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Chair

Mr. Mike Wallace

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● (1530)

[*English*]

The Chair (Mr. Mike Wallace (Burlington, CPC)): Ladies and gentlemen, let me call this meeting of the Standing Committee on Justice and Human Rights to order.

This is meeting 68, and according to the orders of the day, pursuant to the order of reference of Wednesday, November 26, 2014, the subject matter is Bill C-583, an act to amend the Criminal Code (fetal alcohol spectrum disorder).

We have four witnesses with us today, but the final witness, Ms. Bradley, from the Fetal Alcohol Syndrome Society Yukon, has already presented. We weren't able to get her for the question-and-answer period, so she has kindly rejoined us today.

We have three presentations of approximately 10 minutes each.

Our first presenter, Ms. Ross, is from the Fetal Alcohol Spectrum Disorder Group of Ottawa. By video conference from Edmonton, we have, as an individual, Ms. Pei, associate professor at the University of Alberta. As well, from the Assembly of First Nations, we have Mr. Alexis, Alberta regional chief. Then, of course, from the Yukon, we have Ms. Bradley, also by video conference.

With that, we'll get started.

Ms. Ross, the floor is yours.

Ms. Elspeth Ross (Facilitator, Fetal Alcohol Spectrum Disorder Group of Ottawa): Mr. Chair, thank you for the opportunity to address the justice and human rights committee today.

My name is Elspeth Ross. I am a parent and a volunteer service and information provider for FASD. I'm talking to you today from the front end of the issue that you are dealing with. I represent the FASD group of Ottawa, which I have facilitated since 1999.

My husband and I have two sons affected by FASD, who are now in their thirties. I serve on committees locally and provincially, and provide a current awareness service by email now through the FASD-Canadian-News.

ln 1992 I was a parent invited to a national symposium on FAS/FAE in Vancouver. We parents came away all fired up and keen to take on organizing FASD, but we can't do it. Our families are often in crisis and we struggle along without help.

The federal government's FASD framework for action makes the same mistake, putting the onus on the community. We don't see leadership from the federal government or a national effort or agenda on FASD in health or justice, or collaboration with the provinces. It's exciting that there is so much research and action going on in FASD now, but we need more in Canada.

The situation is urgent because more women of chiId-bearing age are drinking alcoholic beverages and binge drinking. Damage is done early in pregnancy and 50% of pregnancies are unplanned.

My husband and I had the advantage of knowing in 1991, when our first son joined the family at 19 months, that prenatal alcohol was a factor and that we should look for help. That's unusual.

Tall, good looking, and good talkers, most people affected have average IQ. My sons both graduated from high school, and one from college, and was married. Both work in masonry with an understanding boss.

My second son was caught shoplifting and did community service. He went for a job interview at a store at noon and went back at 2:30 to shoplift from the same store. Does that make sense? The policeman said, “This young man will learn from his mistakes”. That policeman knew about FASD, yes, and tore up the summons.

The same son has got letters from collection agencies for things he does not remember, probably getting on buses without paying. We don't believe any of his stories. He lost an apartment because friends that he met on the street moved in and of course he lost it. Easy victim.

Both sons have to be reminded over and over, and may not show up for appointments. They need clear and simple instructions. Money flows, documents are lost, and forms can't be filled out. There are complications with addictions, health problems with diabetes type 2 and panic attacks. Supervision, structure, services, support, and luck have kept them out of the justice system.

People with FASD have talents and skills, and we build on these to maximize potential with the theme “Being your best with FASD”.

I'm here today to support the issue in Ryan Leef's bill, which would be a great start. We need the addition of court-required external support plans to facilitate reintegration into society. We encourage expanded use of diversion, conferencing, mental health, and community courts, and supports and services to keep people out in the first place.

FASD is a brain disorder and no two people are the same. You see them in the justice system as witnesses, victims, as well as accused, without recognizing them. Eager to please, people with FASD may waive their rights or take responsibility for crimes of others. One mother reports that her son was assaulted and subsequently appeared as a witness. One day on the stand was a gruelling process for someone easily confused. The accused got off and now the young man has no faith in the system for protection, and is marked for daring to testify.

FASD is often labelled as an attachment disorder, ADHD or autism, which are more acceptable conditions. It's complex, with all those occurring, as well as trauma, and being moved around, and mental health problems.

We need to speak out, but many family members won't speak publicly because of guilt and shame, or being blamed for poor parenting, embarrassment, or because they are afraid their children will be targeted. Getting a diagnosis must be made easier. Some won't try for it because they can't get services anyway. People with FASD are usually too high functioning to qualify for developmental services if based on IQ.

What are the protective factors? The researcher Ann Streissguth referred to the following in 1997: early identification and diagnosis, a stable home, supportive environments, and direct involvement with special services. Families need help to provide information and education, so they know it's a disability; support and understanding; help navigating the system; flexibility; patience; perseverance; and hope.

● (1535)

An Ontario stakeholders group in 2008 found that the biggest needs of families was for help with schools, finding respite, transition to adult services, supportive living and employment, diagnostic services, and knowledgeable professionals.

Parents have to educate professionals one at a time. Some of us are joining with families of other developmental disabilities groups, and we've been asked to work with those in the autism community for police training and a registry of people affected.

People with FASD need an “external brain” or scaffolding to help them cope with everyday life, let alone the extra demands of the justice system. This means a parent/caregiver, spouse, mentor, teacher, case worker, and probation officer. Remember us, too, the parents of adults; we often have information and can be allies.

Lawyers, judges, court and probation workers, police officers, social workers, and prison guards all need training and continuing education. A probation officer reports that she must be very specific with instructions and directions and not task her clients with too much in case they get overwhelmed. She would welcome more ideas on what works.

It's now impossible to keep up with all the FASD news and research, and FASD is often being brought up in court cases. Canada has big conferences. The one in Vancouver earlier this month had 600 participants from 13 countries. The pre-conference day FASD and the law event had 20 speakers with suggestions and innovative ideas. You can see many of these on the web.

However, Canada's west and north is where the action is. NeuroDevNet provides research and interventions. The Canada FASD Research Network in eastern Canada only includes New Brunswick, not Ontario. The Ontario government is only beginning to acknowledge FASD—maybe. All over Ontario there are grass-roots activities by volunteers. A lawyer recently asked our group to provide counselling to help get a client out of jail, but we couldn't do it without funding.

There are two things this committee can do. Invite the FASD play “Jacob's Story” to come from Kingston to present to you. Ryan Leef was there to watch it when we brought them on February 18. You could also listen to the words of people affected who are speaking out more and more, and I could suggest how to do that.

In Canada we expect our federal government to lead and act on issues of importance like FASD. This committee has a unique opportunity to make recommendations.

In conclusion, as you study this issue, I hope you will receive information from all parts of the federal government that deal with individuals with FASD. In 2006, the government determined that the Public Health Agency of Canada would be the lead agency and coordinate activities. Ask them for information on projects funded and efforts to share best practices, which could be useful for the justice system.

Here are four recommendations.

One, provide funding for research and data collection into all aspects of FASD, especially those relevant to the justice system. Two, coordinate national law enforcement and justice system networks and events for sharing FASD best practices, tied to a curriculum for professionals, as well as continuing training. Three, support efforts to create more diagnostic centres across Canada. And four, recommend the creation and funding of case manager positions to help people with developmental disabilities and FASD.

I'd like to thank you for your attention and I look forward to your report and to the changes that may result from your deliberations.

● (1540)

The Chair: Thank you, Ms. Ross. Thank you for sharing your personal involvement with this issue.

Our next presenter is from Edmonton by video conference, as an individual. We have Associate Professor Pei, from the University of Alberta.

The floor is yours.

Dr. Jacqueline Pei (Associate Professor, University of Alberta, As an Individual): Thank you very much.

Thank you to everyone for this opportunity to speak to the committee about this very important issue. I believe you've all received the brief I've written. It provides a lot of the detail and the references. My hope today is to highlight a few key features in that brief and to take it a little bit further.

I'm speaking as both a clinician and a researcher. I work as a researcher with the University of Alberta and the Canada FASD Research Network. I'm also a neuropsychologist who's had the opportunity to work with a number of individuals in the justice system with an FASD. I hope to speak to some specific issues of justice as well as some of the clinical pieces of the puzzle.

I believe you guys have had a number of presentations, and in my brief there's also a discussion about areas of the brain that have been affected and impacted by prenatal alcohol exposure, so I won't revisit that. However, during the question session I'd be happy to address questions and explore some of the ideas around that.

Instead I want to focus today on the portion of my brief that speaks to the risk, needs, and responsivity model. This is identified about midway through my brief. In particular, the risk, needs, and responsivity model is the model that is typically looked at as identifying most faithfully the best approaches to having the best outcome in the justice system. When we employ this model the way it was designed to be employed, we tend to see the best outcomes for any individual across the board.

What is the model? The model starts with risk. How do we assess risk and decide what factors contribute to the risk of somebody engaging in criminal behaviour?

“Needs” is the identification of those criminogenic needs or factors that contribute to why they're involved in the system. Some of those needs might be static or stable, like a history of abuse. Some of those needs may be dynamic or changeable, like being part of a marginalized peer group, lacking a job, or being dysfunctional in their adaptive setting at this time.

“Responsivity” refers to how we respond to those dynamic or changeable needs in a way that creates the potential for change for that individual. Ultimately, when we're talking about the justice system, we're talking about reduced recidivism or reduced likelihood that this person will re-engage with the system.

So that's the model. When it's employed, one of the things we've learned, again with the general population, is that if we have a really good understanding of risk and can then meet the needs that create that risk, we can then match treatment in such a way that it produces the best outcomes. We see a reduction, then, in reoffending when there's an effective match of intervention, sentencing treatment initiatives, and follow-up in the community matching that level of risk and the needs that are presented by that individual. That match is required for good outcomes for an individual.

Now, when I talk about this model, some of the challenges we face in part are in the research world. There's been a large amount of research into risk and what constitutes risk. However, when we start to examine needs and what these needs are, there's less research. Then when we ask what actually works, and what responsivity looks like, there's less research. This is even more true when we start to work with populations that are cognitively diverse or different from the broader population, such as FASD, or fetal alcohol spectrum disorder.

What we are learning is that when we have populations that are more diverse, they may reach a ceiling in terms of that risk factor so that they look very high risk and we can't differentiate that risk anymore to say—within the FASD population, for instance—what the risk looks like, because they all look high risk. So then we respond to them in terms of matching needs with a high-risk offender, which often may mean lengthy sentencing or very intensive treatment approaches. We look at that kind of trajectory

The problem with this is that by not separating the FASD population, we may be providing an intensive level of support to individuals who are actually low risk. Once we examine that cognitively diverse population, and we look at them, we say that they may look high risk compared with the general population, but when we look within that population and actually start researching where they sit, they are not as high risk as we think.

Why is this a concern, you say? We're just giving them more support, more treatment—or often, in cases, a more punitive response. It's a risk because one of the really pronounced features in this model is that when we fail to match risk to our treatment or sentencing response, we can actually do harm and increase the likelihood that an individual will reoffend. If we take somebody who is truly high-risk and give them low-intensity support and treatment or not enough intensive care, there is a likelihood that they're going to get worse. If we take an individual who is low-risk—somebody, say, such as in the shoplifting case we just heard about from our previous speaker—and we say that we want to respond with a high-intensity, punitive sentencing response, we actually see increased recidivism or increased reoffending. So we have done harm and have actually made it worse.

● (1545)

With one-stop shopping—when we use a single-model approach and say that we're going to let the risk come up to the ceiling and are going to respond to this entire population as though they're all really high-risk—we actually create a scenario in which this population may be inappropriately placed within high-intensity services that make things worse for them, increasing the likelihood that they will reoffend and that we will be dealing with them again, which of course is of concern both for that individual as well as for the broader community.

This is crucial to recognize. The choices that we make around sentencing and intervention really can do some significant harm, sending this person back into the system. Providing an assessment that is specialized and that allows us to best understand the needs of an individual will allow us to better differentiate risk, better understand what the criminogenic factors—those needs that are contributing to this criminal behaviour—are, so that we can make sure to target and tailor the response so that it is both of sufficient intensity and of the appropriate type to meet the needs of this individual so that they experience success and that the community is safe.

I'll provide one very brief example of an individual whom I had the opportunity to work with. He was diagnosed with FASD and had entered the system, but there was no knowledge about him by way of specialized assessment. A risk assessment was conducted, he was deemed to be high-risk, was put into high-risk programs over and over again. He was violent, he was aggressive, and he was actually very dangerous to the community at large. At no time was an assessment conducted to determine what his unique pattern of cognitive diversity actually looked like.

They eventually came to me and said: “We don't know what to do. We can't even keep him incarcerated safely.” I went in, worked with him, and conducted an assessment. In the course of that assessment, we were able to identify the fact that the core deficit for this individual was that he was unable to recognize his own regulatory capabilities. Said another way, he was unable to see that he was becoming agitated or triggered. He would seem fine, to everyone he would appear to be fine, and then the next minute he was angry and violent. Nobody understood what was going on.

Through the assessment we were able to identify the fact that he simply lacked the insight and the ability to recognize. The part of the brain responsible to say that the pressure is going up was not working.

What did we do? We said that we could provide a treatment strategy that is responsive to his unique needs as an individual. We put on his arm an ActiGraph, a measurement of his heart rate that allowed us to create a calibrated heart rate over the activity of a day. If his heart rate exceeded that amount—meaning that he was beginning to get angry and agitated—an alarm would go off. This compensated for the failure of his brain to tell him the same information. When the alarm went off, he was then able to separate himself from the situation and engage in some regulation activities to bring his activation level down—he was able to calm down.

He went from aggressive activity every day to none. It was an inexpensive response that allowed him to reduce his offending behaviour substantially. Significant changes occurred, and in the community we were able to redefine and think about how to support him and to put in community supports that were meaningful, based on the fact that now his anger was regulated, or that he had the ability to regulate it.

That required a different level of inquiry, which said that we don't understand these criminogenic needs in a detailed way if we don't look at the brain.

My recommendations to the committee are that we move beyond a one-size-fits-all model of criminal justice. When we're working with cognitively diverse populations such as those with an FASD, it's essential that we look at specialized assessment geared towards informing intervention.

● (1550)

Diagnosis is important, but we need to move beyond diagnosis alone to approaches that also identify intervention approaches that will be the right fit for an individual and allow us to match that individual's needs to our intervention strategies, thereby reducing rather than elevating risk.

Secondly, we need to look at high levels of training that can take place within the system—just as you heard with the previous speaker—to support an assessment, for an intervention approach that recognizes that sometimes we need to shift our approach and respond in unique and creative ways to a population that will be responsive when we do so.

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

The Chair: Thank you very much, Professor.

Now, from the Assembly of First Nations, we have Chief Alexis.

The floor is yours, sir, for 10 minutes.

Chief Cameron Alexis (Alberta Regional Chief, Assembly of First Nations): Thank you very much.

Boozhoo. Tanisi. Aaniin.

I want to thank previous speakers, and also to thank the House of Commons committee on justice and human rights for allowing us to participate in this very, very important presentation.

My name is Cameron Alexis. I am the regional chief for Treaty 6, 7, and 8 in Alberta, and I lead the work on behalf of the Assembly of First Nations executive in the area of justice. I was an RCMP officer for 23 years.

I am honoured to speak to you today about this private member's bill, Bill C-583, an act to amend the Criminal Code (fetal alcohol spectrum disorder).

The Assembly of First Nations has always stressed the importance of flexibility in sentencing. First nations are overrepresented in the criminal justice system. While our population is approximately 4% of the general population, we make up almost a quarter of the present criminal justice system population and over 50% in the western provinces. This current situation is the result of many factors that this committee is well aware of, including colonization, disposition of lands and culture, the intergenerational impacts of residential schools, and the failure of the child welfare system, to name a few.

Currently, paragraph 718.2(e) of the Criminal Code requires that the particular situation of aboriginal offenders be considered at sentencing and requires that a report outlining the individual's background—also known as the Gladue report, from British Columbia—be provided at pre-sentencing.

Bill C-583 would add a definition of fetal alcohol spectrum disorder, or FASD, to the Criminal Code, as well as other provisions for FASD assessment, evidence provisions, and sentencing considerations for accused with FASD. Adding these new provisions to the Criminal Code would allow judges to identify and consider the effects of FASD in the sentencing of the accused.

Some first nation communities have experienced disproportionately high rates of FASD, and the proposed amendments could provide additional context to sentencing and act as a supportive companion to the statement of purposes and principles of sentencing set out in section 718 of the Criminal Code.

We are concerned that recent amendments to Criminal Code requiring mandatory minimum sentences remove from sentencing judges the discretion to appropriately and effectively determine which sentence can best balance all the fundamental objectives of sentencing. Therefore, to achieve its objectives, the bill would require provisions making the mandatory minimum sentencing provisions subject to the proposed provisions of Bill C-583. Otherwise, the bill would fail to provide judges the required discretion to provide creative sentencing, better reflecting the situation and the capacity limitations of accused persons with FASD.

The current criminal justice system has profoundly failed first nations. It has done so in failing to respect cultural differences, failing to address the system's biases against our people, and denying them an effective voice in the development and delivery of service. The introduction of mandatory minimum sentences furthers this fundamental miscarriage of justice and the failure to respect and uphold aboriginal treaty rights and human rights.

In effect, the justice system is investing in the present system instead of preventative measures and proper supports and services for those suspected of and/or diagnosed with FASD, rights including court-ordered FASD assessments as long as the client is not inhibited by lack of funds for costly diagnoses and also that the courts ensure clients are provided with proper supports that respect their rights and those of their biological mothers. This bill cannot have the needed impact while the unique considerations of first nations, including those with FASD, are subject to non-discretionary sentencing conditions.

We have seen the damaging effects of colonization and the residential school system in our communities. The current criminal justice system has consistently and profoundly failed first nations. Without the proper modifications of this bill, it will ensure that this unfortunate legacy continues.

● (1555)

In closing I just want to add a few quick things.

I want to thank all of you for your valuable interventions. I really thank the speakers before me. I also want to thank Ryan Leef from the Yukon for stepping up on this.

As first nations, we continue to struggle with this, and I know from sentencing circles and restorative justice initiatives that we, by and large, cannot factor in FASD. Our people continue to suffer and correction is not the answer. We need prevention.

I deal with people in my own family and in my own community with this almost on an everyday basis. You have to repeat yourself more than several times to even get your message across. We need a different mechanism, and I support the amendment to this bill.

Respectfully, thank you, members of the committee.

Ish nish. Thank you.

The Chair: Thank you very much, Chief.

Now we're going to go to the question and answer period.

This is a reminder that Ms. Bradley gave her presentation previously, so she's here for questions and answers.

Please, it helps both me and those who are on video conference if, when you're asking a specific question, you let the witness know that the question is for them.

With that, we're starting our question and answer session with the New Democratic Party.

Madame Boivin.

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

Thank you to all witnesses here today. It was very enlightening and informative, I must say.

I thank you, Ms. Ross, first of all because of all the work you do. I think it's very important, and sharing your story helps us to understand.

I will keep in mind what you said about how we need more diagnostic centres. I look at the legislation, which in quotation marks is not necessarily even "in front of" Parliament anymore. I think this is important because we're in discussion mode, and we'll make recommendations. Sometimes, maybe it's my age, I get impatient because I think we were all pretty much aware of the situation, but I always learn something and so I'll keep that positive. At the same time, I don't think we'll be able to move it as far forward in this legislature as I wish we could.

However, the point on more diagnostic centres is a very important one because if, at some point in time, we do have a piece of legislation that comes into force, has an impact on the Criminal Code, and changes different things, it will be all fine and dandy but there are a lot of courthouses in this country. It's a big country, and if all the centres for diagnosis are in certain areas, there will be a lot people who will not be able to benefit from this situation. I'm a strong believer that justice should be rendered the same way for everybody.

I think in your testimony, there was some emphasis made by Professor Pei—I hope I say your name right, but believe you me, the way anglophones say my last name, I'm sorry, but not that much.

Anyways, Professor Pei, you were talking about moving beyond a one-size-fits-all system and the fact that we need more diagnostic centres. I am addressing my question maybe to you. How many of those exist in Canada?

Second, the more I hear about FASD, the more I wonder if section 16 of the code in any shape or way could find application because 16.1 says the following:

> No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that renders the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.

I am curious to hear your view on the matter.

For Chief Alexis, thank you very much for the points you made, which were very, very important, because I was also going to say that mandatory minimum sentences defeat the purpose of Bill C-583. I understand from your recommendation, and I'm sure the other members on the panel today would agree with you, that Bill C-583 or whatever shape it will come back in during a new legislature should give precedent to this over any mandatory minimum sentencing.

Those are my questions.

● (1600)

The Chair: Okay, I think the first question is for Professor Pei.

Ms. Françoise Boivin: How many centres do we have in Canada?

Dr. Jacqueline Pei: I'm not certain how many there are. I can tell you that in Alberta, where there are the most centres by far, there are 24. In Whitehorse—and we have representation from Whitehorse here—I think they have a pediatric team and a newly developed adult team, so there are a couple in Whitehorse. There are three in B. C. that I can think of, one in Saskatchewan, and maybe two in Manitoba. I'm just flying by the seat of my pants on that. There are maybe one or two in Ontario through the Sick Kids Hospital.

The Yukon is well ahead in terms of territories setting a precedent, but what we're talking about is maybe three per province on average, nowhere near the number required to meet the needs of the population—not even close. For that reason, I might suggest that it would be lovely to see more of these centres, particularly as we move forward.

But if we look at assessment practices, and say that we need to at least be looking at more specialized assessment practices to begin with, those services are more readily accessible. We want to move towards diagnostic centres, but in the absence of those centres, it doesn't mean there aren't folks in the community who are equipped and trained to provide specialized assessment that may lead to diagnosis.

Diagnosis is crucial. We know that. It's important for us to track numbers and to convey a certain understanding. But diagnosis alone does nothing to support the way we respond to the unique needs of an individual, because individuals with FASD can be incredibly diverse. So, we need to look at specialized assessment that moves beyond diagnosis to inform intervention initiatives. That means talking to community providers—

● (1605)

Ms. Françoise Boivin: Excellent. Thank you.

The Chair: Did you want the chief to answer too?

Ms. Françoise Boivin: Yes. I first wanted her answer on section 16 of the Criminal Code, though. I understand it's very diverse but it could affect the possibility of a person to have *mens rea* when committing an infraction.

Dr. Jacqueline Pei: That's a great question. It's a very difficult one to answer, and there's not a whole lot of research yet that really informs that.

What we do know and understand about the brain is that while understanding may be reduced or diminished, and while there are components of the brain, like inhibitory control and self-regulation, that may be operating at a much lower level developmentally than we would like for an adult, a lot of these individuals do understand right and wrong. Sometimes the NCR, the not criminally responsible, system actually provides a level of treatment intensity that is not an appropriate fit.

We are faced with a system where you may be putting somebody with an FASD who understands right and wrong but can't inhibit or control his or her behaviour with somebody who has experienced a schizophrenic episode where they absolutely had no idea of what reality was or was not.

The Chair: Thank you.

Dr. Jacqueline Pei: So the treatment fit would not be there.

Ms. Françoise Boivin: Thank you.

The Chair: Thank you, professor.

You've run out of time. I'm sorry, Madam.

We will get back to you, Chief, with another question.

The next question is from Mr. Dechert of the Conservative Party.

Mr. Bob Dechert (Mississauga—Erindale, CPC): Thank you, Mr. Chair, and thank you to our guests today.

I want to start with Dr. Pei. You talked a lot about prevention strategies in your opening remarks, and I want to explore the issue of prevention, and the awareness of the general population about the dangers of FASD.

When we last convened, we heard from some experts that there appears to be increased binge drinking among young women generally in our society, and that may be one factor leading to FASD.

My first question is whether you know if the incidence of FASD in Canada is increasing, going down, or remaining stable over time.

Second, do you think Canadians are generally aware of FASD? What suggestions would you have to increase awareness among all Canadians, especially women, of the dangers of FASD, so that one would hope that over time this can be reduced?

Perhaps I could hear from each of the witnesses on that question.

The Chair: You want to start with the professor though?

Mr. Bob Dechert: Yes, thank you.

Dr. Jacqueline Pei: Whether or not the incidence of FASD is increasing is a difficult question to answer. The short answer is yes, in that our numbers are getting higher. Is that because the incidence is increasing or because we're measuring it better and we're seeing diagnostic clinics where we're capturing it? I don't think we've gotten to a point of prevalence or surveillance yet that allows us to say we've diagnosed it at a level across the country and we can say that with any kind of confidence. Similarly there is no evidence that it's getting worse. There are patterns of drinking that we're concerned about, but there is nothing yet to say that we're seeing real change. Until our surveillance...and I know there are work and projects initiated right now and we're hoping to capture that better so we can begin to measure that more effectively.

In terms of prevention and your question about Canadians' awareness of FASD, there certainly are some prevention campaigns around. You will see them in some provinces and different bars. There are commercials out there that talk about not drinking when you're pregnant. My one thought is that when we look at risk factors that contribute to alcohol consumption and pregnancy, we're often looking at issues of women who are marginalized, women who are struggling with mental health issues like depression, and women who are isolated. There are significant features that women are dealing with. For those reasons, in addition to increasing public awareness around health practices and pregnancy—and I know that we don't say what not to do, but say let's be healthy together—we're talking about being positive with women. We also need to look at professionals who work with women who are pregnant, planning to be pregnant, or even could become pregnant, and how to have supportive conversations with women about how to take care of themselves and how to feel comfortable having that conversation about having sex. What are you doing to protect yourself? What are you doing to monitor your alcohol? What are you doing to watch for pregnancy? Those are the kinds of things that the professionals in our communities need to be more comfortable with so they can have those conversations with the women in their communities, all women.

● (1610)

The Chair: Ms. Bradley, would you like to answer the second question?

Ms. Wenda Bradley (Executive Director, Fetal Alcohol Syndrome Society of Yukon): Yes, thank you.

I agree with what Dr. Pei has been saying.

The thing that we found out here by way of conversation, more than any research that's been done, is that there is not easily accessible testing available without someone having to jump through a lot of hoops, if that's a way of putting it. We initiated a study with the University of Alaska in Anchorage and have put up two dispensers for pregnancy tests, one in the college and one in a local bar. There will be two put up in Dawson City in two local bars as well.

They're doing research to see what kind of messaging, or messaging with available tools, is to be used to help women make a more positive choice for themselves. If they are in a bar and drinking and they see this message, then maybe they can check it out right away discreetly and not have any other hoops to go through before that. Then they can make their own choices. I think that's a good question. I think we have to be able to provide accessibility for women to care for themselves.

Mr. Bob Dechert: Do any of the other witnesses wish to—

The Chair: Chief, would you like to respond?

Chief Cameron Alexis: Thank you very much, Mr. Chair.

Very briefly, as quickly as I can, I think in our first nation communities our population is evidence that we are increasing by a rate of 4% plus. Are we prepared for the future? That is a question that needs to be answered.

I think there is much more awareness happening. For example, we are well aware of the sixties scoop and the painful results of it. I don't think our people knew what FASD was at that time or even during the 1960s and 1970s. As we progress, some of us have been affected by FASD as a result of the sixties scoop. Awareness in the first nations communities is lacking. Not necessarily everybody goes to the bar, contrary to popular belief. There are people who drink elsewhere.

Mr. Bob Dechert: Are there—

Chief Cameron Alexis: Prevention programs have to be more prevalent on first nations communities. It has to be funded to address those issues.

Very quickly, just to touch on subsection 16(1) of the Criminal Code, I think we're here because FASD is not factored in to the application of 16(1) when you look at court disclosures, etc. That's why we have to have people affected—

Mr. Bob Dechert: Since you're answering questions right now, Chief Alexis, I would like Ms. Ross to also answer in a moment. But perhaps I could just ask you because you just mentioned the percentage of aboriginal offenders in the prison population. I think you said it was approximately 25%. What percentage of aboriginal offenders in your opinion suffer from FASD?

Chief Cameron Alexis: That is a very difficult opinion to even speak about because as you know, that's why we're here.

Mr. Bob Dechert: Nobody seems to be able to answer that question.

Chief Cameron Alexis: Some of our people are not clinically diagnosed with FASD.

Mr. Bob Dechert: Right, okay.

Chief Cameron Alexis: And right now, sir, if I may, roughly 50% of the present population are aboriginal.

Mr. Bob Dechert: Fifty percent.

Chief Cameron Alexis: Perhaps 50%

Mr. Bob Dechert: Okay. And would you say the majority of those offenders—

Chief Cameron Alexis: That's why—

Mr. Bob Dechert: —have FASD or suffer from FASD?

Chief Cameron Alexis: That is again an opinion that has to come from expert practitioners, respectfully.

Mr. Bob Dechert: Okay.

The Chair: You only have a few seconds left.

Do you want Ms. Ross to answer?

Mr. Bob Dechert: Sure.

● (1615)

The Chair: Ms. Ross, the floor is yours.

Ms. Elspeth Ross: The figure that's often been used is 1% of the population had FASD in 2005. But now there is research coming from the States from midwestern cities of 2% to 5%, at least. People generally assume that the figure is much higher, but we need more funding to do stronger prevalence studies. Prevalence studies are under way, but each province handles prevention in its own way and some provinces have more strategies than others in reaching people.

In Ontario, we had an LCBO awareness campaign not to drink during pregnancy, but it was only for three weeks around September 9. And because a prevention campaign costs a lot of money, if there were more funding, it would be possible to put out more.

We think that people really haven't gotten the message, and there is confusion about how much drinking could be possible, because doctors don't give the message clearly that there should be no drinking during pregnancy or when you think you're pregnant. But that message is not clear, and some people are now getting confused and saying that it's fine to drink a small amount during pregnancy. We simply don't know.

The Chair: Okay, thank you for that.

Ms. Elspeth Ross: So I would say that funding would definitely help. And since we know that more and more women are binge drinking but you often don't see the results in children until grade 1, you may not even see the results until high school because it's not clear. So we know it, and yet we haven't got the proof.

The Chair: Okay, thank you very much.

Thank you for those questions and answers.

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

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

Ms. Ross, at the outset of your remarks you decried the lack of leadership on this issue and you concluded with four specific recommendations. If I have them right, you recommended increased funding for research and data collection, a way for sharing best practices among law enforcement and those in the system, diagnostic centres, and case managers.

I find it interesting that none of the recommendations that you presented to us involved legislative change. They all involve the allocation of resources.

Ms. Elspeth Ross: Well, that's—

Mr. Sean Casey: Just let me finish this.

I don't fault you for that. I guess my point is that all too often what we see from government is an amendment to the Criminal Code to cure all ills, as opposed to fiscal and other solutions.

Those are the recommendations you've put forward. Can you describe for me the present state of affairs with respect to each of them? You've said that they need to be built upon. Can you give us some anecdotes or some sense of where R and D, where best practice sharing, where diagnostic centres, where case manager positions are at the present time?

Ms. Elspeth Ross: That was a big question.

I think I just really thought that diagnostic change isn't going to happen right now. That's why I was focusing on this, which certainly wouldn't include all the answers.

To come back to data collection, I just don't see data collection in terms of.... There are various studies, but they don't seem to be funded, and there could be so much more. When you go to the big conferences, you hear research from South Africa, from everywhere. There could be a lot more in Canada; that's my point. The funding bodies could be funding much more, because we need to speed it up. We are looking for biomarkers, but it's going to take a long, long time to find them. We definitely need to speed it up. When you go to conferences, your head is ringing with research, but I think it would be better if we had some Canadian conferences as well as the world conferences, so that we could focus on what there is in Canada and have the researchers, the clinicians, and everyone together so that we could see where we could pull ourselves up in Canada.

When I look for leadership, I see that the Public Health Agency of Canada was designated as a leader, but there is hardly any staff at all in there. Where is it? In 2012, there was a conference in Vancouver. There is one every year, but the theme in 2012 was FASD and justice. We did see provinces, research, and federal all together in 2012, but now it's three years later, and it seems to have dissipated. From scanning the news all the time and looking at it from the bottom, that's what I see.

I really would like to see much more data collection. We don't have any data storage places anymore. The Canadian Centre on Substance Abuse used to have a very good collection on FASD, but it has dissipated. The library was broken up, so that isn't there.

In terms of your second question about networks, events, and training, there are a lot of things going on. It's all very disjointed. The provinces do their own thing, mostly the western provinces and the north. In the east it's a bit of a wasteland. We would like to see Ontario drawn in. We are the centre of the country. There is some work with Motherisk in Toronto, but—

● (1620)

Mr. Sean Casey: I thought the centre of the country was Prince Edward Island.

Some hon. members: Oh, oh!

Mr. Sean Casey: Thanks for clearing that up.

Ms. Elspeth Ross: If it were a really important issue to people, I think it could be given a much higher priority. The RCMP had some good training a few years ago from Ottawa and from Manitoba. They were even training judges at one point, but that's all finished now. I've looked at this for a long time, and it seems to be going.... That's my conclusion.

You asked about diagnostic centres, too. In Ontario, there are diagnostic teams around the province, and there is a provincial website that gives them all. Even at CHEO, the genetics department will diagnose adults. There are a lot of concerns about the inability to get diagnoses for adults, and they have to pay large amounts of money in many provinces, including B.C. CHEO will diagnose adults, but if there is no information on the mother's drinking, then you don't get it.

Another concern with diagnosis is the lack of funding for psychologists. To get a diagnosis, you need a psychological assessment, and that's not covered by the medical. That's really a problem. That is one of the key problems with that.

You asked me about all the recommendations, so I'm kind of rushing along. As far as the case managers are concerned, that's really what we need. In B.C. they have FASD key workers who can actually act as case managers, but there is nothing like that here. That is why we come down, because that's the reality. A person who is really at risk for the justice system needs a case manager. Struggling families need a case manager, someone to help them navigate the system to get on with things.

Have I answered your questions?

Mr. Sean Casey: You have. Thank you.

The Chair: You can ask one more question, Mr. Casey.

Mr. Sean Casey: Chief Alexis, thank you very much for your spirited critique of mandatory minimums and their disproportionate effect on the aboriginal community.

You may not be aware, but at our last meeting we heard from the Correctional Investigator of Canada, Howard Sapers, who pointed out that the Gladue principles, or paragraph 718.2(e) of the Criminal Code, came into effect in 1996, but that there has been no appreciable change in the number of incarcerated aboriginal offenders. From that, he concluded that it isn't working. How would you react to that, sir?

Chief Cameron Alexis: Thank you very much for the question.

Respectfully, I don't think the Gladue principles are being applied across Canada. That's the problem. It's not so much that they aren't working; it's that they are not being applied by Corrections Canada or other institutions that should be doing so.

That's what I observe, and I think that's the best way to answer that question. I know Mr. Howard Sapers, and he did....

So thank you.

The Chair: You have more time.

Mr. Sean Casey: Are you familiar with Ken Jackson at APTN?

Chief Cameron Alexis: I can't say I am, sir, unfortunately.

Mr. Sean Casey: Okay. So you didn't see the piece he did on the Gladue principles that was published today?

Chief Cameron Alexis: I have not seen that article, sir.

Mr. Sean Casey: Okay, thank you.

The Chair: Thank you very much.

Thank you for those questions and answers.

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

Mr. David Wilks (Kootenay—Columbia, CPC): Thank you very much, Chair.

I thank the witnesses for being here.

Ms. Ross, I want to go to you first, because I think you probably have some of the most valuable information to provide, and we have rather glazed over it. That is, you raised two sons diagnosed with FASD. I'm really curious to understand something from you. In their child-rearing years, you obviously would have recognized certain things that triggered them, or potentially you could have recognized them. Then there would have been things, potentially, that you could have done or your husband have done to de-escalate the situations.

Could you describe a couple of those? It seems to me that this is the catch to all of this.

● (1625)

Ms. Elspeth Ross: People with FASD are very different from each other. We have two sons, one of whom has always had behavioural issues—the second son. The older son never has. He only once got into trouble at school for something or other, although I must say that he did intimidate a few people.

We really kept them very busy, with a lot of supervision, which was part of life for us in terms of being an involved family. I think that is really relevant.

Some things that helped in certain cases were things such as competitive swimming to work out incredible energy, and scouting, camping—all kinds of things. Everybody is different, but you tend to promote the things that kids are good at.

But you're asking me specifically for triggers. I'm not thinking about triggers with respect to my older son, but the younger one got into trouble a great deal and did the most peculiar things. The way we benefited in those days was that you could get extra help in school without having to jump through a whole lot of hoops. Because they needed help, the help was provided, and that is key. But that's not what you get now.

I felt we were lucky, because my second son would do very peculiar things, but instead of panicking, the vice-principal would call and say, “Do you know what he did today?” I remember once he even took some old knife that had no blade on it and put it in his sock. The vice-principal simply called up and said “Do you know what he did today?” instead of making a red alert to somebody.

There was just a general awareness that, yes, these boys had special needs, and they were different. They are both aboriginal, by the way, and that was a factor in their being different in an Ontario community. But the general thing was that we cared and we were going to see what we could do for these kids, and that made a huge difference.

Am I answering your question?

Mr. David Wilks: Yes, because it sounds to me as though it is a question of structure and keeping them busy because they have a high energy rate, shall we say.

Ms. Elspeth Ross: It's keeping them really busy, yes.

Mr. David Wilks: Thank you for that.

I have questions for Chief Alexis and Wenda, but first to you, Chief.

Section 13 of the Criminal Code, which I brought up before, seems to be prevalent. As as a former RCMP officer, you would recognize this. I'm retired from the force as well. It says:

> No person shall be convicted of an offence in respect of an act or omission on his part while that person was under the age of twelve years.

You would know, in your previous career, that from time to time you would be dealing with children under the age of 12 who would be recognized as having challenges and were aiming towards the court system. As a police officer, your only recourse, especially for a person under the age of 12, is to turn them over to social services or to their parents—one of those two. As a police officer, there are no charges involved. You can certainly talk to them, you can certainly try to give them some guidance, but at the end of the day you need to turn them over.

Professor Pei, you can enter into this as well.

Where do you see us trying to recognize and deal with the problems before they get to the court system? We're hearing about them once they get to the court system, but these kids are born with FASD. Yes, they mature at different rates, and yes, they identify differently, but what do you think we can do best for those who start coming into contact with the police prior to age 12?

I'll start with you, Chief.

Chief Cameron Alexis: I agree with you. Yes, under the age of 12, unfortunately, we have to bring them to their respective parents or anyone else whose authority they are under.

I touched on first nations, for example, with the sixties scoop. Nobody really knew the implications or the issues relative to FASD or what the effects were going to be, then or now or in the future.

One of the biggest things that needs to happen is to have prevention programs at the outset. They have be there. Yes, there are some out there, but are we really heightening them? Perhaps not.

I thank the parent who spoke earlier as well. I think that data collection is crucial. Perhaps early diagnosis would be of crucial importance too, because that would factor into exactly what we're talking about here. I touched on it. I've had people whom I deal with who have FASD, and it's very difficult. Everybody is different, and they have different ways of dealing with it. At the same time, with some of them you have to repeat yourself 20 times before they even comprehend what you're trying to say. It has to be dealt with in a different way.

Those are some of the recommendations I would like to make.

Thank you, sir.

● (1630)

Mr. David Wilks: Thank you.

Wenda.

Ms. Wenda Bradley: I think we need to be supplying more frequent support and care for folks. They get into the justice system, and anything they have to go through is not well understood by them or followed. With the work we're doing here—we do a lot of work, because the intensity of justice is quite high for us.... So it's frequency of contact—and this takes lots of people—and contact of shorter duration, because our folks have memory problems. They have problems directing their own thinking, so they need somebody to bounce stuff off. That go-to person will then be the person, if they're available.... That is what we do in our agency. We have a lot of ability to flex; they can come to us quickly and easily.

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

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

[*Translation*]

Ms. Ève Péclet (La Pointe-de-l'Île, NDP): Thank you very much, Mr. Chair. I also thank the witnesses for being here with us today.

My first question is for Chief Alexis.

It was interesting to hear what you had to say about the discretionary power of judges. You are not the first person before the committee to have said that mandatory minimum sentences undermine judges' discretionary power to personalize the sentence.

Howard Sapers, the Correctional Investigator of Canada, said that that there was a contradiction in the Criminal Code. There is a requirement that all of the circumstances be taken into account in sentencing. However, at the same time, minimum mandatory sentences are imposed.

The Canadian Bar Association proposed an amendment to Bill C-583 that would introduce an exemption in section 718 of the Criminal Code to give the courts the discretionary power to set aside the mandatory minimum sentence when it would cause an injustice.

My colleague asked you a question on that, but you did not have time to reply to it. Do you think that principle should have precedence over mandatory minimum sentences in regard to certain problems such as fetal alcohol spectrum disorder, mental troubles, or consideration of the Gladue principle?

[*English*]

Chief Cameron Alexis: Thank you very much for the question.

Yes, I do agree. The position of AFN is that it has to be considered. I don't think corrections is the answer. As a matter of fact, corrections should treat this as a disability. I think the judges should have discretion on whether to send these people diagnosed with FASD into sentencing circles or restorative justice programs where they can repeat messaging if they have to. Putting our people, meaning the first nations people, aboriginal people, into more of a corrections mode, is not the answer.

I hope I answered your question, Ma'am.

● (1635)

Ms. Ève Péclet: Thank you very much. I mean, it was a simple answer, yes or no.

My second question will go to Mrs. Pei.

In your presentation, you laid out a certain model that you would make a priority, which is to assess risk and gravity and match treatments to reduce recidivism rates. We're dealing with a bill right now, so it's like the object of a bill.

I do understand that we want more data collection, more research, and I totally agree. We had a report of the health committee in 2006 that said exactly that.

Where do you see the justice system in this whole risk assessment? It might be a question for Mrs. Bradley and Mrs. Ross to answer. Where do you see the experts and the diagnosis in the whole justice system? How do we complement both the outside and the external help, and financing and research?

Mrs. Ross talked about law enforcement in the justice system coming together for best practices.

Where do you see all of that coming into force? I know that Mr. Sapers talked about...and I'm going to say it in French

[*Translation*]

In connection with mental troubles, he was referring to the courts.

[*English*]

We have special courts for youth. We have special courts for conjugal violence. Where do you see all of that coming together?

Thank you very much.

The Chair: Professor Pei, you have the floor.

Dr. Jacqueline Pei: The risk-need-responsivity model is designed to fit in at the point at which the individual interacts with the justice system, so after arrest. That's where the model fits, the idea being that, currently, it's not uncommon for a court to ask for a risk assessment, to say that they want this to go out to a professional to assess what the risk is of this individual reoffending.

The focus of that risk assessment typically is on our usual risk indicators, things like your peer group, your family structure, environmental supports, your history of criminal behaviour, your use of drugs and alcohol, and a number of environmental variables. What is not examined, typically, in a risk assessment is cognitive functioning, such as what is the brain doing, is there a disability, and is there a unique disability?

As you've heard others say—and I believe Ms. Ross said this when she spoke—you may be dealing with an individual where even if they do stop to ask, “What is the intelligence level?”, that does not tell us very much about this population. Intelligence, as measured by our standard IQ tests, is not predictive of function in any way with the FASD population. The nature of the brain injury is such that function is impaired significantly despite the IQ level. That piece of information is absent in a traditional risk assessment.

When the courts don't extend that assessment to say that they need a further assessment or that they need to bring in an additional specialist who can take a look at some of those brain-based pieces, we're then making decisions around this individual's needs. We're also making decisions with regard to what kind of treatment or response is required or appropriate from the system without the knowledge of their unique brain functioning, which could be a contributing factor to what's going on and really can help us to better match the way we respond, both in terms of sentencing, and those intervention and treatment initiatives.

If we know that an individual has substantial brain injury that impairs their ability to function effectively, then we are needing to look at community-based intervention strategies, which you've heard Chief Alexis speak about.

The Chair: Ms. Bradley, would you like to respond?

Ms. Wenda Bradley: I totally agree with what was just said.

As an example, for our work, we do help folks do what the courts are asking and a lot of it is community work hours to help some of the different needs they have. But we jokingly say at our agency that if we all get in trouble, we've done our community time because the persons we're working with don't and can't organize what they need to do for community time. They can't keep the appointment they have to go to. Sometimes they can't even understand what needs to be done.

One of the situations we're working with now is that they need to shred paper. We're having to teach them all of these things. We're not sure that shredding paper, as community work, is teaching them anything about what they did wrong.

In fact, we would prefer to see restorative justice. Let's work with them and show them what they did wrong. Let's help them make some amends to help them fix that a bit because the two aren't related for the person at all.

Again, our staff are well punished, but the person isn't getting the message that we need to be giving them.

● (1640)

The Chair: Our next questioner from the Conservative Party is Mr. Leef.

Mr. Ryan Leef (Yukon, CPC): Thank you, Mr. Chair, and thank you to my colleagues for sharing their time with me. Thank you to all the witnesses for being here today.

The panel we have today is a great example of the diverse people this committee needs to hear from with respect to a very complex and dynamic issue in our country.

While it was my introduction of the bill and the justice system, specifically, that has brought us here, I'm going to ask some questions related to the front end of this, because it certainly serves the justice system well and serves Canadians well for that system to aim to support prevention activities at the earliest onset. Of course, the earliest onset is prevention, period.

Ms. Ross, thank you very much for your personal testimony and what are very succinct and clear recommendations for the committee.

I do want to turn quickly to Ms. Bradley, a fellow Yukoner, and ask where we're at present day, if you know or if you can share, in the context of the prevalence study that's under way with the Whitehorse Correctional Centre?

Ms. Wenda Bradley: I am not really in the know regarding that, except I know that it is still ongoing. It has been extended so it can be finished, but I think Dr. Pei probably has a little bit more information about what the results are, if she wants to respond to your question.

Mr. Ryan Leef: Great. Thank you.

The Chair: Dr. Pei.

Dr. Jacqueline Pei: I think you answered well. You're right. The study has been extended and so the participants are continuing to gather information.

Essentially, being a prevalence study means that adults who are involved in the justice system in Whitehorse or the Whitehorse region have agreed to participate and are having a full neuropsychological assessment done within an FASD diagnostic context or team. Some of those individuals are then receiving a diagnosis of FASD, and some are not.

They can refer them based on anything, so prenatal alcohol exposure or any risk factors aren't needed. The idea is that we really want to get an idea of who is in the system and how many of them have FASD, which is a question that's arisen from some of the other members today.

We don't yet know what those numbers will look like because we're still conducting the study and the data is being collected. We hope once that data is collected we'll not only have an idea what the numbers are in terms of the number of individuals with FASD—the cultural issues, our representations of what we're seeing—but also in terms of characteristics of the brain that have contributed to justice system involvement.

Mr. Ryan Leef: Thank you for that.

As Ms. Ross indicated from the Vancouver conference we were both at, because we don't know the numbers, I suspect we're probably projecting them to be a bit higher than we anticipate .

The ultimate issue, then, is going to be—and I guess I'm posing it broadly to everybody here, if you could touch on a complex question quickly—that we have to seize ourselves with the role that Canada plays. That's why we're all here. Of course, there are provincial responsibilities, provincial jurisdictions. Some of those really do deal with the earliest onset issues—prevention, health, education—and, of course, "Jacob's Story" talked about our having all of our children captured in one location in the education institution, but those are provincial and territorial responsibilities.

What do you advise this committee recommend to the federal government as the role it can play respecting some of the complexities and jurisdictional issues around those social support networks, education, and health fronts that do belong in the provinces' hands? How can Canada lead that discussion, or at least what recommendations can you make so that we can step forward on this file so we don't lose the ground we've gained here?

● (1645)

The Chair: I'm going to start with Ms. Bradley to answer that.

Ms. Wenda Bradley: Well, I think Canada can lead the way in recognizing the need and showing people that we have a responsibility to persons who are maybe not able to help themselves and not at fault for what their situation is.

This is an organic brain disability. It's not something that has happened to them that they can control, and we must recognize that these folks need that support from the outside community.

The Chair: Professor Pei.

Dr. Jacqueline Pei: Thank you very much for what, I think, is a really important question.

I would like to say that I really think Canada is already one of the leaders in this field, but that there's still a tremendous amount of work to do. We are being looked to, and I think that's a double-edged sword. To say we are a bit of the leaders, it means that we are on the public stage and people are looking to see how we respond. I think that puts more of an onus on us to respond appropriately.

I would like to see national leadership—I think Ms. Ross spoke to the idea—and I would like to see stronger national leadership so we can reduce some of the provincial and territorial disparity in how services are delivered and support networks are put together.

We see some lovely models within individual provinces for how we can make some really effective networks work at a provincial level.

We need to move to a national level. The FASD Research Network is attempting to support that national perspective from a research place. In response to something Ms. Ross said, we do now have a universal central data holder, so we are starting to combine data from all over the country. We are starting to move with that. We need those same initiatives to operate at a public health level so that integration of information is happening with a national directive, not just provincial.

The Chair: Okay.

Chief, the floors is yours to answer the question.

Chief Cameron Alexis: Thank you very much.

So the floor is mine, I can speak for another 45 minutes? Just kidding.

Very seriously, I want to express my thanks to every one of you because this is very important for us as first nations people, because of the sixties scoop and the residential schools, etc. Very simply, I'm here because I want to support the amendments in the bill, through the AFN. We need to treat FASD people. The judges need to factor in their discretion on this. Corrections should be the last answer to all of this. Finally, there should be reintegration programs for our people within this medical disorder.

Thank you.

The Chair: Thanks.

Ms. Ross, the floor is yours.

Ms. Elspeth Ross: I agree with Dr. Pei that Canada is already considered a leader. The world is watching us.

I think that some lead from the federal government is important. The Public Health Agency of Canada does not seem to be powerful enough in doing its coordinating and collaborative role within the government. I think their role as a leader could be strengthened, so there are consistent and sustained projects. We have small projects in a very disjointed way all over the place, little projects where the money runs out in two years, or leftover money. If we pull together in Canada, it could be just absolutely great.

The Canada FASD Research Network could somehow be assisted to bring Ontario and the maritime provinces into their network. They aren't at the moment. It's called CanFASD, but it's not CanFASD. If the government could assist their research role, but they have lots of other tentacles that could be worked out.

There were various examples in the past where there was funding from the national strategic fund, which used to exist, but I don't think exists anymore. There's something called Let's Talk FASD. I gave a copy of it to your clerk for your research people. It consists of parent-driven strategies, which are still valid even though the study was done years ago. But various things could be funded so that Canada pulls together, instead of just being a member of the world in FASD, which is very important, but I think the time is now for us to move together on this. Justice is off on its own, but needs to be brought in, Health and Justice together, and also Public Safety. So those three key things should be pulled together somehow.

● (1650)

The Chair: Thank you, Ms. Ross.

Thank you to our witnesses today for our discussion on this particular item.

You're the last set of witnesses that we have scheduled. We will talk about our report when it comes back to this committee, and then to the House of Commons.

I want to thank each one of you for taking the time and providing your expertise today.

We will suspend for a few minutes, because we are going in camera for directions on drafting the report.

With that, thank you very much.

[*Proceedings continue in camera*]

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