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Chair

Mr. Rob Anders

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● (1530)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): Good afternoon, ladies and gentlemen. This is yet another meeting of our committee on veterans affairs.

Mr. Stoffer wants to be recognized, and I am eyeing him with trepidation and wondering what he's up to.

Mr. Stoffer.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): This is a quick point of order to thank Todd Russell and the great people of Labrador and Newfoundland. Happy birthday to them. We thank them for allowing us into their province 59 years ago on April 1.

The Chair: Well, there you go. That's good to know.

Just so our witnesses know how this whole show works, we are into the study of our veterans health care review and veterans independence program. Our witness, Helen Gough, is an occupational therapist and military spouse.

On the way it generally works, you get 20 minutes. You can mix and match that—you can do 15 and your husband can do five—or you can hog all the time and just have him there for moral support. That's perfectly fine.

Then we will open it up to questions. It's all predetermined and pre-ordained stuff that we bargained about early in the term. The question time goes to the various parties for seven or five minutes, depending on the round. I'll announce when their time comes up.

So the floor is yours.

Mrs. Helen Gough (Occupational Therapist and military spouse, As an Individual): Good afternoon. My name is Helen Gough and I would like to thank you for allowing me to be a witness here today.

I'm speaking today first as a military spouse and secondly as an occupational therapist. My opinions don't reflect those of the Canadian Association of Occupational Therapists, DND, the Canadian Forces, or Veterans Affairs. I'll be speaking for approximately 10 to 15 minutes, and hopefully your questions will reflect my statements today.

[*Translation*]

I will share with you, based on the experience I have acquired through my personal and professional involvement with these organizations, a few recommendations to improve the services provided to veterans.

[*English*]

I commend the efforts of this committee. In particular, I'd like to thank Ron Cannan for his support of veterans, particularly in the Okanagan region.

The work of this committee and the final report and recommendations will be important to military families. It's important for Veterans Affairs services to reflect the reality of the various stages veterans find themselves in. By reviewing the veterans independence program and the health care concerns of veterans young and old, the standing committee identifies the importance of operating within the culture of the Canadian Forces.

Understanding the CF culture is the key to successful integration of health care services and is an excellent way to appreciate the unique health care issues of veterans and their families. Canadian Forces culture encompasses—and health care professionals should understand—living and working in a military environment, typical mental and physical injuries sustained by veterans, posting experiences, the chain of command and unit cohesion, and Veterans Affairs programs and criteria, just to name a few.

As Veterans Affairs probably has already identified, the term “veteran” includes various different types of Canadian Forces members. I conceptualize four branches under the broad term “veteran”: first, the regular or reserve Canadian Forces veteran who has served Canada overseas, such as my wonderful husband here; second, veterans releasing or retiring; third, veterans medically releasing due to physical or mental issues; and the last branch is dedicated to our senior veterans, the ones I serve on a daily basis.

Each of these four veteran types requires unique services from Veterans Affairs and the Canadian Forces. Each veteran type has an organizational culture, climate, value, and ethos. They also have diverse stressors on their health that require sensitive and specific programs. The military family will respond best to approaches that reflect the current situation of veterans. I believe there are tangible methods to this.

Although each type of veteran has individual needs, one component remains consistent. All these veterans are moving away or have moved away from Canadian Forces services. Whether the move is due to a CF posting—which I've done now coming on to four times—a medical release, or a voluntary retirement, each relocation to a new area away from familiar resources provides unique challenges. Creating a clear bridge between the Canadian Forces, Veterans Affairs, and community health programs means veterans and their families can have access to consistent health care professionals who are knowledgeable of the Canadian Forces culture and their specific family situation.

There are currently a number of innovative and well-delivered programs offered to veterans and their families. It's obvious that Veterans Affairs has listened to the recommendations provided by military families, military members, and researchers. Veterans Affairs and the Canadian Forces should be proud of their present host of active health care professionals and their efforts to promote well-researched, evidence-based services that are all client centred. Through my work with VAC, I can speak to numerous examples, as I work as an occupational therapist who assists the senior veterans to live in their homes as long and as independently as possible.

There lies, however, a gap of consistency of health care services between the Canadian Forces bases and those offered by VAC and the community health care sector. With a coordinated effort between the Canadian Forces bases, Veterans Affairs, and the community health care professionals, consistency of health care services can be found. Most of the recommendations, I suggest, have already been created. They just need to be connected.

I'd like to provide two examples of issues that are not being addressed as effectively as they could be.

The first relates to what normally comes to mind when you are addressing the reintegration of a soldier from a foreign posting. For a fictional example, let's take a sergeant who has returned from Afghanistan after sustaining a severe concussion and shoulder injury due to a roadside bomb that took the life of two of his younger troopers. Coming home, he went through rehabilitation under a team of health care professionals made up of enlisted and civilian medical personnel. His family has been receiving counselling and using the teen centre supports at the military family resource centre.

● (1535)

Due to periods of depression, chronic pain, and a desire to try something new, the sergeant and his family decided it would be best for him to medically release and relocate to a rural town in northern Manitoba, where his family lives.

The veteran leaves the military and relocates, taking his family with him. He continues to struggle with his health care issues, and he struggles to find work. Over time, his issues turn into anxiety; however, because he has not had a consistent mental health or physical health clinician screening at various times in his new location, the sergeant and his wife and family have little support.

Hypothetically speaking, if there were a military occupational therapist enlisted on the base, they would know of the impending release of the soldier and his family.

The military occupational therapist can take the first step to assist in the transition by searching out a community occupational therapist prior to the release. Providing there is no Veterans Affairs district office in that area, the community occupational therapist is contacted. An in-service and a Veterans Affairs service handbook are provided, and telephone conversations between the veteran and the occupational therapist begin in order to establish rapport, a technique shown to improve treatment outcomes. These three tools provide consistency and ensure competency of health care.

A releasing treatment plan can also be created between the military occupational therapist and the community occupational therapist. Any resources the sergeant and his family were using on the base are documented, and the community occupational therapist attempts to seek out similar resources prior to the relocation to ensure that there is little lag in services.

The occupational therapist could then arrange an initial meeting with the family in their home, screening for additional needs. The occupational therapist is looking specifically at his various chronic mental and physical limitations and seeing how they are impacting on his ability to obtain a job, to re-engage in his role as a husband and a father, and to manage the routine of personal hygiene and house management, such as paying bills—all these little things that we take for granted. The OT will also make sure he is engaging in recreational activities.

Occupational therapy treatments are targeted at the barriers to his successfully engaging in those types of occupations. These screenings can be done periodically in his new location. Outcome measures could be used to ensure success in the treatments offered.

These services—the community occupational therapist's—are already being offered to individuals in the public. There needs, however, to be an individual who links the community occupational therapist and the Veterans Affairs occupational therapist with the family, prior to their leaving the base. l feel this can be done successfully by Veterans Affairs and the Canadian Forces.

For my second example, l will deal with the less-apparent need for consistent support in the physical and mental well-being of soldiers, particularly as they move away from the Canadian Forces resources and deal with the day-to-day issues of military life. This is my life, actually.

The challenges, both adventurous and stressful, include postings, ongoing back-to-back training, and operational tours over relatively short periods of time, as my family has done for almost 10 years with this gentleman here. Add to this the stress of normal family life, such as typical teenage issues, impacted by the need to engage in a new peer group due to postings and the results of frequent parental absences, as well as stressful reunions, caregiver burnout, and missed employment opportunities, as l have seen in my position as a social service worker.

On the Canadian Forces bases, continuous supports are available. They're excellent. The close connection of the military families, the military family resource services, and the military primary health care unit are very useful when needed.

Off base is another matter. Military families are isolated from this support and unsure of what resources to turn to. This is particularly important when there are overseas assignments or absences for training periods. The lack of a consistent, military-focused outreach person, a person who understands what the family is going through, adds to the challenges being faced.

● (1540)

Civilian professionals, as competent as they are, cannot really understand the typical concerns of the military spouse or the culture of the Canadian Forces in general. Oftentimes, recommended courses of action are not practical or realistic in a military context. For example, before my husband came back to Canada, he had pre-arranged counselling while on decompression leave in Cyprus to assist with his hyper-vigilance and my anxiety over reintegration, and to assist with repairing our relationship due to the long periods of separation we have experienced over the past five years. This counsellor was well advised in trauma relief, and also gave us strategies for reintegration. However, my husband and I spent so much time explaining our current situation and the culture of the Canadian Forces, I sometimes wonder if I ended up developing a better sense of the Canadian Forces than of our marriage and our relationship.

What would have been helpful for our family, and for others in a similar situation, is having one primary health clinician stationed and embedded within the Canadian Forces to connect us to a health professional in the community that we were relocating to. This clinician could have kept tabs on our family as we moved through the various stages of relocation and reintegration. As health problems crop up, we are much more likely to seek out a clinician with whom we have built up a rapport and who understands the situation. I'm sure that other Canadian Forces families who are frequently moving, or are being released from the military, might say the same thing.

I believe that occupational therapists, placed strategically within Canadian Forces bases, could assist with this situation. I feel that OTs can provide a link between the Canadian Forces, Veterans Affairs, and the public health sector. I believe that whether they are being medically released as soldiers or retiring veterans, or are being posted away from garrison, all military personnel and their families should have this. Occupational therapists can be one small piece of the puzzle to assist in bridging this gap, as they are able to successfully screen for and treat both the physical and mental health issues that affect soldiers in their everyday life—and they can refer as appropriate.

This is nothing new. There are examples of various organizations in Canada and other countries that recognize and value the role of occupational therapists among veterans. These examples move away from the typical, more traditional view of what occupational therapists do in Veterans Affairs, such as what I provide for senior veterans.

For example, the United States Army has military occupational therapists. These occupational therapists have established a strong mission and vision and have a deployable role overseas—including in Iraq—as members of combat stress teams. On garrison, these military occupational therapists provide mental and physical rehabilitation.

In the United Kingdom, occupational therapists are key players in acute trauma wards, doing discharge planning at the Royal Centre for Defence Medicine for wounded service personnel. The occupational therapists are actually currently advocating for the enlistment of a military occupational therapist, as they recognize the need for occupational therapists to understand the culture of that population.

In Montreal, the National Centre for Operational Stress Injury employs an occupational therapist who is committed to developing the front-line role of OTs within the operational stress injury clinic. As you know, the clinic services releasing military members and regular and reserve veterans.

In the Okanagan, there currently is an occupational therapist on the VAC rehabilitation team, providing consultations, alongside other health professionals, on appropriate services for injured veterans.

Also, the Canadian Association of Occupational Therapists has plans to initiate conversations with the Department of National Defence to conduct a needs assessment on a Canadian Forces base and, hopefully, within the military family resource centres, which you had represented here a number of weeks ago.

● (1545)

In your report to Parliament, l would like to ask you to consider the following recommendations.

The first is that Veterans Affairs Canada create a clear link between the Canadian Forces and the Canadian health sector by assisting those veterans leaving supports from the Canadian Forces base and relocating to the community.

One way this can be done is by creating a comprehensive service handbook for employees, health care professionals working with or for Veterans Affairs, and medical supply stores, physicians, and pharmacists who service senior veterans not yet connected to the VIP program.

The second recommendation would be that Veterans Affairs recognize the diverse skills of occupational therapists in assisting various types of veterans suffering from mental and physical limitations who are relocating to the community, and appoint one person to identify a community occupational therapist prior to the relocation of any veteran being released.

These two recommendations, which could deliver cost savings over the utilization of a third party resource—as much as I hate to say that since I am a third party resource—are already in place. The information and the key players simply need to be coordinated.

These recommendations will respond to the needs of Canadian veterans and their families, as noted by the prime directive of Veterans Affairs.

The recommendations will also provide veterans with familiar, consistent, and culturally sensitive mental and physical health clinicians and build a clear bridge between the CF and VAC programs.

The creation of the handbook itself would provide health care professionals with a well-established consistent message of programs available through VAC, and provide the clinicians with evidence-based treatment lists specific to each health profession.

Again, l would like to remind the committee that l speak to all of this as an independent military spouse and occupational therapist. It's an honour to speak with you today.

● (1550)

[*Translation*]

Thank you for your attention.

[*English*]

My hope is that l am able to provide the committee with meaningful and tangible strategies to assist with the development of a program that l use in my daily professional life and that l will personally use in the future.

Thank you. I will be pleased to respond to any of your questions.

The Chair: Thank you very much.

Now we go first to the official opposition, which is the Liberal Party of Canada.

Mr. Valley has seven minutes.

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

Thank you very much for that presentation. Thank you for your service. Thank you to your husband for his service. Quite often we have witnesses come before us whom someone intimidated. It's clear that's not the case with you. You're very passionate about what you do, and you made an excellent presentation, so thank you for that.

I normally ask questions about remote ridings and remote areas. You touched on one in your examples, and I'll get to that in a minute. There was a very interesting article in the *Edmonton Journal* by a lady who has presented here before. I'm not sure if it was in person or over the phone, but it was by Norah Keating. She talked a lot about the issues that the family has to deal with.

Can you just give us some kind of insight? We know that often those who come back have traumatic injuries. There are people who have lost limbs, who have lost the use of parts of their body. This is not just starting; we've been aware of the impact on the families for quite a while. In your profession, how do you deal with some of the stresses, which we can't even begin to think of, on the spouse, on the children, on the extended family, first of all in areas that have services, such as some of those you have mentioned, and then in areas that don't have services, such as northern Manitoba?

Mrs. Helen Gough: Are you asking what you would do as an occupational therapist or if there are services available?

Mr. Roger Valley: What would you do if you had a family that was in that situation? You're dealing with the service person. Whether of not he's discharged at this point yet is immaterial. How do you deal with the extended problems, past those of the individual who was injured?

Mrs. Helen Gough: As an occupational therapist, if you're providing an in-service to them and they have the cultural background, which is the service handbook, they would be able to go and they would have an understanding of what programs they would be able to refer to. Occupational therapists have regions that are already established, as you know. So the family, along with the veteran, would become the clients. That's how I see it. So they would be on the roster of this community occupational therapist. They would be on the roster even before they get there. The barrier would be gone because they would be on the roster.

Mr. Roger Valley: Is it automatic that the family is part of that whole system?

Mrs. Helen Gough: I'm hoping it will be, because I think that's an extension of what a soldier is when he goes. An occupational therapist looks at the roles that are lacking, that are not being met day to day because of an operational stress injury. So when you do an assessment from an occupational therapist's standpoint, you're actually looking at roles that aren't developing, and obviously one of the roles of the soldier is to be a husband, or a spouse, or a father, so you're going to help them get back into those routines.

It's all about routines when they get back and they're isolated. That's what an occupational therapist will do. So if you're looking at a role that involves being a father, you're going to be looking at the children; you're going to be looking at the spouse. I definitely feel that occupational therapists need to look at more than just the individual himself; it's a family unit.

Mr. Roger Valley: I want to go to your example of northern Manitoba. My riding is Kenora in northern Ontario. It's very similar, with a lot of the issues of remote sites. I want to again thank you for your recommendations, because too often we don't get clear direction from our witnesses. You were excellent in making your recommendations.

You mentioned northern Manitoba and somebody who has taken medical discharge—and correct me when I go off the track here. They moved for a job closer to family. Because they're at a remote site, there may not be anybody there, but an occupational therapist is going to call them because they're aware of the situation. You mentioned that anxiety builds—it could be job-related, family, who knows what.

How do you react? We deal with veterans all the time and some of the people you mentioned. You deal with the elderly. All those issues are there, and anxiety and all these problems are mounting. You're on the phone, and because of the remote location you could be hundreds of miles away. When somebody already has a problem, as you mentioned, how do you make it work?

● (1555)

Mrs. Helen Gough: Regarding my vision of how this would work, it would be preplanned before they moved. You know the release of the soldier is coming. There's somebody on the base who's already doing treatment. There's a wonderful health care team there already, and they have a treatment plan.

That treatment plan needs to be branched out into the community. It can't just lag behind for six months or a year; it needs to be preplanned before he leaves. Of course there will be additional stressors once they get there, but if a releasing treatment plan is coordinated between a military health care team and the occupational therapist in the community before they get to that location, ideally it will create fewer barriers for treatment and will be offered once they get there.

Mr. Roger Valley: Thank you for that vision. Things may work well in an urban setting, but when we get to the small, isolated communities of 5,000, and the fly-in locations with 1,000 or 250, we hope your vision can be broadened to reach everyone who needs that service.

Mrs. Helen Gough: Absolutely.

Mr. Roger Valley: I think you said your field is the elderly veteran. As members of Parliament—and I've said this many times in this committee—we have trouble reaching out and knowing who our veterans are. You're talking about a system that starts when they're still in service. Are you able to track them all when they leave, or do you lose track of some of them when they go?

When somebody is released from service and they go to northern Ontario, for example, how successful are you at following them when they need help?

Mrs. Helen Gough: I receive referrals. I can drive up to three and a half hours to see a veteran. This is for senior veterans who are living in the community.

I have a recommendation on that.

Mr. Roger Valley: Please go ahead.

Mrs. Helen Gough: It's that travel hours be included in the direct therapy time. I have about six hours to work with a veteran. Typically it isn't so bad if they're in a community that I live near. But rural veterans get less therapy time because my travel is included. Travel hours should be considered under a different allotment of therapy time to provide the same level of treatment. That might resolve a small part of it with regard to some of the rural senior veterans.

There are some younger veterans in northern B.C. They tend to cluster up there, so I hear, maybe isolating themselves a little because of some of the OSI issues they're dealing with. I'm very passionate about that area and would definitely like to see something developed. I would be more than excited to be a travelling OT and pick up these veterans living in remote areas.

As an occupational therapist, I have some different skills that other OTs could learn as well, like frequency capacity evaluations that can be done to help them get onto....

I'm sorry, I think I'm going through your time here.

The Chair: You can go on as you wish. You're our guest. I'm clearly indicating to Mr. Valley that his time is up.

Mrs. Helen Gough: Okay.

A lot of them have pain management issues, and there are certain programs that can be built up. I would love to see one, three, or maybe ten OTs—the more the better—who can go out there and target the new guys being released.

Mr. Roger Valley: How do we get you to northern Ontario? You don't have to answer that.

The Chair: I'm sure she'd be happy to answer it in the next round.

Thank you very much.

[*Translation*]

It is now the Bloc Québécois' turn. Mr. Perron, you have seven minutes.

● (1600)

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Good afternoon, Madam. Thank you for your presentation. However, I believe that your presentation—and correct if I'm wrong—represented nothing less than an ideal. Your work has certainly allowed you to realize that civilians have the same needs as members of the Canadian Forces when they leave their jobs. How can we help our military personnel when we know that throughout this great country there is a huge shortage of professionals, be they physicians or members of your profession?

Please give me the answer.

[*English*]

Mrs. Helen Gough: Wow. If I understand your question, you're asking why the military would be getting these services versus why....

Mr. Gilles-A. Perron: Can we afford to give them to everybody?

Mrs. Helen Gough: I'm here to advocate for my husband as well. I guess I am kind of pushing a product, because I'm sitting here as a military spouse and I would like to have these services. When I tried to find services at certain times when I needed them, when I was posted away from the base, I didn't have them and couldn't find them. I didn't know what they were. So this is my solution.

You're right that it is ideal. But I think that military personnel and their families have special circumstances. I'm sure other people do as well, but this is what I concentrate on.

[*Translation*]

Mr. Gilles-A. Perron: What I'm getting at is that, yes, we have to do everything we can for our Canadian Forces members. However, we can't even provide the minimum to the civilian population. Is it possible to strike a balance between the services you are asking to be provided for the military and those for civilians? I'll just come back to what my friend Mr. Valley said, namely that it's very difficult to find professionals in isolated areas. In the remote areas of Abitibi, where I come from, it is extremely difficult to find a doctor, a nurse or a therapist.

[*English*]

Mrs. Helen Gough: I think they shouldn't be allowed to.... But just because they're relocating, they're being lost. When I moved away from the base, nobody was tracking me. It was my responsibility to seek out treatment, just as it is for any other person. But there should be people who understand what I'm going through and help me connect to those services.

I hope I'm answering your question a little.

[*Translation*]

Mr. Gilles-A. Perron: You're on the right track. Ideally, I believe that your spouse should stay in the armed forces all his life, to receive treatment on a military base and to have a military career spanning 25, 30 or 40 years, and that the armed forces not send him home because they cannot deploy him on a mission any more. The forces should look after him, whether he does nothing or does something else. When CF members go back to civilian life, they have to deal with the same problems as everyone else does on a daily basis, namely finding efficient care, therapists, and so on. There is no problem doing this in Montreal, Toronto or Vancouver, but if you live in North Bay or in Évain in Abitibi, it's not that easy. We are trying to find ways of helping people who live in outlying areas.

● (1605)

[*English*]

Mrs. Helen Gough: I hope I was able to respond to some of your statement in what I answered for the other gentleman. I'm not really sure what kind of question you would like me to answer, unless you have something more you'd like to say.

[*Translation*]

Mr. Gilles-A. Perron: I will make some observations, and then you can address them.

[*English*]

Mrs. Helen Gough: Absolutely, yes, more OTs.

One recommendation I would give, if you want to know of something else, is that if you want to have more occupational therapists in the field, I think enlisting them into the military or allowing them to be enlisted is really going to draw out quite a few people who can't afford post-secondary education or a master's education, because the military is going to pay for that and give them a job when they come out. And that's going to provide more health care services.

[*Translation*]

Mr. Gilles-A. Perron: How do you see that, then? Could your occupational therapists work with civilians? Or, to the contrary, could the armed forces hire civilian occupational therapists to work with military personnel? Would it be possible to train occupational therapists so that they can treat both civilians and Canadian Forces members, instead of having therapists for each area?

[*English*]

Mrs. Helen Gough: This is where the service manual comes in. This is what I'd like to see developed for people who are servicing veterans, all the different veteran types. They would have access to this. This is the compromise I see, the only other way.

The best way an occupational therapist is going to understand the treatment of military personnel and their families is to be embedded, enlisted, to be part of that, as in the United States and as the U.K. is advocating.

The second best thing is to have other health professionals, not just occupational therapists, understand what Veterans Affairs is offering—the programs, the criteria, what Canadian Forces programs are available and where they are, who the area counsellors are and what their numbers are—and also what the mission is, what the vision is, past and present missions that have been going on, the injuries. Have that in a manual. Have that not on a website, not all these different pieces of paper that Veterans Affairs has, which are excellent. It's all out there; it just needs to be put into context and given to these health professionals who are out there.

So all of a sudden, Sergeant Thompson is sitting up there in rural Manitoba, and his nurse has never had a military client and doesn't understand the concepts of what Veterans Affairs gives. Well, it just so happens that...here's my service manual, and I can look up all the different things that Veterans Affairs has to offer. And it just so happens that at the back of the manual someone has decided to provide me, every year, with up-to-date treatment strategies for these families who are up north or in downtown Winnipeg and what can be done with them. These are evidence-based things that have been proven to work.

So yes, civilian occupational therapists, civilian nurses, civilian social workers can effectively treat military families out in rural....

Mr. Gilles-A. Perron: I'm gone. I know. I could feel him.

The Chair: That's why he turns his head.

Mrs. Helen Gough: I hope I answered your question.

The Chair: You are a wonderful witness in terms of being able to help me with my time keeping and that of the member. Thank you very much.

Now on to the New Democratic Party, and Mr. Stoffer, for five minutes.

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

Again, I have to apologize in advance. I have to leave, right after my question, to go to another meeting.

First of all, I want to thank you, sir, for your service and to thank you, Helen, for your service, for allowing us to have your husband serve our country. It's greatly appreciated.

The concern we have, of course, is that we know, sir, that you can't do your job unless your family is taken care of when you're serving your country overseas. If you have children, if you're a parent who has a son or daughter overseas, if you serve overseas, to know that your family back home is okay enables you to do your job. And I think that goes without saying for most of them who are over there.

The concern we have, of course, is in the Auditor General's report that came out a while ago, and she indicated the concerns about the unfortunate lack, not unwillingness, of medical services within DND. They do a great job with what they have; it's just a question of their not having enough. There are not enough doctors, not enough psychologists, and not enough resources at this time to assist that. Brigadier-General Jaeger, I believe, indicated that as well.

One of the concerns the Auditor General indicated was that the government has a moral obligation to look after the families of military personnel, but not a legal one. Some people were questioning whether there should be a legal one. I'm of an open mind on this one right now. I really don't know what the ramifications of that could be or would be.

In your thought process, obviously you would like to have OTs embedded and in places to keep an eye on the families. Would that imply then some sort of over-and-above moral obligation to families, maybe a possible legal obligation to the families as well?

● (1610)

The Chair: Mr. Sweet.

Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC): On a point of order, Mr. Chairman, I appreciate where my colleague is going, but to ask a witness who is not a lawyer, who is an occupational therapist, to make a comment on whether the Government of Canada should have a legal obligation on something is....

This is the first time I've ever mentioned the boundaries of questioning here. It's just that it may imperil the witness in that it's more than what they are knowledgeable of.

The Chair: I think the witness has heard the commentary. I will let her judge her statements accordingly.

Mrs. Helen Gough: If I can be so bold, I have to say that I really don't understand what that all means. I'm sorry, I feel like—

Mr. Peter Stoffer: No, no, that's fair enough.

Mrs. Helen Gough: If it means I get more service...but I don't know, I'm sorry.

Mr. Peter Stoffer: That's fine.

One of the concerns, of course, is finding the resources and the personnel in order to do the work you're asking. This committee was in Shearwater recently, and we spoke to Dr. Heather McKinnon. She indicated that a lot of medical personnel would send veterans over to her, because they had indicated to her that they have difficulty dealing with VAC in regard to veterans' issues. She's a former member of the military herself and she has a clear understanding of what they're going through.

I think this is what you're saying, that if people are trained and have a clear understanding—they may even be members of the military, but in an OT circumstance—then they'll have a much clearer understanding of what your husband goes through and then what you go through. I think that's a wonderful recommendation, and we thank you for that.

Have you had an opportunity, then, or would you take an opportunity later—Mr. Cannan could probably arrange this for you—to speak to the defence committee as well? As Madam Hinton often mentions, some of these issues cross both defence and veterans affairs.

So would you take a future opportunity, do you think, to speak to the defence committee as well? I think your wonderful presentation should be shared among as many people as possible.

Mrs. Helen Gough: That would be an amazing opportunity. As long as they're as nice as this panel, then I'd be happy to.

Mr. Peter Stoffer: Again, I thank you for your efforts.

Finally, are enough people that you know of interested in taking OT as a career? One concern is finding the people to do this. In your circle of knowledge, do you think there's an appetite for young people to get into this field in order to move that forward? It's one thing to say more OTs; it's another to find them.

Mrs. Helen Gough: I think having an opportunity to have your education paid for is definitely a drawing card.

I saw occupational therapists in action. That's why I decided to become an occupational therapist. When people start understanding what occupational therapy is, then I think they will too.

Also, I've applied for a grant to go down to Texas, to the base there, to seek out more information about what occupational therapy could possibly look like in the military. Hopefully I can do that in June, as long as I get the finances to do that. If I can bring that information back, then I'll be able to share that more with people and get them more interested. I hope to write a paper.

Next month I'm also visiting, in Birmingham in the U.K., occupational therapists who are working with veterans there. I want to see what occupational therapy looks like embedded into a military context, and bring that back and share it with people. What does it really look like? Even I don't know what it really looks like. As I mentioned in my opening statements, the Canadian Association of Occupational Therapists is looking to do a needs assessment with DND and the Canadian Forces to find out exactly what we would look like.

So I think people would be interested in occupational therapy that's military-specific. Also, the public sector health care clinicians will have a little bit of an understanding with the service manual that's provided.

● (1615)

Mr. Peter Stoffer: Thank you.

The Chair: I don't normally do this, but I'd like to quickly interject on the question that Mr. Stoffer raised. And I just want some thought on this, not speeches per se.

At the end of the U.S. Civil War, the State of South Carolina spent 97% of its entire budget just paying for amputated limbs. So when we raise the question of legal liability for the services of people on behalf of their state or their country, we sometimes have to be mindful of the implications of that—for whatever that's worth, sir.

Mr. Peter Stoffer: If I may interject, the reason for it is that I have asked before for the clerk to get the minutes of that public accounts meeting out to all of us. The senior military personnel said that this is an issue they would look at. They didn't reject it; they just said it's something they would look at.

The Chair: I understand it's urgent. It has implications above and beyond.

Mr. Peter Stoffer: I know. That's why I said Defence.

The Chair: Okay. Now we're going to head over to the Conservative Party, and Mrs. Hinton, for seven minutes.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): Thank you, Mr. Chair.

Thank you for coming, Helen, and thank you, Captain, for your service to your country. You've been tremendous moral support to your wife today, and I am sure she has been tremendous moral support to you as you've done your job for our country. It's nice to see.

I've been making a number of notes. I listened quite carefully to what you were saying. I certainly have heard from other witnesses regarding a manual or handbook. I think that's actually a very good idea, and it's something that as the veterans affairs committee, we could certainly put forward .

The other thing you mentioned that has to do with treatment of veterans, which is what we're really here about, is that you'd like to see an exclusion of travel time from the number of hours allotted for treatment. That seems like a reasonable thing as well, because if you're a therapist and you have to travel an hour and a half to get to that veteran, it shouldn't come off his occupational time. So that's something we could certainly have a good look at here.

You made some other comments today, though. Let's go back to the medical discharge, someone who is medically discharged from the military, because that person is truly a veteran. That person has been medically discharged, so now we have a problem that we have to help them with. And they're going to move—I'm using your example of the move to Manitoba.

Is there anything standing in the way of a veteran's gathering his medical treatment plan from his current therapist and asking the therapist for a recommendation to another therapist in the new community? Is there anything that prevents that from happening?

Mrs. Helen Gough: No, but I believe the rapport needs to be built before that. There needs to be something before they get there. What's to say it's not going to fall through? What's to say there is no occupational therapist? When you have a mental illness, organization and motivation and those types of things that we take for granted don't necessarily happen. Also, there might be anger in the home. There may be stuff.... I'm sorry, I'm not speaking very eloquently. There might be issues that keep them from reaching out to services on their own.

That would be great. Have a nice little piece of paper with all their treatments and everything, walk in and hand it to an OT, hand it to a nurse. That would be great, but that step does not always happen.

Mrs. Betty Hinton: We're talking about two different things here.

Mrs. Helen Gough: Okay, sorry.

Mrs. Betty Hinton: From my perspective, anyway.

You're talking about someone with a mental illness as a result of service, and I was talking about someone with a physical illness. So in the case of someone who is going through physical therapy of some description, I was wondering if there is anything standing in the way of their getting their medical information and a recommendation from their existing therapist to get one in a new community. That's where I was going with that one.

Mrs. Helen Gough: Yes, that's possible. I think that's happening now. Whether or not there's consistency, I'm not sure. Whether they actually go there and get the therapy, I'm not sure.

Mrs. Betty Hinton: Okay, but going back to what we're looking at in this committee, we're trying to make improvements to the veterans independence program and to veterans' health care in general. As an occupational therapist, can you elaborate on what kinds of services you do provide to our senior veterans?

That would be one question.

And do you believe that occupational therapists are provided with enough knowledge about Veterans Affairs Canada programs to be able to help veterans as they are treating them?

● (1620)

Mrs. Helen Gough: I'm going to answer the second one first.

I started with Veterans Affairs in September, and I honestly can tell you that I had very little knowledge as a private practitioner to understand the system very well. And because I'm one of these crazy people, I went out and made a point of gathering as much information as possible. I feel that it's very convoluted. I really had to pull everything together, and I still don't know if I have it all.

I'm talking just about my little role as an OT and what I needed to do, so I don't even really understand the larger scope of it. I don't know what the rehab team does. I don't really know what nursing does, or the health care team. I can't speak to them. They're excellent. They're knowledgeable and they're accessible. That's definitely a kudo to the VIP program, because I have a direct line to them. But I really didn't feel that I had something that told me what was being offered.

Mrs. Betty Hinton: So if you're going to work for Veterans Affairs Canada as an occupational therapist, you think there should be more information given to that person.

Mrs. Helen Gough: Yes, policies, vendors lists, area counsellors' numbers.

Mrs. Betty Hinton: That's fair. That's actually a very helpful comment.

In one of the other comments you made earlier, you said something about knowing in advance that a person is going to be released. You know months in advance in the military that you're going to be released. I agree with you on that. You would know that you were going to be released from the military in advance. But with a military injury that happens while the now-veteran, then-serving member is in a war zone or on peacekeeping, or whatever it happens to be, there isn't any way to know in advance that the person is going to be injured.

That was just a point, when you were talking about advance notice. It's going to be very hard to touch all those bases.

I didn't get an answer from you on the first one. As an occupational therapist, can you give us an idea of what you do for the veterans?

Mrs. Helen Gough: I'm given an excellent occupational therapy assessment through the Internet, through the web-based Internet, from Veterans Affairs. The assessment form they provide us is absolutely excellent. It covers all areas of everyday life and is very client centred.

I just want to comment that, specifically on the Veterans Affairs assessment, it asks, what are the veteran's wishes and what is their perception of the problem? That's an excellent question to be on there, because it really allows me to start right from scratch with the veteran.

So I walk in and introduce myself, and they usually see me as a little girl and they have trouble taking me seriously for about 10 minutes. After we get over that, I go through their health concerns. I do a physical assessment, I do a mobility assessment, I do a power mobility assessment if that's what they're looking for, and I do a home safety assessment to decrease falls. Those are the types of self-care stuff that I'm looking at.

Occupational therapists, however, can do more than that. That's a very traditional role, a very prescriptive role, but we can do more than that.

I just received a referral for the first time to do pain management with a gentleman who is a veteran, who I believe is in his early eighties. That is something that not very many occupational therapists and the physician get to do. It's something we are able to do, but typically in the VIP program we don't get the opportunity.

I feel that occupational therapists can be used with veterans, senior veterans, in a leisure mandate as well. A lot of these veterans are restless. They lose their spouse. They're sitting at home. They don't sleep, because their bodies don't move. They don't sleep, because they're worried. They're used to bringing their wife to the hospital all the time and they had this role, but they don't do it anymore. So occupational therapists also look at leisure areas and recreation, and I think that should be expanded upon.

We also look at environmental barriers. A lot of these veterans would love to leave their house. I give them a scooter, power mobility, and they love it. But then they can't get to the Legion, because the Legion doesn't have a ramp that goes up.

Well, the cool thing about occupational therapists is that if we had the boundaries to open it up for us to assess the community where this veteran wants to go, we'd be able to allow them to access these recreation places. Then we can provide our recommendations, give them to Veterans Affairs, and hopefully they can be an advocate for their own people and say, “Hey community, hey MP, this is what we need changed in our community to make it more accessible.”

● (1625)

Mrs. Betty Hinton: If we could bottle your enthusiasm and sell it, we'd all be rich. Thank you very much.

The Chair: That's true.

Now we'll go on to what we call our second round. You've taken care of all the parties now, so in the second round everybody just gets five minutes rather than seven.

We'll go again to the official opposition, the Liberal Party of Canada, and Mr. St. Denis, for five minutes.

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

And thank you both for being here today.

I think what might be throwing some of us off in terms of trying to understand the very good work that you and others in your field do is the words “occupational therapy”, because I think we think of it in a different context.

If you had to choose another name or words to describe what you do vis-à-vis veterans, still being occupational therapists, how would you describe yourselves? We've heard about the buddy system, assigning another, maybe younger, healthier veteran to work with an older, not-so-healthy veteran, to kind of be a guide through the system. It seems to me you're professional helpers.

How would you describe yourself, not using the words “occupational therapist”? That's a technical designation.

Mrs. Helen Gough: Right now I have a very traditional role. As an occupational therapist, I work with safety in terms of breaking down barriers, more environmental barriers, so they're safe in their homes. They live there as long as possible, and they love Veterans Affairs because of that, but I'm thinking there's more to it, as I was mentioning. So unfortunately I'm a safety officer right now, but I think it's more than that—if that makes any sense.

Mr. Brent St. Denis: When you start out with your training, is it more general than what you are being called upon to do vis-à-vis veterans?

Mrs. Helen Gough: Absolutely. I'm excited to do more. I feel I have more training to let me do more than what I'm doing.

Mr. Brent St. Denis: So where's the limitation? It would seem to me that leaving aside the issue of how much it would cost to have occupational therapists right across the land—and in an ideal world that would be great, to use your words—there is the limitation from the Veterans Affairs side that says you're assigned to a veteran, Mr. Smith, and you're limited to so many hours or so many visits, that this is all you can do. Is that what it comes down to?

Mrs. Helen Gough: It does, pretty much. The health care team is very accommodating in giving me more hours if there's a more complex case. Without hesitation, they trust me and what I'm doing. If I say this veteran needs a little bit more time, he's having some cognitive limitations with power mobility, we can assign him a rehab assistant to train him on the new power device, for example, which is pretty complicated for someone who's 91 years old.

So we have flexibility, and it's excellent. I've never been declined more hours, but I don't believe the travel time, for example, should be considered therapy time.

● (1630)

Mr. Brent St. Denis: So there's still a gap. Notwithstanding your good intentions in a given case, there are limitations.

Are you permitted to train a child of this veteran who lives nearby, a spouse, or a volunteer to take on some of the less technical work that you do, after you're finished? Because you get a budget allocation, either in hours or per veteran, are you allowed to train somebody to take over?

Let's say it's a literacy issue. They don't understand the forms they get in the mail. Are you allowed to—

Mrs. Helen Gough: That wouldn't be my area. I know the area counsellors are good advocates for that type of thing, but that is a huge barrier I see with my veterans. They will ask me on a number of occasions to help them fill out their forms. They cannot see. I cannot call them on the phone. When I call them, they do not understand what I'm saying. Can you imagine me giving them a 1-800 number? That doesn't work.

But training someone else to do my job? Maybe I'm a control freak, but I wouldn't allow someone else to do that. I like going in. I like making sure I do my follow-up, making sure the equipment is installed correctly, that the easy-lift chair or the power device is still working. And then if there are any outstanding questions and my case is closed, the area counsellor can always follow up.

Mr. Brent St. Denis: Could any of the work you do or some of the gaps that you see need to be filled that you can't do—because you're there and you're seeing these gaps—be solved in some instances with a video? Through the Internet, if they have access to broadband, webcams, and so on, is this a possibility? Or are we dealing with clientele—

Mrs. Helen Gough: I see what you're saying. So you would be able to talk someone through a routine assessment?

Mr. Brent St. Denis: There are certain medical programs through which seniors are checked on several times a day. They have to go to their computer and they have quick access.... Anyway, is there a potential—

Mrs. Helen Gough: That's interesting. I had not thought of something like that, but that is definitely something I would look into to find out more about it.

Mr. Brent St. Denis: The suggestion is yours.

Mrs. Helen Gough: Maybe I'll put that down in the long brief I gave you. Do you need another page?

The Chair: Thank you.

To Mr. St. Denis, there's lots of space in here, so she should have plenty of opportunities to follow up with these solutions.

Now on to *le Bloc Québécois avec Monsieur Bouchard pour cinq minutes.*

[*Translation*]

Mr. Robert Bouchard (Chicoutimi—Le Fjord, BQ): Thank you, Mr. Chairman.

I would also like to thank our witnesses.

If I understood correctly, there are not enough therapists to look after veterans. This is a known situation. I also gathered that veterans do not always receive treatment which is appropriate for them. Is this an organizational problem or is it due to the lack of professionals available to treat veterans?

[*English*]

Mrs. Helen Gough: I'm sorry, but are you asking if some veterans are receiving inappropriate therapy? That's how I understood it, sorry.

[*Translation*]

Mr. Robert Bouchard: In your presentation, you said that some people do not receive appropriate care. That's what I gathered from your presentation. Is this an organizational problem or is the lack of treatment due to the shortage of professionals?

[*English*]

Mrs. Helen Gough: I believe it might be organizational.

My example is that I didn't know where I was.... No one followed me, so no one knew where I was, and no one knew where he was posted. We're posted to Kelowna, but his medical system, for him to go to get his teeth checked, is in Chilliwack, and his.... You know, some people don't have a veteran that.... By the way, when I use the word “veteran”, I mean people like my husband as well. So I'm using that word interchangeably. As I mentioned, there are different types of veterans, in my mind.

So I think it's an organizational problem. If we could track people on these frequent moves, these constantly changing situations these veterans are experiencing, and if they could be watched when they are suddenly released, as she mentioned—because they're in a unique position—then I believe they will get the right care.

I don't know if this is answering your question, but I do believe it's cultural too. I tried to find services on five occasions; I actually went to counsellors five different times. I'm telling you that I really believe that if they understood what the culture was like.... I actually had one counsellor tell me to quit school and to go home. I had another counsellor tell me that I was overreacting, because I broke down about the training of a military soldier who had been killed on a base. One of the counsellors told me she was horrified by the number of times a rocket attack hit my husband's base when I was on the phone with him and a communication lock-down was happening. Those are things I had to deal with. She was horrified, and she couldn't help me with them.

People need to realize those things. I really believe they need to understand that these are things I deal with; for 10 months, these things were constantly happening. So I think there are special circumstances that clinicians need to understand about who we are as military spouses, which I speak as right now. So if people had been tracking me....

So it's an organizational problem, and it's also just cultural.

Hopefully that answers your question, sir.

● (1635)

[*Translation*]

Mr. Robert Bouchard: I have another question for you. You have been involved with the military and you currently work as an occupational therapist. Do you believe that the current culture within the armed forces leads members who are physically or psychologically injured to quit the military?

I have an additional question. Should CF members who have been physically or psychologically affected be encouraged to do something else within the armed forces? In fact, this might be a better kind of therapy. Further, if these people were integrated into the regular forces, it would reduce the number of veterans.

[*English*]

Mrs. Helen Gough: Occupational therapists have the ability to assess the functional ability of a person. You can be certified in functional capacity evaluation, which looks at different components, psychological and physical, of people who are injured psychologically or physically. Once you break that down, you can find out what their capacity is, whether that be physically lifting and moving or whether that be how much of an attention span they have to read a book or be on the computer. Occupational therapists can provide this to soldiers—and they do right now, as third parties—to find out what it is they can do.

If soldiers have decided that enough is enough and that they need to get out, that they can't handle the military, then there is the VAC rehabilitation program. I don't have the specifics on that program, because I'm not involved in it. If they've decided that they want to stay, it is possible that occupational therapists can assist with finding an occupation within the Canadian Forces that is meaningful to them and that they and their families feel is safe and secure and fits their physical needs. If they have an amputation, maybe we can assist them and bring them up to a level so they are able to....

We also have to keep in mind the mandate of soldier readiness. They have to be prepared to go into combat. What that means I don't know, but of course I'm an enthusiastic person, and I think we could probably get them to that level. But we have to keep in mind that they need to be combat-ready. If they're not, then they put other people at....

The Chair: You can go on as long as you want.

Mrs. Helen Gough: You don't want to give me that.

I think there are places in the military for them, if they find that meaningful. We can't just provide them with some desk job that they're not going to be happy with.

The Chair: Thank you.

You got good value for money there. You had five minutes but went to eight. That's pretty good.

Now we're going back to the Conservative Party of Canada. We'll have Mr. Shipley for five minutes.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Thank you, Helen, for coming, and your husband also, for what you are doing.

You mentioned being enthusiastic, which is a bit of fresh air but is also a bit of an understatement with respect to what you must apply to your patients, to the people you meet. You need to know that even though we have professional training, the attitude and enthusiasm an individual brings into the home counts so much. I would say to you that you would be a great therapist to have in anyone's home to help, aside from the professional part of it.

● (1640)

Mrs. Helen Gough: Thank you.

Mr. Bev Shipley: I'm trying to understand the overlap between an occupational therapist and a physiotherapist.

Mrs. Helen Gough: Do you want to know the difference?

Mr. Bev Shipley: Yes. Where is the overlap, or is there one? I think there is. First, I'm trying to understand what the difference might be. Second, what are the benefits of some of those overlaps in terms of the integration that we may have? Right now we have occupational therapists for veterans, but not for the Canadian Forces in our corps of defence. I'm trying to understand a little about the overlap between the two, if you can help me.

Mrs. Helen Gough: Occupational therapists can look at and bridge the psychological and physical limitations of a person. They do quite a bit. Physiotherapists and occupational therapists overlap slightly. They can overlap quite a bit on the physical component. But what we're able to bring to the table is the concept of taking in—it's a fluffy word—the holistic view of a person, including the family. They look at the psychosocial aspects and the cognitive and mental disabilities people have.

Physiotherapists are specialized, and they're excellent. They have been part of the Canadian Forces since, I believe, 2000. They've served in Bosnia, helping soldiers. I think there was a pilot project done with that. They also provide ergonomics in the workforce. I'd like to know a little more about that and where that goes, because I know that occupational therapists also provide that service quite frequently.

Mr. Bev Shipley: Are there other areas of specialty? In the medical field, there are specialists in particular areas. Is that a fact with occupational therapists?

Mrs. Helen Gough: Absolutely. There are hand therapy specialists. I'm currently taking stuff in hand therapy, so that's a specialty area. Not anyone can just walk into it. Really, there's anything. I'm certified in pain management, psychosocial, which is actually, interestingly enough, a pilot project being done in the Canadian Forces now—I don't know if you're aware of it—with a goal attainment program. I'm certified in that. Actually, I'll be using it for the first time with a senior veteran. That's the one I was talking to you about before, and it's going to be really interesting to use. So that's a specialty, of course.

If occupational therapists were embedded into the forces, we would need to send them to do special training. Right now the Brooke Army Medical Center down in Texas is actually a training facility for Canadian Forces health care professionals and can be used for occupational therapist training.

Mr. Bev Shipley: So if they're embedded into the Canadian Forces, they're embedded in. But once someone becomes a veteran and you have specialists in OT, and they get spread out around the country, and they go to small towns where we struggle to have doctors, let alone others.... If occupational therapists are specialists, how do we overcome the issue of veterans who are in small towns having different needs from those dealt with by occupational therapists who actually are specialized and deal with the special issues that are different amongst veterans? Because now they're not embedded, they are dispersed.

Mrs. Helen Gough: Right. I see what you're saying. So if you had the occupational therapist who's embedded and enlisted in the military and the veteran leaves, and now they're being offered an occupational therapist who is a generalist, say, in a rural town, you're wondering what the difference will be.

I think that's where the treatment plan comes into play. How are we going to supply what they've already been given, not only to, say, pain management that they're receiving or if they're receiving vocational counselling? The treatment plan before releasing them is crucial to figuring out what they're going to need over here in rural Manitoba. Now, if you can't supply it, then maybe we need to reconsider the timing. Maybe we actually might have to take that rural OT and get him or her trained in PGAV, with the pain program. Or maybe we have to do those kinds of special little things.

I know this is the ideal. I'm sorry sir, because I know you're saying that other people need it too. But maybe that's what we need to do.

But maybe a lesser solution that doesn't cost as much would be to find a university or a person who specializes in the area of the discipline, say an occupational therapist, and they collect evidence-based new articles that are the most recent things shown to work with veterans with specific problems, that can be distributed to occupational therapists in rural towns, and they're able to reference those. At least they're providing something more than the general treatment that they might be providing now, as I do.

● (1645)

Mr. Bev Shipley: Thank you.

The Chair: Thank you very much.

We now go back over to the official opposition, and to Mr. Russell, for five minutes.

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

Good afternoon. I certainly appreciate the effort you've taken to present us with such detailed information from your perspective, in the particular vein of occupational therapists.

I'd like to build on something that Roger Valley brought up, which is in the papers today, and which is with regard to the effects on military families. It seems that it's not only that the veteran or the soldier suffers, but the family suffers or is affected. So I think we can extrapolate—maybe not one to one—to say that if we're talking about veterans' issues, it's not only the veteran we're dealing with, it's the family.

I'll make the hypothesis that you won't have a really healthy veteran unless you have a healthy family that surrounds that veteran. So if you go into a situation, if you're called in to go to veteran so and so, do you have much interaction with the family? I know you're dealing with senior veterans, and I'm not sure what your experience is with families, but do you deal with the family at all in terms of doing the assessment on the veteran himself or herself?

Mrs. Helen Gough: I get a referral for the veteran. It's impossible for me not to look at the other stuff that's happening; it's impossible. I don't know whether that's just me, or is OT training in me, or what it is, but I definitely do. I know I can't treat the spouse, but I definitely take them into consideration when I'm there.

I feel I have to. They're part of the solution, really. Whether that's my having to train them in strengthening exercise—and I do them at the same time—or whether it be that I just place the grab bar two inches over because that little women and the six-foot-tall man have to.... And those are very prescribed, traditional OT things.

I know that may not sound like a big deal to people who are listening or who are going to be reading this, but little things like that really do help maintain the spouse's staying in the home as long as possible, which keeps the veteran healthy, which keeps him moving, keeps them going and feeding off each other.

So I take them into consideration. As to whether I'm supposed to, maybe I shouldn't be talking like this, but I do take them into consideration.

Mr. Todd Russell: I think that's ultimately the point I'm trying to get at.

You're talking about it in terms of your particular occupation as an occupational therapist. But do you feel that in other professions, other services that may be provided to the veteran, that same type of approach should be taken?

Mrs. Helen Gough: Absolutely.

I realize, though, in saying this, that you're going to have to put more money into it, I guess, because you're going to have to spend longer hours. If you were to say “Helen, you get to treat not only the veteran but the family”, I'd be putting in much longer hours. I may not mind; other people may mind. You'd have to probably put in equipment for the spouse as well. So there are obviously ramifications to saying, “Helen, as an OT you can now go to see the spouse”.

But what I was reading in some of the other things you spoke about, in previous sessions, is that it might cost less to do that in the long run. I'd be happy to do it. I think it's a very holistic approach for occupational therapists to take into consideration. Whether or not it's doable financially is, I guess, for you to decide.

● (1650)

Mr. Todd Russell: Have you been in situations in which you're working with other care professionals dealing with the same veteran?

Mrs. Helen Gough: Yes, actually, that just happened recently. I happened to show up, and a physiotherapist was the community worker for the wife, and so we were able to brainstorm. It was an excellent opportunity. Being an isolated OT, because I'm in private practice, I go in alone, so having that....

Is that what you were asking?

Mr. Todd Russell: Yes. But in terms of a care plan for the veteran...?

Mrs. Helen Gough: Yes. The health care team really does provide —

Mr. Todd Russell: If you're surprised when somebody else is there, is there much sharing and collaboration?

Mrs. Helen Gough: I think there is. If it comes across that our community occupational therapist, sent by Interior Health, is working with a veteran, we'll talk about who's going to take the referral, because obviously we can't overlap. I have access to Veterans Affairs. I literally have access to the phones of the area counsellors. That's excellent, because then I can just pick up the phone and talk with them and bounce things through.

It's the same concerning pressure management, which is a huge issue for veterans, with the nurse. I phone them up. They're right there, so I can collaborate with them, even as a private practitioner, which is great because I'm out on my own. I don't work for Veterans Affairs; I work for myself.

Mr. Todd Russell: What I'm taking from some of your testimony is that we should push Veterans Affairs to take a more holistic approach to the care of veterans—and to doing away with even some of your sense of trepidation about saying “Okay, I'll move the bar two inches”, which I would also say is important—particularly with emotional issues that veterans and their families deal with.

Mrs. Helen Gough: Absolutely.

Mr. Todd Russell: I thank you for sharing that.

Mrs. Helen Gough: Thank you.

The Chair: At this stage, my list is now exhausted, unless—

Oh, I'm sorry, Mr. Sweet; I'm a bad man. I thought you were crossed off already, sir; my humble apologies.

Now it's the turn for Mr. Sweet of the Conservative Party.

Mr. David Sweet: Thank you, Mr. Chair.

The testimony has been so robust and so complete that most of what I needed to know I have learned. But I want to have the witness maybe expand on what she alluded to a number of times, the understanding of the CF culture. Obviously that's very important to you.

In working with other occupational therapists, have you noticed some very clear examples, when someone comes from the public health care system and tries to serve someone who's a veteran, that they have some real lapses in their ability to bridge their service properly into their life?

Mrs. Helen Gough: Which type of veteran do you mean? Are you talking about senior veterans, newly released veterans, or veterans like my husband?

Mr. David Sweet: For any where you've seen an occupational therapist, who is solely used to treating patients in the public arena, now having to come into your role. What kinds of gaps have you seen that are substantial?

There are two things: what kinds of gaps; and second, is there a way to accommodate them? It's quite easy for you, as you live with your husband. Well, sometimes you do. These folks are often away.

Mrs. Helen Gough: He's back today and leaves in a week. I get him home after three months. This is good.

Mr. David Sweet: Another occupational therapist does not have that advantage, has no military experience, so give me an idea about that.

Mrs. Helen Gough: I have an excellent example of this happening two months ago. I typically don't share, if I don't need to, that I'm a military spouse. I can talk their lingo, first of all. I can tell what they've done, and it's amazing how you can build rapport because of that.

I walked into a gentleman's home. He is 92 and can barely walk. He is very enthusiastic. His wife is a veteran as well. They live together in a cute little suite. I went through my whole spiel and didn't talk about combat at this point. I was about to leave and I saw a plaque on the wall. I thanked him for his service and told him it was wonderful. He was a fighter pilot or a mechanic of some sort. He sat down on the walker I had just provided him with—thank you very much, Veterans Affairs—and he started crying. Obviously this had happened before, because his wife didn't react.

He looked at me and said, “I need to tell you something. I need you to know that a young girl came to him and said I had grieving issues, and she went through this whole spiel about how to grieve properly. I just want to tell you a little bit about myself. When I was in the war, I sat at a table with all these other pilots, and then we went out the next day and half of them were gone. We ate at that table, and then they were gone. She came and talked to me about all these ways of grieving so I could deal with it.” He said to me—and I couldn't have said it better—“I need you to know, and I need health nurses to know”—he didn't know what an occupational therapist was—“that we as soldiers grieve differently. We don't use the same services. We don't use the same techniques as civilians would use.” I looked at him and thought, thank you very much for putting it into perspective.

That is exactly what I am trying to say here. Whether or not health professionals are going in, he didn't respond to it. He had all of it. He was there. He knew it. He heard the techniques. But he said he needed something else that was military, soldier-specific, to teach him about grieving—how to grieve at the age of 92, after losing six men, after coming back from war.

They're still worried about that. If you want to know if veterans who are 80 years old have any kind of trauma exposure, ask them how they're sleeping, because what's going to come out is whether or not they are tossing and turning and having nightmares. I don't want my husband at the age of 80 tossing and turning, so I have to sleep in another bed. Some of these veterans' wives sleep in separate rooms because the veterans cry out at night.

I work with a veteran who is 50 years old. He is incontinent at night because he still has nightmares about being on fire and he cannot get out of his bed. These are things they are still dealing with at this time, but what do we do with that? I don't know.

I just put in an application to do research to seek out information on veteran-specific occupational therapy techniques for mental health, and I'm going to do a full literature review to find out what people are using right now for veterans of all ages. Obviously it's not working. I shouldn't say it's not working, because I know that it is, but there are little gaps, and we need to find them.

I hope that answers your question.

● (1655)

Mr. David Sweet: Thank you, Mr. Chair.

The Chair: Always when I say we've had our last question, of course that spurs others. Now we are on to the Liberal Party of Canada, the official opposition, Mr. Valley, for five minutes.

Mr. Roger Valley: You didn't let me finish last time.

The Chair: Sir, carry on.

Mr. Roger Valley: I have a very quick question. We're having a little debate, and this is a new committee. We debate around here about who is our responsibility. I thought I heard you say something, so I want to ask you specifically.

My impression is that when you sign on with the armed forces you become a client of ours because you're going to get to be a veteran. Would you share that? You pointed out your husband, and I took it to mean he'll be our responsibility eventually.

Mrs. Helen Gough: Dare I say I think he's your responsibility now—

Mr. Roger Valley: Thank you very much for that.

Mrs. Helen Gough: —because I do believe there are some veterans like us...and when I say “veteran” in this sense, I mean a veteran like my husband. When we leave the base, we're not near anything. We're not near services. We don't have the military family resource centre at the BCDs in Kelowna. He doesn't have medical treatment. One gentleman who moved out at the same time as he did, as a regular force, hasn't had his teeth checked in two years.

So dare I say that I feel Veterans Affairs should be responsible for those couple of soldiers. There aren't many, but there are a couple of us who move so frequently that we need that support.

Mr. Roger Valley: That's what we noticed when we travelled to the bases, and we have a couple more bases that we're going to right away. That's what the people who are enlisted right now, who are serving right now, seem to believe, that we're going to be there looking after them—

Mrs. Helen Gough: Absolutely.

Mr. Roger Valley: —so they want impact right now.

That's all I had to ask. Thank you very much again for your service. Thank you for enlightening us and thank you for looking after us.

The Chair: Thank you, sir.

Now, Mr. Cannan, I believe you wanted to make some closing remarks.

Mr. Ron Cannan (Kelowna—Lake Country, CPC): Thank you, Mr. Chair.

I'd like to thank Helen and Captain Mike for coming together and for this opportunity to share their experience and their vision of how we can look after our veterans, as men and women who have served, who are serving, and who continue to serve, and those who are in retirement.

It's not hard to get engaged in your compassion and your enthusiasm for this issue. You talked about the whole holistic and multi-disciplinary approach and about coming with a seamless transition—between Veterans Affairs and working with Health Canada—and a more cost-competitive approach. You've done a very extensive brief here. Have you actually looked at costing it out to see what kinds of dollars we're looking at?

● (1700)

Mrs. Helen Gough: No, I haven't. That's definitely not my area. I come as a front-line worker, and I definitely don't have the expertise to look at cost-effectiveness. I assume it would be more cost-effective to use the resources that are already there instead of creating new ones. I think that would be more cost-efficient.

Service manuals. You have the information. Put them together. Assign someone to get it and get them out there. I think service manuals would be less than creating a whole different website and getting one person to walk around and do services, etc.

So no, I haven't, but if you wanted to do that for me, that would help my case.

Some hon. members: Oh, oh!

Mrs. Helen Gough: Ron, will you do that for me?

Mr. Ron Cannan: You're great at delegating.

As mentioned by some of my colleagues, the aspect of skilled labour shortages was raised. For occupational therapists, is there a good intake, and what's the timeline for somebody to enter the program and graduate?

Mrs. Helen Gough: If you do it as long as I have, it's taken an extreme amount of resources and a couple of tours to get me through, but it's been eight years of full-time school. Right now the timeline for occupational therapists to go through, I believe, is four years—it's getting more competitive—and then two years to do your master's as a clinical occupational therapist. There are outlines there now that the Canadian Forces can use, just taking into consideration physiotherapists and social workers who are already being put through the system as military personnel. I think the system is already there; we just need to open that up to occupational therapists.

Is that what you were asking?

Mr. Ron Cannan: Yes.And right now Veterans Affairs does not have any OTs on staff?

Mrs. Helen Gough: Yes, they do. As I mentioned in the opening, Veterans Affairs in the Okanagan has Carole Kennedy, who's the rehabilitation assistant. She also has the contract for district occupational therapists and she gives out referrals. She has got on the rehabilitation team.

I can't really speak too much about the rehabilitation team. I really would recommend the committee look into it, because that health care team is what the new releasing members are going to be using. I would love to see somebody look into it because I'd like to know more about it. I'm not sure if there are any occupational therapists in other districts across Canada on the rehabilitation team. If there aren't, I'd put it out as a recommendation, that there should be an occupational therapist on the rehabilitation team who's connected to the Canadian Forces team. Hypothetically there's an OT in the forces at that point, they connect up together, and it's those two who are actually being used to create the treatment plan.

Mr. Ron Cannan: That's what I was wondering. That's where you get that seamless plan.

Mrs. Helen Gough: Exactly, yes.

Mr. Ron Cannan: Okay, thank you. It's all coming together.

And I'd like to thank your mom and your sister for their support as well, for coming all the way from London, Ontario, today. So thank you.

And happy birthday, Mike.

The Chair: Hear, hear!

Mr. Ron Cannan: We really appreciate your support for veterans and your serving our country. And it's a loss to the Okanagan.

For our committee, Captain Mike's getting transferred to Alberta.

Mrs. Helen Gough: We got our posting message yesterday.

Mr. Ron Cannan: Yes.

Thank you very much.

Mrs. Helen Gough: He's only been in there for five months, in the Okanagan. There you go.

The Chair: Well, welcome to Alberta. We can always use more soldiers.

I appreciate your taking the time. I particularly appreciated some of the stories you shared about some of the veterans you've dealt with. I think they were touching and appropriate, given the issues we're dealing with. So I deeply appreciate that.

At that stage, as committee members, I know we are minutes away from a vote in the House of Commons. I'll just touch on one thing. I usually wrap this up by kind of rolling us into the next series of business. So if committee members wish to say good-bye or shake hands, etc., I'm just going to carry on as chair doing what we do here.

I want to let members know that we still have some more witnesses to appear with regard to this study we're doing. We also have the trips that are coming up, to Petawawa, etc.

Now, we still have some spaces coming up—I think it's Thursday next week—and there are two things that are kind of rattling around as issues. One is that whenever this Parliament wraps up, I think it is of value.... Mr. Stoffer moved the motion in a previous committee meeting some time ago, but I think this idea of separating Veterans Affairs from National Defence has served veterans well. And regarding the idea of decorating the room and designating it as such, the clerk and I were talking about the letter that's going to the Speaker of the House. I think that has value, serving as a precedent for future Parliaments with regard to carrying that type of tradition on.

Anyhow, it's something we may want to consider in that Thursday meeting or some of the ones we have upcoming, after the witnesses are extinguished, with regard to what types of things we want to designate in that regard.

The other thing is this idea of a comparison study with some of the other countries and their veteran services. I know the witness today touched on the United States in terms of some of the services they provide. I know Mr. Perron has touched on that before with regard to post-traumatic stress disorder in Vietnam veterans, etc., and then there's just some suggestions down here.

Mr. St. Denis.

● (1705)

Mr. Brent St. Denis: While you were talking about some of the things we could do in the future, you said we have a little bit of time between now and the return from the Valcartier trip?

The Chair: I don't want to speak out of turn, sir, without having too much knowledge at my fingertips. I believe it's two Thursdays from now, not this Thursday but the next Thursday.

Mr. Brent St. Denis: Okay, because I wonder if, rather than losing a day, we could have one quick look at the report. A reread together wouldn't be a bad idea too, in my view. We could do it on the bus.

The Chair: Yes.

Mr. Brent St. Denis: Bring a bottle of Gravol and....

The Chair: Yes, that's actually something—

Mr. Brent St. Denis: I don't read on moving vehicles very well, but I would try.

The Chair: No, I think that's actually something we need to make sure we serve notice to Michel with regard to, as well. The intention, of course, and we've discussed this at previous meetings, is to have our trips—we've heard a number of witnesses—and come to a wrap-up with regard to a report and recommendations, just so he's apprised and knows that's coming up.

Are you suggesting then, sir, maybe for that Thursday upcoming, that we have some sort of a draft?

Mr. Brent St. Denis: Yes. We may hear something in the two base visits that's important, but the context and all of that.... The most I could imagine changing is a recommendation, a sentence here or there. I thought we could do the homework on the body of it, so we can spend more time afterward on the recommendations. I know we went through it once, but it was tweaked at the meeting, and I think a —

The Chair: A revisit, then.

Mr. Brent St. Denis: A revisit, because it's important enough that I think a second reading wouldn't hurt at all.

The Chair: I think that's very fair.

Michel, can you keep that in mind for that Thursday coming up?

As I said, we're just minutes away now from the vote, so I'll just go ahead and adjourn.

This meeting is adjourned.

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