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Chair

Mr. Rob Anders

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● (1535)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): Good afternoon, committee members. This is yet another meeting of our Standing Committee on Veterans Affairs. We are continuing with our study of the veterans health care review and the veterans independence program.

Today our witness is Maggie Gibson, a psychologist with the veterans care program.

Just so you're aware, I think the clerk has informed you that you have ten minutes, but if you want to go a little bit longer than ten minutes, that's probably acceptable. Usually our witnesses as a group testify for twenty minutes. After that we'll go to questions from our committee members.

The floor is yours.

Dr. Maggie Gibson (Psychologist, Veterans Care Program; Member, National Initiative for the Care of the Elderly): Thank you very much.

I am actually here representing NICE, the National Initiative for the Care of the Elderly, of which I am a member. I am a psychologist, and I work at a veterans care program in London, Ontario, at one of the large priority-access-bed facilities in Canada.

The National Initiative for the Care of the Elderly is an international network of researchers, practitioners, seniors, and students dedicated to improving the care of older adults in Canada and abroad. NICE is funded through a new initiative grant from the Networks of Centres of Excellence.

Our members represent a broad spectrum of disciplines and professions, including geriatric medicine, nursing, social work, gerontology, rehabilitation sciences, sociology, psychology, policy, and law. We promote and facilitate interdisciplinary collaboration between and among researchers and practitioners to improve the care of the aging population in Canada and elsewhere.

The overarching emphases of NICE are networking and knowledge transfer—that is, getting good research into practice.

NICE has three overarching goals. The first is to help close the gap between evidence-based research and actual practice. The second is to improve the training of existing practitioners and geriatric educational curricula, and to interest new students in specializing in geriatric care. The third is to effect positive policy changes for the care of older adults.

With that as the background of who it is I'm representing, I'd like to provide some comments from NICE for the committee.

NICE would like to compliment Veterans Affairs Canada on the thoughtful consideration of aging issues that is reflected in the work of the Gerontological Advisory Council's report, *Keeping the Promise*, and in the veterans health services review. To further this good work, there are three specific issues that NICE would like to bring to the committee's attention.

First, we note that several of the issues of concern to NICE—in particular, caregiving, dementia care, and end-of-life care—are easily identified in the work to date. NICE has also identified elder abuse and mental health as priority issues for improving the well-being of older adults.

Mental health is an underserved focus in health care for seniors. This is evidenced by its prioritization within the NICE thematic framework as well as by the coming together of the Canadian Coalition for Seniors' Mental Health—another organization that I am a member of and have been on the steering committee of—specifically to advocate for improvements in this aspect of care for older adults.

Mental health is a critical component in any broad-based health promotion strategy. It's well known that poor mental health has implications for the ability to access, assimilate, and derive benefit from interventions that aim to enhance, maintain, or restore independence, that aim to improve functional autonomy, and that promote quality of life.

So mental health problems and illnesses are not well served by home care programs in general. We hope that appropriate attention will be given to the promotion of mental health in any changes to the veterans independence program that result from the committee's deliberations.

Second, we applaud the committee's interest in making services under the veterans independence program available to a greater number of recipients. We agree that the services provided should be based on assessment of needs. We note that the evolution of needs across the lifespan is an important consideration. An effective and user-friendly monitoring process will be essential to ensure that the provision of services stays current and timely.

We suggest that the inclusion of older adults in the process of developing and implementing monitoring will be essential to its success. Routine monitoring that is triggered by the passage of time is important, but even more important is the realization that health status can change rapidly for seniors, especially for those with a more tenuous hold on their independence. The needs-based assessment protocols that are developed should encourage self-monitoring and user input in the face of significant change on an ongoing basis. We would suggest that expertise in knowledge transfer and networking should be accessed to develop creative, state-of-the-art approaches to shared care in this context.

Third, we agree with the goal of supporting a range of residential care options for seniors, and agree that efforts should be made to encourage and enable older adults to reside independently as long as possible.

● (1540)

We note, however, that there is a risk in conceptualizing long-term-care homes as the residences of last resort. This has the potential to exacerbate the stigma already associated with this residential care option. For many reasons, a substantial number of veterans and other older adults need full institutional care if they are to survive. It has been said that a society can be judged by how it cares for its most vulnerable members.

Communication and advertising about changes to the current system should not suggest that those veterans and families who do not need long-term-care placement are somehow more successful than those who do. We also note that it will be important to ensure that the new emphasis on health promotion and innovative service delivery is as valued for those who reside in long-term-care facilities as it is for those who remain in their communities.

Thank you for the opportunity to present these views to the committee.

The Chair: That was incredibly succinct. You were actually under six minutes. All right. Fair enough.

Mr. Gilles-A. Perron: It's quality.

The Chair: It's quality. That's right, Mr. Perron.

We will now go to the rotation. We have the Liberal Party of Canada, represented by Mr. St. Denis, for seven minutes.

Mr. Brent St. Denis (Algoma—Manitoulin—Kapuskasing, Lib.): Thank you, Mr. Chair, and thank you, Ms. Gibson, for being here and helping us out with our study.

There are a couple of things.

Have there been any studies answering the question of whether things like Alzheimer's are less or more prevalent among veterans as compared to the general population? Is there any correlation between military experiences, whether they were wars long ago or more recent peacekeeping conflicts, and the onset of Alzheimer's, or is it accepted that dementia—and these are almost the same thing—is strictly genetic or an environmentally driven condition?

Mrs. Maggie Gibson: I'm not aware of any studies that have specifically set out to determine whether the incidence is different in a same-age, same-circumstance elderly male population who aren't veterans versus those who are. I'm not aware of any studies that have taken that actual approach.

Based on what we do know about Alzheimer's, I think your second point, that there really is more in the genetic and the environmental area, would explain the incidence. I don't think there have been any studies that have specifically addressed whether trauma-based combat situations contribute to a higher incidence of Alzheimer's. I would be surprised to find that the incidence was different in that population, but I don't think the research is being done.

Mr. Brent St. Denis: I'm just thinking of a couple of veterans who come to mind in my own riding, for whom Alzheimer's has become a serious issue. One was getting VIP help, and he is at a point where the family is trying to decide on the best course going forward. He is physically capable of staying at home, but due to his wandering and so on, it might be unsafe for him to be at home.

Are there any standards that help professionals and families decide? VIP is designed to help people transition in their older years, allow them to stay at home, and provide help through a transition until such time comes, should it come, that they need to be put into a domicile. Are there any standards or metrics that are used, like a checklist of questions, to allow the professional and the family to say "Here's the point in time. The VIP has been great. The grass is being cut, but now it's time to move Dad to the regional home"?

● (1545)

Mrs. Maggie Gibson: Two things come to mind in response to your question. One is that the need for institutionalization is often driven by a whole combination of factors, and many of them are caregiver-focused. So if a caregiver who has been managing someone who has a progressive dementia has a fall and ends up in hospital, then it's more likely that the veteran who had the dementia is going to have to go into a long-term-care home, because the caregiving support systems aren't there any more.

So one issue is the progression of the disorder, and the other issue is the stability of the environmental supports. There are some things that can happen in the course of dementia that make it increasingly difficult for people to be managed at home, regardless of whether the situation is stable or not, and that's when some of what they call the psychological and behavioural symptoms of dementia start to become more prominent, which happens as the dementia gets worse. This is the wandering, the aggression, the inappropriate behaviours and hallucinations—the kinds of behaviours and symptoms that can become a lot more difficult to manage in a home and community environment. So if the disease progresses so that those start to become more a part of the symptom picture, that may be what triggers the need for institutionalization, even though the family or the spouse hasn't changed.

On the other hand, the disease could be fairly stable and the caregiving situation could change, and all of a sudden that requires institutionalization.

To go back to your previous question, about what research there's been, well, I don't think there's been a lot of focus on determining whether there has been a higher incidence of dementia in veteran versus non-veteran populations. There has been quite a bit of research done, and quite a bit of this has come out of the United States, actually. They've looked at older veterans who have managed quite well through their middle-aged years—they worked, they had a good career and a good early retirement—and then they developed dementia. The combination of the dementia and what that brings in terms of the ability to cope and to reason and to function, together with the losses that come with aging, can create a pretty volatile situation that becomes quite difficult to handle. So you can get a situation whereby the normal stresses of aging are exacerbated.

Mr. Brent St. Denis: Thank you.

It occurred to me that an operational stress injury, or post-traumatic stress disorder, I would say, simply anecdotally, is more common among veterans than in the general population. So I was just wondering if there are any complications. As difficult as the operational stress disorder might be in the working-life period of a veteran, does it complicate an Alzheimer's situation further? Is that part of a cocktail that makes late-life care more difficult? Or does one sort of get shoved out of the mind as Alzheimer's takes over?

Mrs. Maggie Gibson: I think it can shape the symptoms. For example, in a long-term-care facility what you can have is someone who was in a prisoner of war camp who experienced all the things that go along with that and then functioned very well. And now they're in a long-term-care home because of their Alzheimer's disease, and when the nurses come in the middle of the night to wake them up for some reason or another, it can trigger reactions that are based on previous experiences. That can happen to anyone with Alzheimer's. They can have in their demented state previous experiences triggered, but the nature of the kinds of experiences the veterans might have available to be triggered may be connected to their previous experience.

● (1550)

[*Translation*]

The Chair: Mr. Perron, from the Bloc québécois, you have seven minutes.

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Are you giving me Madam's four minutes?

[*English*]

The Chair: I don't know if the other committee members would approve of that, Mr. Perron.

[*Translation*]

Mr. Gilles-A. Perron: Good afternoon, Mrs. Gibson. Thank you for coming. Your presentation was very interesting.

If I understood correctly, you're in favour of home care. You said it was important for seniors to stay in the community or at home for as long as possible. Do we have qualified people to help them, those who are called natural helpers?

In my friend Gérard Asselin's riding, for example, there's a problem issue. A certain Antonin Lévesque, an elderly veteran, has serious problems. His wife, who is nearly as old as he, is no longer physically able to care for her husband, so much so that she was forced to put him in some centre for a few weeks before bringing him back home. How do we resolve this kind of situation?

[*English*]

Mrs. Maggie Gibson: This is exactly why I think we have to be really careful about looking at it as a continuum of care with multiple options and about making sure we're making the decision that provides the right care for the person in their circumstances. If the person has the kinds of needs that are easily met by the services available, then they're going to be able to be kept in the home longer. But once you start to get into the mental health issues and the dementia issues and so on, there may not be readily available professional assistance in the existing home care service roster to provide the care that's needed.

The human resource issue on the health care professional side is a big problem, in terms of adequately servicing home care clients, absolutely. That's why you also have to be careful, in your assessment process, to make sure you're taking a very broad-based look at assessing need. It's not purely function—what you can do under the ideal circumstances—it's a question of what's really available to you and the kind of support you are going to need.

It's also a question of recognizing that people don't necessarily go into long-term care as a one-time thing, whereby they go in and never come out. There's a quite a revolving door for long-term care as well. People may need to be in long-term-care beds for a while and then are able to go back to the community at different stages of their life, depending on what resources are available to them.

I think we need to become much more flexible in how we think about all the different options along their care continuum and how these can intersect and work together to meet different needs at different times.

[*Translation*]

Mr. Gilles-A. Perron: I'm going to show my colours. I'm stubborn, or obsessed by post-traumatic stress syndrome among our young soldiers. I prefer to call that a psychological injury, a psychological war injury, than post-traumatic stress syndrome. That's my thing.

We had a chance to hear from a number of psychologists, who explained the matter to us. I have a question and I can't answer it because I don't have the necessary qualifications. If we increased awareness among soldiers, if we made them more aware that they might suffer psychological shocks in a situation or theatre of operations, would that be beneficial to them? Would they suffer less from psychological injuries? Last time, my friends from Valcartier had two and half hours of training and were told a little about post-traumatic stress syndrome. Should they be told more about it, should more be said about it to the families who stay at home and to the children of those soldiers who stay at home when their father is out perhaps being killed? I'd like to know your opinion, your point of view on that in general.

● (1555)

[*English*]

Mrs. Maggie Gibson: You give me a very nice opening, because as I said, I sit as a member of both NICE and the Canadian Coalition for Seniors Mental Health. I definitely think we should be as willing to talk, to educate, to communicate about mental health disorders—the risk factors, the potential solutions to them—to make it as open a conversation around mental health issues, be they PTSD, depression, anxiety, substance abuse, or other conditions, as we are to talk about the potential for your getting diabetes or heart disease or any of the other much more acceptable medical diagnoses.

Many of us in the mental health community are hoping there will be an opening up of the dialogue through the new mental health commission, for example, and that people will start to feel as comfortable in any professional context, be it soldiering or nursing or whatever it happens to be, talking about mental health issues as they are talking about any other health issues.

[*Translation*]

Mr. Gilles-A. Perron: Could that be a kind of assistance? I imagine myself in an armed vehicle driven by a co-worker: if I've been trained or if I have certain knowledge, I may realize that my co-worker is having problems related to post-traumatic stress syndrome, that he's endangering my life and that of all the soldiers in that vehicle.

Even though I don't have any proof of this, I believe that we're not giving enough information to these young soldiers, who could say that they're having problems, that they don't feel right and that they have to consult someone. They could also say that their co-worker is having problems or that he isn't feeling right. Am I right?

[*English*]

Dr. Maggie Gibson: I think you're absolutely right that there should be much more open information about mental health issues, and that health promotion in the mental health area can only be a good thing. For example, you see commercials on television asking you if you would recognize the symptoms of a stroke or of diabetes. There shouldn't be any big secret about what the symptoms of mental health disorders are, so that they can become de-stigmatized. People could be better able to recognize them, better able to support their colleagues and peers, and better able to direct individuals to appropriate professional care.

Mr. Gilles-A. Perron: Merci.

The Chair: Fair enough.

Now over to the New Democratic Party's Mr. Stoffer for five minutes.

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

Maggie—if I may call you Maggie—thank you very much for coming out today.

We're heard testimony from other folks that there are just not enough people like you around. Obviously, if we have these great plans, and even if the government and the opposition agree that *x* number of dollars will go into funding, and we'll do everything that's been recommended to us, if we don't have the physical human resources to do them, it could all go by the wayside.

What recommendation can you give to federal and/or provincial governments to encourage people to take this up as a career, as an opportunity to help people, to make a decent living, as obviously you have, and to encourage them that it is a wonderful and valued career? Year in and year out we seem to have this problem of getting people to take this up as a profession. What recommendations can you give to us that we can then pass on?

Dr. Maggie Gibson: I can speak to the area of psychology. If you go to the website of the American Psychological Association in the States, you'll see that they have all sorts of informational, promotional materials directed at encouraging people, and especially students, who are interested in the mental health field to take up a career in care of the elderly or in geropsychology.

The Canadian Psychological Association is doing more in that direction now, and I'm involved in some of that. I really think that the focus has to be on the education system, and we need to make people more aware of the interest, the potential and the value of careers in the care of older adults earlier in their careers before they've selected their focus, before they're in graduate school and have already decided what they're going to do, and have started down a track that it's hard to turn from.

It's not just the mental health professions that are facing difficulties. Certainly geriatrics is facing difficulties as well in terms of recruiting enough people who want to specialize in this area.

People specialize through the education system, so we have to be working with the colleges and universities to create more interest and have more educational offerings early on that will steer people in those directions.

● (1600)

Mr. Peter Stoffer: As you know, we've been told repeatedly that mental health issues are provincial responsibilities, except in some cases in which Veterans Affairs Canada applies for veterans or their families. What role do you see for the federal government in doing that, in assisting the provinces and getting the word out that because of our aging society—not just in the military aspect, but our overall society's becoming older and older—the problems of dementia or Alzheimer's and other concerns will be coming up to us rather rapidly? The perfect storm is coming in this regard. We see it, but we don't actually know how to handle it, in terms of encouraging....

What role do you see the federal government taking in assisting the provinces in doing this?

Dr. Maggie Gibson: I probably don't know the political systems well enough to really speak to that, but I can give you an example.

Mr. Peter Stoffer: Go ahead.

Dr. Maggie Gibson: The Public Health Agency of Canada is doing stellar work around increasing the profile of seniors in emergency preparedness, both nationally and internationally. I am involved with some of that, and it is being driven very much by seeing the need. It is very dedicated to having people move forward, getting things on the agenda of the agency, and creating enthusiasm for the work within the professional and practitioner community so that people like me, who don't work for the government or the Public Health Agency, are quite engaged in participating in the projects and initiatives they're putting forward.

It's a personal example of where seniors' issues are being very well dealt with in the emergency preparedness field in Canada because of the leadership being shown by the Public Health Agency.

Mr. Peter Stoffer: Thank you.

The Chair: Thank you, Mr. Stoffer.

Now we'll go to Mr. Shipley with the Conservative Party for seven minutes.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Thank you, Mr. Chairman, and thank you, Ms. Gibson, for coming in.

I'm glad I had a chance to meet you earlier. My riding runs just north of London, so we're not very far away. I'm very familiar with the hospital system, and not so much with Parkwood Hospital, but I certainly have been there. It is an amazing facility for what it does for our seniors and our veterans.

We've talked to a number of witnesses from all areas. Clara Fitzgerald and Dr. Mark Speechley were here. Is there a connection between the National Initiative for the Care of the Elderly and the Canadian Centre for Activity and Aging?

Dr. Maggie Gibson: They are also from London. I'm pretty sure Clara is also a member, as I am, of the NICE network. I am not sure about Mark, but I wouldn't be surprised if he were also a member.

The way to think of the NICE network is that it's a grant-funded infrastructure that really brings together a whole variety of people who work for other organizations. Many of us who work in gerontology find ourselves members of NICE, the Canadian Coalition for Seniors Mental Health, and the Canadian Association on Gerontology. We sort of cross-reference all of these different organizations. The Centre for Activity and Aging is at the University of Western Ontario. I know that some of them are also members of NICE.

● (1605)

Mr. Bev Shipley: Okay. I was trying to get the connection, because I don't think it was mentioned to us during their presentation.

Dr. Maggie Gibson: It may not have been.

Mr. Bev Shipley: I know we have a lot overlapping initiatives out there.

On what you are doing, we and all witnesses have said that anything we can do to keep our seniors, our veterans.... There's always this correlation between the general-public senior and the veteran senior. What are the correlations, and how has what has happened to our veterans affected them compared to the general-public senior? Obviously we have post-traumatic stress in our society, but how does that differ in veterans compared to the general public? We've had a lot of discussions about that.

I'm wondering if you can help us. The operational stress injury clinic is part of the Parkwood Hospital. Can you tell me how that is going? We've had discussions around operational stress injury. What can we do to help with that?

Dr. Maggie Gibson: Unfortunately, I'm not going to be able to answer that question to your satisfaction, because I actually work in the geriatric component, the long-term-care component, at Parkwood Hospital in the veterans care program. I don't work in the operational stress injury program. Certainly there would be people well able to describe that program in detail to you. My focus is geriatrics.

But in terms of your question about how veterans are different, one of the things in long-term care that I think is particularly important is that the long-term-care veterans population is mostly male, and the long-term-care population from the community is predominantly female.

That's going to change for a couple of reasons, partly because the demographics in the mortality rates are changing—men are living longer—and partly because family structures are changing. The given scenario where you have the younger spouse who cares for the older man who is then able to live out his whole life at home is going to change as well, because the family structure is changing.

What we have in the veterans care population is a real opportunity to understand what the needs of aging men are that then can be extrapolated to what the needs of aging men in the community are going to be over the next few decades when the numbers start to balance out and we will have more equal numbers of men and women surviving to older ages.

Mr. Bev Shipley: Can you help a little bit with what you mean by "the needs"?

Dr. Maggie Gibson: For older men who have dementia, who move into long-term-care facilities, or who want to stay at home, how do we best support their function, their quality of life, and their interests, as opposed to what are the best ways to meet the needs, wishes, quality of life, and all the rest of it, of older women? And there are gender differences.

Mr. Bev Shipley: Yes. I think most of us know that.

I want to follow up on something that I know my colleague Peter brought up too. It has to do with professional care, just to expand a little bit on that.

One of the things that is always a concern is where do we get the professional care? That was one of the questions.

In every town in Ontario—and I suspect it's pretty much the same across the country—when we're looking for doctors, or we're looking for specialists in some areas but always doctors, each town is struggling to meet the medical needs they find within their community. When we have the same issues in our long-term-care facilities, how do we supply those facilities in terms of the professional needs we have?

Do you have any recommendations on how we can share, how we can work with the communities, work with the general public, on being able to get the care that is needed?

● (1610)

Dr. Maggie Gibson: It's a clearly recognized problem, and actually this does come back nicely to NICE, the organization I'm here representing, because one of their three objectives addresses that issue head-on. One of their objectives is to improve training of existing practitioners, improve geriatric curricula in universities, and interest students in specializing in geriatric care.

They don't have the answers yet either, but it's actually one of the organization's three priorities, to face that issue head-on and start to think about what we are going to do. I don't think anyone has the answers yet.

Mr. Bev Shipley: Well, it all takes so much time.

Speaking of time, thank you, Maggie.

The Chair: You're on cue, let me tell you.

Now we'll go back over to the Liberal Party of Canada and Mr. Russell for five minutes.

Mr. Todd Russell (Labrador, Lib.): Thank you, Mr. Chair.

Good afternoon, Ms. Gibson. We're glad to have you here as well as, certainly, your presentation in raising the whole issue of mental health and its importance in terms of this particular study.

I just have a question. I was struck when Health Canada appeared before us and they listed a couple of statistics. I don't know exactly what they were now—I don't have the paper in front of me—but they said that the vast majority of the elderly in a certain category said they were in good health when they were asked. Then there was another statistic that said, basically, in the same group there was a high percentage with at least four chronic diseases they were managing and a higher percentage dealing with at least one chronic disease, but still when asked how they would view their overall health, they said it was very good.

So I asked them that question, and they said that was a state of mind. I still feel a statement such as "I'm in a good state, even though I have four chronic diseases" is quite interesting. Could you speak to that at all?

My second question would be this. Because we're talking about veterans and we're targeting programs around veterans, we know there are going to be certain similarities between elderly or seniors or the aged and veterans as a subgroup. But if we're talking about veterans specifically and we're talking about programs targeted towards veterans, we know some of them are going to be similar to what you would do for similar types of populations. Is there anything specific that we should be addressing for elderly veterans, which make up the vast majority, so that our resources, time, and efforts are more targeted?

Those would be my two questions.

Dr. Maggie Gibson: I think with respect to the second question, it's really more a matter of being able to target veteran populations with programs that are.... It's a contained population, so you can target veterans populations with ideal programs, with model programs that are focused on different issues. We don't know because we aren't targeting the elderly who need assistance with ideal and model programs in general, but we can at least think about targeting the veterans population, which is a defined group, with what we think are really ideal programs. Then when they work and when we figure out what works about them, why they help, and which pieces of how they help are really because it's focused on men or on long-standing relationships between spouses or on something about having that camaraderie of the veterans' identity, we'll be in a good position to learn from those programs and figure out how they could be translated to the broader community.

The literature on Second World War veterans internationally really seems to show that one of the things that has been very protective for veterans in many countries is the camaraderie. It is the fact that their services were acknowledged and continue to be acknowledged through remembrance kinds of activities. That sense of appreciation and of being cared for is actually correlated with good mental health in the face of many aging challenges.

It's really worth looking at the studies that go across the Finnish, Russian, British, and American veteran populations to see where some of those commonalities come out. One of them seems to be that if you have been through a really traumatic event like a war, the remembrance component and the acknowledgement component carried out through your life is a protective factor. That's different from the rank and file community person who may have various traumas occur to them but not in any kind of systematic, organized, acknowledged way.

So there are some advantages to the veterans group that I think we can capitalize on, in terms of developing health care programs for an aging population that will be really quite model programs. I think that's what Veterans Affairs has tried to do in many ways.

I apologize; I have completely forgotten your first question. What was it?

● (1615)

Mr. Todd Russell: Just to paraphrase, if you have four chronic diseases and you say your health is in good condition, the explanation is that it's a mindset.

Dr. Maggie Gibson: A lot of the research would say that when people answer that question—how's your health?—they actually are using their own age group as a reference. When you ask someone who is 85, how are you doing?, they don't look at you as the 28-year-old interviewer and say, well, not very good compared to you. They think of their own reference group and say, well, I'm not doing too badly compared to my peers. In the scientific world that's the kind of explanation for why you get someone younger who has no chronic diseases thinking, how can you be saying you're healthy? Look, you have two diseases. But really, compared to your peers, you're not doing so badly.

Mr. Todd Russell: Does that sort of say that those others have six chronic diseases, or something of that nature?

Dr. Maggie Gibson: It could be.

Mr. Todd Russell: Thank you.

The Chair: Thank you, Mr. Russell.

Now to the Bloc Québécois, Monsieur Asselin.

[*Translation*]

Mr. Gérard Asselin (Manicouagan, , BQ): Good afternoon, Mrs. Gibson. I very much enjoyed your presentation, despite the lack of time that was allotted to you, and I want to congratulate you on it. Perhaps we could have given you a few more minutes, in view of the interest your presentation raised among committee members.

We know today that a boy or a girl who decides to join the Armed Forces is under the responsibility of the Department of National Defence. When he or she leaves National Defence, that responsibility is transferred to the Department of Veterans Affairs.

As Mr. Perron said earlier, there is little training or information on the consequences or the mental health problems that may arise.

In one article, for example, we learned that, in the United States, at least 6,256 persons who had served in the Armed Forces committed suicide in 2005, an average of 17 persons a day. The average in the general population is 8.9 per 100,000 inhabitants, and the average for veterans in the United States is 18.7 to 20.8, twice that figure.

Veterans in my riding are lacking information. First, they spent time in the Canadian Armed Forces. They went into combat. They have a file number as veterans, but today those individuals are elderly, often disabled and have lost quality of life. They are therefore left to their own devices because they don't know that there is a health program for veterans. They don't know that they could be receiving some kind of financial compensation or that various programs are there. Unfortunately, veterans are left to their own devices from the moment they leave National Defence.

This happens at the expense of their health and families. A number of them become discouraged and commit suicide. I think veterans should at least be informed about federal government financial assistance from the moment they join the Armed Forces. Veterans should also be constantly monitored to eliminate health problems or at least to provide them with the services to which they're entitled as veterans.

If a veteran from my riding came to see me in my office and asked me whether I could tell him where in Quebec he could get the relevant information for veterans, I would be at a bit of a loss and I would have to turn to Mr. Perron—somewhat as I did this morning—in order to be able to communicate with the Department of Veterans Affairs.

I think there is a considerable lack of information on health, follow-up, programs and financial assistance to which people are entitled. People often can't stand it and decide to commit suicide. There are cases of suicide, but there are also cases of murder.

I would like you to tell me how the government could improve the federal system in order to help veterans and to reassure them about health programs.

● (1620)

[*English*]

Dr. Maggie Gibson: I can offer some experience.

I don't know that I have the answer to what the government should do, but one of the things that's really dramatic that's happening with younger populations is the reliance on the Internet. Not our elderly population so much, but younger populations go to the Internet to get information. And I think an informed public is a good thing. I think one of the best things we can do is get the information out there in user-friendly websites so that anything that is public information and anybody who wants to learn about it can learn about it. Because you or I or anyone else is not able to retain all the information about all the services, programs, and different aspects of things, and veterans' care is only one of the things you need to have on your plate.

I can't tell you about a clinic I'm not involved with, but it would be easy enough to find the information. I agree with you, I think more information is better, and the way of the future is Internet access, so good websites that put everything available to the public out there in easily accessible ways is the way to go. If there's information that people should be able to access and that you should be able to direct people to, figure out ways to get it on the web.

[*Translation*]

Mr. Gilles-A. Perron: You may continue, madam.

[*English*]

Finish your explanation. The time limit is not for you, it's for us.

The Chair: Part of the reason I show committee members the clock is that they are showing courtesy to the other members who are waiting in line to ask questions.

Thank you very much.

Now over to the Conservative Party of Canada, Mr. Epp, for five minutes.

Mr. Ken Epp (Edmonton—Sherwood Park, CPC): Thank you.

Welcome to the committee. I appreciate your presentation.

You made a statement earlier that I found intriguing. You said that generally in the seniors facilities the number of females exceeds the number of males, and certainly that's true. I think of the place where my mother is: it's three-quarters female and one-quarter male. You said that with respect to veterans those numbers are reversed. That leads me to believe... I wonder whether the veterans, who probably are more representative of the male of the species, go to these places when they are younger? Is that what's happening?

Dr. Maggie Gibson: I don't follow you.

Mr. Ken Epp: If there are more men there, is that because a disproportionate number of the armed forces, especially at that age and back then, were men than women? Is that the reason, or do they come to the centres earlier in life?

● (1625)

Dr. Maggie Gibson: No. In Parkwood Hospital, where I work, the priority access beds are 98% for veterans simply because they are coming from an era of the Second World War and the Korean War when men were much more likely to be involved. That will also change when geriatric services are needed for current cohorts of veterans. We will see many more women than we do now when people from the armed forces today become veterans and need geriatric services in their old age. But right now the war veteran population is mostly male.

Mr. Ken Epp: Okay. The place where you work is primarily veterans?

Dr. Maggie Gibson: Let me remind the committee for my own purposes that I am here representing the National Initiative for the Care of the Elderly. I happen, as a member of that, to work at Parkwood Hospital, which is part of St. Joseph's Health Care London, a large hospital with a lot of different kinds of services, but it does include 300-plus beds with priority access for veterans, and I have been working there for 15 years.

Mr. Ken Epp: Okay.

The next question I have also has to do with gender. Is there a significant difference in the psychological needs in terms of intervention between the males and the females? Is it different or is it similar?

Dr. Maggie Gibson: I think in the gerontological literature we're starting to see more appreciation of the issue of gender and more realization that as men and women age—what it's all about is aging successfully, happily, actively, whatever it happens to be—they have had different life courses, different activities and interests, and they've gotten to different outcomes in their lives. They might all need, for example, some supportive counselling, but the content of that counselling is going to be driven by who they are, which is in part driven by the fact that they're men versus women.

So a man might, for example, find the retirement stage of life a very challenging psychological period, whereas perhaps an older woman who didn't experience a retirement phase of life, but experienced something else to do with family or whatever, depending on how she lived her life, is going to have different issues. Our current generation of older women were less likely to have worked outside the home. Depending on how she lived her life, her issues are going to be different. The content of her counselling and her interaction with a mental health provider is going to be different from the man's.

Mr. Ken Epp: Okay.

It seems to me also, just in my observations, that one of the largest problems in these facilities is the issue of loneliness. I wonder whether you would address that generally, especially because of the fact that often you have these centres to look after the elderly. They are not available where the people live, so they will end up actually moving farther away from friends and family because they need the physical facility. Do you have any comments or recommendations in that regard?

Dr. Maggie Gibson: I do. I think that loneliness is a huge problem for older adults, and I think it's one that's not easily solved, because in part it's a result of circumstances.

If you think of the statistics, 2,000 veterans are passing on per month—I think that was the statistic that came out of the Gerontological Advisory Council's report. Many older veterans become lonely because their associates pass on. One of the advantages to communal living environments for older people is that if the environments are designed and programmed properly, they can combat loneliness. So the problem of keeping people in the community can be that their circumstances in terms of friends and families change such that through no fault of their own they become socially isolated and lonely. Communal living environments, be they assisted living or long-term care or whatever, that have good programming can give people a new lease on life and a new opportunity to participate in things and to become engaged in things and to really enjoy their last years in a way they wouldn't have if they were still living independently in the community.

So you have to be careful, in terms of promoting independence and community living, to make sure that people don't outlive the supportive network that's available to them and, through no fault of their own, come to require the development and the assistance to develop another supportive network, if they are going to have social connectedness and friendship and all the rest of it in their latter years. Loneliness is a huge problem.

● (1630)

Mr. Ken Epp: The chairman is busy, so I have one—

The Chair: You're over time, if that's what you were going to ask, sir.

Mr. Ken Epp: I don't want to ask about the time. Let me just finish this round, unless you're going to cut me off, Mr. Chairman.

The Chair: Well, if the other committee members are amenable to that, sir....

Mr. Ken Epp: Yes, I'll just be about another minute.

The reason is I have a 94-year-old mother and she is in one of these facilities. I go to visit her as often as I can, but unfortunately she's some eight hours away from where I live, so it's not that often. But I go there and I observe.

I observe that one of the biggest psychological problems that she and her friends there experience, I think, is that transition from being useful and helpful to others and giving, to being on the receiving end, to needing help, instead of being able to give help. Generally, when I talk to especially the old men in that place, they feel so useless. They want to fix something, they want to do something, they want to build something. They're doers, and suddenly they don't have that opportunity there.

I often think that some of these seniors places should have some activity that is actually useful in the community, maybe something they could build, making lampposts that can be spread throughout the town. Then these guys can say, "Look, we built those". It gives them something. Is there anything like that generally? Again, just give a general response.

Dr. Maggie Gibson: The large veterans care facilities across the country, like Parkwood, and there are 12 or 14 of them, are extremely well equipped. They have all sorts of activity options. Parkwood, for example, has a woodworking studio, a clay studio, a textile studio, bowling alley, pub, and a putting green. There are lots of leisure and recreation activities. It's viewed as "This is your life. You live here."

Your quality of life is important. You need to have recreational activities that are appealing to you, so that means a range of activities, and you need to have an opportunity, if you so choose, to be involved in things that are more work-like, such as building things, being involved with the intergenerational programming and so on.

The concept that residential care facilities need to be communities in which there is a range of activities people can engage in so they experience both pleasure and meaning as they live out the end of their lives is well accepted in the gerontological literature and well studied in terms of how important that is for people's well-being and health. Does it always get into practice? Not always. Not everywhere.

Mr. Ken Epp: Thank you, Mr. Chair. You've been exceptionally kind to me as a visitor here.

The Chair: Sir, you've gone 10 minutes and 13 seconds, which is quite impressive. Yes, the committee members have been gracious.

There was a spot for one of the opposition parties, Mr. Epp doubled his time, and that spot was not taken by one of the parties, so now it moves to the Conservative Party yet again.

Ms. Hinton, for five minutes. After that, it's Mr. Stoffer.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): I doubt very much that I will take five minutes.

I would like to begin by thanking you for appearing today, Ms. Gibson.

I apologize profusely for my late arrival. I take the veterans affairs issues very, very seriously.

I was delayed because I had the pleasure of meeting a gentleman named Guy Gruwez, who is a special visitor from Belgium, and his wife. Mr. Gruwez is visiting from Ypres, Belgium. He is the honorary chair of the Last Post Association in that country, and he has chaired that position for 40 years. He had an opportunity to meet with the Prime Minister, and I was privileged to be there with him.

So I do apologize for being late. I give you my word that I will read your testimony from cover to cover. I appreciate that I have capable colleagues who stood in my place.

I did get back in time to hear a comment from Mr. Asselin, who is also a visitor to this committee today. He talked with great passion regarding veterans, which I do appreciate.

One concern I have is that you made a statement that 70 veterans commit suicide each day. I asked the clerk where that came from, and apparently it is a newspaper. I would like you to table that. That number sounds absolutely obscene, and I would appreciate very much if we could get to the bottom of that.

● (1635)

[*Translation*]

Mr. Gilles-A. Perron: Mr. Chairman, I have a point of order.

[*English*]

Mrs. Betty Hinton: I don't want to get into debate; I just want to see the document.

[*Translation*]

Mr. Gilles-A. Perron: I would like to give Ms. Hinton some information. It's an American study.

[*English*]

Mrs. Betty Hinton: I'm sorry, I don't have my earpiece in because it's my speaking time.

Mr. Gilles-A. Perron: It's important to give you the information.

[*Translation*]

These are American statistics that appeared in *La Presse*. According to the article, approximately 6,250 Americans committed suicide, which means 17 a day.

[*English*]

Mrs. Betty Hinton: Thank you. That's clarification enough, then. That has nothing to do with Canadian veterans. When I heard that 70 veterans were committing suicide each day, the red flags went up. I thought that was virtually impossible.

Now I understand. I also understand that it is the newspaper, so it would be an opinion piece, and it's not backed up with statistics.

Mr. Gilles-A. Perron: They are American stats.

Mrs. Betty Hinton: Okay, American stats. Well, Americans are in a lot of different war-torn places, so the number of suicides may or may not be accurate. But I wanted to check on that.

In terms of my late arrival, and I hope you accept my apology, is there anything you would like to leave this committee with, as a last word, if you will? Is there something you feel we should be aware of so we can do a better job of serving our veterans?

Dr. Maggie Gibson: I think the folks around the table have raised really important issues, and I'm very reassured to see the depth of concern and the depth of understanding of both gerontology and veterans issues. You don't always encounter that when you're talking to a group. So I feel that we're in good hands to see what will come of the committee's work, and I appreciate the opportunity to have participated in that.

Thank you.

Mrs. Betty Hinton: Thanks very much.

If either of my colleagues has anything to add and I have any time left, please feel free to use it.

The Chair: There's a minute and a half, if they wish.

Mr. Epp.

Mr. Ken Epp: I have just one quick question. It has to do with people who are in your line of work.

Are there adequate training facilities in Canada to train for the geriatric service industry? I almost shouldn't use that term, but as regards training of workers who will care for the elderly, are there adequate facilities in Canada? Do you have a staff shortage in that area?

Dr. Maggie Gibson: It isn't so much about the adequate facilities, it's whether there are geriatric courses on the curricula of universities. I would say that in psychology departments we aren't doing well enough in that area at the moment to be prepared to serve the changing demographic, the increasing number of elderly people. I think everyone is aware of that. But the short answer would be that we in psychology, as well as in other health professions, need to ramp up our training in geriatric issues—definitely.

Mr. Ken Epp: Thank you.

The Chair: Thank you.

Now we'll go to the New Democratic Party and Mr. Stoffer for five minutes.

Mr. Peter Stoffer: Thank you, Mr. Chair.

Earlier we had talked about the aspect of where we would find the future psychologists to help our aged and our veterans. You had mentioned war-torn experiences and the military aura that is around it, I think you succinctly stated, because of the remembrance, things such as veterans week and everything else, and the pride they have in their medals and people thanking them.

The nice thing in Canada over the last bunch of years is that there has been a new, growing awareness of our veterans. I think one of the reasons for that is probably because so many World War II and Korean veterans are getting older and the fact that we lose an awful lot of them every day because of old age or sickness.

For people training to be psychologists, especially when it comes to veterans and their families, would you recommend that they have not necessarily military experience, but an embedded experience with the military when they go not just to Afghanistan, but to Haiti, to Bosnia, or wherever they go in the world, so that they themselves can experience at a younger age some of the concerns these men and women will face 20 or 40 years down the road?

The reason I say that is in the study of PTSD we found that PTSD can strike you right away or it can afflict you years down the road. When they're going to people at OSI centres and such and talking to them, we've found that the people who were talking back should have a clear understanding of what it was like for them in that regard.

Would you make that recommendation, if the government were to fund that type of activity, to assist people training to be psychologists for specifically the military, veterans and their families, that they have an embedded experience in that regard?

● (1640)

Dr. Maggie Gibson: I understand what you're suggesting. I wouldn't recommend that because I don't think that's exactly how it works. You can end up working in a variety of different areas, so you're not going to have a whole lot of people who are, at the get-go, declaring a career in veteran-specific psychology, for example. You wouldn't have a huge number of people who make that kind of clear and very defined career choice. I think the broader issue is that in training in disciplines such as psychology, medicine, or whatever, it's not the kind of counselling model where the expectation is that the healer should have the experience of the people they're going to help.

For example, for psychologists who choose to work in child abuse, or psychologists who choose to work with epilepsy, or psychologists who choose to work with dementia, it's the scientist-practitioner model, but it's where you're building on the body of work and you're definitely getting practical experience in your training working with that population but not necessarily personal experience. In many cases, it's not feasible and not the training model.

Mr. Peter Stoffer: Thank you.

The Chair: Thank you very much.

At this stage, unless there are any other committee members who wish to add in at this point, I think we've exhausted questions.

Before we depart, we do have some things with regard to our logistics officer and the upcoming trip. There are some packages that will be handed around, and she'll be available to answer any questions.

So at this stage now, thank you very much to our witness for your presentation and for answering our questions. I know Mr. Epp, particularly, is appreciative of the time you took to answer his questions. You were very accommodating. Thank you very much.

If you don't mind, I'm sure some committee members will come by to thank you. We appreciate your visit.

Before everybody leaves, though, I just want to address some of the things about the itinerary and the upcoming trip.

Just so that Mr. Stoffer and others are aware of how this works, our person at the back, Kate, who's delivered these packages to us, is not able to appear as a witness, so if you do have questions, officially the way it's supposed to work is that you direct them through the chair.

Could everybody please open their packages and itineraries? As you can see, there's a cheque for per diems and what have you. I'm just flipping through here. We have some calculations of the per diems, both in English and French, the people who will be accompanying us. Now we see Kate's full name, Kate Bourke. We have the itinerary here. I'm just flipping through. I'm sure you're doing the same. There are maps.

Just bear with me one second, Mr. Epp, I'm just making sure I'm familiar with the document before we start referring to it.

Now, as recognized, we'll hear from Mr. St. Denis and then it's Mr. Epp on deck.

Mr. St. Denis.

● (1645)

Mr. Brent St. Denis: I comment just to commend the clerk and Kate for accommodating a number of suggestions along the way. They're doing a great job.

Some hon. members: Hear, hear!

The Chair: Mr. Epp.

Mr. Ken Epp: Mr. Chairman, as you know, I'm here on behalf of Mr. Sweet, my colleague, today, and I would be remiss if I didn't bring him a cheque.

Some hon. members: Oh, oh!

The Chair: I believe the suggestion, Mr. Epp, is that we will trust internal mail to do that.

Mr. Ken Epp: Well, as long as he doesn't hold me accountable for losing this.

The Chair: Oh, that's right—Mr. Sweet will not be attending. He will not be accompanying us, actually.

Mr. Ken Epp: Oh, okay.

The Chair: He has some conflicting issues with regard to his itinerary.

Mr. Ken Epp: Oh, okay, so he won't be on the tour.

The Chair: He won't be expecting anything from you, sir.

Mr. Ken Epp: So I'm off the hook. Thank you. I just want to make sure I'm fulfilling my duties.

The Chair: Absolutely, sir. You're very diligent that way.

Do we have any other questions from committee members at all?

Mr. St. Denis.

Mr. Brent St. Denis: If I may, I'll point out that because I can't meet the group Sunday night, I'll be arriving at the meetings at nine-ish Monday morning. A previous engagement doesn't allow me to get to Vancouver for the charter, but I've arranged all the flights with the help of the staff.

The Chair: Wonderful.

Mr. Shipley.

Mr. Bev Shipley: I am just taking a look through the itinerary, and I have a question about dress. When I have been on some, there have been witnesses in the morning, and then we toured in the afternoon, so we had to wear a suit and all that sort of stuff. I'm not seeing that here.

I am just asking, to be respectful of the people we're seeing, whether it is casual. Do we need to bring a suit or a sport jacket and tie?

The Chair: There is a specific answer, Mr. Shipley: business casual, no jeans.

I would assume if we were travelling as an ad hoc committee, with actual tables set up and witnesses appearing and that type of thing, you'd probably be best to be in a suit and tie. But since we haven't structured anything as much as that, I would say business casual.

But there you are: we have a ruling on “no jeans”.

Mr. Stoffer.

Mr. Peter Stoffer: Mr. Chair, if you would be kind enough to look at the page that says Thursday, February 14, I think you will see that there is a typographical error here—not that I would ever accuse Kate of anything wrong.

The Chair: Could you refer to a specific page number, sir?

Mr. Peter Stoffer: Page 9. It talks about transportation to Goose Bay, but I think they mean to Shearwater.

Ms. Kate Bourke (Logistics Officer, Committees Directorate, House of Commons): It is to Shearwater. I sent out a revised e-mail, but unfortunately it was already printed in this before I headed over here with it. You have all received an e-mail recently with the revised itinerary. I apologize.

Mr. Peter Stoffer: Just to give the logistics officers a heads-up, when we're in Shearwater I'll be at home, so I won't need a place at Shearwater.

The Chair: Fair enough. Are there any other questions?

Mrs. Hinton.

Mrs. Betty Hinton: I have a comment I'd like to make, but it has nothing to do with the trip, so I'll wait until you're finished.

The Chair: All right.

Are there any other questions about the itinerary? No? Then thank you very much.

Oh, I have a question from Mr. Russell.

Mr. Todd Russell: Is the flight out of Ottawa not charter, but just a commercial flight?

● (1650)

The Clerk of the Committee (Mr. Alexandre Roger): You refer to the flight out of Ottawa to where?

Mr. Todd Russell: To Vancouver.

The Clerk: Yes, that's commercial.

Mr. Todd Russell: So we only pick up the charter in Vancouver?

The Clerk: That's right, to go to Comox.

Mr. Todd Russell: And then the rest of the way?

The Clerk: Yes.

Actually, we fly commercially back from Calgary to Ottawa afterwards.

Mr. Peter Stoffer: If you can stay at the Crown Isle, it's a nice place, with a beautiful golf course. I actually shot a 90 on that golf course.

A voice: For nine?

Mr. Peter Stoffer: I did not cheat. I had four witnesses. They saw it, and I didn't even keep the score. It was great.

Mr. Ken Epp: How did you do on the second hole?

The Chair: I'm sorry, there is a bit of a logistical issue here.

From what I understand, we had initially wanted to stay on Comox, the base itself. I understand the base commander is somewhat resistant on that issue. I understand it's a rare thing, and they may feel their accommodations are not up to snuff.

Are the accommodations for the members of Parliament up in the air, then?

Okay, we've reserved at the Crown Isle. It's up to the committee to decide. They're reserved.

Sir, I'm sure, if you lobby your colleagues, you'll get your way. I don't doubt this.

Are there any other questions, comments, or thoughts?

Now we go to Mrs. Hinton.

Mrs. Betty Hinton: Thanks very much, Mr. Chairman.

I mentioned earlier Guy Gruwez. We have new members on this committee and we have some substitutes. If you'd just indulge me for a minute, I can give you a bit of background on this gentleman.

Mr. Gruwez is the honorary chair of the Last Post Association in Belgium, and he served as the chair for 40 years.

For almost 80 years, members of the Last Post Association have been responsible for what I would have to call a remarkable ceremony that honours those Canadians who fought and died in Belgium in the First World War. Every night at sunset, without fail, before hundreds of local citizens and tourists, members of the association play the Last Post at the Menin Gate Memorial.

Listed on the memorial are the names of 7,000 Canadians who gave their lives in the Great War and who have no known grave. That's what this is all about.

If you're not familiar with the Menin Gate and ever have an opportunity as an individual or a member of a committee to visit it, I would strongly suggest that you do. The time I was there.... There's a huge open dome at the top of this facility, and literally thousands of poppies floated down during the Last Post. I'm just talking about it now and every hair on the back of my neck is standing up.

So if you ever get an opportunity and you want to see how grateful other countries are for Canadians, the brave men and women who served in the war, that's something you'll never forget.

Thank you for that indulgence.

The Chair: I think it was a useful indulgence.

Mr. Epp sent me a note asking whether we should be in camera for this.

Mr. Epp, I'll just let you know in front of the committee that I almost never go in camera for anything. I figure, what's the point?

Mr. Ken Epp: Some committees I have attended do that when they have internal committee business like this.

The Chair: Understood.

I think the only time we've ever done that was for national security reasons.

Mr. Stoffer, your question toward the end about psychologists who had experience reminds me of a scene out of a Rodney Dangerfield film where Sam Kinison, who's a comedian, is playing a Vietnam veteran professor at a university. The young student asks him a question about Vietnam, and this guy jumps back and says, “Were you in Vietnam? What you were doing there?”, etc. The kid freaks out and says no, and then he says “All right”. Anyhow, it reminded me of the Sam Kinison role.

Mr. Peter Stoffer: I did like her answer. You don't necessarily have to be embedded to be able to assist someone who's had a traumatic experience. I thought that was a good answer.

The Chair: That's a very fair answer.

Thank you. The meeting is adjourned.

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