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Chair

Mr. Rob Anders

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● (0905)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): We have a teleconference call this morning. We do have quorum. We have our witness online. According to my BlackBerry, we're still two minutes early, so I'm just going to give it another minute. That way no committee member can complain about the meeting starting early.

Is Dr. Dorothy Pringle there?

Dr. Dorothy Pringle (Council member, Gerontological Advisory Council): Yes, I am.

The Chair: I'll tell you what, then. We'll go ahead and get started.

Dr. Pringle, the way this usually works is that you have 20 minutes to present. You can take that full time if you wish, or not. That's entirely your prerogative. Then what happens is we open it up to questions from committee. The timing and the order, the rounds and all that type of stuff, are already predetermined. That's generally the way it works.

We're right now conducting a study of the veterans independence program and health care review. Dr. Pringle is with the Gerontological Advisory Council.

Dr. Pringle, the floor is yours.

Dr. Dorothy Pringle: Thank you very much. I really appreciate having this opportunity to talk with you. I very much appreciate your interest in this.

I've been a member of the Gerontological Advisory Council for about five years. I'm not one of the original members, but I chair the working group that developed the report *Keeping the Promise*. I'm a nurse, and my clinical and research areas really focus more on long-term care, particularly the quality of the daily lives of people with dementia who live in long-term care.

I also do work at the other end of the spectrum, and that's on health promotion. I've done a lot of work with public health and have taught health promotions to nursing students for many years. I'm chairing the health promotion committee of the advisory council and working with Veterans Affairs staff to determine how Veterans Affairs can put into place the programs and systems that are proposed in *Keeping the Promise* and those that will lead, we hope over the long run, to better health outcomes for all veterans. There's a second committee, chaired by Dr. François Béland, that is working on assessment of needs, the types of screening tools that will be used to assess individuals at various stages of their involvement with Veterans Affairs. Both of these committees met for a full day two weeks ago to begin the work of identifying how we should go about developing what our particular objectives are.

Veterans Affairs staff had done a lot of work in preparation for these meetings. Our aim is to have a fairly comprehensive report going to the Gerontological Advisory Council meeting the first week of July in Charlottetown.

I thought I would start by talking about the health promotions committee specifically. I want to review the principles that we've adopted to guide the committee's work as we identify how we are going to develop the programs and develop access to these programs across all of the areas in Canada.

Our first principle is that we be very pragmatic and realistic. We intend to recommend programs that are doable and how to get programs into place across the country. We're only going to recommend evidence-based programs; that is, programs for which there is sufficient researched evidence demonstrating that they are effective in achieving better health outcomes.

We shall take an incremental approach. We'll start with programs for which evidence exists now of their effectiveness, then develop a process whereby we or the staff of Veterans Affairs continually assess the research evidence, so that as other programs are demonstrated to be effective, they would be added to the repertoire of programs that Veterans Affairs has available.

We'll also be forward-thinking. In *Keeping the Promise*, as you know—because I've read the transcripts of your previous interviews—we were asked specifically to deal with war veterans, that is, World War I, World War II, and Korean war veterans, although we really focused on World War II and Korean war veterans.

I think the programs we are going to recommend have to be relevant for veterans and their caregivers. Initially, these folks are in advanced age, but we need to be laying the foundation for all veterans—those in their middle years. The average age of Canadian Forces veterans now I believe is 56, but there are much younger veterans as well. We need to put in place now the types of programs and processes that will serve veterans of all ages.

In *Keeping the Promise* we propose creating a new role: the early intervention specialist. These are the health promotion specialists. Let me tell you, I think that's still not the right name. We struggled with this, both within our working group and on the Veterans Affairs council. We quite liked the term "health navigator", but it did not go over well with the veterans groups, so we're using the term "early intervention specialist". That sounds a little too medical, I think, so that's an area where we still have to do some work. I will refer to the role as early intervention specialist because that's what we've documented in *Keeping the Promise*.

These individuals would be added to every team in every regional office. The number of individuals would be determined by the size of the office, both in terms of the number of veterans they serve and the geographic distances that the area is responsible for.

After an initial screening of a veteran who contacts Veterans Affairs, if the veteran has demonstrated that they do not need health services, the veteran would be referred then to the early intervention specialist. They would have an additional assessment at that point to determine what their health promotion activities were. What kind of nutrition did they have? What's their weight? What kinds of exercise activities did they participate in? Did they have chronic illnesses that they were managing? They would be with the early intervention specialist if they were managing those chronic conditions fairly well, but there might be additional work needed there.

There would be an additional screening, and if that early intervention specialist identified, on this more intensive screening, that the individual needed services, that individual would also be contacted by a care coordinator. When I say "individual", I'm talking about the veteran and a caregiver. We are very much of the approach, and I hope you took that from the *Keeping the Promise* document, that you must provide services to both the veteran and his or her caregiver. With that, the early intervention specialist would then work with the veteran and his or her caregiver to determine what types of health promotion activities would suit them, and they would benefit from and then organize that with them. We are not going to leave it to the veteran to make all of these arrangements. People at 80 and 85 need somebody to attach them to programs.

We're focusing on programs for health promotion that can be established in every area office. We began by examining programs in four areas: nutrition, physical activity, falls prevention, and chronic disease management. We looked at the area of social integration because of its relevance for the mental health of veterans, but we decided that rather than treating it as a separate category, we would link it to physical activities and other areas, because social integration can frequently be realized by participating in other types of activities.

● (0910)

Again, we're identifying which interventions are most appropriate for the early intervention specialist and which are more appropriate for the care coordinator.

I'm going to focus most of the rest of my comments on the work we've done around physical activity, partly because there is more evidence in this area and because more programs designed particularly for older people have been evaluated in this area.

There is very strong research evidence about people who are physically active and engage in regular physical exercise, regardless of their age; it applies to people even in advanced old age. These people are healthier, they have lower blood pressure, they're at better weights, they have lower diabetic rates, and they have lower rates of frailty. If you can get younger people, or if younger people are actively engaged in regular physical activity and do it on a sustained basis, clearly there are better and more dramatic effects in terms of health outcomes than when you start with people who are already old. But when it comes to physical activity, the phrase "it's never too late" really does apply.

I'm pleased to say that a good deal of the evidence that links health outcomes to physical activity is Canadian research. We are looking a populations that we will be dealing with in the future. It's not specifically related to veterans, however.

It is critical that the programs we are recommending be evidence-based—I've said that several times now—but it's also very important that the programs be accessible and affordable. That's where Veterans Affairs really has a major role to play. It needs to establish the programs, monitor their quality, develop ways of making them accessible to veterans and their caregivers, and ensure they're affordable, either by paying the cost or by supplementing the cost.

We know that if we start with an 85-year-old veteran and his 82-year-old wife and get them both into exercise programs, it's not going to have huge effects, but it will have some. We know that if we can get the 50-year-old veteran into these programs, we can expect a much larger effect. We can get the 35-year-old veteran into programs. These programs have to be different, because different generations have different attitudes towards physical activity. We might expect the 35-year-old veteran to already be into physical activity programs, and even the 56-year-old. Baby boomers have a very different attitude toward physical exercise; a lot of these people will have personal trainers. That is not likely to be the case for the 85-year-old veteran.

There are four physical exercise programs we are looking at in depth because there is demonstrated effectiveness for all of them. One is called enhanced fitness; one is called active choices.

Enhanced fitness is an individually oriented program. This would be useful for veterans who are not interested in or do not want to participate in a group activity, but it is a prescribed exercise program with a lot of telephone contact with the veteran by that early intervention specialist to review how things are going and to discuss any effects, both negative and positive, that the veteran might be feeling. We're looking at that as one type of program.

PACE is another. PACE stands for People with Arthritis Can Exercise. We know that there's a higher prevalence of arthritis in older veterans than there is in the population at large. We believe there's good American research that demonstrates a link between military service and the subsequent development of arthritis. We want a PACE program in place in every area, as well as another program called “Growing Stronger”.

● (0915)

We would expect the early intervention specialist, within that specialist's area, to identify existing exercise programs wherever they're located. They may be offered by veterans organizations such as the Legion or the army, navy, and air force veterans organizations. They may be offered by the YMCA, by seniors clubs, or even by for-profit fitness clubs. The early intervention specialist needs to know what's already available. What kinds of programs are they? Do they conform to the evidence-based programs that we are going to mount or support?

If they are not available, then the specialist will work with veterans organizations, the YMCA, or private clubs to get them established and then link veterans to them through these screening processes. The early intervention specialist will determine the transportation needs of the veterans, will develop transportation for these programs, and will fund or supplement fees to make it possible for the veterans to access the programs.

The early intervention specialist would then stay in touch with those veterans. It's not a matter of linking them and then moving out. We see ongoing contact to see how things are going. If the program isn't working for the veterans, then they need to work with other programs.

When I say this, it's not about imposing this on the veteran. This would be worked out with the veteran and caregiver on what they're interested in and what's possible for them. They would then get them into those programs and stay in touch with them. We expect positive health benefits and positive social participation benefits from this.

We are proceeding to seek out and appraise research on other programs. It's going on right now. We'll be working hard at that over the month of June in preparation for our July meeting.

We've also had consultations with Dr. Mary Altpeter. She's worked with Victor Marshall at the University of North Carolina. She is really the American specialist on these kinds of health promotion programs. It's not only activity but health promotion programs that affect other health areas.

We will be coming forward with a recommended list. We expect it will not be very long. While we have lots of research linking nutrition and health outcomes, exercise and health outcomes, social participation and health outcomes, the programs that have been developed and assessed in terms of effectiveness and the research done on this are much more limited.

We are systematically reviewing that. A lot of work has been done in terms of bringing this research together. It's those kinds of summaries and critical appraisals that we're reviewing.

We recognize this will require additional resources. But we believe, and we've certainly had nothing but support from Veterans Affairs in believing, this kind of investment is what we need to do now in order to have better health outcomes for veterans in the future.

I know in earlier interviews with Victor and with Norah Keating, you discussed the need to identify veterans and to encourage them to contact Veterans Affairs. They can be screened and linked to programs for health promotion and to the health services they require.

We've spent quite a bit of time talking about how we can reach veterans, because, as you know, Veterans Affairs does not have a roster of all the veterans. For those who are already connected to services—and I think it's 40% of veterans who are already in the VIP program—that's not a challenge. But we do need to reach the 60% of veterans who are not connected. We've discussed using *Salute!* and other communications from Veterans Affairs, and using the organizations like the Legion and the army, navy, air force, etc.

● (0920)

I believe at an earlier meeting you suggested that it might be possible to work with the offices of members of Parliament to reach veterans in their constituencies, through their communication vehicles and other contacts. I think that's a wonderful idea, because it's been a challenge for us to identify how we would get to these people.

Rather than talking more about other programs, I think I'll stop so that we might move on to questions and discussion.

● (0925)

The Chair: You have impeccable timing.

Dr. Dorothy Pringle: Was that 20 minutes?

The Chair: It's 20 minutes and 20 seconds right now. That's very impressive.

Dr. Dorothy Pringle: Wow, I had no idea.

The Chair: Very impressive. You could teach a few things to our committee members.

Mr. Valley, for the Liberal Party, you have seven minutes, please.

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

Good morning, Dr. Pringle. I'm sure my chairman wasn't talking about me, because I'm known not to be long-winded. Thank you. You had very good opening remarks.

Actually, I'm going to go to my last point first, because you just touched on it. One of the struggles for members of Parliament has been, as you mentioned—and I was probably the guy who recommended it—to have a list of the veterans in our ridings.

I would ask you to consider something, and it was mentioned at a previous meeting, but I'll bring it up here. I was wondering if your group would make a recommendation that we could be provided a list in our ridings. We know the privacy laws. We deal with them every day, but we have access to all kinds of information. You just brought up a figure that I've been curious about for a while: that 60% of veterans are not connected to any organizations, or that we're not touching base with them.

A recommendation from your group that members of Parliament could be provided with this list.... We only have the best interests of these veterans at heart, and we want to be a point of first contact in many instances. We travel our ridings extensively. We would be the perfect people, but because of the rules that are in place right now, we can't do it. A recommendation from your group to start building that list and providing it for members of Parliament would go a long way.

Dr. Dorothy Pringle: Let me say that I believe 60% of veterans are not now receiving Veterans Affairs—They may very well be connected to the Legion or other veterans organizations, but they're not in a long-term care facility, in a veterans bed or a community bed funded by veterans, and they're not receiving the VIP program.

I read the transcript. I think you had that discussion with Brian Ferguson and Darragh Mogan. I'm happy. I think we can bring that forward and then look at how we overcome—and what needs to be done to manage the privacy side of things but also to make it possible for you people to be in touch with veterans that we're aware of.

It may be as simple as asking the veterans who are receiving services whether or not they're prepared to have their names released to you.

I don't see that as a huge problem.

Mr. Roger Valley: Thank you for that. And from your side, if you'll follow up on that, we will do our part here.

I'm going to branch off just for a minute, and I don't do that too often.

The committee has not even been out of this room 12 hours. We had a fascinating night last night. We had probably 30-plus PTSD survivors and some professionals in the room.

We know your focus is on World War II and Korea, but you mentioned earlier that you look at all veterans and the different ages, realizing we have to serve them all.

One of the things I heard last night, which was quite surprising—we know there are always institutional problems and administrative problems—and I'd like a comment on it, is that all of these survivors deal with different challenges, and they meet them as well as they can to survive every day, but the administrative problems or the institutional problems inside Veterans Affairs are one of the hugest obstacles they face.

For health care providers, you've mentioned repeatedly that early intervention is important. Last night we heard that the lack of health care providers, the challenges of health care providers working with veterans who are suffering from any of a host of things, from PTSD to other issues, and their inability, really—this is what they feel, rightly or wrongly so—to get access—or if they have access it's cut off. They build up trust with the people who are working with them, through this early intervention, and then it's not carried on.

So it was a bit of a surprise for me—and I'm sure for the committee members—that we have this problem inside the system to the extent we do. I'm wondering if in your deliberations or your discussions with other professionals on the committee you have run into this. Do you know how widespread the problem is?

● (0930)

Dr. Dorothy Pringle: First, I don't know how widespread the problem is. I am not surprised to hear it, because it is a problem in our health care system that we're underresourced in a number of areas. That's the system.

You understand that Veterans Affairs really is a gap filler. They are not the first line of services. They build on what is available through our provincial health care systems. Because we run into shortages in those systems, veterans are going to run into them.

I have to say that we're so new at recognizing PTSD as a problem and its extent. If you go back and look at the history of the various wars, right back to the Civil War, there is documentation of PTSD, but it was never called that. It was never recognized in terms of how serious or long-standing it was, how much it affected people over a very long period of time, or just how prevalent it was.

We have not ramped up systems sufficiently to deal with the extent.... I know it's a high priority for veterans at Ste. Anne's, and they are developing and testing programs to be put in place across the country.

I regret that's the case, but I'm not surprised at hearing it.

I have to say that our council has recognized it. We haven't dealt with it to any great extent because we're dealing with Second World War and Korean War veterans.

Mr. Roger Valley: Thank you, Doctor.

I'll be very brief, very quick.

Since you are dealing with those two groups, we heard repeatedly from the group last night that one of the biggest challenges they face is not necessarily in health care but the red tape.

Even at Veterans Affairs, through your group, I'm sure you've had to deal with red tape when dealing with the age of the veterans. So it's not necessarily health care.

Maybe a clerk could help them through some of the red tape. It's a part of government, but we have to find some way. This is a huge concern for these veterans and the ones you talked about.

Dr. Dorothy Pringle: You're absolutely right. We did hear that veterans need help, not relating to PTSD, but to other services within the VIP program. It's not just with funds to get snow clearance, groundskeeping, etc.; they need help to get that in place, not to be left on their own to make those arrangements. We've made that recommendation in *Keeping the Promise*.

The people who they are working with in Veterans Affairs, whether early intervention specialists or care coordinators, have to help them navigate the system and complete whatever forms they need to complete, so that they get the services.

Mr. Roger Valley: Thank you.

The Chair: Thank you, Doctor.

Now over to Monsieur Perron of the Bloc, for seven minutes.

[*Translation*]

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Good day, Madam.

I listened carefully to your presentation or rather, to your theory about early intervention specialists. I think it has some merit, but I wonder whether this approach is feasible. You talk about committing additional funds and hiring more individuals to work in this area, whereas we are already having trouble filling positions.

The second part of my question reflects a serious concern of mine. It is no secret that the Canadian population is aging. What do we do about the so-called regular population? Does your intervention plan for veterans also apply to miners, for example? They too have contributed to this country's growth and development.

Lastly, I would like to know what this proposal will cost?

● (0935)

[*English*]

Dr. Dorothy Pringle: The early intervention specialists—I'm addressing now your question about the potential difficulty in being able to recruit the people who will fill the early intervention specialist positions—will not be health care providers. We're not going to have nurses or physical therapists in these positions. We're likely to be hiring people who have degrees in ergonomics or in physical and health education. I think that's a different pool. It's a pool that I think is pretty vibrant across the country, and I think clearly it won't be easy—it never is—and in some of the areas that are more remote it will be more difficult. But I think it's doable, and we will find the individuals to do it because we have I think a clear idea of the backgrounds they require and know the sources of people with these backgrounds.

In terms of what we're recommending and its value to the population at large, I don't think there's any question about it; it's the kind of thing the Public Health Agency of Canada and public health departments across the country struggle with, which is how to get the population at large to take better care of their health and engage in health-promoting activities.

I was pleased to see that ParticipAction was started again, because I think it's the kind of organization that relates to the population at large and makes the same kinds of recommendations as we're making for the veterans population.

[*Translation*]

Mr. Gilles-A. Perron: Madam, I can see that a double standard could be at play here. In your presentation, veterans and ordinary people who are getting older— people like me who are 66 years of age, and my father— are not treated the same way.

It is all well and good to want to help veterans, but it is important to think about the aging members of the general population as well. This is a problem in Quebec, in Ontario and in all other provinces, especially in remote areas. We need to remember that Canada is a country made up of remote areas. It is one thing to receive treatment in Toronto, Montreal or Vancouver, but it is quite another matter when you come from Elliot Lake, like one of my colleagues, or from Saint-Lin-des-Laurentides.

[*English*]

Dr. Dorothy Pringle: I think we made a decision as a country that we were going to honour the veterans by providing services to them that exceeded what is available to the Canadian population at large. That was a tribute to the fact that they put their lives on the line for us.

So I think there is a double standard. I think it's a double standard that as Canadians we have bought into and feel very strongly is deserved. The VIP program really is a double standard. It provides to veterans services that are not available across the country through our provincial programs. Some home care programs are more generous than others, in providing home-making and groundskeeping, but most of them do not—particularly the latter. That is a responsibility of people who live in their own homes.

So yes, there is a double standard, but one that we accepted.

Let me say that I know Elliot Lake—I lived in Sudbury for four years—and I know it has become a retirement town and that they need services there and have to rely on the services that are available in that region. I think we need to have very good home care programs across the country to meet the needs of all citizens, and we need to reach out on the health promotion side to all citizens. But we are reaching out farther for veterans.

● (0940)

[*Translation*]

Mr. Gilles-A. Perron: Thank you, Madam.

[*English*]

The Chair: Eight seconds over, Mr. Perron.

Mr. Gilles-A. Perron: I'm a hero.

The Chair: I know, and that's why we want to hear from you again.

Mr. Stoffer of the NDP for five minutes, please.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you, Mr. Chairman.

I first want to say that in my ten years as a member of Parliament, last night was the best committee I ever attended in terms of the meeting. I thought you, Mr. Chairman, did an outstanding job. It's a pretty sensitive thing to cut people off who want to talk, but I thought you did it extremely well, and my hat's off to you. I thought yesterday was very uplifting. I wasn't sad at all. It was actually quite a remarkable thing to witness. So that one's in the memory bank for a while.

Madam, thank you very much for your presentation. I have only two questions for you.

When you make the recommendations to government, do you put any fiscal parameters around them? Do you advise government how much it may cost them and, if not, why not?

Second question: do you compare the work or the studies you do with other countries that we are allies with, for example, the United States, Holland, Britain, New Zealand or Australia, in terms of how they treat their aging veterans and their families as well?

The last question for you is this. When a veteran passes on and their spouse is left behind, do you feel there's not all of a sudden a disconnect from that individual? I ask this because we all hear from family members whose veteran has passed on, and it's very difficult for them to approach the government or the department in any way to try to achieve services they may require.

Thank you.

Dr. Dorothy Pringle: The council itself does not do the work on the fiscal side of the recommendations. We don't have the expertise to do that. But the staff of Veterans Affairs does do that and does assess what it would cost, and they've been doing that on the recommendations for *Keeping the Promise*.

We're told on the council about what kinds of aids would then be required to put into place the recommendations, and we push back and say you have to do better than that in terms of getting these programs in place. But we don't do the fiscal analysis itself.

We try to be realistic around what's possible. We're not recommending a personal trainer for every veteran in order to achieve a higher level of physical activity. But we do believe it is possible to put in place and give access to physical activity programs that meet the needs of individual veterans.

We do look at what is available in other countries and what they make available to their veterans. I'd say we have looked at the Australian situation, perhaps, more than the U.S. I don't believe the U.S. is doing anything particularly on the health promotion side of things.

In the Australian situation—and now I'm talking about the *Keeping the Promise* working group—we had the benefit of a staff person who was on exchange from Australia, and he worked in the veterans affairs directorate in Australia. He was a very knowledgeable individual. Again, he had firsthand knowledge of what was going on in Australia, and he was one of the staff people who worked with our *Keeping the Promise* working group. So we had good access to that.

We relied a lot on the research done in Australia on the long-term effects of deployment on the health of Korean War veterans. We were very influenced by that research.

● (0945)

Mr. Peter Stoffer: What about the last question regarding the spouses of veterans who have passed on?

Dr. Dorothy Pringle: I know this came up earlier. The Gerontological Advisory Council did recommend to Veterans Affairs that the services available to veterans through the VIP program had to be made available to their family caregivers and that these services had to remain not only for a year following the veteran's death but for the remaining lives of these caregivers. I believe that is being put into place now.

We're absolutely in agreement that the caregivers should receive the same consideration and access to services as the veteran.

Mr. Peter Stoffer: Thank you.

The Chair: Thank you, Mr. Stoffer.

We'll go over to Mrs. Hinton and the Conservative Party.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): Good morning, Dr. Pringle.

Dr. Dorothy Pringle: Good morning.

Mrs. Betty Hinton: I've listened very carefully to some of the comments you have been making today and with great interest. It's obvious to me that you're leaning very much toward the exercise and prevention side of things, which I happen to think is a good way to go.

In terms of what we're able to do for veterans now and what you'd like to see changed, I have asked the same question of every witness we've had on this particular issue. If you could personally change one aspect of the system as it is now, what would it be? That's the first question.

I have a couple of comments. It's interesting how people who hear the same information perceive that information. You said that 60% of people are not involved with Veterans Affairs right now, and what you meant was that they're not in a long-term care facility. I actually think that's good news, not bad news, although I want to make certain that the 60% who don't need that care now have access to it.

One other comment I wanted to make is that the average age of a Canadian veteran is 36. We've got a few years left here to try to do the things you're speaking about, which is to make people more flexible and in better physical condition so that hopefully they don't have all those issues to deal with when they become 80 or 85 years old.

Would you mind answering that first question: if you could change one aspect of the system as it is now, what would it be?

Dr. Dorothy Pringle: I've got to stick with the health promotion theme. I think VIP works very well. I think there are some wrinkles in the sense that people need more assistance in linking to services—that is, they need help in getting the person to shovel the snow, etc.—but even that's getting better across the country. I think VIP is working well.

I think the long-term care is working better because of moving beyond just the designated veterans beds in veterans facilities. Going to the community beds has made a big difference. Our recommendation is that we need to make access to retirement homes and assisted living easier, which will improve that whole residential side even more.

I think there's been a huge gap in Veterans Affairs on the health promotion side. We've been waiting until veterans got into difficulty before we really admitted them into the service end of the system; we provided help to them after they were frail and after they could no longer do things. We don't know how long they were in difficulty before they contacted Veterans Affairs. I think if we can link to as many veterans as we can find in this country, get through to them on the health promotion side, and work with them, we'll have a better chance of either eliminating or delaying some negative health consequences and we will have better attachment. We can get them VIP services earlier, if that's necessary, and they won't have to get sick before we start working with them.

● (0950)

Mrs. Betty Hinton: We're certainly in agreement on that one as well. If I'm hearing you correctly, the only aspect of the current system that you would change is that you would like to see Veterans Affairs, the department itself, become more proactive in making sure our aging veterans are kept in better physical condition than they are today, for example, and you think that will make a significant difference to the well-being of our veterans, because—

Dr. Dorothy Pringle: Let me clarify. You asked me for the thing I would change most. That's what I would change most. I think there are other areas that we need to improve, and giving access to assisted living is one of them. For me, I think we would get the biggest impact if we began working with veterans immediately upon their leaving the forces, stayed in touch with them over their lifespan, and made available to them health promotion strategies, activities, and links into programs. We should be able do that from the time they leave the forces.

Mrs. Betty Hinton: That's helpful. Thank you very much.

As a gerontology committee member, you deal almost exclusively with senior veterans. I would imagine you would have very little exposure to the younger veterans. Is that a correct assumption?

Dr. Dorothy Pringle: That's true.

Mrs. Betty Hinton: Do you think there would be any benefit to your committee members interviewing and speaking to some of the younger veterans, in a proactive manner, once again, so that you're preparing them and yourselves for the future?

Dr. Dorothy Pringle: We have a little access to the younger veterans through the membership of the Gerontological Advisory Council of the representatives of veterans organizations. They're younger and they represent a variety of experiences. But it's not extensive contact.

I think there would be value in having a better feel for the 35-year-old veteran. I think the average age of the Canadian Forces veteran is actually 56, not 36—at least that's the information I have.

But for veterans of the 1970s, 1980s, and 1990s and people who are leaving the forces now, I think we would be able to take into account those experiences when thinking about the programs that will be needed over the next decade.

Mrs. Betty Hinton: Thank you very much for your input. I appreciate your testimony today.

The Chair: Thank you very much, Mrs. Hinton.

We'll now go to Mr. St. Denis of the Liberal Party for five minutes.

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

Thank you, Dr. Pringle, for joining us today.

Elliot Lake was mentioned. I'm the member of Parliament for the riding that includes Elliot Lake. You're right that thousands of Canadians have moved there. As we're being broadcast around the world on the web, more are invited to join us in Elliot Lake.

I want to add to my colleagues' comments in thanking the chair, the clerk, and the researcher for facilitating last night's excellent meeting.

Dr. Pringle, I think one of the challenges for our older veterans and the new and emerging veterans as they retire—one of the things they face to varying degrees—is the issue of red tape. It's not only the paperwork. It's the effect of the paperwork on their health. If the health issue is in the nature of a mental injury, I would say it has a more exaggerated impact versus an injury that is physical. But in either case, it would have a negative impact.

In your work, do you deal at all with ancillary issues such as processing veterans into and through the gateway and through the system? What's the impact on their general health and the frustration levels they may feel?

● (0955)

Dr. Dorothy Pringle: We're aware of this, and we are made aware of it by the representatives of veterans organizations on our advisory council. I think it is a problem in our current system, and it's largely driven by all of the different eligibility criteria. It means that people who need some kind of contact don't get it, because they can't pass the first barrier of getting into the system or they don't meet an eligibility criterion.

I think on our recommendation that we work on needs-based access and we contact every veteran, if we can, and connect them to Veterans Affairs, whether they need services or not, they may very well need assistance in navigating the health care system.

We're proposing in *Keeping the Promise* that for the early intervention specialist it would be part of that individual's role. If this person is part of the caseload that she or he is working with, they need to identify whether or not there are health promotion programs that this individual would benefit from and would be interested in participating in.

They also need to help the person navigate the system, get through the red tape, and complete forms. But I expect there would be far fewer forms if we had a needs-based system as opposed to eligibility criteria.

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

There's a word that comes to mind. You said the word “navigator” was not generally accepted by the veterans.

One job I had when I was younger was an “expediter” in a factory. An expediter is somebody who goes and find the parts that the assembly line is waiting for, because they're somewhere in the factory. In the same vein, I think these folks need an expediter to make sure they get into the system as they need to be and are processed efficiently and fairly.

Dr. Dorothy Pringle: That's a great name. I think it's a great title.

Mr. Brent St. Denis: Related to the red tape, from your experience, how would you describe the attitude of the military, whether it's DND or Veterans Affairs, or the government in general, historically, towards injured veterans? Are they seen as being still part of the military family and we have to do our best, or are they seen as a drain on the system, especially those with mental injuries, where it's not visible, and are maybe even seen, sadly, as pariahs—or they feel that way, a lot of them, anyway? How would you describe the general philosophical approach to those who have left the military, particularly those who are injured in some way?

● (1000)

Dr. Dorothy Pringle: First of all, I have limited exposure to this. We don't have contact with DND.

I will say that I have not encountered negative views at all from the Veterans Affairs staff, and we work with a lot of staff, both in Charlottetown and people across the country. Staff come to our Gerontological Advisory Council meetings and participate in discussions, so we get exposure to that.

The thing is, when the veteran is coming to Veterans Affairs now, I think the injuries that are clearly linked to war services have been identified and those people are in the system. It is long-term possible complications of wartime service that are surfacing now. It's these older veterans, where it's not an amputation; it's not an obvious injury. It's a consequence of either deployment or military service, like arthritis. The research is fairly recent still on linking the long-term effects of military service to old age health problems.

That's the group that we see, and I think we have a good feel for them. I can't really speak with any knowledge or authority on the experiences of young injured veterans.

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

The Chair: Thank you.

Now we'll go to Mr. Gaudet, from the Bloc, for five minutes.

[*Translation*]

Mr. Roger Gaudet (Montcalm, BQ): Than you, Mr. Chairman.

Good day, Ms. Pringle. You may find my question amusing, but in your opinion, would it be a good idea if veterans lived close to military bases?

When I was attending the seminary run by the fathers of the Very Blessed Sacrament, each seminarian had morning chores. In all, 150 students attended this private school. There was only one custodian on staff and each student had daily chores to perform. The seminary did not employ any outside staff. All work was done by the students.

Do you think it would be a good idea to house veterans on a permanent basis in either temporary or permanent housing built by the government for forces members? Would that make for a better quality of life for veterans? And here, I am not just talking about veterans, but about nurses and other personnel along with their families. Veterans could then discuss their experiences with younger CF members. I am not sure whether this would be a good idea. What do you think?

[*English*]

Dr. Dorothy Pringle: I think it has a number of problems. The young soldiers who are serving in Afghanistan and the ones who are killed...so we become very aware of each of these individuals.... You hear that this person is originally from Nova Scotia but they're based in Petawawa, or they're from Ontario but they're based in Edmonton. I have no military experience of my own; I've not been involved with the armed forces. So I think it might be a nice idea for those veterans who choose to remain close to the bases, where they received their deployment, but I think we have to honour the fact that they have the right to live anywhere. And for many of them, they would want to move back closer to their families, I would expect, or for jobs. They need to be able to go wherever the jobs are and finish out their working lives in those communities.

It's not likely, if they have lived for 20 years in Sudbury after leaving the military, where they might have been based in New Brunswick, that they would want to move back to New Brunswick for that, except for some folks whose family might be there or because they've maintained close links. So I think it may be attractive for some folks, but I think for a lot of veterans, it would not meet their needs.

● (1005)

[*Translation*]

Mr. Roger Gaudet: Thank you.

[*English*]

The Chair: Thank you, Mr. Gaudet.

Now we have Mr. Shipley.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Thank you, Dr. Pringle, for joining us today. When you're talking of *Keeping the Promise*, you talk very much about poor health in later years. In fact, poor health in later years is not inevitable, and you talked a bit here about health promotion. Last night, as many of us will talk about for a long time, many talked about how important it was for education.

In terms of education, they were talking certainly about themselves and understanding it better, but mostly about their supporting families and caregivers—not the professional people. In fact, I had some sense that some professional people clearly don't understand PTSD or some of those affected diseases that come following trauma.

You talked earlier about realistic ideas. One of the things they talked about, which struck me, is why there hasn't been a book written by those who have been affected by PTSD, so that it's basically one of those peer things. Many of those folks were affected with their families. Their families still don't get it; they still don't understand it. And I think it's hard sometimes for a family member to understand when it's coming from that individual rather than coming from someone extended from the family or outside of the family.

Do you have any comments on that?

Dr. Dorothy Pringle: I appreciate what the individuals were telling you. I have a master's degree in psychiatric nursing, and I've worked in that area for a long time. I think mental illness, regardless of the form it takes, whether it's a schizophrenic kind of disorder or a PTSD disorder, is very difficult for the public and for family members to relate to and to try to get a handle on. So I think these veterans are experiencing what folks with mental health difficulties have always experienced.

I think anything that can be done to help families, the community, and actually health care providers—who are not experts in this area, but who really appreciate the nature of what is being experienced—would be helpful. I think a book would be great.

Mr. Bev Shipley: You've targeted that. Could you help us help them in terms of how that would get organized? Who would be best for them? Who would be the ones they could go to? Who are the ones we could go to? Who would be the best service provider for that?

Dr. Dorothy Pringle: Who would be the best service provider around the book?

Mr. Bev Shipley: To get one going—

Dr. Dorothy Pringle: I'm talking off the top of my head now, but I wonder about one of the veterans organizations. It would either come from Veterans Affairs, in terms of their communications department—that's a possibility—or I can see the Royal Canadian Legion taking this on as a national initiative. Do they do that type of thing?

There may be a variety of ways of getting that accomplished. It is a great idea.

● (1010)

Mr. Bev Shipley: It struck me as something that was actually needed for the general public, for the families. That would likely be an important step.

The other thing you talked about was fitness. Although we may not be in the category of being the best in fitness, it's important in later years, and through our lives.

You talked about it being better to be integrated. Is it better to be integrated into groups than trying to do things on your own? One of the things we hear is that when you come back after a trauma, people tend to seclude themselves. They tend to not want to be out, and yet as we will hear, once they pass through a time when they can get over a barrier and get out, it is better for them, even though they still have trauma effects hitting them.

I wonder if you have some comments about how we can understand the best way to get them into physical fitness, whether on an individual basis with personal trainers, or is it better in some cases to have them integrated into some sort of slow plan, so that they are with their peers? Part of this seems to be physical fitness, but it's also being able to talk to your peers.

Dr. Dorothy Pringle: It depends on the individual. The research shows that when individuals get into a program in which they are expected to take up a physical activity on their own, they don't maintain it. Their participation goes on longer and with better effect if they have support and contact by somebody and by telephone.

One of the programs that we're seriously looking at is an individual home-based physical activity program, supplemented by weekly contact—in our case by that early intervention specialist.

For those individuals who are not willing or interested in participating in a group, that program is probably the better one for them. They could also graduate from that program, because once they are feeling better—very frequently they don't feel up to getting out to groups—they may then be willing to join a group, but it will have to be a graduated kind of effort. Other people enjoy and get a lot out of group activity, and it's as much if not more the social side of things as it is the exercise. So if you can get people into group exercises that we know are useful and effective for them, that's more sustaining over the long term.

It is not a "one program fits all". Each of these individuals has to be assessed, and it has to be determined with that individual and the caregiver, because we see this as equally important for the caregiver.

It may be that some caregivers would get involved, and then eventually the vets would get involved.

Mr. Bev Shipley: Again, thank you very much for your comments.

The Chair: Thank you, Mr. Shipley.

Now, on to Mr. Valley, with the Liberals, for five minutes.

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

Thank you, Doctor.

I believe the report came out six months ago in November. Can you remind us of what the next steps are, because we've heard over and over again that we need to get to a needs-based system? So would the first step we take be that?

When we heard from other witnesses, there were meetings planned in the future for your group. Can you tell us what the immediate future is?

Dr. Dorothy Pringle: We're meeting the first week of July in Charlottetown, and that's where the two groups, the health promotion committee and the assessment committee, are both reporting.

Our report came out, and by the time it was translated and got to Veterans Affairs for their work it was probably late summer. They have been working on it. They came back to us asking for assistance in terms of developing the implementation plans.

I think the needs-based one is moving ahead, and that's why the assessment committee has been investigating and making recommendations around the particular—I'm going to use the word —"instrument", or the assessment tool that needs to be put in place in order to move us to needs-based. Our health promotion committee will be making its initial recommendations in July about where we should start in moving the health promotion side forward and redefining the roles of the care coordinator to expand them.

I can't give you a date when the changes will actually take place, but I've been at an awful lot of meetings this spring. We met with folks from Treasury Board as they began to work on the financial side of things. We're very hopeful that this is going to begin to be implemented maybe later this year, or certainly early next year at the latest.

Our council meets twice a year. This year we had an additional meeting because we were working on implementing *Keeping the Promise*.

● (1015)

Mr. Roger Valley: Thank you, Doctor, and thank you for your dedication.

You used a term earlier that I hadn't thought of. You said that Veterans Affairs is a gap filler between the provincial systems. Sometimes, as we heard last night, there's more gap than filler. We all know of the shortages of some of the health care professionals across Canada, of all health care workers, and that must impact some of what you're trying to do for veterans.

We know there's been less and less of a federal presence in the ridings and in the communities. We've moved to local contracts for providing services in rural areas and local contracts with provincial hospitals. Does your group think these are complex enough, or is it something we need to expand on with the provinces? Recently in the media we've seen issues where some of the survivors, or veterans, or their families have issues with some of the provincial health care systems.

Dr. Dorothy Pringle: I think we're all subject to the limitations of our provincial health care systems. There are excellent aspects of these systems but also limitations. I think there are definitely gaps at this point in time.

I'd say home care may be one of the least well-developed sides of our health care systems across the country. We don't have sufficient budgets in there; we don't have sufficient nurses, physical therapists, homemakers, personal support workers, and that kind of thing. That affects the services to vets. That's where Veterans Affairs steps in and increases the amount of homemaking and increases the amount of personal care. It usually does not have to increase the amount of professional services, but if that's necessary, they will do that.

Everybody is limited by the availability of professional workers. We do not have enough physiotherapists, and we particularly don't have enough care programs in the home. I think that is an issue. It's recognized, and I think whenever it can be solved by contracting with private sources, for physio or whatever, that's done, but that doesn't always work. It is a limitation that affects all of us.

Mr. Roger Valley: Thank you, Doctor.

I serve a rural riding, one of the larger ridings in Canada, and I thank you for your dedication. I've heard you say several times that the focus is on the large urban centres because your services are there, but it's sometimes the veterans who are out in the rural areas who, while we don't forget them, have a much greater difficulty receiving some of those services.

Thank you.

Dr. Dorothy Pringle: Yes, I agree.

The Chair: Thank you, Mr. Valley.

Now we'll go to Mr. Sweet with the Conservative Party for five minutes.

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

Thank you, Doctor, for all your good work and your answers to our questions today.

I recently had a veteran come into my office. I can only speculate that his age was close to 80. He had been exposed to asbestos and was not receiving services from Veterans Affairs. Fortunately, after one appeal, he was able to get services. Of course, subsequently, he was able to enroll in the VIP program. This will ensure that his wife gets these VIP services, but he was totally unaware of that.

One of the things I really liked about the last two witnesses from your council...one of the recommendations you're making is for a proactive solicitation for veterans services. Is that correct?

● (1020)

Dr. Dorothy Pringle: Yes, absolutely.

Mr. David Sweet: What role is this early intervention specialist going to play in that? I'm just trying to get a handle on it. What kind of person is this early intervention specialist going to be? What kinds of credentials do they have? Is this going to be a jack of all trades, or is this someone who's going to be a registered nurse?

Dr. Dorothy Pringle: It is not likely to be a registered nurse. We need the registered nurses mainly for the care coordination and the hands-on care.

We saw this person as being probably a graduate of a program like physical education and health. There's a lot of health promotion in those programs, and there are a lot of those programs across the country. They may be a community college graduate with a diploma in a health promotion area.

They won't necessarily all have exactly the same background. They may be a graduate of Guelph's program in gerontology, for example, but they would need to learn the job. For those who have a less strong background in health promotion per se, that would be an area they would have to develop more expertise in.

That would be part of Veterans Affairs' job, to get all of these people up to speed on the areas of expertise required for this position. But we don't see nurses, physiotherapists, or social workers filling those early intervention specialist roles.

Mr. David Sweet: Okay, but this would have to be somebody with quite sophisticated capabilities. They would have to be a full-rounded resource for the veteran.

Dr. Dorothy Pringle: Absolutely.

Mr. David Sweet: I don't want to get too much into operations, but I'd like to get a picture, as a member of this committee, about how you're envisioning this, because it sounds as though you're a management specialist.

Do you see a kind of a phone bank of people with some interpersonal skills who would contact the veterans, and once they would find a veteran who required the services, they would then hand them off to an early intervention specialist?

Dr. Dorothy Pringle: That could happen. Let me say that there may be veterans who are currently in the VIP program, for example, in which there's a caregiver, and who should be part of an activity program or a nutrition program, etc. The area care coordinator would refer that person to the early intervention specialist. That could be a way of getting in.

It could be through a phone call from a veteran who phones Veterans Affairs because they read about this in one of the MPs' newsletters or they may get *Salute!*, which is the Veterans Affairs newspaper, and read, "Please contact us. We're interested in helping you improve your health." They make a phone call to find out what that's about.

They would be screened in terms of whether or not they need health services per se. If the screening indicated that they would need that, they would immediately be referred then to the care coordinator in their area.

If from the screening it doesn't look as though they require services, then they would be referred to an early intervention specialist and another assessment, a much more in-depth assessment, is done then, on the phone initially, and then in the home, if that's shown to be necessary.

Mr. David Sweet: Great.

By the way, was I being too presumptive? I presumed you were a doctor—physician—with management skills, because you said you were helping them put into place the measures that would be required to make the programs work to keep a promise. Is that your expertise—management?

● (1025)

Dr. Dorothy Pringle: I'm a nurse, not a physician. I have done a lot of work in administration. I've held a lot of administrative positions.

As a council, we're making recommendations for what Veterans Affairs needs to have in place—the people resources, the communication lines, the screening tools, etc.—to make what we recommended in *Keeping the Promise* operational.

Mr. David Sweet: Okay. I was on a fishing trip a little bit. I just wanted to know if you had the management expertise and what challenges you saw right now in moving ahead with these new initiatives, based on what you've seen so far in the interaction with the management at Veterans Affairs Canada.

Dr. Dorothy Pringle: I think the biggest challenges are recruiting and training the early intervention specialists. That's huge.

Second is reshaping the role of the area coordinator and adding more into that pool to move them to being more interventionist as care coordinators. That role has already expanded from what it was 10, 15 years ago, or even five years ago. We see pushing that further. There's a lot more involvement of the caregiver, so that area coordinator needs to be able to assess not only the veteran but also the caregiver and the family situation.

I think the biggest challenges are getting the right people in place and then getting them trained to the level required to fulfill what we're promising in *Keeping the Promise*.

Mr. David Sweet: The very fast-selling management book, *Good to Great*, says that's always the biggest challenge, getting the right people on the bus.

Thank you very much.

The Chair: Thank you very much, Mr. Sweet.

Mr. Shipley.

Mr. Bev Shipley: Thank you. I have a couple of questions just to wrap up.

You mentioned you appreciate the veterans' support. I think that's important, not just for the political side, but I think it's important that the veterans know they have a support group like yours that is working for them. I think actually we need to take that a step beyond. You're dealing mostly in terms of a Gerontological Advisory Committee; that indicates the age group. I think now we're talking about expansion into the new vets. These issues you're dealing with are the same issues they're going to be dealing with at some point in time.

I'm just wondering, when we talk about some of the issues that veterans have to deal with when they come back, if there's a difference...? We have civilians and the RCMP who go through these traumatic diseases or experiences. Maybe it's the trauma that brings on the disease, or the injury. Post-traumatic stress, as we call it, is one of those.

Do you believe there's a difference between the individual who is in the public and has not been involved with the armed forces and those who have been involved with the armed forces in terms of some of the treatment they may need?

Dr. Dorothy Pringle: Yes. We're learning that now. That is what I'm going to refer to as the deployment research, which showed that you don't have to have a physical injury in order to have long-term effects of military service. Simply being in military service and being deployed has the potential to have negative health consequences over a very long time.

I think that research influenced us greatly in terms of moving off this eligibility criteria as the entry to services in Veterans Affairs and moving to a needs base, so that if you were in the military, you may have been discharged in good health, but there's no way of knowing what the long-term consequences of that military service are.

So 30, 40 years later, as an aged person, you need to have access to and the benefits of services from Veterans Affairs.

● (1030)

Mr. Bev Shipley: The message has been very strong from a number of witnesses—actually, just what you're saying—about moving to a needs base rather than an eligibility base, just because it should be based on needs, not on eligibility, and I think too for the protection of the system and the protection of all the people who are involved with it.

One of the things you mentioned and that we've heard, though different terms have been used, is to get through the red tape, basically—the "navigation" of it has been one of the words. Clearly in some way we need to simplify the process and start to get rid of some of the bureaucracy there just for the sake of having the bureaucracy and of the paper load.

In some other industries, in manufacturing and what we've done in businesses, we've said we want to cut some of this paper by 20%. I'm convinced that this is likely one of those areas we should focus on: getting rid of some of the paperwork for these people.

One of the things, too, that has been implemented and that we didn't have but will have coming on very shortly is the ombudsman. It doesn't matter how good the system is; there are always people who fall through the cracks or need assistance to get to where they want to go. I'm hopeful that this ombudsman will be very helpful in having an independent view and being of assistance.

Can you give me a comment on how beneficial that will be?

Dr. Dorothy Pringle: I would agree with you that, first of all, a needs base should help us eliminate a lot of the paperwork and the red tape. I know you've talked about this previously.

I think the ombudsperson will be useful. I'm not sure it's possible to make a perfect system or to have any system work perfectly or in the right way for everybody, so you have to have something in place that allows people to say when the system hasn't worked for them. I think having an ombudsperson in place is a good way of identifying where the issues are.

Certainly now I'm familiar with the ombudsperson's role in hospitals. You may think you're in good shape in the hospital, but this person is beginning to hear the same story from several individuals; that helps you to know you have a problem in this area.

Mr. Bev Shipley: Can I just have one more quick question? I don't mean to cut you off, but I'm running out of time here.

One of the things we're concerned about, and everyone is, is the availability of professional services—and we know it's across Canada—doctors, specialists working in the public sector within our community, and also working with our veterans through Veterans Affairs. Do you see this as a need that's likely going to happen? Do you see that doing it brings complications?

Dr. Dorothy Pringle: If I'm understanding the question, I think it is likely that a lot of the direct care staffing is going to be outside of the Veterans Affairs system, that there will be contracts with people rather than direct care staff added to Veterans Affairs. That's probably true for physicians as well.

We have not talked about this at all on the council or with Veterans Affairs, but there may be some areas, and these would be in the more rural and more remote areas, where in fact there needs to be a Veterans Affairs base team. We need multi-disciplinary teams, for which maybe Veterans Affairs has to hire individuals directly in order to get them into those locations, because they're not available otherwise.

● (1035)

Mr. Bev Shipley: Okay, thank you.

The Chair: Thank you, Mr. Shipley.

Mr. Stoffer, we're going to go back to you for five minutes.

Mr. Peter Stoffer: I have just one quick question for you, Madam.

I already see sort of a problem that may exist. When you indicate that there may be people who are contracted to Veterans Affairs to go out and do assessments on veterans or their spouses, the reality is that most things are based on a fiscal budget: what can we afford; how much money does the department have to do the work it is asked to do? You have a person go in and give an analysis or a review of veterans and their family, their situation, and what they consider they need. But sometimes the analyst's view of what the veteran needs may be completely different from what the veteran thinks he needs. So who has the final determination of what a veteran actually needs?

A veteran may say, "I need this, this, this, this, and this." The person who does the interview or the analysis of it may say, "No, in our opinion, we think you need this, this, and this." Who's the final arbitrator on that one? Does the benefit of the doubt go to the veteran, or does it go to the department, which ends up paying for this?

Dr. Dorothy Pringle: I think, to the extent possible, you try to reach common ground on that. That's one of your jobs as somebody who's doing assessments, to seek the view of the individual veteran and the caregiver of what their needs are. Frankly, in our experience there, in many cases they're likely to underestimate what they need, so they have to be persuaded that in fact they do need assistance with homemaking and so on. Then you need to give them your professional view, based on assessment of what they need. So you bring both of those together.

I think the final arbitrator would be Veterans Affairs. It would not be the contracted person in that home. That person would bring both views: the family strongly believes and cannot be persuaded otherwise that this is what they require; my professional view is that this is what they need, and we were not able to resolve these differences. That would then go to the Veterans Affairs team, and they may then have a meeting. It may be that you need to have a meeting with this family around trying to work this out.

I think we've heard earlier that the benefit of the doubt should go to the veteran.

Mr. Peter Stoffer: Thank you.

The Chair: Thank you, Mr. Stoffer.

Mr. Valley.

Mr. Roger Valley: Thank you, Doctor. I believe you're the third witness we've had from this group, your Gerontological Advisory Council.

Dr. Dorothy Pringle: That's right.

Mr. Roger Valley: It's very excellent testimony. We're very impressed with your work. But we're political people, and just as a side note, I made one recommendation before.

Clearly, your passion is for all veterans. We know you had to focus on the Second World War and Korea. But the term of your council, "gerontological", means different things to different people, and at some point you may want to reflect that you're serving all veterans and the name of that council doesn't really reflect that. I may be splitting hairs, but I'm very impressed with the work you've done to this point and I think your name should reflect that you serve all veterans. So take that with a grain of salt.

We're very proud of the work you've been doing. Thank you.

Dr. Dorothy Pringle: Thank you very much. I really appreciate that feedback.

If we are going to serve all veterans, we need some additional people on the council, because we need people who have expertise in health and services for younger people, who would reflect the age group of the Canadian Forces veterans. In our committee, the expertise really is on people who are in the older age group.

Mr. Roger Valley: Thank you, Doctor.

The Chair: At this stage, Dr. Pringle, I think we have exhausted or come to the end of our questions. Thank you very much for your presentation today.

Dr. Dorothy Pringle: Thank you very much. I have appreciated this opportunity.

● (1040)

The Chair: We have a couple of things we can deal with. One, as I mentioned, is a visit to the Department of National Defence and Veterans Affairs Centre for the Support of Injured and Retired Members and Their Families here in Ottawa. It looks as though we can set that up for June 7 during the meeting time. If the committee would enjoy this, I think it would be useful.

Mr. Stoffer gives a thumbs up to that.

Would people be generally receptive to seeing that? Okay, fair enough. We'll look towards setting that up.

Just before I recognize Monsieur Perron, I also want to say that it would be nice for us to be able to get to the recommendations on our post-traumatic stress disorder study if we have time today.

Go ahead, Monsieur Perron.

[*Translation*]

Mr. Gilles-A. Perron: Mr. Chairman, I have some serious concerns this morning.

Some friends confided in good faith to me that headhunters were currently searching for potential candidates to fill the position of veterans' ombudsman. The process is quite advanced and candidates have already been found. Just to confirm what I am saying, one of the prospective candidates is a certain Mr. Leduc.

Something else is also troubling me, namely the fact that Mr. Victor Marchand, the Chair of the Veterans Review and Appeal Board, is involved with this initiative.

[*English*]

The Chair: Monsieur Perron, some other committee members are raising this point. Due to the legal issues with regard to employment contracts and stuff like that, we may want to go in camera to discuss this issue, because it could have implications with regard to the process. If you'll bear with us, I think we should probably go in camera for any discussion on individuals with regard to that position.

[*Proceedings continue in camera*]

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