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Chair

Mr. Rob Anders

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● (0905)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): Good morning, ladies and gentlemen.

I hope it's muggy enough for everybody outside.

We are yet again pursuing the veterans independence program and the health care review. Today we have Norah Keating. She's not here with us, but I understand she's online now, and the technicians are getting that set up. She's with the Gerontological Advisory Council.

This is the second time I've had the experience of chairing a meeting in which somebody is coming in via teleconference.

The Clerk of the Committee (Mr. Alexandre Roger): She's there.

The Chair: Hello, Norah, are you there?

Dr. Norah Keating (Member and long-term care and mental health specialist, Gerontological Advisory Council): Yes, I am.

The Chair: Wonderful.

The way this works is that we are all seated around our table with bright, smiling faces, freshly scrubbed and ready to go.

What happens is that you have up to 20 minutes to give your thoughts on these matters. Then after that we have a predetermined party rotation, and the questions come up, and you handle them. It may last a while.

How does that sound?

Dr. Norah Keating: That sounds just fine.

The Chair: The floor is yours, then.

Dr. Norah Keating: Thank you, and thanks very much for inviting me to address the committee.

You will have heard from Dr. Victor Marshall, who chairs the Gerontological Advisory Committee, and from Mr. Brian Ferguson and Darragh Mogan from VAC, who have given you some background on the reasons why the advisory committee was invited to write the report *Keeping the Promise: The Future of Health Benefits for Canada's War Veterans*.

What I'd like to do is briefly address the main issues that they have covered, adding some additional comments based on the questions you asked of them. I have been able to look at those transcripts. I also will highlight issues in the report that we believe will be important in its successful implementation.

I have been a member of the Gerontological Advisory Committee of Veterans Affairs since its inception. My areas of expertise are in families and aging, in rural communities, and in long-term care. I must say that my expertise in mental health is mainly in the areas of how families provide care to older relatives with cognitive illnesses such as Alzheimer's disease, although my research team is now engaged in research on the impact of acquired disabilities on individuals and their families.

I co-direct an international research team for research on aging policies and practice and often consult with government departments and NGOs on social and health policy issues in aging. In my experience, the VAC Gerontological Advisory Committee is unusual, in that it is a standing committee of the department that brings together key stakeholders from the user groups, which are the veterans organizations, and the researchers in an ongoing dialogue with the department. It's actually a great mix of people with the on-the-ground experience of the veterans organizations as well as those with a national view of the issues.

Our mandate on this committee is to speak to the best ways to support health, wellness, and quality of life for war veterans and their families, from World War I—although I think we now have only one survivor—World War II, and Korea.

Keeping the Promise sets out a comprehensive, integrative health and social services system for these older veterans. I am an author of the report, along with Dr. Dorothy Pringle, who I think you're going to speak to in the next few days, and Dr. François Béland. The report was vetted by all members of council and endorsed by the veterans groups.

As you've heard, its main recommendations include combining existing VAC programs into a single program called veterans integrated services. I want to add that we think this integration is really essential. For one thing, the integration allows for a combination of the health, income security, and social connections that we know are key determinants of well-being in later life. Integrated services allow for much more ability to address the needs of a person and to take into account the context in which he lives. Supporting people in later life is not just about addressing physical frailty or providing a pension; it's about helping them to age well in the place where they live.

Integration is also important in that it allows for one point of entry into a set of services that cut across what commonly are stovepipes of health, social services, income, and housing, and to accommodate a range of people, from those who are living independently but could benefit from health promotion activities, to those who need nursing-home-level care. Older adults are incredibly diverse, and we can't forget that. I believe that this model is what the experts in aging see as ideal, and seeing it in practice would be a wonderful gift to Canada's veterans. Integration also drastically reduces the set of eligibility requirements that have become increasingly complex over 60 years of adding and tweaking programs to address the needs of an aging group of veterans, who in the 1940s needed educational programs and affordable housing for their growing families and now may need social connections and supportive housing.

● (0910)

The second principle, which is one I won't dwell on and which has been spoken about by the other presenters, is to base eligibility on needs rather than on the veteran's status. You've heard our phrase that represents this principle: a veteran is a veteran is a veteran.

I think there's unanimous agreement among the GAC, veterans groups, and department members that complex eligibility criteria serve no one well. I'd like to reiterate that this doesn't mean that all veterans would receive services under the proposed VIS, but all would be eligible if the need arose.

The third principle in the report I think also warrants some comment. Our recommendation is for an integrated program of services to veterans and their families. Now by families, the GAC is thinking primarily, though not necessarily exclusively, of older veterans and their spouses. Almost all the World War II and Korea veterans are men. For those with chronic health problems, their wives may have cared for them for many years, providing round-the-clock support and delaying nursing home placement. After the death of their husbands, services to these widows should continue.

But thinking about families also means assessing the needs of these couples while both are alive. For example, it's important to assess the capacity of an older spouse to keep a veteran at home and to support her if the decision is to do so. We're thinking, as well, of other situations, such as those in which the veteran is a caregiver to his wife. Current programs in the department that focus on veterans as clients wouldn't allow for things like the home adaptations needed to accommodate the spouse of the veteran who uses a wheelchair, respite for the veteran who is the caregiver, or management of home care services to provide personal care to the veteran's wife. Family needs are central to this new view of veterans services.

The final point I'd like to emphasis is that VAC is providing services to veterans in all parts of the country. Veterans live in a wide variety of communities with very different resources. Even rural communities, an issue that's come up in your previous discussion, differ greatly, ranging from having, for example, about 1% of people in the community over age 65 to more than 40%. And they differ greatly in the services they provide and their supportiveness to older adults.

This is one of the reasons why we believe that front line staff who will implement the veterans integrated services must have the authority and flexibility to shift and allocate resources to meet veterans' health and social needs and take into account the setting in which the older adult lives.

That concludes my opening comments.

● (0915)

The Chair: Thank you very much.

Mr. Valley would like to lead off from the Liberal Party for seven minutes.

Mr. Roger Valley (Kenora, Lib.): Thank you, Dr. Keating.

I'm guessing that you're out in Alberta right now.

Dr. Norah Keating: I am.

Mr. Roger Valley: Good.

First of all, thank you, and through you to all your members, for all the good work, really volunteer work, you do on this committee. We appreciate it.

I should know this, but I don't have that document with me, *Keeping the Promise*. You've been a member of the committee since its inception. So how long has that been?

Dr. Norah Keating: It's been about ten years.

Mr. Roger Valley: Well, thank you for that service.

I hate it when you answer my question. Your last comment answered the questions I had ready. You mentioned at the very start that part of your expertise is in rural involvement. And you just answered part of my question by talking about the differences in rural Canada between rural Alberta, rural southern Ontario, and rural northern Ontario and Quebec. There's a total difference in what “rural” means.

Dr. Norah Keating: Yes.

Mr. Roger Valley: I'm not sure of the term, but when you're deciding or thinking about what you're going to do or how you want to serve these areas, how do you gain that experience?

Dr. Norah Keating: Well, my research group has just finished a three-year program of research on older adults in rural communities. So we have a lot of background information, particularly on rural communities in Canada, which helped us develop the report, *Keeping the Promise*, and which we're using to advise the department.

That knowledge is something we've gained over the last number of years, really, specifically to help Veterans Affairs think about how to do this, how to support veterans who are living in rural Canada. It turns out that rural Canada is older, in general, than urban Canada and is aging more quickly. So it's an important question.

Mr. Roger Valley: So you do have the experience, and I'm not questioning that. I'm just trying to cover issues for my riding.

You mentioned that we've raised this before. It probably was through me, because in our parties down here and in our discussions, there's a totally different understanding of what rural Canada is. When you say southern Ontario, you think of it as farming communities and everything else, but where I live it's isolated reserves.

Dr. Norah Keating: Right.

Mr. Roger Valley: And I have 21 fly-ins, for which the only access is by air. Is there someone else on the committee, or is that where you gain your experience? I'm just trying to find out exactly where the information came from.

Dr. Norah Keating: I'm the main one on the committee who has research experience that I've been using to feed into the department. Of course, for many years the department has been providing services to veterans all over the country. So they have the on-the-ground experience. I think the main thing we've learned from the work we've done is that these communities are diverse, and you've identified that well. Even in rural Canada there isn't one solution for how best to serve people.

We do know that generally in rural Canada, frail older adults end up in nursing homes sooner than those in urban Canada do, because there aren't the other services available to support them at home.

Mr. Roger Valley: Thank you. And that's exactly what we see: with the pressure in the last decade or so on health care, we're seeing fewer and fewer services provided out in those areas. Of course, we understand when we live in these small communities that we're not going to have the level of service that the larger centres do, but we've seen the squeeze on health care. We've seen the removal of physicians, of psychiatric services. There's not necessarily a total removal, but they're physically removed. They're basically dealt with through technology in a lot of ways. So how we cover that base is always a concern, and I continue to raise that whenever I have the chance.

You mentioned that you have contract workers or you have services as reasonably close as possible to the actual individual?

● (0920)

Dr. Norah Keating: I'm not an expert on the on-the-ground services that the department provides, but certainly they do provide services to their veterans across the country, and I think they, too, see the challenges in providing these services to rural communities, particularly those at a great distance from service centres, acute care hospitals, etc.

Mr. Roger Valley: In my riding—my home town is about halfway between Winnipeg and Thunder Bay—just finding out what services and service providers are available has been a challenge, because they switch off from one location to another. There's a large base close to Winnipeg. Sometimes they have service, and sometimes it comes from Thunder Bay. So even as the member of Parliament, it's hard for me to keep track of who's doing what and where they're doing it.

Dr. Norah Keating: Yes. And I think one of the things in this report that I would underline is that one of the things the front-line worker working with the veteran would be doing is navigating through all of these services. It is a huge challenge for anybody to find out what those services are. It is certainly an immense challenge if you're a caregiver to somebody who's frail and you're trying to wend your way.

So I think that could be one service the department could do more on, which would be tremendously important to people.

Mr. Roger Valley: One last issue I'll raise is that we do serve in both official languages. One of the challenges I have—and I haven't raised it here before—is that different languages are spoken in my riding. It's not so much a case of the veteran's not being able to speak English or French, but it's his caregiver's not being able to. As he ages, if his caregiver speaks Ojibwa or Cree, it's very difficult to deal with. I don't have the answer for that. I just wanted to flag that issue.

Thank you very much, Doctor.

Dr. Norah Keating: Thank you.

The Chair: Thank you very much.

Now we're over to Monsieur Perron with the Bloc for seven minutes.

[*Translation*]

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Good morning, Dr. Keating.

I am pleased to see that you have experience with the elderly. But one thing you have not mentioned at all is that the elderly must be kept in their regular environments as long as possible, with informal caregivers such as family members.

To give you an idea of what I think, I will give an overview of Quebec's policy on the elderly. There is a program in Quebec to help build or modify what we call multi-generational homes. The government provides financial aid to sons or daughters who want to modify their houses to provide a home for their parents in their later years. In addition to providing money to help purchase concrete, bricks, etc., the program offers financial aid such as tax deductions, etc.

It also provides nursing help from a CLSC, a local community services centre. The nurses provide home care regularly, once a week or more often, when one of the two parents is sick.

According to Quebec studies, because of this approach, the elderly are less sick. They are no longer isolated. I always joke about this and say that when we are alone, the only thing left to do is think about our past sins or the ones we have yet to commit. We are giving them a new view, and the results seem very good. This program has existed for 10 or 12 years now in Quebec, and we keep it going year after year. We are building more and more multi-generational homes in all corners of Quebec, especially in rural areas. My friend Roger had this concern.

I would like to hear your thoughts on the Quebec system. Does this already exist in Canada? If not, would it be possible to do it? I would like to hear your views on this.

● (0925)

[*English*]

Dr. Norah Keating: Thank you.

Certainly the areas you touch on are ones that are very important. As we have over the last decade or two in Canada focused much more on the family members and friends who are providing care to frail seniors, we've begun to think about what kinds of things would support them in the work they are doing. Fewer and fewer older adults in Canada are in nursing home settings. So as you say, most of the care is being offered to people at home. Many of the services that you talk about that are being offered in Quebec certainly are things that can make a tremendous difference to families in their ability to take on this task.

One of the things that we highlight particularly in the *Keeping the Promise* report is the question of housing, which you talk about, and that having more housing options, including the ability to adapt one's own home or the home of a child, if that's where you're living, can make a very big difference in people's ability to stay out of nursing homes. What we'd like to avoid, if possible, is people's placement in higher levels of care than they need.

As you know, the services available to caregivers vary tremendously across the country. So I cannot comment specifically on what is available in which locations, but this is a very important issue on the agenda, I think, of most provinces, and certainly of Veterans Affairs, which is to think about families and support those members who are providing care to older adults and to veterans.

[*Translation*]

Mr. Gilles-A. Perron: Thank you, Dr. Keating.

[*English*]

The Chair: Thank you, Monsieur Perron.

Now we're on to Mr. Stoffer, with the NDP, for five minutes.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Dr. Keating, it's an honour to meet you via the radio. It must be fairly early in Alberta now, and thanks for getting up and helping us out.

Dr. Norah Keating: You're most welcome.

Mr. Peter Stoffer: I appreciated your presentation on the fact that a veteran is a veteran is a veteran. As we heard the other day, a widow is a widow is a widow.

I have a couple of questions for you. You work on international collaborative research projects. Are there any countries now that have a better or a more advanced program in looking after veterans and their elderly caregivers than we have? Is there anything we can learn from countries like Britain or Australia or the States, or are we the leaders so far in this particular aspect?

Dr. Norah Keating: There are huge differences around the world in programs that are available, for example, to support caregivers. Some of the models we see in Scandinavia, for example, spend more effort on things like providing financial compensation to caregivers, including things like pensions for caregivers.

An issue that's going to come up more and more in Canada is the question of how people who are caregivers manage if they need to leave the labour force and their own income is greatly reduced. That's less of an issue in this report because we're talking primarily of caregivers who themselves are elderly and are no longer in the labour force.

So that is some of the work going on in our research team to look at these models of support to caregivers around the world.

Mr. Peter Stoffer: Thank you.

Does your organization do any kind of financial analysis of the costs of these extended services? As you know, everything has a particular cost to it, and governments, and particularly departments, are all going after the same dollar.

For example, if we extended the VIP program to every widow and every veteran, would you have an estimate of what that would cost? We hear figures of anywhere from $280 million to $320 million. But we also heard the other day from Mr. Ferguson that having the VIP program actually saves the government money.

I'm wondering if you've done any cost analysis—or is that part of your mandate?

● (0930)

Dr. Norah Keating: It hasn't been part of the mandate of the committee, so we have not done program cost analyses.

I think the general comment would be that services provided outside a formal care setting are less expensive in public dollars than services provided in a community or a home setting. I think that would probably have been the principle on which Mr. Ferguson was making those comments.

Mr. Peter Stoffer: You indicated that not all veterans would be eligible for various services. As you know right now, one of the eligibility requirements is income. If you're a veteran with a fairly high income, you're not entitled to services, whereas if you are a veteran with a lower income, you may be eligible. I've always thought that was wrong, because when you sign up for the armed forces they don't ask you how much money you make.

Dr. Norah Keating: Right.

Mr. Peter Stoffer: So I figure when you're a veteran and you're elderly, regardless of your income, if services are provided, you should all be equal.

Is that the direction your organization is advising VAC, or would you still put in that income eligibility requirement?

Dr. Norah Keating: The principle in the report is that of need. So, for example, if you're an older veteran, regardless of your income, and you're socially isolated, then you may be identified or express a need for being better connected. So there could be an intervention on the part of the department to help you get connected to others, to have friendly visitors, or to get engaged in whatever things would help reduce your social isolation. It would not be income dependent.

Mr. Peter Stoffer: Thank you very much.

The Chair: Now, on to Mrs. Hinton, for seven minutes.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): Good morning, Dr. Keating, and thank you very much for being here.

Dr. Norah Keating: Good morning. Thank you.

Mrs. Betty Hinton: You've made some really interesting comments today.

The one thing I think we sometimes lose track of is that government doesn't generate any income. Its only income source is taxpayers.

You spoke about Scandinavian countries. Could you give me an idea of what the income tax levels are in the Scandinavian countries versus Canada? That's the first question.

And secondly, in your opinion—this may not be fair, and if you can't answer it that's okay—

Dr. Norah Keating: Okay.

Mrs. Betty Hinton: What is the best province to be a senior veteran right now, because of the fact it's provincial as well as federal?

And thirdly, if you could personally change one aspect of the system today, what would it be?

Dr. Norah Keating: Okay. I can't speak to the question of income caps in Scandinavia. Unfortunately, I don't have those sorts of data available. It's a good question, but I can't help you in that respect.

On which province it's best to be an older veteran, the nice thing about the Veterans Affairs mandate and programs is that they fill gaps. The whole idea of Veterans Affairs is that wherever you're living, you should have the same access to services provided by the department. So I think, in general, and particularly with the implementation of the recommendations in this report, that veterans across the country should be equally well served.

As for the one aspect I would change in the present system for veterans, I would say, absolutely, the simplification of all these eligibility requirements. I've consulted with the department for ten years, and I'm still not sure if I could fully pass the test of knowing what all the current eligibility requirements are for programs. So that would be the number one change, I think.

Mrs. Betty Hinton: That's really great to hear, because I happen to agree completely with you. I can't answer all of the questions I asked you. I was asking them of you to see if you could give me some facts.

I'm from British Columbia, and I do recognize there are more and more senior veterans, as well as seniors generally, moving toward the west. I think it probably has a lot to do with the weather, but in terms of services, I'm not sure whether we're keeping up with that sort of thing.

With regard to the taxation levels, I don't have an exact figure either, but my understanding is that it's about double what we pay in Canada. They're able to provide all those additional services because they have a much larger tax base from which to do it. A better way to put it is that they take more taxes.

You also made some interesting comments about rural Canada being older than urban Canada. Maybe as you get older, you get wiser and you get out of the city.

● (0935)

Dr. Norah Keating: Well, you know, there is some of that migration. It's interesting that we're beginning to see some of that migration of people out of cities to smaller communities at retirement, so there is a bit of that. There is the other direction, of course, too, where young people are leaving the small communities and coming to the larger centres for work. So it works in both directions.

Mrs. Betty Hinton: It does.

Just touching again on simplifying the eligibility requirements, most MPs spend a great deal of time trying to walk senior veterans through the red tape—and there's a lot of red tape. So I agree that it needs to be simplified.

Are there a couple of pointers you would like to suggest that this committee might recommend to Veterans Affairs to make it simpler?

Dr. Norah Keating: Well, I think one of things we tried to emphasize a great deal in this report is that eligibility for services from the department should be based on two criteria. One is military service, and the other is need, period. So if we can do that, I really think people in the department would be terribly grateful. I know that those who are trying to be on the receiving end of services would be greatly relieved also, and it sounds like people like you believe it would reduce their workload as well. So I think it really is something the department has actually wanted to do for a long time.

What I've come to understand over the years is that as the group of World War II and Korea veterans has become older, the way the department has attempted to meet their needs is to add new services as the group has aged. Those services have been layered onto things previously there, and that's where you get this complexity.

So it would be quite a major revamp, but I truly think there's a lot of will to make it happen.

Mrs. Betty Hinton: Thank you, Dr. Keating.

I think I can speak for all members of this committee, and I know I can speak for government, when I tell you that we'll do our utmost to simplify the system.

Dr. Norah Keating: Wonderful. Thank you.

Mrs. Betty Hinton: Thank you.

The Chair: Thank you very much.

I very much enjoyed the idea of military service and need.

Mr. St. Denis, for the Liberals, for five minutes please.

Mr. Brent St. Denis (Algoma—Manitoulin—Kapuskasing, Lib.): Thank you, Mr. Chair.

Along with my colleagues and their thanks, I thank you for your participation today, Dr. Keating, and for your work in support of seniors.

Dr. Norah Keating: Thank you.

Mr. Brent St. Denis: I'd like to focus a bit on the family aspect of support for elderly parents, in our case veterans, but obviously your answers may apply to all such family situations. I may be generalizing by saying that in the generations past, as our parents got old and needed help, we tended to do that at home as much as possible, because the institutions and hospitals weren't as readily available. We've gone through a time when there were the bricks and mortar available for the most part, and that's where we tended to spend our last days.

I guess this is the first part of my question, but I sense that the pendulum is swinging back and more and more people are choosing to spend their final days, weeks, months, at home with family, whether it's a young woman with cancer or whether it's a senior who knows the time is coming. Whether it's a veteran or a senior non-veteran, is there an acceptance in society that this pendulum does exist, the swinging back does exist, and if so, are we really planning for more and more of the home-based final days in terms of caring for our parents? We're going to be there some day, too—to those who may be listening to this on webcast—and we'll be facing that. I am wondering about the overall philosophical approach to where we will be with this in five, ten, or fifteen years.

● (0940)

Dr. Norah Keating: An excellent question. I think there is a fairly high level of understanding now that we are in that kind of third era in which families, in particular, are doing the vast amount of care of frail older adults and of younger adults with disability. In fact, in our own work, we and others would suggest that about 80% of the care of older adults is provided by families. And the people who are presently in nursing homes tend to be those who are very old and who have some kind of dementia.

Having said that, I think we're still really beginning to catch up in our understanding of how we might best support families who are providing that kind of care. That's where a lot of the emphasis is now, I think, and that's why this report really is about focusing on not only the individual veteran, but on family members.

There's a lot of interest, I think, in families and caregiving and how to support those family members. I think we can continue to do better by thinking about the variety of caregivers. The kind of support an elderly spouse might need could differ considerably from the support needed by a daughter who's a caregiver, who's trying to juggle her own responsibilities to her children, her labour force engagement, and her care of her mother or father.

Mr. Brent St. Denis: Thank you.

I think that 80% figure is a very interesting one.

As a society, we spend resources—maybe not enough—as a community on helping young families learn how to parent, the health aspects of raising children and so on, but I don't know if we do as much of that in teaching ourselves how to prepare for and help others, our parents and family members, in their final days. Is there an educational part of this that is still in evolution?

Dr. Norah Keating: Do you mean in terms of the support?

Mr. Brent St. Denis: Well that, yes, I suppose, or more generally, when it comes to aging issues, whether it's for personal health or whether it's for care of a family member.

Dr. Norah Keating: Not in a nationally coordinated fashion, or even coordinated at the provincial level. Much of the education and training of people who are caregivers is being provided, I think, through the voluntary sector, NGOs and so on. This is not a job, I think, that most people anticipate, even though we do know that we're all getting older, as are our parents. So often people are not really looking for that kind of education or support until they are thrust into the role of being a caregiver. We could do better, I think, in doing things like supporting some of the national caregiver organizations that are attempting to provide this information in a way that's accessible to people.

Mr. Brent St. Denis: Thank you.

If I have a chance, Mr. Chair, to come back, I'll be glad to take it.

The Chair: Sure.

Now on to the Bloc. Monsieur Gaudet for five minutes.

[*Translation*]

Mr. Roger Gaudet (Montcalm, BQ): Thank you, Mr. Chair.

Dr. Keating, my first question is the following. Mr. Ferguson told us this week that there were 50 teams in Canada. Do you believe this is enough? What services do these teams provide? Are they doctors, nurses, etc.?

[*English*]

Dr. Norah Keating: Unfortunately, I'm not an expert on the departmental numbers of teams and the training that those team members receive. I'm certain that the department would be happy to provide you with that information, but I'm not in a position to do so.

[*Translation*]

Mr. Roger Gaudet: Thank you.

Earlier you spoke about integrated services for families. Could you tell us more about this program?

● (0945)

[*English*]

Dr. Norah Keating: The idea of the veterans integrated services, which we're proposing in the report, is that the veteran could be given services that would range from those that are mostly health promotion—getting information, for example, about making their home safer, or getting connections to a physical fitness program that might help them remain more physically fit and able to do things for themselves—right through services that might help support someone who's quite frail and who may need personal care.

It's the idea of the integration of these services that is particularly important, we think, from the point of view of the department. Many of these services are already available in separate service bundles from the department right now. This means as well that if a veteran has some sort of health crisis or has a change in their status, they can easily move towards a higher or different level of service. So it really is the integration that's particularly important.

[*Translation*]

Mr. Roger Gaudet: This is my last question. I agree with offering a VIP program for veterans. But would you recommend that we offer this service to all of Canada's elderly?

[*English*]

Dr. Norah Keating: I think that this program is certainly the kind of model that those of us who are experts in aging think is ideal, and I would be delighted to see something like this extended to other seniors.

[*Translation*]

Mr. Roger Gaudet: Thank you.

[*English*]

The Chair: Now on to Mr. Shipley with the Conservative Party for five minutes.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Thank you, Dr. Keating. It's great to have you join us in this matter this morning.

Dr. Norah Keating: Thank you.

Mr. Bev Shipley: I have just a couple of questions.

You mentioned earlier that senior, older vets...people are very diverse. Are they more or less than the new vets? Is there a difference? Is there a different expectation for the vets or older people?

Dr. Norah Keating: We don't have the expertise with younger veterans, so I can't speak to that issue specifically. Except that we do know that as people move along life's track they become different from one another, so that there is great diversity. Situations make a huge difference. Younger vets—

Mr. Bev Shipley: Is there a different expectation, do you think, by senior older vets from what there is by seniors who are not vets?

Dr. Norah Keating: Do you mean a different expectation by veterans compared with other seniors?

Mr. Bev Shipley: I mean older seniors—other seniors who are not vets—in terms of expectations of services and those sorts of things.

Dr. Norah Keating: One of the things that we see with this cohort of older adults is that they're probably, in general, not nearly as demanding as we expect the next generation—the baby-boom generation—to be, for services.

I can't say—I just don't know—whether veterans have expectations that are different from those of other seniors about services.

Mr. Bev Shipley: We've had a fair bit of discussion around needs-based and entitlement-based services. I want to follow up.

One of the things I've found with seniors is that it isn't always about the money. For those who have the money, it's about the availability of the service. I don't know if you have a comment about that.

In fact, for many seniors, if they have the financial wherewithal, it is not that they feel they shouldn't—in fact, most of them feel that they should, because they've been blessed in this great country with a number of things. But one of the things they often don't have is the access, or the road map for how to get to the services they actually need. I don't know if you have any comments on that.

Dr. Norah Keating: I would say that in general, what people of all ages, and certainly older adults, wish to do is to be able to live their lives in the place where they'd like to be. For older adults who may need particular supports to do that, absolutely, it's a question of getting access to the people or the services that can help them to do that. If those are not available, then having a higher income may not help them at all to continue to be able to live their life in the way they'd like to.

So access to services and people and support can make a huge difference to older adults.

● (0950)

Mr. Bev Shipley: One of the things you had also mentioned—and I don't have the exact wording—is that as people become older and become frail, it's easier if they move to an urban area rather than remain in the rural area. I don't know if I got the gist of that right.

I come from a rural area, as some of us do. I find that in the rural area where I come from, there's actually a tendency for more care in the home by extended family. That may not be the case. I'm just wondering if you have a comment on that.

Dr. Norah Keating: One of the things we know generally, in rural Canada, is that older adults who are quite frail and need high levels of care often go sooner into a nursing home than would those in urban areas, and that's primarily because they can't get the community services.

It is true, and certainly we've found in our own work, that the smaller the community, the more likely it is that people in the community will be helping out. Whether that's done out of virtue and community cohesiveness or out of sheer necessity is hard to know for sure. But there is a sense that rural communities are particularly cohesive and supportive to older adults. And in many cases, that's absolutely correct.

Mr. Bev Shipley: I have just a quick one.

One of the things we talk about and have a concern about in Canada, regardless of what age you are or whether you're a veteran, is the availability of specialists, the shortages in the medical profession, and being able to have the access. We say we can supply the service. One thing we don't want to do is to say that we're going to supply these services and then actually not be able to have the professional people there to do the work and to supply those services.

When you're doing your study—and I've read through some of it—is that a concern, and how do you want to deal with that?

Dr. Norah Keating: The medical system has been aware of the challenges of providing medical services, particularly specialist services, in rural Canada for some time. I don't have particular expertise in that whole area on how we're managing.

I know that there have been a number of experiments done in issues like tele-health, for example, but I really don't have the expertise to speak to that in much detail.

Mr. Bev Shipley: Thank you.

The Chair: Okay.

Now over to Mr. St. Denis, for five minutes.

Mr. Brent St. Denis: Thank you, Mr. Chair.

Maybe I could just pursue my earlier line of questioning on family and family supports. My colleague Mr. Perron had asked about the home renovations, refits to accommodate an aging parent. Depending on the province, there are various programs. The employment insurance program has been changed in the last couple of years to accommodate immediate family members who may be able to stay at home to support an ailing parent or other close family member. I think Mr. Stoffer asked about other countries, and I think Betty Hinton did as well.

If you could have your way and the resources to do it, are there obvious gaps, more likely systemic gaps, that you would immediately deal with and that would pay immediate dividends if the resources were put in place to deal with them?

● (0955)

Dr. Norah Keating: In terms of support to family members in particular?

Mr. Brent St. Denis: Yes, support of family, in support, then, of the aging or ill parent.

Dr. Norah Keating: Well, the main issues that we addressed in this report are determining what it is that would be the best support to that older person and his or her caregiver, in trying to craft those services to the needs of that particular older couple or parent with child caregiver.

For older spouses, very often the kinds of services or supports they need are a break from their caregiving. If you yourself are in your eighties and providing care on a 24-hour basis, you need something of a break. Services that provide support to caregivers who are younger would be the kinds of things you're talking about that would allow for job protection of an employed caregiver who needed to take some time off to provide extra services.

So I guess my main comment, and I think what comes through in the report, is that the idea would be that if you're looking at need, you take whatever is the repertoire of services available and craft a set of supports that best fits that older adult and his or her caregivers in the community where they happen to live. I know that's a fairly general comment, but that's certainly the principle.

Mr. Brent St. Denis: That's helpful.

A number of years ago the federal government opened or started discussions with the provinces and territories on a national home care plan. There have been conferences, and of course the idea is of a continuum of all ages of the medical needs in a home setting.

You just mentioned in your last response, if I understood you, that not every situation is the same as the next, and their needs would vary. In your thinking, is there a place for a national home care program? Obviously we're leaving aside funding concerns and the extent of such a program. But should we as a nation get more serious about that?

We do have gerontology in-home workers, but it's not regulated, as I understand it, and it's not overly organized. I'm just wondering if you could comment on national home care in this context.

Dr. Norah Keating: Let me give you an example of a pilot project that Veterans Affairs did in recent years that I think addresses this issue. They were concerned that there were a large number of veterans who were on waiting lists for nursing homes. The intervention project was to offer people a set of enhanced services at home or nursing home placement. The enhanced services at home were services like personal care, assistance with housekeeping, etc. The waiting list virtually disappeared.

People do, for the most part, given the choice, wish to be at home rather than in a nursing home setting. That means we need to think about the best way to provide the support that we can to people who are living at home. It's beyond the mandate of our committee to speak to the question of national home care programs. I believe that more and more older adults will be living at home or in settings that are outside of nursing homes. There will continue to be challenges in finding the best ways to support them.

Mr. Brent St. Denis: Thank you, Dr. Keating.

● (1000)

The Chair: Thank you very much.

Now we've over to Mr. Sweet with the Conservative Party, for five minutes.

Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC): Thank you, Mr. Chair.

Dr. Keating, thank you very much for your work. As Ms. Hinton has already mentioned, we're very grateful. I understand from Dr. Marshall last time that ten months went into the working of this report. I'm certain that I can speak for all the Canadian people in saying that we're grateful for your work towards veterans.

Dr. Norah Keating: Thank you.

Mr. David Sweet: I wanted to ask you whether it was strictly the mandate of Veterans Affairs that kept the study limited to the World War I, World War II, and Korean veterans? Is there a reason why the study didn't go as far the veterans from Bosnia, some of whom would be entering their older years now?

Dr. Norah Keating: Yes. The committee on which I serve is the gerontology advisory committee, so our mandate always has been, from the beginning, to direct our attention to those older veterans. There is another committee of the department that addresses these kinds of issues related to younger veterans. So that period definitely was the mandate for our committee.

Mr. David Sweet: I asked Dr. Marshall last time whether he felt the new veterans.... I was at a retirement party for a general last week, and, of course, being on this committee, you look at a soldier entirely differently. You look around the room and just see how physically fit everybody is. I'm wondering, although I know you've been focusing on older veterans, whether you see a difference in attitude towards health in the younger veterans now who are aging.

Dr. Norah Keating: Because I'm a gerontologist, and that's where my focus is, I really can't speak to that question. In terms of the way the committee structure in the department is organized, Dr. Marshall will be sitting on the younger forces, new veterans charter committee. There's going to be, I think, a fair bit of crossover in direction between the two committees. I would certainly expect that the *Keeping the Promise* document and the work we've done will be part of the consideration of that other committee, but I just don't have the information on the younger veterans.

Mr. David Sweet: I'm certain that other committee would be able to determine through their studies some recommendations concerning how decisions that are made earlier in life impact how a person ages later. That would be critical in Veterans Affairs' dealing with them at a younger age.

I looked at the study and I didn't see this indicated. How many veterans were interviewed for this study, doctor?

Dr. Norah Keating: The *Keeping the Promise* document was not specifically based on our going out and doing direct interviewing. We drew on a large number of studies of veterans and older adults that have been done both by committee members and other people in North America and elsewhere, to put together the report. So the work was based on research done by the department, on work done by other organizations, and by input from the veterans organizations, particularly those that are members of the advisory committee.

Mr. David Sweet: I asked that because we're on another round of study on post-traumatic stress disorder and I want to find out the psycho-social aspect of what these veterans are wrestling with right now.

I was fascinated, and I mentioned this to Dr. Marshall, how you drew out in the study the accessibility of places where the veteran can stay physically fit and well. I had an example of that in my own family. Do you also see that capability from the psychological-social aspect, that if they have those services close at hand they'll also be able to stay psychologically well?

Dr. Norah Keating: Yes. I think the fundamental principles we began with were these ideas that aging well is an aggregate of physical and mental well-being—having sufficient income and social connections. Those principles are well established in research. We've seen lots of evidence that, in combination, those are going to help people age well, across the life cycle. Certainly the social and psychological elements of one's life are as important as those other elements—definitely.

● (1005)

Mr. David Sweet: I don't know if you have an ongoing dialogue with Veterans Affairs, but we had the assistant deputy minister in the other day.

I'm referring to page 21, where you talk in your study about being proactive rather than reactive. There's a tele-effort right now to reach veterans in order to make sure they are aware of services and that they have access to them. Is that part of what you're talking about with the, for lack of better words, one-stop shop kind of integration? Maybe you can flesh it out, because it has been asked about a couple of times.

Dr. Norah Keating: We work very closely with the department. One of the things they're trying to do—and the veterans organizations are helping considerably—is to make contact with veterans who are not currently clients of the department. That's part of that effort.

The integration is the one-stop shop. Yes. Once you have made contact with the department there is an effort to determine the nature of your needs. With these integrated services, there would be a much better ability to meet those needs in a coordinated fashion.

Mr. David Sweet: That's great.

So that we're not assuming anything, you've used the term "aging well" in the study, as well as here in the questioning. Can you give us a brief description of what you would consider is aging well?

Dr. Norah Keating: Yes. I think Dr. Pringle will speak more to this issue when she meets with you.

We use the term "best fit". Aging well is really having the best fit between who you are, the resources you have, your goals in life, and the setting in which you're living. For you to age well might mean living in a rural area surrounded by your family and being connected to nature. For someone else it might mean living in an urban environment, being as independent as possible, and so on. There's no one formula. It really is about one's personal preferences, resources, and the setting in which one lives.

Because they become somewhat less resilient, what happens as people grow older is that it's more difficult for them to work that match out. That's where the support comes in.

The Chair: Thank you.

Now we'll go to Mr. Stoffer with the NDP for five minutes.

Mr. Peter Stoffer: Thank you very much, Mr. Chairman.

Thank you again, Dr. Keating.

I have a couple of questions.

You indicated that one of the criteria should be military service and/or need. Is that correct?

Dr. Norah Keating: And need.

Mr. Peter Stoffer: I'll take you to a story that happened a couple of years ago in my riding, with an individual who was a war veteran. He was becoming very frail. He liked to stay in his basement near his wood heater and do his crosswords. At night he would have to go up the stairs in order to go to bed. He found it difficult to get up those stairs, and he asked if he could get a lift for his house. DVA's initial response was no, because his elderly wife could help him up the stairs. The definition of "need" was different there. What he thought he needed and what the DVA individual thought he needed were different.

Who should determine the need? Should it be someone from DVA with the flexibility to say yes or no? I'm thinking of various prescription drugs, hearing aids, whatever it is that they require. In order to facilitate better conditions in their home, for example, their home may have to be modified, outside or inside. Who determines that need?

Dr. Norah Keating: I think it's an excellent question and something the department is going to be wrestling with over the next little while as they begin to put the practical detail to the report we've written.

As you know, the report is written at the level of the principles and overall models. It's not written at the level of the detail, which is something that certainly the department is going to work out.

Of course once you move to thinking about families as the focus, the other thing that certainly we found in our work with families is that what a daughter might think is relevant or important may not necessarily be what dad thinks. So there's a lot of work to be done in fine-tuning that whole question that you raise.

● (1010)

Mr. Peter Stoffer: When you were accessing your report, was Mr. Sweet's question about what consultations were there with veterans...? Does your report also go on the premise of the benefit of the doubt? As you know, the new charter states that, and the previous minister and the current minister and many of us have said the same thing: that the benefit of the doubt should go to the veteran and/or the family. But of course that's easy to say and maybe fiscally difficult to do. So was your report based on that premise?

Dr. Norah Keating: From our interaction with the department, that's the idea on which they'd been attempting to provide services to veterans, given their complex eligibility criteria these days. So I think the benefit of the doubt is something they have been trying to use over the last number of years to do that.

I would think the same principle would apply, but perhaps be somewhat less important. If we can really work out this whole needs-based approach, the department won't be having to wend its way through all of these sometimes almost contradictory criteria about eligibility. If those are swept away, this benefit of the doubt will become less of an issue.

Mr. Peter Stoffer: Thank you very much.

The Chair: All right, thank you.

Now on to Mrs. Hinton, for five minutes.

Mrs. Betty Hinton: One of the things you'll note if you come to this committee again is that we have wonderful research people as well, and we have staffers who can actually get you answers when you ask for them.

I'll just give you the answer to the question I asked you earlier. I received a report on the OECD official statistics for 2006.

Dr. Norah Keating: I'm impressed at the timing of your research.

Mrs. Betty Hinton: This is regarding taxation levels, which is an issue that was raised earlier this morning.

It says here that the average Canadian pays 25.4% of their wage for taxation—I think you'd find some Canadians who would disagree with that figure—and in the Scandinavian countries it's 44.1%. So it's pretty clear why they're able to do some things we're not able to do.

I also wanted to just mention to you that I had the pleasure last week of being on the steps of Parliament Hill with Senator Marjorie LeBreton, who's been assigned as the minister for seniors, and Minister Solberg. We've just struck an advisory committee to address the general needs of seniors in this country, so they will probably be working hand in hand with your group. And you're working with veterans' needs. So it's a wonderful situation when you actually get the information straight from the horse's mouth.

Dr. Norah Keating: Yes.

Mrs. Betty Hinton: Is there anything you'd like to close with, any opinions you would like to leave us with? I was quite impressed with the changes you thought would pay immediate dividends, and I happen to agree with them. Respite support for caregivers is pretty nearly essential, and job protection for those who take the time off to support seniors would be a wonderful way to go too. But is there anything else you'd like to add?

Dr. Norah Keating: I think those would be the main issues.

Going back to the report, I think Veterans Affairs is in a wonderful position because they can top up other services, really, to meet the needs of older veterans very well. I have long been almost a cheerleader for the department, in the sense of their ability and willingness to really provide a set of services to older Canadians.

So I'd just reiterate that I do believe that the model we're proposing is something that will benefit these older veterans, and presumably the upcoming cohorts of veterans as they age as well.

● (1015)

Mrs. Betty Hinton: Thank you, Dr. Keating, and please keep up the good work.

Dr. Norah Keating: Thank you.

The Chair: Thank you very much.

Now we go on to Monsieur Perron with the Bloc, for five minutes.

[*Translation*]

Mr. Gilles-A. Perron: Mr. Chair, I only need a few seconds.

Dr. Keating, when you met with veterans of a certain age, the ones we might call traditional veterans, were you able to detect, in terms of mental health, any symptoms of post-traumatic stress because of what they experienced during the Second World War or the Korean War?

[*English*]

Dr. Norah Keating: In the research that we did for the department in rural communities, we were not focused particularly on mental health, so I can't address your question directly about PTSD.

Certainly we met with veterans, some of whom were very active and engaged and quite well, and others who were needing nursing-home-level care. So we saw a huge variety of health status and mental health status among the veterans and other older adults we talked to. I can't specifically say whether or not people we met were suffering from PTSD because we weren't really asking those questions.

[*Translation*]

Mr. Gilles-A. Perron: My question is to confirm what I learned this week. On Monday, Tuesday and Wednesday I attended a symposium on post-traumatic stress in Montreal. It was Veterans Affairs second National Operational Stress Injuries Symposium.

There was an American at the symposium—we know that Americans have been interested in PTSD since the Vietnam War—who said that the majority, or a good number, of ordinary veterans, if I can call them that, would have or could have experienced post-traumatic stress. However, because of their education or their pride, etc., they are apprehensive and do not want to talk about it. They prefer to talk about things other than how they feel. This is what we heard.

Is this statement true?

[*English*]

Dr. Norah Keating: I would expect that you may know more about this issue than I do. The only thing I could say is that we now have a great deal more knowledge about mental health problems than we did 50 or 60 years ago, so that many of the mental health problems of people post-Second World War likely simply were unrecognized. So I take your comments, and I know there's a tremendous amount of interest in PTSD these days, so I'm pleased to hear that there was such a conference.

[*Translation*]

Mr. Gilles-A. Perron: Thank you, Dr. Keating.

[*English*]

The Chair: Mr. Perron, thank you.

Now we go on to Mr. Valley with the Liberal Party, for five minutes.

Mr. Roger Valley: Thank you, Mr. Chairman.

Thank you for being a cheerleader for the department, Doctor. I think good work has to be recognized and I think Mrs. Hinton just recognized the low tax rates in Canada as something we can all take credit for from past governments.

Some hon. members: Oh, oh!

Mr. Roger Valley: They're giving me a bit of the gears here.

You have to forgive us, Doctor, for always returning to the younger veterans, but our focus is all veterans and we know your focus is gerontology.

Dr. Norah Keating: Yes.

Mr. Roger Valley: You mentioned in your opening comments about understanding what the veterans who came back from the Second World War needed, and I think your terms were that they needed education at that time and now it's moved on to health and social considerations. If we're going to serve our veterans properly in the future—and we know the ones who are coming out of the forces are much younger right now—we need to know basically what they're going to need. I know that's not your area of expertise, but it's something we need some guidance in.

You mentioned the other committee that's looking at the younger veterans. Do you think that, as they age and they get into the field that you represent, there will be the exact same things? Will it be health and social considerations? Is that going to be consistent with old age?

Dr. Norah Keating: This is one of the questions that gerontologists have been wrestling with for some time now, the question of whether each cohort or group of older adults is going to be the same. In some sense, I think in general, we would say yes. People do, throughout life and as they grow older, have social needs and health needs.

It also has to be known that each group of older adults is living in a different kind of social setting with different sorts of major events and economic climate. Those are the things that are extraordinarily difficult to forecast.

We know some things like adults at middle age right now are far more likely to be in the labour force, particularly women, than were women of the generation who are now over age 80. This in itself means that they have different trajectories in terms of their income, their availability to provide care for others, etc. So that's just one small example about how things may be different because of the circumstances of this next group of people who are growing older.

● (1020)

Mr. Roger Valley: Thank you.

You noted that it's difficult to forecast; it's almost as if we should have some kind of chart in front of us of a veteran at 30, a veteran at 40, a veteran at 50, and what possible services they're going to need. I don't think we have that kind of thing, and it might be something we have to consider in the future.

Thank you, Doctor.

The Chair: We now have Mr. Shipley, with the Conservative Party. Mr. Stoffer has requested that he have a chance to intervene afterwards.

Mr. Shipley.

Mr. Bev Shipley: Thank you, Mr. Chairman.

Again, thank you, Dr. Keating. In terms of the report that's been delivered, the work that you're doing as volunteers, I think each of us sometimes slides over this, and as we mention how much we appreciate it, it doesn't always ring to the real amount of appreciation that's out there. We tend to focus on our questions, but I think each of us has tried to illustrate in some sort of language the appreciation on behalf of the veterans of what you're doing, which is incredible. I just leave that as a comment.

Dr. Norah Keating: Thank you.

Mr. Bev Shipley: Secondly, I want to follow back through on the question where I was going in terms of the availability of services, and I'd ask whether, in particular, there is a concern in terms of the specialists who are required and the service providers who are required.

Dr. Norah Keating: One of the things we found in the work we did for the department on rural Canada is that different kinds of services are more important to people, to older adults and to older veterans, in different kinds of situations. For example, if you are someone who has reasonably good health, who drives a car, and who is used to travelling some distance from a larger service centre, it may not be a huge issue to you.

We interviewed people in one community that was about a two-hour drive from a major service centre, and those who were driving and were in reasonably good health were not concerned about lack of local physicians or specialists, because they were able to get there. So it depends. For some people who are very frail and who need specialists' care, this could be a real concern.

So it's hard to generalize. It depends on the veterans and their particular needs.

Mr. Bev Shipley: Thank you.

In your report on page 15, where you talk about how 40% of the war service vets are receiving some VAC health benefits now, in the second paragraph you talk about how there are a number of reasons why the remaining 60% are not using these services. Then in the second bullet you talk about how they may not know about the services that are available. I think, clearly, we need to do as much as we can to make those services known to our vets, firstly.

Then there's a third bullet that says "They may not ask for service". Are we obliged to provide the service when they don't ask for it, do you believe?

Dr. Norah Keating: That's a difficult question. There are of course some people who don't wish to have services. One of the frustrations we found among service providers in the research that we did was among those people we came to call "stoic". You probably know them: these are people who really are quite self-contained, who don't wish to have to depend on others, and sometimes would refuse services perhaps to what we might think is their detriment.

There are ethical issues here as well that are very tricky about how much one imposes, how much one stands back and is concerned about people not doing well, that are very much practice issues that face-to-face caregivers and service delivery people have to confront fairly often. So I can't give you a definitive answer to that question.

● (1025)

Mr. Bev Shipley: One of the comments that has come forward is that if someone hasn't been part of that service as a veteran and passes on, then their widow does not have access to those services. I think we need to consider how we work around that.

Dr. Norah Keating: Yes, that certainly has been one of the drawbacks to the current set of eligibility criteria and the focus specifically on the individual veteran, not on his family.

Mr. Bev Shipley: Those are my questions, Doctor. I appreciate very much your entertaining our questions today and being on the committee.

Dr. Norah Keating: Thank you.

The Chair: Thank you very much.

So far we only have two other people on the list who wish to speak. Mr. Stoffer is interested in an interjection here and asking questions, then we'll deal with Monsieur Perron's request afterwards.

Unless anybody has any objections, I recognize Mr. Stoffer.

Mr. Peter Stoffer: Only one question.

For aboriginal or first nation veterans, when they age there are some cultural and obviously historical sensitivities around them that would be met. How do you see DVA in the future ascertaining peculiar circumstances with them in terms of their needs, as apart from non-aboriginal veterans?

Dr. Norah Keating: That's a very good question.

I think part of what we hope this new approach to services might take into account are cultural differences, not only community settings but cultural differences. First nations people have a particular kind of tradition. Older adults who come from different religious or ethnic backgrounds may as well.

I cannot speak specifically to how that might be done with first nations veterans. I know there's an awareness in the department about the differences. Certainly the research on aging that has been done with aboriginal people shows that they are much more likely to have high levels of chronic health problems at younger ages than non-aboriginal older adults.

Mr. Peter Stoffer: Thank you.

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

Monsieur Perron's interjection will be something independent of this, so what I will do now is take the opportunity on behalf of the committee to thank you very much for your presentation this morning.

Some hon. members: Hear, hear.

The Chair: I want to let you know that I, and I'm sure everybody here, learned a great deal. I know the time difference was touched on by one of our other members here. While 9 a.m. is a reasonable time for us, 7 a.m. is an earlier one for you. Thank you very much for accommodating us in your schedule.

Dr. Norah Keating: Thank you so much.

The Chair: Bless you for your work.

Thank you.

I actually find that sometimes I learn more through the audio than I do through a visual presentation. I don't know what that implies about my learning technique.

Monsieur Perron would like to talk to us. He's been at a Sainte-Anne's PTSD event.

[*Translation*]

Mr. Gilles-A. Perron: It is up to you to decide if you would like me to briefly summarize what I saw and heard on Monday, Tuesday and Wednesday. I will do it for your information. This symposium was very interesting. I think the problems it addressed were fascinating. There were so many information sessions offered that it was hard to choose which ones to attend.

I think I was the only one who was not a psychologist or a psychiatrist, other than the symposium organizers. More than 450 people, psychologists and psychiatrists from all over Canada, the United States and some European countries as well, met to review the current situation.

My first reaction was to notice how far behind we are in terms of research. It is not just in the area of post-traumatic stress or human psychological behaviour that our American friends are much more advanced. In terms of post-traumatic stress, we are very far behind, but fortunately there has been some good research conducted in the United States, which we can use. They have been interested in this since the Vietnam War, while we started taking an interest in it barely five years ago. That is hard to believe.

But there is hope. I brought the program from the symposium to provide you with names of experts, such as Matthew Friedman, one of America's foremost authorities on this topic. During his presentation, he referred to the findings of young psychologists from McGill University, the University of Toronto and the University of Manitoba. So there is an exchange, and our young academics are perhaps better informed than older Canadian psychologists about the experiments conducted by the Americans.

I can also say—although not with as much certainty since I did not meet enough people from these countries—that we are no more advanced or farther behind than France, Belgium, Germany, etc.

What interested me particularly, was to learn who can suffer from post-traumatic stress, and that post-traumatic stress is not restricted to our soldiers. There are about 10 or 12 types of stress that can affect some people at any time in their lives. For example, it could occur following a rape or an automobile accident in which the person witnesses the death of a best friend. These are events of the same type, but naturally, it is much more likely for them to happen on the battle field than in everyday life.

What can we do? First of all, people who are experiencing stress must be able to recognize that they are having problems and realize that they must see someone. Second, the quicker this is done, the better the chances of healing, not 100%, but I think the figure provided was 67%. Yes, I am looking at my notes, and the figure was 67%.

So I have realized the importance of increasing awareness among the young soldiers who are enlisting about this phenomenon which could occur. I also realized that there was a serious shortage of professionals in Canada and Quebec able to treat this condition.

● (1030)

Because of Canada's geography—we have three or four large, urban centres found within one strip of land, while the rest of the country is mainly rural—it is difficult to establish a front line for intervention. When a young soldier suffering from post-traumatic stress begins to feel like something is wrong, he or she does not need to see a specialist for an initial consultation. However, the person he or she does consult must be very familiar with that condition. If PTSD is identified, the patient could be referred to a centre such as Sainte-Anne Hospital, for example.

There is still a lot of work to be done. Most of the psychologists there said we need to find a way to establish networks to provide primary care and initial contact in Canada's more remote areas. This aspect is crucial. We are starting to see this in rural areas, but this will take some time.

As an example, Dr. Friedman said that, since the United States began their research into this area shortly after the Vietnam war, every year, more and more psychologists and psychiatrists are earning their degrees, specializing in this area. He told me an interesting fact during a one-on-one conversation. According to him, we should not be too quick to trust our statisticians, because their calculations are inaccurate. I asked him what percentage of our young soldiers return from combat suffering from various degrees of post-traumatic stress—the intensity is not always the same—and he said that, in the United States, that figure is 39%. Statistics suggest that, in Canada, the percentage is approximately 12%.

My next comment is addressed mainly to Betty. I was surprised to learn—and I would have never believed—that women are more likely to suffer from post-traumatic stress than men. The difference, in terms of percentage, is minimal. The difference is 10% compared to 8% in the general public, not in the army. I was surprised by that. I though the rate would be the same or almost the same. But no, 10% of women suffer from post-traumatic stress compared to 8% of men. What is the reason for this difference? I do not know, I am not an expert. I learned this during the last day, yesterday, but I did not really understand what they were saying.

The three days were very worthwhile. Another surprising piece of information that must be considered is that approximately 25 to 30% of young people who begin treatment leave the program prematurely. Why? No one knows. Psychologists do not know why, but between 25 and 30% of young people who begin treatment abandon it after three or four sessions. Psychologists do not know how to retain them. The success rate of treatment is 67% and the time it takes for the treatment to be successful can vary between a few months and a few years.

I asked about post-traumatic stress among traditional wartime veterans—those we know are now in their 80s—and I learned that the stress dates back so far back that it is nearly impossible for the victims to heal. We can try to make the illness less painful by encouraging them to have a more active social life and become more involved in their families, with more intergenerational contact. We can help them alleviate their problem, but healing PTSD or post-traumatic stress is nearly impossible at that age, because they do not have many years left. Their suffering could take 10, 15 or 20 years to heal.

I could go into greater detail. Furthermore, I asked for a report on all the sessions, and I could forward you that report, if you like. There were 33 sessions in three days, and most were taking place at the same time. I was able to attend about 15% of them. I missed one session that I would have liked to attend, on suicide among people suffering from post-traumatic stress. Unfortunately, I had already decided to go to another, more important session. It would have taken three or four people to attend all the sessions.

● (1035)

● (1040)

[*English*]

Mrs. Betty Hinton: That's very interesting. It sounds like it would have been a wonderful session to attend to get all of that information.

When you were giving your report and mentioned the young people who were leaving, the first thing that popped into my head was perhaps there's some correlation between mental health and physical health. Quite often people who are prescribed antibiotics for some sort of physical ailment take half the prescription, and because they start to feel better they stop taking their prescription. Maybe the same sort of thing is happening on the PTSD side.

Mr. Gilles-A. Perron: That could be.

Mrs. Betty Hinton: You start to feel better and think, “Okay, I've had enough of this. I'm done, I'm fixed”, and away you go. So we have to find a way to encourage people to stick with the whole treatment.

[*Translation*]

Mr. Gilles-A. Perron: They make every effort to try to maintain an inward life. A last resort could be to use a rifle and say that, if they do not come... They go. They are obligated to let them go.

Indeed, I was very surprised to learn that, of all the physical illnesses one can have before leaving, including heart, respiratory, muscle, mobility, weight, liver problems... Our society must take a closer look at PTSD, which can affect not only soldiers, but also rape victims or people who have been in an accident, for example. Society must take a closer look at this problem.

[*English*]

The Chair: My guess is that a number of quitters feel some sense of relief in quitting because they think they're somewhat cured. The other thing is that having dealt with some of these painful issues, and what not, they may determine after some treatment that they've had some help and don't want to deal with it any more.

Mr. Gilles-A. Perron: Those are problems, and there's the distance problem. Maybe he's tired of taking the bus for three hours each way to go to a one-hour treatment every week. I know it's tough. It's practically not doable to give the treatment at his home. But there are all kinds of reasons why 30% of the people quit before it's over.

The Chair: Mr. Sweet is next, and then Mr. St. Denis.

Mr. David Sweet: How much of it was focused on general PTSD sufferers in the military? Were some sessions focused strictly on the military?

Mr. Gilles-A. Perron: The first day it was mainly general. The second day it was on the military and young vets, to give them better service. They recognize that they don't get better service because we're not equipped, we don't know that much, they live all over the place—all that stuff.

At the end of the first day we had a good case. People from Petawawa came and said, “I'm okay. I'm a brand-new person.”

By the way, I was able to talk to someone named Danielle—I don't remember her last name. She suffered from it in Bosnia and is ready to sit on one of our sessions. She's working for Veterans Affairs in Kingston. So it's a good story. It's happening, but the problem is that we may have one good story but we might be missing ten because of lack of professionals, service, and everything.

What can we do? We can try to improve as much as possible, but we won't be able to reach 100% of them.

The Chair: We'll have Mr. St. Denis.

Mr. Brent St. Denis: Maybe Michel would just make note of that thought for a possible future recommendation, if we agree.

You talk about the people taking a bus, maybe, and that's why they're discouraged to go and get treatment. When it comes to mental disorders, a lot of the work is talking. You know, you're talking to your counsellor or you're talking to your doctor.

I know that they now use telephone consultation. Maybe you have to visit the doctor one out of three times, but for the in-between two sessions you can spend the time on the phone. Did that come up at all? I'm just wondering, when you look at the distances and the time, whether more telephone intervention is something we should look at, especially for our rural veterans, and so on. I just wanted to raise that, because lots of it is talking, you know.

● (1045)

[*Translation*]

Mr. Gilles-A. Perron: I do not know if such treatment is effective. Therapy involves an element of human contact. The patient sits facing someone they trust, with whom they can talk. Their gestures and body language can be observed, the patient can be touched, and so on. Over the telephone, however, there is a physical barrier. I do not know too much about it, I am just saying.

[*English*]

out of my brain. I don't know if I'm telling you the truth or not.

The Chair: It could be an option.

Mr. Brent St. Denis: And I don't disagree that eyeball-to-eyeball contact and how we.... But if the telephone gives you even half a solution for somebody, as opposed to no solution, maybe there is some place for it. I know it's done in civil society that you go for your session and the one or two sessions in between, depending on the circumstances, are by phone.

Mr. Gilles-A. Perron: Or it could be to follow up.

Mr. Brent St. Denis: You have a combination.

Mr. Gilles-A. Perron: I don't know. You might be right.

The Chair: You can do therapy over the phone all the time.

Mr. Brent St. Denis: Well, people seem to call those other lines, apparently, the 999 lines, you know.

The Chair: Fair enough.

Mr. Shipley, did you have something?

Mr. Bev Shipley: I think it likely was dealt with. Thank you.

The only thing I was going to mention, and not to put Mr. Perron to work, but I found interesting his oratory on it, was that you talked about the complexity of some of the speakers. But actually, Gilles, an executive summary from you of what you felt and heard, in layman's terms, I think would be beneficial to this committee, if that hasn't already been addressed. I don't want to put you to a lot of work.

Mr. Gilles-A. Perron: I know that Greg was there.

[*Translation*]

I told Greg Thompson that I very much appreciated that, in his opening remarks, he recognized the presence of Bloc MP Gilles A. Perron in the room. He did not have to do that. He asked me to stand up, so that people would recognize me as an elected representative. I must say, I really appreciated this gesture, which showed class and decorum. Perhaps it sounds like “brown-nosing”, but I would like to tell everyone about it, because I found it very touching. Furthermore, Greg asked his photographer—a lovely young woman—to take some photos of the two of us. So, some photos were taken of us together. I do not know what he will do with them. He was extremely nice to me. Please tell him that I really appreciated it.

[*English*]

The Chair: They're in his wallet, I think.

I'd like to thank everybody.

Monsieur Perron, just talking to the clerk, one potential is.... You've obviously done a great deal of research on this. Maybe we could even have you as a witness at some point with regard to this.

Yes, Mr. St. Denis.

Mr. Brent St. Denis: Mr. Chair, on that very point, I agree with Bev that we not create lots of work for Gilles. But it might be simply that sometime, at the end of a meeting, we take half an hour and put Gilles there. If you had your thoughts prepared, that could be the summary, as opposed to making a bunch of work for you.

● (1050)

The Chair: Monsieur Perron, I just want you to think about this. We have Senator Dallaire appearing for an hour and a half. The last half-hour is open. I was thinking I could distribute the letter that we sent off to the minister, but that won't take long at all. That could be left until the end of the meeting or done very quickly. You're certainly welcome to have the half-hour if you wish.

Mr. Gilles-A. Perron: I'll have my thoughts organized to make a good summary verbally.

The Chair: With that, the meeting is adjourned.

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