnosed significant mental health disorder. There is also an increase in the prevalence of those people who become ill while they are incarcerated. The criminal justice system is trying to sort out your question right now. We're seeing it with debates about the "not criminally responsible" provision. We're seeing it with evaluations of mental health courts. There is a general recognition that prisons should not become asylums, and we should not be criminalizing people's ill health. That does not take us away from the fact that some people who are mentally ill also come into conflict with the law.

Your question is exactly the focus of a tremendous amount of attention within the criminal justice system right now. I have been involved with training and explorations with police, judges, prosecutors, and correctional system operators to address exactly that. How do we stream people into options other than carceral options, and whose job is that?

Mr. David Wilks: In my previous life as a police officer the challenge that always existed was that we would identify someone we knew had significant issues, whether it be FASD or anything else down the line, but it was not the responsibility of the police to be the social worker. We would hand that off to, hopefully, the appropriate agency. The challenge is that you would continually run into the same person, and it becomes frustrating for all agencies because you recognize that person needs help, but no one knows where to go.

It's interesting, Mr. Sapers, in your comments you may have hit the nail on the head when you said paragraph 718.2(e) of the Criminal Code, which was enacted in 1996, expresses the need for judges to consider all other sentencing alternatives before sending an offender to prison. It's already there. It's been there for about 20 years. The challenge is that the courts are reluctant to do it at the best of times.

When the police come into contact with an individual who is identified with FASD, or any other form of mental illness, and they're filling out the RCC, the report to crown counsel, could there not be some form of identification in that form that says, "We've identified that this person may need some form of help and we strongly suggest to you, crown counsel, to make it emphatic when you're presenting toward the courts that alternative means should be found as required under paragraph 718.2(e)"? That puts the onus back on the courts.

● (1615)

Mr. Howard Sapers: I think that there are a number of potential procedural fixes like that, but I've had the crown tell me about the challenges they have when it comes to satisfying the court when it comes to bail and remand decisions. Defence counsels talk about the challenges that they have because the person has no fixed address or doesn't have anybody who will provide surety. There are all kinds of things.

I've had—from your world you know this—police say that they can't tie up endless resources sitting with people in emergency rooms and hospitals. When the hospital has a zero tolerance policy and when somebody's behaviour is so disruptive that they call the police because they want somebody arrested, that's what they need. Yes, everybody recognizes that this is somebody with a mental health issue, but it's also creating another problem in terms of the operation of the hospital.

All of these things go into the mix, including repeated contact. As you say, it's often the same person you see all the time. It's repeated contact. Very sadly, in criminal justice, it's one of the only social initiatives, social programs, public services, where we continue to do the same thing over and over again and expect a different result. It's very frustrating for the police to have to deal with these individuals time and again and it doesn't affect change.

But I think you're right. There are a number of procedural fixes that could have a positive impact.

The Chair: Our next questioner is from the NDP, Madam Péclet.

[*Translation*]

Ms. Ève Péclet (La Pointe-de-l'Île, NDP): Thank you very much, Mr. Chair.

My thanks also to our witnesses for being with us today.

In a reply you gave earlier, you said that emphasis should be put on prevention. I understand the premise that we want to invest in education and awareness. I think that we all agree on that.

A Department of Justice study mentions that the courts have no particular approach in FASD-related cases. You also said that there are other issues related to mental health. With autism, or other disorders of that kind, the courts have no real approach either. The study continues: "There was no consistent approach to responding to offenders or victims with FASD mentioned in the case law." It also says that, in most cases, it was not incorporated or considered in the judicial decision-making.

Do courts have difficulty in handling all the cases where there are mental health issues? Could you tell me more about that?

● (1620)

Dr. Ivan Zinger: Both courts and communities are realizing more and more that individuals with mental health issues are often criminalized and brought to court, to the extent that a number of cities in Canada have set up specialized courts to deal with cases of that kind. This is a very good attempt to redirect individuals to solutions other than incarceration, such as making them undergo treatment appropriate to their mental health condition.

An unpublished study by Professor Steve Wormith at the University of Saskatchewan took another look at the effectiveness of the courts that deal with mental health issues. The study shows that there was a 17% reduction in the recidivism rate for people who went through that kind of court compared with those who went through a court in the traditional system.

It is certainly valid to ask judges to be more proactive and to know exactly what kind of person they are dealing with when a penalty has to be imposed. If there are problems related to FASD or other mental health issues, judges have to be sure that those aspects are considered and the decision they hand down is fair and equitable.

Ms. Ève Péclet: You are touching on my second point.

If I understood your presentation correctly, you are in fact saying that Correctional Service Canada does not identify those people who, unfortunately, really have greater needs and who differ from the majority of offenders in federal penitentiaries.

What do you think of the idea of providing at least a general framework for the guidance of the courts in diagnosing fetal alcohol disorders? That would not only be consistent with our principles of criminal justice and sentencing, but it would also be of benefit to Correctional Service Canada, which could also work in parallel to identify those individuals. In your opinion, then, the general framework of the bill would work for everyone.

Dr. Ivan Zinger: Yes. When correctional services receive an accused who has been given a sentence, they have to look to see whether the judge has expressed any reservations or documented any problems. If so, they have to take them into consideration when the sentence is administered. In that case, clearly there would be a benefit. However, we feel that we cannot put all our eggs into that kind of basket in an attempt to solve the problem. It is always better to be proactive.

Ms. Ève Péclet: Now you are touching on my third point.

In the Canadian Bar Association's brief, they deal with sentencing and the discretionary power of the courts. They say that mandatory minimum sentences are unfortunately more and more frequent in the Criminal Code. When judges are dealing with people with fetal alcohol disorders or other neurological or psychological conditions, this takes away the judge's discretion and makes victims out of the people who have to be put into prison, resulting in even more injustice.

In the document, they call for an exemption to section 718 of the Criminal Code "to avoid the mandatory minimum if an injustice would result", especially for those with FASD or other mental health issues.

What do you think of that proposal?

● (1625)

[*English*]

Mr. Howard Sapers: There is a contradiction between a mandatory minimum penalty and the discretion that's called for in section 718.2. On the one hand the code prescribes judicial discretion to be used and to seek alternatives. On the other hand sections in the code prescribe mandatory minimum penalties. That's hard to reconcile from a sentencing position.

The Chair: Our final questioner for this panel is Mr. Dechert from the Conservative Party.

Mr. Bob Dechert: Thank you, Mr. Chair, and thanks to our guests for joining us today.

Mr. Sapers, in your opening comments you mentioned that the estimates of prisoners in the federal corrections system that suffer from FASD ranged from between one in 10 to one in four, I believe you said.

Is one in 10 the number of people who are actually diagnosed with FASD and one in four an estimate of the total population? What's the relation between those two numbers?

Mr. Howard Sapers: The 9% to 10% is really based on the most recent study that was published by the Correctional Service of Canada. They did a prevalent study in June 2011. There are other studies that have generated retrospectively; in other words, they have gone back afterward and looked at populations and they've said, okay, we find the prevalence to be 22%, 23%, 24%. There are different studies using slightly different methodologies to determine the population.

The Correctional Service Canada prevalent study that found the 10%, or the just under 10%, also found another 15% where file information was incomplete. People exhibited many of the characteristics, but they couldn't confirm or deny a diagnosis. Even in the CSC study, which only finds 10%, they suggest it could be another 15%, bringing you back to the one in four or 25% for the prevalence of FASD.

Interestingly, they also found 45% of offenders, who weren't FAS-disordered, had other neuropsychological deficits.

Mr. Bob Dechert: Okay.

I think one of you mentioned that the percentage of the aboriginal population in federal institutions is approximately 25%, or just under 25%. Do you have any idea what percentage of the aboriginal population suffers from FASD?

Mr. Howard Sapers: I don't.

Mr. Bob Dechert: Okay.

Some of our other witnesses—especially the promoter of this motion, Mr. Leef—have suggested that for some people who suffer from FASD, having structure and routine in their lives is actually beneficial.

I understand that there aren't programs in the federal system. There may be some programs in provincial systems that deal with FASD. If you could combine an appropriate program within the correctional system to provide that structure and stability, do you see any benefits in approaching it in that way?

Mr. Howard Sapers: Yes, probably, but keep in mind that program success is as much about the multiple modes of program delivery and information delivery and support as it is just about structure. Running up against rules and not following instructions is a problem, so structure without all of the other supports that an individual needs in order to achieve success.... They are very important.

Mr. Bob Dechert: Yes, so there may need to be some flexibility in the way the rules are enforced, maybe in a special unit of an institution.

You mentioned that people with FASD are often more impulsive, often show less judgment in particular situations, and are perhaps more violent, as we've heard from some. That would suggest to me that leaving them out in the community is perhaps not the best answer, but there has to be some institution with a special knowledge of how to deal with them.

I want to go on to your other point about the need for some recognition of mental illness in general. I think you said in your opening remarks that the approach should include all forms of mental illness and not just people who suffer from FASD.

Can you compare for us some of the other forms of mental illness that you see can be identified among the prison population and how those with these mental illnesses compare with people with FASD in the way they're treated within the prison system, or in the way they respond to the rules and structures of the prison system?

● (1630)

Dr. Ivan Zinger: As I indicated before, the demand for services is extraordinary in corrections. I mentioned that a little more than 60% require psychological and psychiatric services.

In terms of diagnosis, more than half of those who suffer from mental health issues have a diagnosis of a substance abuse disorder —that's a really significant one—and there is a high prevalence of mood disorders. There are also anxiety disorders, and of course the more serious disorders, such as schizophrenia and major depression.

The service is equipped to deal with a variety of these issues by providing even psychiatric hospitalization for the more acute, more problematic cases. They are now attempting to expand their intermediate care services and then there is also primary care, so—

Mr. Bob Dechert: I'm going to cut you off.

Does it make sense to delineate just people with FASD, as distinct from people with any other form of mental health issue, in terms of sentencing?

Dr. Ivan Zinger: Given the prevalence, I think that in order to raise awareness among judges so that they can better tailor their sentences and maybe even provide guidance to the correctional service, you would be better off to broaden it to any cognitive deficit as well as any relevant mental health issue.

The Chair: I appreciate that.

Thank you for those excellent questions today.

Thank you for being here from the Office of the Correctional Investigator. You did a fantastic job of giving us really good input into the study we're doing.

We're going to take a three-minute break until we get our folks on video conference lined up. We'll suspend.

● (1630)

(Pause)

● (1635)

The Chair: I will call this meeting back to order. We're the Standing Committee on Justice and Human Rights.

For our second panel, we have three folks here via video conference, and Ms. Cook has joined us here live.

Professor Popova gave her presentation already. She's from the Centre for Addiction and Mental Health, and is on video conference from Toronto. She can answer any questions you may have that you didn't have time to get to. From the Society of Obstetricians and Gynaecologists of Canada, we have with us Jocelynn Cook, scientific director. From Edmonton via video conference we have, from Alberta Health Services, Ms. Gail Andrew, medical director, fetal alcohol syndrome disorder clinical services, and site lead, pediatrics, at the Glenrose Rehabilitation Hospital. By video conference from Whitehorse, Yukon, we have Rodney Snow as an individual.

As is listed on the agenda, I will go first to Ms. Cook. The floor is yours for 10 minutes.

Dr. Jocelynn Cook (Scientific Director, Society of Obstetricians and Gynaecologists of Canada): Thank you.

I think you all should have a PowerPoint deck. I'm a scientist, so you're going to be stuck with doing things the scientist's way. I also submitted a brief.

I am the scientific director of the Society of Obstetricians and Gynaecologists of Canada. I was formerly the executive director of the Canada FASD Research Network, which is a national research network that facilitates policy-relevant research in Canada. I also worked for the public service for about nine and a half years—all within FASD. I also have had a scientific research career in the field that I've been in for—I counted this morning—23 years. I'm starting to feel a bit old.

Thanks for having me here.

Dr. Popova and Dr. Andrew and I exchanged slides so we shouldn't have any duplication, so that's good. We know that your time is valuable.

Today I'm going to take a bit of a different approach and talk a little about the context around women and alcohol. We know that women do drink during pregnancy and we know that no woman actually wants to harm her child.

There are a lot of different reasons why women do drink during pregnancy. The first slide shows some of those reasons: prior history of alcohol consumption; family background of alcohol use; history of in-patient treatment for problematic alcohol substance use or mental health problems; previous birth of a child with FASD; unplanned pregnancy; emotional, physical, or sexual abuse; low income; limited access to health care.

The burning question in the field since I've been in it for a really long time is: how much alcohol is too much? How much can a woman drink that's going to be absolutely guaranteed to keep her fetus safe? The answer is that we don't know. We can't scientifically figure out an absolute safe amount or an absolute risky amount. The amount of alcohol required to cause damage differs, based on the individual, on the fetus, and their interactions in the womb together.

We know that the dose of alcohol is important. Research does show that binge drinking is more harmful. When your blood alcohol level goes up and stays up high for a while, like frat party drinking, and then goes down, that's more harmful than sipping on a beer all day long.

We know that pattern and timing of exposure during pregnancy is important. As the baby develops, when alcohol is a factor, what's developing at that time can be specifically influenced. The important thing to know is that the brain is developing throughout gestation and is always susceptible to alcohol. We used to be able to give alcohol to mice on a certain day of gestation—just one day—and they'd be born with limb and kidney defects. You can give it on a different day and they'll have facial features. But the problem, as I said, is that the brain is always susceptible.

We know that genetics play a factor. We know that smoking and other drug use comes into play. General health, nutrition, stress, trauma, and age of the mom are all factors on how susceptible that fetus is to prenatal alcohol exposure and the damage. There's recent data now that I think is very exciting, probably more than others, that shows that stress and nutrition factors in mom, even before she's pregnant, can have a susceptibility factor on her developing fetus. That's called epigenetics, and it's very fascinating. There can be brain changes in moms that can be passed on to babies and affect their susceptibility as they're developing.

We always say that no alcohol is safe because that's the truth; we don't know any different.

The next slide talks about some of the data from the Canadian community health survey about alcohol use among women. It is a problem in women of child-bearing age. You can see that moderate alcohol use is very high in the 19-to-34 age group, and this age group accounts for about 80% of the pregnancies in Canada. We know that about 50% of pregnancies are unplanned, so alcohol use among women in Canada of child-bearing age who are at risk for being pregnant is significant.

The Canada FASD Research Network has a first-ever database of individuals with FASD. We have 289 individuals in that database, and we're collecting information around their brain function and what kinds of interventions have been suggested, so we can try to figure out what the best match is. The gentleman earlier talked about the importance of mental health and brain function and how we can match that to programs or treatments that improve and maximize outcomes.

● (1640)

This data hasn't been published yet. It's new. It's hot. It's exciting. But the characteristics of adults with FASD in our database—alcohol problems, marijuana use, drug problems, past or current trouble getting and keeping a job—are for greater than 50% of the adults. Eighty-five per cent have trouble living on their own. There are some who could be homeless. Eighty-five per cent had no high school diploma, 63% were a legal offender, and half were a legal victim. Many of the patients were institutionalized at the time of assessment or in the past. Fifty-seven per cent had been in the hospital, and 40% in jail. These are the adults in our Canadian database. There are lots of challenges with daily living, social-skill deficits, and the majority had family abuse problems as a victim, aggressor, or both.

These individuals are very affected. Their brains are much more affected than we initially thought they would be, but diagnosis really does matter. Many of you may have heard of the diagnostic guidelines that the Canadian Medical Association published in 2005. We've revised those guidelines, thanks to funding from the Public Health Agency of Canada, and they're being published, hopefully in June. We just resubmitted them to the *Canadian Medical Association Journal*. The guidelines talk a little bit more about screening and how to recognize when alcohol use during pregnancy may be a problem.

We know that diagnosis improves outcomes, the earlier the better. Part of that is because people understand the implications of FASD, what it means, and we can try to develop integrated care teams to get families the supports and services that they need. Diagnosis is important. It identifies neurodevelopmental strengths and weaknesses so that we can better match, as I said, treatments and interventions. It's complex, and I will mention that we do have an initial diagnostic database that could be very powerful.

So why doesn't any of this matter? We know that women drinking alcohol during pregnancy is still a significant issue in Canada. Prevention in the current social context is key. Drinking alcohol is sexy in a lot of ads. It's very socially acceptable. Helping women to understand not just the harmful effects of alcohol on fetal growth and development but also the harmful effects of alcohol on health in general....

Individuals with FASD have neurodevelopmental impairments, which you heard about this morning—and Dr. Andrew will talk more about those—that put them at risk for adverse secondary outcomes, such as trouble with the law and mental health issues. A study by Jacqueline Pei, who I think is going to talk to you next week, showed that 95% of individuals with FASD had diagnosed mental health issues. They have brain structure differences and brain function differences. That's very important when you think about treatment of individuals with neurocognitive impairments. Diagnosis is critical to understanding brain function, and adaptive programming can improve outcomes for affected individuals and their families.

We know that brain impairment really does affect outcomes. We know that in our database individuals had more central nervous system impairment than was anticipated. Consensus from experts in the U.S. and a few Canadians who populated the panel suggested that treatment approaches that rely on assumption of normal cognitive functioning are likely to be less effective with individuals with FASD, and that makes sense. That's what you heard from the other individuals who spoke just now.

We also did an interesting study where we worked with mental health centres and substance abuse treatment centres. We did some education with the front-line workers, and we taught them to screen for possible FASD. We collected some data from that. We're analyzing that now to see, if they understood that parental alcohol exposure may be a factor, how they interacted with these individuals and how they changed what they were doing so that they could better improve outcomes.

In terms of what we really need, we need access to capacity for diagnosis, because that's so important. We need standardized data collection or we're never going to be able to make any really good evidence-based decisions on what works and what doesn't work, and what the specific characteristics and matched treatment approaches are. We need training in education. We learned in our study that front-line workers felt a lot more comfortable dealing with individuals who had FASD when they understood the implications of FASD and that these people weren't misbehaving because they meant to. We need more research on specific interventions or supports that improve outcomes for affected individuals and families across the board—across services and across systems.

● (1645)

Thank you. Was I on time?

The Chair: That was six seconds over, but we'll give it to you. That's okay.

Thank you, Dr. Cook, for that presentation.

Now we will go to the video conference from Alberta Health Services. Dr. Andrew, the floor is yours for 10 minutes.

Dr. Gail Andrew (Medical Director, Fetal Alcohol Syndrome Disorder Clinical Services, and Site Lead, Pediatrics, Glenrose Rehabilitation Hospital, Alberta Health Services): Thank you very much for having me today.

I'm a clinician, researcher, and I also do a lot of education and training around fetal alcohol spectrum disorder and other neurodevelopmental disabilities, as I am a developmental pediatrician.

What I'm going to talk about to you today is more from that clinical, medical, diagnostic perspective. I think we've heard from our other presenters that FASD is common, maybe in up to 5% of the population, it's very expensive, and it is overrepresented in the justice system. As I've worked across the lifespan, it's overrepresented in children who are in the foster care system as well. It's a lifelong disability, and I strongly feel it is a mental disorder. In the DSM-5, which is the diagnostic and statistical manual, it is currently being considered for psychiatry use, so it is definitely recognized as a mental disorder caused by damage from prenatal exposure to alcohol.

It is an invisible disability because we only see the dysmorphic face of full fetal alcohol syndrome in about 10% of the population. As Dr. Cook explained, we create FAS in the laboratory rat models and we know it's just a small window of time, three days, in human gestation where that face is a result of the teratogenic effect of alcohol. It's not surprising then that we don't see the face in most individuals affected by prenatal exposure to alcohol.

We also don't have any biomarkers, such as a blood test. There are some biomarkers of interest in the research world, such as eye movement, but we have a lot of research ahead of us before that becomes a clinical tool. Right now we need to assess 10 different brain domains in the clinic in order to make a diagnosis of fetal alcohol spectrum disorder. It's also a differential diagnosis. We consider many other factors.

We also know that prenatal exposure to alcohol is often not the only factor. Dr. Cook mentioned some of the maternal stress factors, maternal nutrition. There's also genetic endowment. We also know that postnatal stressors, especially in the early years—exposure to trauma, maltreatment, toxic stress, and so on—can also have a long-term impact on brain development that is not necessarily reversible by simply optimizing the environment if we've lost that window of time in the early years.

Currently, we don't have diagnostic capacity in Canada, although we're far ahead of many other countries to provide the diagnosis. There's less diagnosis available for the adult population. There are some good models of diagnostic clinics embedded within the justice system that I think need to be followed as examples of good practice. The diagnosis is not just a label of a four-letter word. It must lead to a constellation of strengths and challenges for that individual so that we can design the appropriate intervention programs.

I'm going to talk a little bit about the scientific evidence we have from both the animal models, as well as from the human neuroimaging and neurochemical techniques that support that alcohol exposure prenatally does indeed cause brain damage.

We know that alcohol can alter the brain cell development in the neurons by causing simply cell death, or it can interfere with the neurons migrating to the right level of the brain where they need to be for functioning and then connecting with other neurons, because that's how information is conveyed from neuron to neuron. It can interfere with myelination, which is an important part of that conductivity of those pathways. It can cause epigenetic changes and it can alter neurotransmitter activity. Neurotransmitters are those chemicals that go from one brain cell to the other in brain functioning. The brain neurotransmitters impacted are dopamine, serotonin, and glutamine, which are implicated in almost all of the mental health disorders that we know of. It can also alter the stress response through the hypothalamic-pituitary axis and cortisol, so if you have the normal stress responses, you can see in certain situations the right outcome is not going to happen.

One of the exciting parts is neuroimaging studies. A clinical MRI that I do today on my clients shows me usually no abnormalities in structure unless we have abnormal neurological findings that I find on my clinical exam. But in our lab we're able to do very highly refined imaging and we do see abnormalities, specifically in decrease of brain volume and abnormalities in cortical thickness. There's actually less thinning, so less pruning goes on. Pruning is important in normal learning and development.

● (1650)

We see reductions in key pathways connecting one part of the brain to the other, especially the frontal lobes of the brain, which are the seat of our executive functions. Those pathways are reduced, and we've seen, in our own research lab at the Glenrose, a direct correlation with one pathway and difficulties with reading.

Functional MRIs have shown that there is a difference in function in different areas of the brain. One study showed that the frontal lobe of the brain was working harder as the task got more complex, but it was less efficient and it led to early mental exhaustion. Again, harder work doesn't necessarily get you a better result.

We talked a little about the adverse environments that can be compounding the effect of prenatal exposure to alcohol, and I think this is an area of.... I'm always looking for opportunities for prevention intervention. When we look at adverse life experiences and we look at why women drink, they're all rooted in the social determinants of health and this is an opportunity to put in place interventions and preventions to break this multi-generational cycle.

I'm going to quickly go over some of the brain assessments that I can do in my day-to-day clinic.

An average assessment costs about $4,000 and you can see from the number of domains that we test why this is an expensive assessment, but it's worth the money and investment to inform best practices moving forward. Intellectual ability is one area that we use as a baseline, but IQ does not define the disability and level of impairment in individuals with FASD. Often their IQ levels are within the average range. We need to move beyond the basic testing into assessing memory, attention, executive functioning, and adaptive functioning.

One problem with an IQ above 70 is that currently you do not qualify for any of the supportive funding or housing systems as adults, and in most cases as children and teenagers, you don't qualify for extra educational supports. What happens is that you then transition to adulthood without essential academics, training, or employability options. You have no funding. That can lead to homelessness and unemployment. Food as a commodity is scarce. You're in a homeless situation. You can see this person coming in contact with other people who may drag them into becoming involved with the law. We know when we look at intellectual abilities, often individuals with FASD are slower at processing, so this has implications in a very fast-moving court scene, arrest situation, where they may not be processing all the information.

One of the areas we also look at is academic abilities, learning. Reading disability is very common when we do our academic assessments. They may have superficial reading abilities, so that they can read the words but they lack the comprehension and understanding. You can see how somebody reading their parole conditions or reading a document that they need to sign to say this is what happened.... Don't necessarily leap to the conclusion that they have understood what they have read. This may explain a lot of our breaches.

Math disability is really important, which impacts both money and time management and understanding. No wonder our individuals don't show up on time for an appointment or they don't understand the financial value of items and they aren't able to handle their own money for budgeting and daily living without extensive mentorship and other external supports.

Attention issues are another I'd like to cover. It's very common, about 65% of individuals with FASD also get a diagnosis of attention deficit hyperactivity disorder. They have problems focusing on what is relevant, inhibiting responses to what is not relevant. They're easily distracted by extraneous cues in their environment. Having a short attention span impacts your ability to learn in the academic world, but you also can't learn from day-to-day experiences. If you have FASD with a short attention span, you may not be paying attention to all the information in your environment. You can't put the information into your memory and retrieve it when you want it, and then you can't use any of this information for the right decision-making at the right time. This can help explain a lot of them not being able to learn from their mistakes or the consequences of their actions. Don't assume the individual with FASD who appears to be listening is attaining and processing the information.

● (1655)

Memory problems are also significant, both in verbal memory and in visual-spatial items. Short-term memory and long-term memory can be impacted. If you have an impaired memory, you may not be able to remember and use the information that you were taught in your group therapy session in order to use it in that moment in time when you need to use it. Memory deficits and FASD are especially more noticeable in an emotionally charged situation, such as being interrogated for a crime or being a witness on the stand when you're a victim. Problems with memory can lead to confabulation.

● (1700)

Executive function is a really core deficit. Executive function refers to higher order processes that result in goal-directed behaviour, such as planning, organizing, impulse control, inhibition, flexible thinking, working memory, reasoning, and so on. We can measure all of these in our clinic situation, and we look at all those core deficits. They can certainly explain why somebody is not able to control their impulses and make the right decision at the right time.

Communication deficits, which I've already alluded to, are significant. They can present well, talk a lot, but don't always understand at a higher level. We analyze, in our clinic situation, inferencing, predicting, social communication deficits. All are implicated in getting into trouble with the law. Social communication deficits are also implicated in making bad social choices, getting in with the wrong crowd, and then being led and becoming more of a victim rather than a perpetrator.

All of these deficits lead to impaired adaptive functioning, which at the end of the day is how you function safely in life and independently. We often say our individuals with FASD are maladaptive, but really they just simply can't use all of the information from their environment to make that right decision at the right time. We need to put in place good strategies.

We've already talked about the overlap with mental health, and when you reflect back on the fact that our neurotransmitter systems are changed by the prenatal exposure to alcohol, there's no wonder that we have a higher level of mental health disorders associated with FASD.

In my briefing notes I did provide a reference to the legal conference that was held in Edmonton on the legal issues of FASD. It has been printed through the Institute of Health Economics website and I would refer the members of this committee to have the opportunity to both look at the consensus conference and the document that was developed as the result of that. Many learned individuals contributed.

Thank you.

The Chair: Thank you, Doctor, for that presentation.

Our final presenter before we go to the rounds of questions is Mr. Snow, as an individual from Whitehorse, Yukon.

The floor is yours, Mr. Snow, for ten minutes.

Mr. Rodney Snow (As an Individual): Thank you, Mr. Chairman.

I am, as you say, Rod Snow. I work as a lawyer in Whitehorse in the Yukon, but I appear today as an individual and not on behalf of any client or organization.

Let me start with full disclosure. I'm not an expert. I'm not an expert in criminal law and I'm not an expert on FASD, but over the last 10 years I have taken part in the national conversation on the treatment of individuals with FASD in the criminal justice system. Today I want to tell you about some of what I've learned and about how you can make a difference, I think, in the lives of individuals with FASD.

At the risk of repeating some of what you may have heard already, let me start with some of the key facts that have framed elements of this national conversation. First, FASD is a permanent organic brain injury. There is no cure, although outcomes can improve with treatment. Second, characteristics of individuals with FASD include impaired executive functioning, lack of impulse control, and difficulties understanding the consequences of their actions, so they often don't learn from their mistakes. Third, criminal law assumes that individuals make informed choices, that they decide to commit crimes, and that they learn from their own behaviour and the behaviour of others. Fourth, these assumptions are often not valid for individuals with FASD, so our criminal justice system fails them and it fails us.

So what do we do?

I start from the proposition that nobody is more morally innocent than a baby born with a disability. When that baby grows up and is unable to meet a legal standard of behaviour because of his or her disability, the state does not deliver justice by punishing, yet that is what we do in Canada.

The tools that Parliament has given crown counsel and judges are limited. If you speak to people who are working on the front lines, you will hear the same story over and over again. It goes something like this. They will tell you that too often children with FASD start out in the child welfare system. They proceed into the youth criminal justice system as teenagers, and then move into the adult criminal justice system, where the cycle starts all over again. They know that jail time will not rehabilitate, deter, or cure the individual with FASD, but they have few tools to stop this revolving door. Eventually everyone gets out, but the time in jail has done little to help the individual or to improve public safety. This is where you come in, as members of Parliament. We need you to support changes to the Criminal Code and our corrections system so that they are smart and effective on crime.

We know that the old approach is not working. We need a new one that's designed to succeed. I think it was Einstein who said that doing the same thing over and over again and expecting a different result is the definition of insanity. There's a broad consensus that law reform is needed. In 2010, with the support of crown prosecutors and defence lawyers, the Canadian Bar Association supported initiatives in this area by federal, provincial, and territorial justice ministers and called for measures to decriminalize FASD. Then justice minister Nicholson quickly said FASD is a huge problem in the justice system —“huge problem”, his words, not mine.

Provincial court judges support the bar association's call for reform. FPT justice ministers committed to dealing with FASD as an issue of access to justice, and in August of 2013 Justice Minister MacKay made a public commitment to act on this issue. So I was excited when Ryan Leef introduced Bill C-583.

● (1705)

Bill C-583 has three main elements. First, it defines FASD. Second, it allows a judge to order an assessment, and third, it allows FASD to be considered a mitigating factor in sentencing. All three elements are important, but I want to draw your attention to the section that allows a judge to presume that the cause of FASD is maternal consumption of alcohol if there is good reason why that evidence is not otherwise available. We want to avoid situations where everyone knows that FASD is involved, but an assessment remains inconclusive because this evidence is missing.

I don't have to tell you, Mr. Chair, that Bill C-583 received support from all parties. I sat on the Yukon legislature when Yukon MLAs unanimously passed an NDP opposition motion to support Bill C-583, and I understand that MP Casey has introduced Bill C-656 that adopts much of Bill C-583 and goes further in the areas of external support orders and corrections reform.

I was disappointed when Bill C-583 was withdrawn. Many of us thought that, with support from all parties, it had a chance. Now we turn to you and your committee, because we feel that it's the best hope for reform. I urge you to listen, and listen carefully. Please consider action that can be taken to prevent FASD, to encourage assessments, and to improve outcomes for those in the federal penitentiary system.

I also encourage you to hear from people with this disability and their families. People with disabilities have often said, “There should be nothing about us without us.” When you report, please do not confuse the need for more medical research or scientific study with the value of Bill C-583. Do not say that this is a complex, intractable issue, and therefore, Bill C-583 or its equivalents need more study before action. It needs more political courage and leadership.

I think Ryan Leef has done his part, with limited resources. It is now time for Minister MacKay, with the resources of the Department of Justice at his disposal, to honour his 2013 commitment to act.

When you report, say that the criminal law needs to be reformed and that Bill C-583 is a good start. Please say that unequivocally and unanimously. Do not sacrifice the good in the pursuit of the perfect. If you back Bill C-583, you'll make a positive difference in the lives of individuals with FASD.

Parliamentary leadership matters. By doing so, you will encourage further action in our communities, provinces, and territories, and that, too, is good.

Thank you very much.

● (1710)

The Chair: Thank you for that presentation, Mr. Snow.

Now we are going to the question-and-answer portion, and a reminder that we have Professor Popova with us from the Centre for Addiction and Mental Health. Please, because we are doing video conference, make sure all the individuals know which one of them you're asking the question of, and it will be much easier.

With that, the floor goes to Madam Boivin of the New Democratic Party. The floor is yours.

Ms. Françoise Boivin: Thank you so much.

Thank you to all the witnesses. This is very interesting.

I first have a few comments for our colleague Rodney Snow.

I totally agree with you. In a sense, it's kind of disturbing, because I did think that we would advance with this. It's rare in this committee that we have unanimous consent for something, so it was pretty uplifting to see that we would advance in the sense of what have been some recommendations, either from the Canadian Bar Association or promises from two justice ministers. I feel as though we're back to square one, if not a bit further back, but anyway....

I appreciate tremendously the scientific experts, because this is not my field of expertise. I deal with law. I take to heart your last comment that we shouldn't sacrifice the good to try to strive.... It's always better to go for the best, but at the same time, if striving for the best means that we're totally frozen and not acting, there's a big problem. I appreciate my colleague Sean Casey's bill, but since he already had his turn, we will not be debating his bill either. I don't exactly know how we'll be able to move this faster in this legislature, but anyway, we'll do our part.

I'm not a medical specialist, obviously. I'm a lawyer, with all that that means, which sometimes is nothing.

Voices: Oh, oh!

Ms. Françoise Boivin: I listened very hard to the explanations.

I loved your passion, Dr. Cook. I love people who are passionate. I'm passionate about law. You're passionate about mental disorders. I seem to understand that there are so many things that science realizes and learns about every day. I keep hearing the definition of FASD, and I know there are people who say that it doesn't fit the criteria of section 16 of the Criminal Code, but section 16 of the Criminal Code talks about somebody not being responsible because of “a mental disorder”.

I would like the three scientific people who are here today to enlighten us. Why would it not be a possibility that somebody is not guilty because of FASD? Is it possible that there might be cases? I seem to understand from the testimony of the three of you that not everybody is the same, that FASD doesn't have the same impact on everybody. We just heard from Mr. Sapers, *l'enquêteur correctionnel*, who seemed to say that it's not advancing anywhere, that nobody seems to be even talking about it in courts so our jails are full of people with it.

What can we do? Why isn't it subject to section 16 of the Criminal Code?

The Chair: We'll start with Ms. Cook.

Dr. Jocelynn Cook: Let me start by saying that internationally FASD is starting to be recognized within the context of law. We know that there have been meetings. There's a big FASD and mental health meeting that happens in Vienna in the summer, and they are having a huge focus on FASD this year. It's starting to get some international traction in terms of that.

As a clinician, Dr. Andrew can answer this much better than I can, but we know that individuals with FASD differ in their neurodevelopmental deficits for a lot of reasons. We know, as Dr. Andrew suggested, that some of the traditional measures of whether you understand or not may not be relevant here, because the patterns of where the brain has issues are different from those of other neurodevelopmental disorders.

We're trying to figure out how different, and we're trying to look at other individuals who have neurodevelopmental disorders. How are they different and the same as individuals with FASD? How are their brains similar and different? Are there patterns that are similar and different? This is so we can understand some of the more specific effects of alcohol. We know—

● (1715)

Ms. Françoise Boivin: But I heard Dr. Andrew say that sometimes they have a hard time understanding the consequences.

Dr. Jocelynn Cook: Right. That's a traditional—

Ms. Françoise Boivin: Isn't that the definition of a mental disorder, based on section 16? My point is that we want to make this a mitigating circumstance on sentencing, but are we not missing the whole situation on the actual commission of the infraction?

Dr. Jocelynn Cook: Gail, do you want to answer that?

She has her hand up.

Dr. Gail Andrew: I have to preface this by saying I am a medical doctor and not a lawyer. I actually had an opportunity to speak with Professor Steven Penney, a professor at the faculty of law, University of Alberta, to give me the *Reader's Digest* condensed versions of section 16. Certainly our individuals with FASD would qualify for mental disorder.

The diagnostic process I very quickly outlined is a rigorous process. We look for three different areas of brain impairment. It's not just a little; there is significant impairment. We actually do a numerical ranking system where three is the highest level of impairment. There is a scientific rigour to how we approach the diagnosis with FASD.

My discussion with Professor Penney was that, yes, we have a mental disorder, but are our individuals incapable of appreciating the nature of the act or omission, or knowing it was wrong? We know we must show the impairment to know the natural consequences of the act, and to know that it was wrong either legally or morally. When I look at the impairments in brain function that I can assess every day in clinic, most of the individuals who get diagnosed with FASD would qualify for that level of impairment, but they do need the in-depth assessment.

The Chair: Professor, would you like to answer that question?

Dr. Svetlana Popova (Assistant Professor, University of Toronto, and Senior Scientist, Social and Epidemiological Research, Centre for Addiction and Mental Health): Hello, everyone. I just wanted to add to the medical and epidemiological evidence that I presented two weeks ago.

I want to remind you that 90% of people with FASD suffer from conduct behavioural problems and disruptive behavioural impulsivity; 80% have receptive and expressive language deficit; and 70% have developmental and cognitive disorders and developmental delays. Therefore, people with FASD should definitely be treated differently in the legal system as patients with cognitive, intellectual, and functional impairment.

FASD needs to be defined under the Criminal Code. Procedures should be established for assessing the range and severity of FASD so that its role in an offence can be taken into account in sentencing as a mitigating factor. Presumably that would allow offenders to be steered toward the support they might need, rather than just incarcerated.

Ms. Françoise Boivin: I get your point, Professor Popova, but my question was whether or not it could have an impact on the actual commission of the infraction. Is it a mental disorder that would make the person not guilty because of reason of a mental disorder?

The Chair: Okay, you can think about that answer because her time is up. We may get back to that question again.

The next questioner is from the Conservative Party. Mr. Seeback is up first.

● (1720)

Mr. Kyle Seeback (Brampton West, CPC): Thank you, Mr. Chair.

I'm going to pose this initial question. I've heard a number of discussions on how an FASD diagnosis takes place. I don't have my witness list here, but I heard someone mention 10 different brain "blank" for diagnosis. I don't know if that was 10 different brain tests at $4,000, or....

How detailed does the testing have to be? How long does it take in order for this assessment to be made for an individual?

The Chair: That was Dr. Andrew.

Mr. Kyle Seeback: It was Dr. Andrew? Okay.

Dr. Gail Andrew: Yes. Dr. Cook can also join in, as Dr. Cook is one of the leaders in the development of the revision of the Canadian guidelines for FASD assessment, although the guidelines are being developed with extensive consultation with experts across Canada, the United States, and internationally.

The 10 domains are different categories of function within the brain that we separate out. I mentioned just a few in my presentation. There is intelligence, academic achievement, attention span, memory, executive functions, adaptability, and mental health. As a physician, I also look at the motor system, neurological control, etc.

Mr. Kyle Seeback: So it's a very detailed test.

I have limited time here, so in general terms, how long would it take for someone to be assessed? Is it one meeting? Is it weeks, months, days?

Dr. Gail Andrew: In my clinic we see the individual over about a day and a half, and then the diagnosis is formulated in the other half-day and a full report is generated. It's two days for an adolescent or a child.

The adult has different challenges, because if they are homeless, we have to find them, feed them, give them a mentor. I run an adult clinic, so this is our process. We connect them with a support person who is able to navigate the system with them, because if you have an FASD, you aren't able to navigate the system even to get your foot in the door. I've done some work in the justice system. I must admit, we have a captive population. We can do the diagnosis quite quickly in the justice system.

Mr. Kyle Seeback: Professor Cook, do you agree? Are you on the same page with that?

Dr. Jocelynn Cook: Yes, and I have one quick thing to add. As Dr. Andrew suggested, 10 parts of brain function are assessed. You have to get three hits to meet the criteria, but our new data show that more than 50% of individuals have nine hits. That's really impaired, much more than we initially thought, to go back to your question.

Mr. Kyle Seeback: The cost of the test is around $4,000.

Dr. Jocelynn Cook: Yes. Sometimes it's $3,000, sometimes $4,000. It depends on whether you have to hunt down bio-mom, or find the data, whether you need a cultural interpreter. There are different kinds of teams for different—

Mr. Kyle Seeback: If a court doesn't order the assessment, which would be paid by the province, then the individual person who is trying to assert the FASD would have to find the way to pay for that personally, I take it.

I'm going to share the rest of my time with Mr. Calkins.

The Chair: Mr. Calkins, the floor is yours.

Mr. Blaine Calkins (Wetaskiwin, CPC): Thank you, Mr. Chair.

My first question is a joint question to both Gail and Jocelynn.

First of all, I think, Gail, you said that a capacity for diagnosis is lacking. I wrote that note down. If you could, elaborate on that for me. Is this because we don't have enough medical expertise, because we don't have enough technical expertise, because we don't have enough financial resources...? Can you tell me why that capacity for diagnosis is lacking?

Jocelynn, my question for you relates to the "what do we need" part—the second bullet there, on standardized data collection. Do we know enough about all of the aspects? It sounds to me as though we're still in a very dynamic state concerning learning about the full suite of what fetal alcohol spectrum disorder is, and so on. Do we know enough yet to create a standardized list? If we don't get the standards right now, that sets the benchmark for the future, and it is much harder to change, if we don't get it right the first time.

The Chair: Dr. Andrew, you're up first.

Dr. Gail Andrew: I think you're right on all those points. For example, in Alberta we have 24 diagnostic clinics. Most of them are funded through the province. The individuals who are seeking assessment do not have to pay. It's covered through our health services. There are a few private centres where you would have to pay privately.

For the current assessment centre that is within one of our youth correction centres, the funding is shared between Health and Justice —they split costs—and so the individual doesn't pay. We do not have as many physicians who have spent their life career, as I have, in this disability. I am an academic professor at the University of Alberta and I'm training, trying to get the next generation in place. With good clear guidelines, which we currently have, through training and mentoring we should be able to produce the next cohort of physicians who could be part of the team. It's a multidisciplinary team, so we need to have the same rigour of training within psychology, the training of speech or language pathologists, occupational therapists, or social workers.

I can speak for the University of Alberta; this has become a huge focus of our work. Across Canada we are fortunate. In the west to have more clinics than the east. We are mentoring more and more clinics as they show interest in being established in the eastern provinces.

● (1725)

The Chair: Dr. Cook.

Dr. Jocelynn Cook: A couple of years ago we did a little bit of analysis. We identified 2,000 slots for diagnosis, based on the current capacity at that time, and 3,500 for the demand. So there was a supply-demand issue, as Dr. Andrew suggested.

As for data, if we don't collect data we're not going to have any story to tell. We know enough about the FASD diagnosis, and there are some screening tools. We're starting to get the whole country to collect the same data when they assess their patients for FASD, whether they have it or not, and to say what they recommend in terms of supports and systems.

Justice in the Yukon is interested in collecting some of this standardized data to go into.... I don't know whether it's going to go into our database or not, but they're looking at collecting some of it so that they can see the trends and make some understanding about demand for services, supply of services, and what the patterns are for brain dysfunction. If you have X, Y, and Z, it might be different from A, B, and C, and you might need a different intervention. That is where data comes in.

Mr. Blaine Calkins: That's important. That leads me to my ultimate question. Are we far enough along in the research identification of fetal alcohol spectrum disorder to make a determination that we are going to exempt somebody from a sense of fulfilling justice by providing provisions in the Criminal Code that exempt somebody, whether through section 16 or through a bill like Ryan Leef's? He's a good friend of mine and a great colleague here in the House.

Are we confident enough that the medical system and the whole determination process is good enough that we're going to deny somebody a sense of justice in order to achieve an outcome on behalf of somebody who, through no fault of his own, finds himself in a situation?

Dr. Jocelynn Cook: Here's my science answer because I'm not a lawyer. Thankfully, I haven't had any run-ins with justice.

We know individuals have severe neurodevelopmental deficits. We know they don't learn from experience. We know they don't understand consequence. I'm saying this in general terms because there are both ends of the spectrum, and we know that. There are brain tests that show this dysfunction.

We also know, from evidence, that individuals with neurocognitive deficits don't do well in other types of system treatment outcomes, for example substance abuse. They forget to come to group, all of that. That's from U.S. data, so it's a little bit by proxy, which means that we're making a bit of a leap on what makes sense. The interpretation of that within the justice context may be better left to people who understand the justice context, but that's what we know empirically and that's true.

I'm happy to share with you our draft paper that's not published yet on the characteristics of the individuals in our database. That might be helpful. It's the first Canadian data that exists. We're getting ready to submit that for publication. That may show you the depth of impairment and where people are impaired, and that might help.

The Chair: Thank you, Doctor. Thank you for those questions and answers.

The next questioner is from the Liberal Party. Mr. Casey, the floor is yours, sir.

Mr. Sean Casey: Thank you, Mr. Chair.

Mr. Snow, I'd like to begin with you, but first of all when Madam Boivin asked a question of you she indicated that the private member's bill that I introduced—which borrowed generously from Mr. Leef's and also from the Canadian Bar Association in respect of the consideration of FASD as a recognized disability within the corrections system—was not going to get a chance for debate. That's probably correct, unless there is the political will among any parliamentarian who is in the order of precedence to trade places. That would be the only circumstance under which we would see a debate on Bill C-656 before Parliament, if there were a trade up. Otherwise, we're left with a bill that was introduced, to your great excitement, and then withdrawn.

You indicated in your testimony a couple of things that I want to come back to. One is that the bill introduced by Mr. Leef was a good start and that the perfect should not be allowed to be the enemy of the good. You called upon Minister MacKay to bring the resources of his department to bear to advance this.

Given your call to the minister, and given your identification of the private members' efforts to date as a good start, what improvements would you recommend on the initiatives that have been taken to date? If you had Minister MacKay's ear, and you were to say to him, “This is what you need to do to get as close as possible to perfect”, what recommendations would you have?

● (1730)

Mr. Rodney Snow: Thank you for that question.

Let me say that I think, as a I listened to the conversation here today and as we learn more, there are probably a lot of ideas that can come out of the work of this committee that might help to answer that question. I haven't had the benefit of sitting in on all the hearings, as you have.

One thing I think is important and that I would encourage is something you picked up in your bill, and that's the provision for external support orders. Everything I have been told by people who work closely in the system is that structure is important. If we can give the judges—who seem to be at the centre of dealing with a lot of individuals with this disability—the ability and the tools to make orders that will allow follow-up work with individuals who have FASD so that there is structure in place and so that can continue, even sometimes after probation is done and people are back in the community, that would be helpful. I think that's one idea. I noticed you have picked that up in your bill.

Mr. Sean Casey: We heard at an earlier meeting from Wenda Bradley, Fetal Alcohol Syndrome Society of the Yukon, and Dr. Cook just referred to the work that's being done in the Yukon. We didn't get a chance to ask any questions of Ms. Bradley so I'm going out on a bit of a limb here, Mr. Snow, to ask you whether you are familiar with the Yukon study that is presently in progress, and what you anticipate it will add to the conversation.

We're going to give Dr. Andrew a shot at that one as well, but from a local perspective is there anything you can offer, or do you want to hand the floor to Dr. Andrew?

Mr. Rodney Snow: I'm happy to hand it to Dr. Andrew.

Mr. Sean Casey: Dr. Andrew, you had your hand up.

Dr. Gail Andrew: Yes. I've been very fortunate to work with the Yukon government on this particular project. There is a project within the jail itself to provide diagnostic assessment of individuals. It's not mandatory so we do get their consent.

We're looking at actually validating some screening tools that could potentially be very useful across all of the justice systems to identify individuals who may have an FASD. We're looking at their brain profiles in detail. We're looking at additional substance abuse issues, mental health issues, and we're looking at recommendations post-release from serving their sentence. We're looking at what their brain profile tells us that we need to put in place to support that individual after they leave so they don't go through that revolving door.

It's an in-depth study. There is a service component. We're helping these individuals, but we're also collecting valuable data that will give us the profile of individuals who are currently in the justice system.

The Yukon has also just established an adult clinic where they are going to be seeing individuals, hopefully, before they ever set foot in the justice system. With this diagnostic information that will be strength and challenge based, we can look at what are the wraparound support systems in the community that individuals will need to prevent them from ever encountering the law, such as housing, community participation, and what they need in terms of funding so they aren't hungry and homeless.

We have learned through the literature that there is importance in trusting relationships and mentors. That's where the communities in the Yukon are really grasping this big picture of what we need to do, not just for diagnoses but the bigger piece of prevention.

I'm the clinical consultant. I mentioned I do a lot of training and teaching. I've been involved in training both of those teams, and via Telehealth I am their clinical consultant in helping interpret the brain dysfunction.

● (1735)

Mr. Sean Casey: Professor Popova, when you testified before committee, you gave us a lot of numbers. I want to know if I have this one right and whether you could tell us a little more about it.

You indicated that the cost to the correctional system in Canada, if I heard you correctly, was $378 million for FASD. Have I quoted you correctly, and can you tell us anything more about that number?

Dr. Svetlana Popova: Yes, it's correct. We recently estimated that the cost of corrections was associated with $378 million per year, annual cost. We were not able to estimate the cost associated with police and corrections because the data actually doesn't exist.

I think more importantly I would just reiterate that based on justice statistics in Canada, data and epidemiological data, we estimated that youths with FASD were 19 times more likely to be incarcerated than youth without FASD in any given year in Canada.

We also estimated—it's presented in one of my slides—that the total annual cost of corrections among adults was more than $356 million, and among youths it was approximately $17.5 million. There was a gender difference. Of course, males accounted for the largest proportion of this cost based on the male-female gender ratio that we obtained from Statistics Canada.

The Chair: Thank you very much, Professor, for those questions and answers.

Our next questioner, from the Conservative Party, is Mr. Dechert.

Mr. Bob Dechert: Thank you, Mr. Chair.

Thank you, ladies and gentlemen, for joining us and sharing your expertise.

Dr. Cook, I just want to mention that my father was an obstetrician and gynecologist, and practised for over 40 years in the city of Hamilton. I very much appreciate the work that you and your colleagues do in research and caring for people.

You mentioned in your comments that a significant number of women of child-bearing age are drinking, and you also mentioned some other drugs and how they might also impact. Is the incidence of FASD increasing over time? Is it decreasing, staying the same?

Dr. Jocelynn Cook: That's a really good question. Is the incidence of FASD increasing? Is awareness of FASD increasing so that women are disclosing their alcohol use more? Are we diagnosing more so that we can say there's more FASD?

● (1740)

Mr. Bob Dechert: Are you diagnosing more?

Dr. Jocelynn Cook: Yes. In Canada we have many more diagnostic clinics than we did in the past. They're continuously opening in different places. Quebec has its first one now; it's exciting. We are diagnosing more.

We're trying to change the stigma around alcohol use in pregnancy so there's not the shame and blame context. We're hoping that women are becoming more comfortable talking about alcohol use. We're doing a lot of education so that everybody understands the potential implications of alcohol use during pregnancy. We're working a lot with health professionals and front-line workers so that they know how to talk to women about alcohol use, because there's an art to that and there's a relationship piece to that.

I don't know. Dr. Popova has done a lot of work on prevalence in Canada. We know different populations have a higher incidence. We know about child welfare, as Dr. Andrew suggested. We know justice. We know some isolated communities. There are lots of other factors for that.

I don't know the answer to that. I'd like to think it's decreasing, but the prevalence of women drinking during pregnancy is not decreasing.

Mr. Bob Dechert: Okay. I think Dr. Popova wants to comment as well.

Dr. Jocelynn Cook: I think the incidence of women drinking dangerously during child-bearing age is increasing.

Mr. Bob Dechert: You do think the drinking is increasing.

Dr. Jocelynn Cook: Yes, the drinking is increasing, and the pattern.

Mr. Bob Dechert: Yet there's advertising. Generally you see it on bottles of alcohol, on bottles of beer and wine. Sometimes you see it in bars and restaurants. There's a notation on a menu or on a sign in the bar that there's a danger in doing this. Is there a need for more of that kind of advertising and public education about the dangers of drinking during pregnancy?

Dr. Jocelynn Cook: There is a need. At the SOGC, the Society of Obstetricians and Gynaecologists of Canada, we talk a lot about healthy pregnancy in general and making a package. Nutrition is important. Stress is important. Not taking drugs is important. Alcohol is important. It's a whole package of education around how to have a healthy pregnancy and a healthy baby.

You have to take the data with a grain of salt sometimes, because some women will report that they're drinking during pregnancy but they're having half a glass of wine.

Mr. Bob Dechert: Just before we go to Dr. Popova, do you see a similar impact with use of other drugs, for example marijuana? Does that have a similar kind of impact that alcohol has? No? Okay. Any other kinds of drug use?

Dr. Jocelynn Cook: No. There's a big study going on around the effects of THC, which is the active ingredient in marijuana. I haven't really looked closely at that report, but it just came out. I can access that. It's not teratogenic like alcohol. It doesn't cause birth defects in the brain.

Mr. Bob Dechert: That's fair enough.

Dr. Popova, you had a comment.

Dr. Svetlana Popova: Thank you very much.

I just wanted to add about the prevalence of FASD. We don't know the true prevalence of FASD in the population of Canada. We have very outdated estimates, which were adopted from the United States. We believe it's only 1% of the population. Currently we are conducting a population-based study among elementary school children, and hopefully, in a year or so we will have a better idea about the prevalence of FASD in the general population.

We don't think that the level of FASD is decreasing. Unfortunately, it will increase in the near future for two reasons. The first reason is that alcohol consumption, especially among young women of child-bearing age, is increasing, especially binge drinking, which is the most detrimental pattern for FASD. The second reason is that the majority of pregnancies are unplanned. We believe that in developed countries it's about 50%.

Thank you.

Mr. Bob Dechert: Can I ask a question that I failed to ask Dr. Cook?

I thought you said there was maybe some scientific evidence that drinking prior to pregnancy may have some impact. Is that true?

Dr. Jocelynn Cook: Oh, that's exciting. That's a new field of epigenetics. There is evidence.

Voices: Oh, oh!

Dr. Jocelyn Cook: Sorry, but I do love it. To me, it's huge. It's showing that there can be changes in a woman's genetics that can be passed on to her developing fetus that may make it more susceptible to toxic insults, including alcohol.

Mr. Bob Dechert: Okay, interesting.

Dr. Andrew...and then if I can, Mr. Chair, I'd like to ask Mr. Snow a question.

Dr. Andrew.

Dr. Gail Andrew: I'm all in support of awareness prevention campaigns through posters, coasters, or whatever it takes, but there have been really good studies that show awareness of the harmfulness of drinking during pregnancy does not necessarily change the behaviour. The stories of my birth mothers are horrendous. We have looked broadly at the social determinants of health. They are living in poverty and in domestic violence. They are in situations where even if they desperately want to change behaviour, they cannot without help. That's where we need those high-risk mother programs to actually bring them into harm reduction and a therapeutic environment.

● (1745)

Mr. Bob Dechert: Well, hopefully, we can collectively come up with some more strategies to reduce the incidence of FASD over time.

Mr. Snow, at any time have you represented clients in the criminal justice system, in your practice, who have FASD?

Mr. Rodney Snow: Not in the criminal justice....

Mr. Bob Dechert: Okay, so you don't do criminal defence work?

Mr. Rodney Snow: No, I don't, sir—

Mr. Bob Dechert: But I assume you know lawyers who do. My question is around section 718.2 of the Criminal Code, which allows a defence counsel to raise any issue that might impact the sentencing of an accused who's been convicted that might be a mitigating factor. I wonder if you could tell us, if you know, do defence counsel typically raise this? If not, why not? If they don't, do you think they're negligent in not bringing it up if there is some evidence that their client may suffer from FASD?

Mr. Rodney Snow: Let me say that I think one of the biggest barriers to raising this issue is the inability to get assessments. At least that's the case in the cases I've heard about from individuals I've spoken with, and it's not just defence counsel. It's prosecutors whom I've spoken with as well who are very clear that they think we can do better in dealing with individuals with FASD. But a whole lot of it comes back to assessments—assess, assess, assess. We have to have the information for the judges.

Mr. Bob Dechert: Do you think a defence counsel who didn't raise it with his client as something that could affect the client's sentence would be seen as being negligent?

Mr. Rodney Snow: No, I don't think so.

Mr. Bob Dechert: Okay, thank you.

The Chair: Thank you for those questions and answers.

Our next questioner is from the New Democratic Party, Madam Péclet.

Ms. Ève Péclet: Thank you, Mr. Chair.

Thank you very much to all the witnesses for your great testimony.

[*Translation*]

My first question goes to Ms. Popova.

The figures you gave us are interesting. I am going to repeat what my colleague said, that the costs of correctional services have reached $378 million.

By way of comparison, can you give us any figures about individuals with FASD who have been incarcerated through the justice system and about others who, after being diagnosed, might have been taken into prevention and educational services? Do you have any figures for us about that?

You have given us figures about the costs of correctional services, but do you have any about the costs of prevention and education?

[*English*]

Dr. Svetlana Popova: Thank you very much for this question.

Actually, right now, you have given me a brilliant idea for further research, because such numbers don't exist but it would be great to estimate and show the difference.

Thank you.

Ms. Ève Péclet: Well, my pleasure.

The Chair: Madam Péclet, do you want Ms. Cook to respond?

Ms. Ève Péclet: Yes.

Dr. Jocelynn Cook: I want to do that study too, though there are data that show the cost of an individual with FASD versus costs for individuals without FASD. Costs haven't been partitioned out in terms of justice versus...but they would run the gamut, including social services, child welfare, health, and those kinds of things. We know that individuals with FASD cost more, but comparing them to the folks who tend to revisit the justice system is a really great question. I'm excited for that study.

Ms. Ève Péclet: My second question has to do with the $4,000 we have to pay to assess someone. How does the cost to the state for assessing people and redirecting them to good resources compare with just saying, we're not going to assess them and we're going to put them in jail? I would be interested in knowing which policy is better for the state to have.

It's really interesting because my second question would be for you, Ms. Cook. I have a letter written to the committee by the Canadian Academy of Psychiatry and the Law. I'm going to read it in French because I have it in French. It says:

● (1750)

[*Translation*]

> The proposed distinction in Bill C-583 is not supported by psychiatric diagnostic standards. In fact, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association, the North American authority in diagnostics, does not recognize FASD as a separate or distinct disorder, but rightly includes it with other forms of developmental delay.

[*English*]

I would just like to have your comments on that. Have you read the definition in the bill and what would you say about this paragraph in the letter?

Dr. Jocelynn Cook: Gail will have an answer for this too. In rewriting the diagnostic guidelines, we tried very hard to use terminology congruent with that in the DSM-5. We call it the psychiatrist's bible. This is for psychiatrists to diagnose behavioural disorders. FASD has lots of other aspects to it as well. It's neurodevelopmental. There is actual brain damage associated with it. Psychiatry is one part of it and one member of the diagnostic team is a psychiatrist, but FASD is bigger than psychiatry. That's how I would answer that.

Gail may have another take on that from a clinical perspective.

The Chair: The floor is yours.

Dr. Gail Andrew: Thank you. I introduced myself as a developmental pediatrician. Developmental pediatricians are trained to look at neurodevelopmental disorders, and in fact in very young children and infants we can see some of the early signs of affect dysregulation. That is one difference between the professional distinctions. Psychiatrists predominantly look at mental health disorders. As developmental pediatricians, we look at neurodevelopmental disabilities such as brain injury and acquired brain injury. FASD is an acquired brain injury. We just didn't see the accident because it happened in utero.

Ms. Ève Péclet: Would you see a difference between other types of mental illnesses? My colleague talked about section 16, which talks about a “mental disorder”. Would you say that FASD would be a different type of mental disorder, or is the definition in section 16 broad enough to include that?

I know, Dr. Andrew, you said it would fall under section 16.

Dr. Gail Andrew: Maybe I can answer a little bit of this.

I would say that fetal alcohol spectrum disorder is much broader than a mental health disorder, because it impacts communication and all of those other brain functions. It is often comorbid with an anxiety diagnosis or a diagnosed depression or disruptive mood disorder, but FASD is much bigger than anxiety itself. If you have just anxiety, albeit a significant disability, and all of your other brain functions are intact, you are very different from somebody who has FASD and who has significant impairment across many areas.

The Chair: Does anybody else want to comment on that?

Dr. Jocelynn Cook: I had to think about it.

Mental illness is here; FASD is here. The data are very strong and show that 95% of individuals with FASD have a diagnosed mental health condition such as anxiety, depression, those kinds of things, which are in the DSM. That's why we work very closely with having that addressed properly.

The other important thing is that traditional treatments for mental illness diagnosed by the DSM may not actually work for individuals with FASD, because their brains aren't built right sometimes and they don't work right sometimes. That's really important to remember as well.

It's just bigger—a lot bigger.

● (1755)

The Chair: Can we get a brief answer from you, Professor Popova? You had your hand up.

Dr. Svetlana Popova: I just wanted to add that we recently conducted a systematic literature review. We gathered all available medical and epidemiological literature. We found that more than 400 disease conditions are associated with FASD, and the second-largest group was mental and behavioural disorders. A tremendous number of mental conditions are attributable to FASD. That's why we call it a spectrum; it includes a wide range of mental disorders.

The Chair: Thank you for those questions and answers.

Finally, Mr. Wilks, from the Conservative Party, the floor is yours.

Mr. David Wilks: Thank you, and thanks to the guests today.

My question is going to be more on the criminal side of it, because that's what I'm used to. I just wanted to touch a bit on NCR, section 16, that we seem to have latched onto a little bit. The challenge with NCR is in regard to how far down the Criminal Code you go. NCR is normally reserved for the gravest of the grave. It's not reserved for shoplifting. It's not reserved for impaired driving. The judge can deal with those through various different ways of sentencing, if they so choose. I've never seen an NCR on shoplifting or impaired driving, and I don't know if I ever will. I think we may be looking at something that doesn't really apply unless it's the gravest of the grave.

The other issue that I wanted to get to is section 13 of the code, which we don't talk about much, which states that no person shall be convicted of an offence in respect of an act or omission on his or her part while that person is under the age of twelve years.

I bring this to each one of you to give me a brief answer. As a police officer I dealt with the same 10-year-old over and over, knowing full well that there can be no criminal involvement whatsoever. The option for the police officer is to turn that child over to social services. That's really the only option they have, so that child is turned over to social services. The police officer knows that there's something going on there. The police officer also suggests to social services that the child should probably not go back into his or her home environment. The challenge is that the parents may be part of the problem, but there needs to be some form of investigation to do that. Then social services turns around and says they don't have the authority to do that, that their job is to integrate the child back into the family.

There is the cycle, until the child becomes 12, when the police can actually do something about it criminally. It seems to be the catch here that until the child is 12, nothing can be done. Once the child is 12, if they've been identified with FASD, as all of us in this room would probably agree, it's too late. They've now had to enter into the criminal justice system, whether we like it or not.

My question is to each one of you. We've all identified what the factors are for FASD. We've all identified what could lead to it. How do we intervene at a young age so that they don't get to the criminal stage?

I'll start with Dr. Popova, and go to Dr. Andrew, and then Dr. Cook.

Dr. Svetlana Popova: I will give just general answers to that—

[*Technical difficulty—Editor*]

● (1800)

The Chair: We can't hear you now.

Dr. Cook is still here.

Dr. Cook, the floor is yours for now.

Dr. Jocelynn Cook: There was only one good study that was published in 1993 in the States, which showed the protective factors for improving outcomes for individuals with FASD. The top two were diagnosis before age six, because you can hopefully link to supportive services, and a stable home environment.

There is also lots of data that shows that kids with FASD who are in the child welfare system—or child whatever we call it in Canada—skip around to all different sorts of placements. That's not good and we know that. Depending on the family environment and situation.... Sometimes they're trying to be a stable family environment, but the kid has a lot of issues that are FASD related. Sometimes it's not a stable home environment.

I hear the same story. I have a friend who is a judge. She used to be in Saskatchewan and is now in B.C. She said, “I see the same thing. A ten-year-old kid is in front of me a hundred times in a year. I don't know what to do.”

That's significant.

The Chair: Dr. Andrew, you're back.

Do you have an answer to that?

Dr. Gail Andrew: Actually I share everybody's angst and concern.

I spend a lot of time trying to look at the brain profile in preschool children who are prenatally exposed to alcohol. I may not necessarily give them a full diagnosis, but I get a pretty good sense of what they need in terms of services and supports. We try to put those in place, hopefully while the child is with their family of origin, and if the family of origin is not able to look after the child to then make recommendations for alternative placement. This is why we have to know the best interventions for those individuals.

We are currently doing some research here at the Glenrose in the young population, as we call it.

In fact, I referred previously to the Institute of Health Economics conference on legal issues in FASD from September 2013, and that was the exact question that the Honourable Ian Binnie had given me to address during those proceedings. What we presented in the proceedings was the need for a wraparound service for young children and then longitudinal follow-up of their developing brain, and supports across all transitions.

We don't have all of that data yet, but hopefully with longitudinal supports we can circumvent that child ending up in the law.

The Chair: I want to thank all of our witnesses today. It was an excellent panel. I want to thank you for all of your expertise and work in this area.

I do want to remind committee members that we have four more witnesses. One is a repeat witness, who was here but not presenting, so there are three presentations, I believe, on Wednesday, for the full two hours. But I want to leave about a half an hour, if we can, to give direction to our analysts on the report writing that they need to do for us. I would ask that you give that some thought, and maybe even talk to each other in between times.

With that, I'll move to adjourn. We have a vote at 6:30.