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Chair

Ms. Niki Ashton

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● (1530)

[*English*]

The Chair (Ms. Niki Ashton (Churchill, NDP)): I call this meeting to order.

I'd like to begin by welcoming our witnesses today.

Hugh Armstrong, who is a professor, will be speaking to us today. We also have Judith Wahl, executive director of the Advocacy Centre for the Elderly.

Each of you will have ten minutes, and then we'll open it up to questions from the members.

If you're ready, Mr. Armstrong, we're ready for you.

Professor Hugh Armstrong (As an Individual): Thank you. I'm as ready as I'm going to get, I guess.

Thanks very much for the invitation to appear before you on the important issue of the abuse of older women. I'm here as a researcher who has, with Professor Pat Armstrong and others, for the last 15 years or so been examining the health of older women and men.

As I'm sure you all know, the majority of older Canadians are female, and this female majority increases with age. Their care providers, both paid and unpaid, are overwhelmingly female, and are on average getting older as well.

I mention the providers along with the recipients of care, because we know that the better the working conditions for care, the better the care is likely to be.

Our research has of late focused on the essential but relatively unexamined group of providers usually called personal support workers, or PSWs. They particularly work in home care and in long-term residential care facilities. They are typically unlicensed, not considered to be professionals, and often not even counted as health care providers.

Not only are PSWs relatively invisible in academic and policy discussions, so too are long-term residential care facilities—nursing homes, as they're often labeled. These homes are typically seen to indicate failure: failure of the individual to remain sufficiently independent, failure of the individual's family to provide needed care, and indeed failure of the medical profession to provide cure.

How are we to understand abuse in nursing homes, where about 200,000 Canadians live and more will live in the years to come? By one estimate, an additional 120,000 will live there by 2041. About one in five aged 85-plus now lives there. About 70% are women, and their paid care is provided by a workforce that is as high as 95% female.

So we're talking about a gendered living and working environment. Its female domination, in terms of numbers if not power, combined with its reputation as a site for failure, goes a long way to explaining why the nursing home sector is under-resourced, undervalued, and under-researched, and why it is a site for the abuse of workers as well as residents.

Our approach to the study of abuse owes much to what Paul Farmer calls structural violence. He is a U.S. medical doctor who has long worked in the central plateau of rural Haiti, where he has analyzed what, for example, lies behind the death of a young woman with AIDS. What lies behind is a set of human decisions, decisions that are responsible, directly or indirectly, for the death of this woman and other deaths—so too with our examination of the abuse experienced by both workers and residents in Canadian nursing homes.

Structural violence defies easy description. The specific instances are often hidden from view. The victims are typically anonymous, with little opportunity to have their voices heard. The distribution of the violence is embedded in cultural, historical, and political economy contexts that are difficult to disentangle. But with some persistence, the violence veil can be lifted.

In one survey conducted in 2006, we asked PSWs how often they experienced physical violence at the hands of nursing home residents and their relatives. Fully 43% reported suffering such violence on a daily or almost daily basis.

It need not be this way. Our survey was adapted from one conducted the previous year in four Nordic countries, where 6.6% of comparable workers in comparable facilities reported experiencing daily or almost daily violence.

In other words, the Canadian experience with violence was over six times greater than that found in Denmark, Finland, Norway, and Sweden taken together. The weekly rate in Nordic Europe was an additional 11.1%, by contrast with the Canadian rate of an added 23.1%.

Moreover, the Canadian survey question was restricted to actual violence. The Nordic question also included the threat of violence, making the Canada-Nordic gap even greater than over sixfold.

● (1535)

When we conducted follow-up group interviews with Canadian PSWs to validate, elaborate on, and explain the survey findings, we learned of widespread under-reporting of the violence—not only to management and to workers' compensation, but also to our survey itself.

The paperwork involved in preparing written reports is onerous and time-consuming. Management too often blames the workers for any reported incident. The workers in turn don't want to make life worse for their residents—for instance, through the imposition of physical or medication restraints.

Most importantly, violence in long-term care is normalized. It is seen as just part of the job, in Canada if not in Nordic Europe.

What lies behind this stark contrast between Canada and Nordic Europe? It's not differences in the characteristics of the resident populations, for they have similar age and sex profiles and similar percentages with cognitive impairments. Instead, we must look at the underlying working conditions.

We asked, for example, about basic tasks that are left undone. You'll perhaps be encouraged to learn that the Canadian residents are almost always fed. Other tasks left undone, in increasing order of frequency, are bed changing, changing clothes, turning, toileting, bathing, teeth brushing, and, at the bottom of the list, foot care.

With only 15% of residents always receiving needed foot care in Canada, can we be surprised that mobility is so low and pain and frustration so high?

Staffing levels in Canada, and especially in our for-profit facilities, are too low to provide adequate care. Moreover, the official staffing numbers tend to conceal how many workers are actually at work. Short-staffing occurs when workers who are sick or on vacation are not replaced and when positions are left vacant. Among Canadian workers, 46.2% report working short-staffed more or less every day. For Nordic countries, the figure is 15.4%, or one-third, as prevalent.

In addition to staffing levels, there are differences in the degree of worker control and autonomy. Only 24.4% of the Canadian workers can influence the planning of their day's work all or most of the time, as against 45% for their Nordic counterparts. The Canadians report being not trusted and report being too closely monitored by their supervisors, 27.4% versus 7.9% in Nordic Europe. They lack sufficient time to discuss difficulties with colleagues all or most of the time, 80.5% as against 46.6%.

Facing all these working conditions—and more, which I lack the time to discuss this afternoon—it is no surprise that frustrated and uncomfortable residents strike out at PSWs.

So far, I've touched on basic physical activities like eating, dressing and toileting. Also important for health and well-being is what might be termed social care. When we asked PSWs about sitting for a cup of coffee or tea with a resident, over half responded that this rarely, if ever, occurs. Surprisingly, it is even more uncommon in Finland, but in the rest of Nordic Europe this is the case for less than a third. In Denmark, only one in six report that this seldom if ever happens.

Another social care question concerns how often workers accompany residents for a walk. We were frankly surprised to learn that the Canadian rates were higher, so we pursued the issue. It turns out that in Nordic Europe this question was interpreted to mean a leisurely walk outside the facility, whereas in Canada it meant walking a resident to a meal or to a toilet. When we asked in Canadian group interviews about walks outside the facilities, a common response was laughter to this bizarre question or suggestion.

I am going to close with another instance of what we term structural violence—that is to say, abuse that need not occur.

We asked in the group interviews about the use of incontinence pads, or adult diapers. Here's what they told us.

They talked about the recent introduction—this was five years ago—of disposable paper diapers that are made available only grudgingly, perhaps only one per resident per shift. The workers try to “steal”—that's their term—and hide extra diapers for their residents, but they face “diaper police”—again their term—or managers who search out and repossess all the hidden stuff.

● (1540)

The innovation contained in these disposable diapers is that they indicate when the saturation level reaches 75%. The workers are firmly instructed not to change the diapers until this level is reached.

They do their best to care for their residents, but they don't feel good about what they have to do. Indeed, they feel abused themselves, and fully understand the violence they experience from residents confronted by such discomfort and indignity. As one PSW put it to us, “I'd hit out too if you left me in that.”

Abuse needs to be understood as the direct or indirect consequence of decisions made by people in power. The abuse may be experienced by the workers, the residents, or both. My focus has been primarily on what the workers experience, but the abuse against workers and the abuse against residents are linked, just as, in my view, the presentations by Judith Wahl and I are complementary. Care is a relationship, and the conditions of care work establish the conditions of care.

Thank you.

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

We can now move on to Ms. Judith Wahl.

Mrs. Judith A. Wahl (Executive Director, Advocacy Centre for the Elderly): I too want to thank you for giving me the opportunity to present to you. I apologize for the lack of a written submission. I only got the call last week to present, but I will be providing some other written material for your review.

I want to give you a context for my remarks. I work at the Advocacy Centre for the Elderly. I'm the senior lawyer. I'm a legal practitioner. As you can tell from my grey hair, I'm an old lawyer. I've been a lawyer now for 35 years, and I've been at the Advocacy Centre for the Elderly for 27 years.

The Advocacy Centre for the Elderly is a community legal clinic that provides legal services to low-income seniors across the province of Ontario. All of our practice is focused on legal problems experienced by older adults. Almost all of our litigation is related to various forms of abuse. The majority of our casework and client representation involves advice to and representation of older adults who are victims of abuse, primarily by family or close friends, people they expected to trust but who then took advantage of them. We've dealt with the full range of abuse, primarily financial abuse. But unfortunately, we've dealt with cases of sexual abuse, physical abuse, and emotional abuse, many of which were Criminal Code offences.

We also deal with a lot of abuse in the systems that are meant to assist seniors. We call this systemic abuse, and it's all those services that are supposed to provide the supports but that don't necessarily follow the law. We often call this “good law, bad practice”. We see this, for example, in hospital discharge policies. We actually take the position that almost every hospital in Ontario, and I would say across the country, probably has an illegal discharge policy that ignores seniors' legal rights in respect of choice and their role in decision-making in the health system.

In Ontario there's an effort to try to get seniors to pay high per diems that are outside the OHIP ranges. This is just an example that we see in practice, but we see this across all kinds of practice. The diaper example is a good one. The law in Ontario, and I would say, again, across the country, in each province, is that people are intended to be kept clean and dry at all times; having 75% on the diaper isn't necessarily clean and dry. It victimizes the workers and the seniors involved.

We have had experience with hundreds, if not thousands, of abuse cases, and have had experience seeking remedies for our clients. We also have experience doing public legal education on elder abuse prevention and the various legal issues, such as power of attorney. It is a key tool that in fact is not supportive of seniors but is used to financially abuse seniors, even though doing a power of attorney is often promoted in provincial and federal elder abuse campaigns.

I have actually had a lot of contact with the federal-provincial-territorial committee that has been working on elder abuse issues, and I was very pleased that I was asked to contribute to the review of the pamphlets. The pamphlets were amended to reflect that you have to use caution when using powers of attorney. I think those are important messages that come out through those campaigns.

Our primary focus in the education is to seniors, for knowledge of prevention, but also to service providers of all types—health professionals, police, home care workers, and front-line staff in various service agencies—so that they'll know the law, develop their own policies and practice on elder abuse prevention, give a response that is within a legal framework, and challenge their own misconceptions about aging and abuse. Those misconceptions often contribute to the abuse.

Please note that the law on elder abuse is not only about the Criminal Code or adult protection. Krista James, from the Canadian Centre for Elder Law, is actually a friend of mine, and she shared with me her submissions. She ably outlined all of that kind of legislation. I encourage you to look at the materials she's produced.

I can tell you that in practice, we actually use the law across the board. We use family law, privacy law, health law, law in capacity and decision-making, real estate law, and consumer law, all in providing elder abuse response.

What I'm really pitching to you is to look at the broader scope of elder abuse. That's what we use to help our clients. The federal response to elder abuse also needs to look beyond the Criminal Code and elder abuse awareness in a narrow sense. You need to look at the federal role in health funding, housing, legal aid, and privacy, as a few examples.

Because there's limited time, I'm going to go right to some recommendations. The theme I'm going to give you is about training, tools, and time, not necessarily law reform.

First is criminal law. The Criminal Code itself, in my opinion, works quite well. It's good law, but I think some of the practices in respect of the implementation of the law are the real problem.

● (1545)

The Criminal Code includes various sections that respond well to elder abuse. We don't need a special offence of elder abuse. In fact, if you had a special offence, that actually would divert attention from the theft and physical assault and all the different core crimes and would end up limiting a response and create barriers to prosecution.

The Criminal Code also includes sections to accommodate special needs of older victims of abuse in giving testimony and in giving evidence in advance of a trial to both preserve the evidence and to ensure that the prosecution can continue, even if the older witness is unable by physical or mental disability to testify at the time of trial of the accused. There are provisions in the code for audio and video taping of evidence—they're called “KGB statements”—that can be used as evidence.

The Criminal Code sentencing provisions are also good in the sense that if the victim is an older adult, that is taken into account and could be a factor in considering the sentence.

But as to the challenge in the criminal justice system, I would go, again, training, tools, and time. With respect to the training of police officers, I've been involved in a great deal of training at the Ontario Police College and the Toronto Police College. There's a need for training in dealing with investigation of crimes against the elderly in different settings. The police need to know the law related to long-term care, privacy, capacity, retirement homes, home care, and resources in the community to support older victims, especially to help them address the reluctance of older witnesses to testify, or to even complain.

In the course of the education that we do, I frequently have the officers chant “Talk to the senior”, just to get the message across that they need to focus on the senior. Many times in investigations in the past, some officers have told me that they talked to everybody around the senior, but not the senior. It's more challenging to deal with the senior. There may be a communication challenge, or the person may appear more frail than they are. Although they may be still very capable, very able, people will still talk around them. So it's looking more from the senior's perspective.

The next is tools. I have one simple example of tools that the police need. We have provisions about videotaped evidence. I have been told by a number of police officers that they don't have the videotape equipment so they can't take the evidence. How are you going to use those provisions? That's a very important thing. There was a recent Supreme Court of Canada case, Regina v. Khelawon, that dealt with this particular issue. The evidence was thrown out, I think partly because the officers didn't do the whole gamut of things they were supposed to do in order to preserve the evidence. They may not have been supported; they may not have had the tools.

The next is time. We need time to ensure that the police are given time to do investigations of abuse cases. Some of these crimes are very challenging, I know. I've had a lot of contact with the Ottawa police, who have an elder-abuse unit. I can think of one of the offences that the police investigated. It was a case of multiple offences by a PSW who was financially abusing seniors. They were all small amounts of financial abuse. Cumulatively, she had stolen thousands. To do that investigation on all those small bits, the police don't necessarily get the supports to do that. This unit did. But if you're a police officer in Toronto and other cities, they might not get the supports and the time to do that. They would simply say they don't have the time to do it.

So that's training, tools, and time. I now want to go on to privacy. I'm going to say, respectfully, there's a need to amend Bill C-12. This is a bill that's now on the table to amend the privacy legislation, because the amendment to proposed subsection 7(3) will open the door to increased financial abuse of older adults, not increased protection.

This amendment will permit disclosure by federally regulated financial institutions, such as a bank, to the client's next of kin, or the authorized representative of the client, in the belief by the bank personnel that the senior, who is the client of the bank, is a victim of financial abuse. So it's giving permission to the bank to disclose private information about the senior's account on the assumption that the senior is a victim of abuse. Disclosure is to the family members of the senior. It also says to other governmental organizations.

This amendment, to permit the disclosure to next of kin and authorized representatives of the seniors, I think needs to be changed, because those are the abusers. Almost every single case we've had over the years on financial abuse is abuse by family and friends.

● (1550)

This amendment will permit the banks to tip off the potential abusers, to inform them of the abuse. What can the banks do now? The banks actually can talk to their customers. They can start with the senior. If the senior is incapable, they can then contact the governmental institutions. That amendment is fine.

For example, in Ontario, they would contact the Office of the Public Guardian and Trustee, who could investigate the allegation that the senior is not capable. Then, if the senior is capable, they can help provide supports to that senior through assistance in going to the police or a legal organization to address the abuse. Or they could become their guardian to regularize the situation.

So the reports to the public—

The Chair: Ms. Wahl, I'm sorry to interrupt. We have just a few seconds left. Please conclude your thoughts.

Mrs. Judith A. Wahl: Okay.

So there are the PIPEDA amendments, and also, I would say in summary, there's a need for funding for legal aid. My centre has been the only legal aid service for seniors for 25 years. There's now one in British Columbia, and there's a little unit in Alberta. I think there's a need for additional legal aid services, because otherwise seniors don't know their rights. They can't get assistance on the civil side.

The Chair: Thank you very much.

Mrs. Ambler.

Mrs. Stella Ambler (Mississauga South, CPC): Thank you, Madam Chair.

My thanks to our witnesses for appearing today. I appreciate your thoughtful presentations. I have a few questions.

Dr. Armstrong, I am curious about the comparison between the personal support workers in Canada versus those in the Nordic countries. I found the statistics that you quoted interesting, but really disturbing. I'm wondering about the difference. You mentioned underlying working conditions, low staffing numbers, and so on. I'd like to explore what we can learn from how they do things in institutions in Nordic countries versus the mistakes that we're making here that result in a 43% violence rate against personal support workers.

Do you think there's a lack of respect for people who work in the business of looking after seniors? That's the first thing. Then I'd like to know if you've come across examples of institutions that are trying to combat this problem. I'm concerned that it's this pan-institutional problem. There must be in Canada some institutions that are better than others. If so, what are they doing that other institutions are not doing to support their workers in treating their seniors better?

● (1555)

Prof. Hugh Armstrong: I'm 68, and I'm thinking ahead. I too would like some better places around, and so that's what our big current project is looking at, what we call "promising practices"—not "best practices", because that term is by definition decontextualized. You can't simply import something from one place and put it in another.

Certainly we've found some promising practices in Canada. We're looking for some more. The current study involves not only Sweden and Norway but also Germany, Scotland, England, Texas, and California, as well as five Canadian provinces. We're casting a pretty broad net. It's a seven-year study, so I can't report a lot on it yet, but I can certainly say that I've been at Abbotsford House here in Ottawa, for example, which I think is doing a lot of things right. We have had a meeting with the folks at Baycrest in Toronto, and I think they're doing a lot of things right.

Certainly, when you talk in terms of averages, or the sort of gross statistics I spoke of, you miss a lot of the variance between the good and the not-so-good.

Another thing I will say is that one of our research collaborators on the current project is Margaret McGregor. She wrote a paper for the IRPP a few months ago, and she looked at a whole range of studies and found that one big difference is that not-for-profit facilities tend to do better than for-profit. The reason is pretty straightforward. They tend to get the same kind of money. Sometimes the not-for-profits get a bit more because they get charitable donations, and the municipal homes for the aged, as they used to be called, sometimes get a bit extra because the municipality kicks in. But on the other side, the for-profits take money out for the obvious reason that they have to extract profit. The for-profits tend to have even lower staffing levels than the not-for-profits, and our argument is that the not-for-profit levels are too low.

There were some good studies in the States on hours of direct nursing care per resident per day, and the studies differ somewhat, but they usually come in at 3.75 hours per day. No Canadian jurisdiction meets that, so it's partly just a matter of resource availability. We treat the homes as embarrassing places we don't want to think about. We treat the workers as low-paid, low-skilled workers who we aren't going to think about much. That's one factor.

Another, which doesn't entail people having their hands out for more money, is how the work is organized. One of the things we found in the Nordic countries is that the workers have a lot more control over their work, so they can decide, well, today this person needs more help, or perhaps I will spend some extra time having a cup of coffee with that person, because then I will build up a relationship of trust and familiarity, and I'll be able to read the body language better; this person may be cognitively impaired, but there are degrees of impairment, and she will recognize me and I can help that person better in the bath and not get scratched because I'm not doing it the way she wants.

So the two main things are, I would say, staffing levels and also workers having more respect, more control, and more autonomy in what they do.

● (1600)

Mrs. Stella Ambler: Thank you. That's interesting.

Do you think inadequate staff screening is part of the problem here in Canada, or perhaps screening training? Or are there other factors?

Prof. Hugh Armstrong: I'm a university professor. I'm always in favour of education.

That said, I don't think training is the main thing. We've been impressed by how skilled, how sensitive, how knowledgeable these workers are. They're not credentialed in the main, although they are beginning to get credentials. They work more unpaid hours than even hospital workers, and hospital workers donate more hours than do other workers. These are highly committed, highly skilled workers in a difficult situation.

I'm all in favour of their having more training, especially as more of the residents come in at younger ages; they get kicked out of psychiatric hospitals.

The Chair: We'll have to end there, Mr. Armstrong. Maybe we can pick up in the following questions.

We'll go to Ms. Mathyssen.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you, Madam Chair.

I want to thank you both for your presentations. I think you've shed a great deal of light.

I have many questions. I'll try to be succinct.

Dr. Armstrong, the question was about how we can improve the system, how we can achieve the kind of positive results we would want for our seniors. In about three years, the federal government is going to undertake a review of the Canada Health Act with the provinces. It seems to me that this review would be a golden opportunity to take a look at home care and long-term care and for the federal government to compel the provision of more funding and that it be part of what the provinces must deliver.

Is that a reasonable statement in terms of how we could achieve better results?

Prof. Hugh Armstrong: There are a couple of things I'd say about the renewed accord in 2014.

One, I hope that like the last time around it will be stable and predictable for a number of years. The provinces and territories need that.

The second thing I would say is that medicare is working in the main, and it's very popular, but it's insufficient. You've identified two of the main areas where we need somehow to figure out how to expand it, probably without touching the existing 1984 Canada Health Act but supplementing it with new legislation that goes along the same directions. That's the second thing I would say, and I would pharmacare to home care and long-term residential care.

The next thing I would say is that the Canada Health Act should be enforced, and it should be enforced on the federal government. It's the federal government that hands over the money based on conditions, and it doesn't enforce. I mean, sometimes $5,000 because somebody did some extra billing in B.C. or something...but basically, in my view—and this is a personal view not backed up by the research I've done—the federal government should be showing more leadership. It did in the establishment of what we call medicare.

Times have changed. People don't stay in hospital nearly as long, for good reasons as well as for not-so-good reasons.

We need to amend the overall system to make it more of a system.

Ms. Irene Mathyssen: So instead of finding fault with the PSW, we have to look to the federal government.

Ms. Wahl, I was very interested in everything you had to say as well. On the whole, my sense was that you're saying that you're against protectionist legislation. We know that there is an effort ongoing by the federal government to bring in more legislation geared at stemming elder abuse.

Could you talk about why the laws, while well-intentioned, don't work in practice?

● (1605)

Mrs. Judith A. Wahl: More protectionist legislation is not going to fix the elder abuse. It's a band-aid, in my opinion. That's my experience in looking at the adult protection legislation that's in some of the provinces in Canada.

I also have had information from Charmaine Spencer, who I know also testified, who has been doing research specifically on adult protection, and I share her same approach to this.

It doesn't work because it's reporting to a third party, who then is supposed to respond. I must tell you that when I 've done that research.... Now, I'm not researcher like Dr. Armstrong, but when I've done that inquiry about, “Okay, so then what are the responses?”, I've found that the response system doesn't respond, or else they refer the senior back to the very services who reported to the response system.

So it's using money that should be going into direct services for this side service that makes it look like something's being done but nothing is being done.

The experience in many jurisdictions is that this kind of legislation just ends up dealing primarily with what I'll call it self-abuse, the person who has deteriorated, the people with capacity issues, the hoarders, the people who are living at jeopardy in the community alone. It deals with those, but not with those like the gentleman who we assisted who was living in a mansion in Rosedale who had given power of attorney to a friend. He was in his nineties. He was losing capacity, and his friend then took more than $1 million from him without his knowledge.

Fortunately, a relative of his helped him to get to us, and we assisted him in getting recovery. Unfortunately, the man died before everything was concluded.

So it's that kind of thing. It's not going to be picked up by some kind of magic reporting system.

Ms. Irene Mathyssen: I'll try to be succinct, Madam Chair.

So we've heard that we need proper health care funding and to include long-term care and home care. You made reference to housing. One of my concerns is what we heard in regard to seniors being vulnerable to abuse because they're stuck in housing that is unaffordable or they're prone to abuse because they're vulnerable. They cannot find adequate housing.

Do we need a national housing policy that extends to senior populations? Do we need a housing policy, period?

Mrs. Judith A. Wahl: I do believe we need a housing policy. There are some people who will need alternative housing, either to get away from the abusers or because.... I'm living in Toronto, and I have a lot of clients who are house rich, cash poor. They live in these houses that are falling down around them. They really need to leave.

They actually will get money out of that, but there's a certain percentage of people who are very poor who don't have the money from the sale of a house to accommodate them. They have nowhere to go. They need some support. They need housing with supports. That is also really lacking. We're ending up by leaving this to a private industry, the retirement home industry. A lot of seniors can't afford to get that housing with supports. We need a national housing agenda.

Ms. Irene Mathyssen: Thank you.

Prof. Hugh Armstrong: Can I add a quick comment to that?

The Chair: You have ten seconds.

Prof. Hugh Armstrong: Thank you, Chair.

When we were in Sweden, we asked about long-term residential care. Our Swedish hosts had trouble finding it for us because it looks like the rest of the housing. It's not segregated or stigmatized.

Ms. Irene Mathyssen: It sounds like a healthy community.

The Chair: Perfect. Thank you very much.

We'll now go to Ms. Young.

Ms. Wai Young (Vancouver South, CPC): I'd like to also thank both of you for coming. You obviously have a huge range of experience between the two of you. Some of our previous witnesses have been very enlightening as well. Thank you both for your insightful presentations.

I have a mother who's 78 and who's in her third seniors housing situation, so I know a fair bit about seniors housing—in B.C., anyway, because I'm from Vancouver. I also certainly know about senior abuse, because she has spent four years in the court system and is just settling her situation there, some of which did include abuse. She actually had a home invasion where the police refused to take any kind of report. We finally had to push that whole agenda. She has gone through court and everything else.

Anyway, I don't want to bore you with her details, because I know you've probably heard it a thousand times. I want to zone in on certain things and certain comments that have been made here.

I'll start with you, Professor Armstrong. You mentioned that you're doing a seven-year study. Can you tell us who's funding the study?

● (1610)

Prof. Hugh Armstrong: I'm delighted to tell you that it's the people of Canada, through the Social Sciences and Humanities Research Council. We got in just under the wire before SSHRC decided that they weren't going to consider any projects that had to do with health.

I think this was a disastrous decision on their part. They basically said that they don't get enough money, and since CIHR—the Canadian Institutes for Health Research—gets a lot more, why don't they do everything to do with health?

The trouble is that CIHR came from the Medical Research Council—

Ms. Wai Young: In the interest of time, can you just tell me how much the study is being funded for?

Prof. Hugh Armstrong: It's $2.5 million over seven years. There are 25 co-investigators.

Ms. Wai Young: It sounds quite comprehensive, would you say?

Prof. Hugh Armstrong: We're trying, yes. Several countries—

Ms. Wai Young: You sound fairly happy with this.

This government has funded a whole series of studies, because we also heard from Dr. Lynn McDonald, the scientific director of the National Initiative for the Care of the Elderly. She has said that HRSDC has put in a pile of money and we have conducted numerous studies on this. We certainly heard this from the witnesses.

Would you say that today, as compared to five years ago, more money has been put into research on this specific subject than before?

Prof. Hugh Armstrong: No, I wouldn't. I think it's a different kind of research, more located in the medical profession and in related health professions. It's very difficult for social science and humanities researchers to get money these days.

That's what I was speaking to when talking about SSHRC having gotten out of the field. I very much hope they get back in.

Ms. Wai Young: All right, so you're not aware of the fact that there has been more money put into this, then?

Prof. Hugh Armstrong: I know there's more money every year, and even in real terms, after inflation, there is more money, no question. It's more a matter—

Ms. Wai Young: So there is more money, then. That's not what you just said. You said the opposite.

I just need some clarity for the purposes of knowing.

Prof. Hugh Armstrong: I come from the social sciences. My closest collaborators in our current project and elsewhere are in the social sciences and humanities. We are finding it more difficult. There is more money going into medical research.

Ms. Wai Young: Thank you so much, Dr. Armstrong. I'm a sociologist. I come from the social sciences as well. So I do know that there has been more money. Can you confirm for this committee that there has been more money put into the study of this area?

Prof. Hugh Armstrong: No, I cannot.

Ms. Wai Young: Okay.

Judith Wahl, I have a question for you as well.

Sorry, I'm rushing through and I apologize. We have very little time.

You, Ms. Wahl, have said that using money that is going out but not being used very effectively.... Actually, I would really support that statement. I think that's very true. As you know, this government under the Public Health Agency has something called the family violence initiative. The Public Health Agency of Canada coordinates 15 partner departments, agencies, and crown corporations who are looking into senior abuse and all of this.

I would imagine that within 15 partner departments, agencies, and crown corporations, we probably spend tens or hundreds of millions of dollars, in hundreds of programs and services, because I am a sociologist, and I'm familiar with some of these, having walked through the service end with my mother. She does receive services and programs, etc., that are ultimately funded by the people of Canada, as you so rightly say, Professor Armstrong.

Therefore, my question to you is that rather than just throwing more money at this at this point in time, would it be useful, in these kinds of studies that Dr. Armstrong is conducting, for us to be looking at efficiencies? How can we be more efficient with the money that's currently there? Then we can build on that. I know, having gone through my mother's situation, that there are numerous inefficiencies in the system we currently have that are not being addressed.

Mrs. Judith A. Wahl: I'm not going to be able to give you a good response, because I'm a lawyer, I'm a practitioner, I'm on the ground, and I see a lot of people struggling with the systems they're working in. I can't say necessarily that it's inefficiencies. People are doing a lot more with less nowadays.

I work in a service funded by the provincial government, and we're told to find efficiencies. Everybody is doing that. I think people are on a pretty thin edge of the wedge everywhere.

I'll use police as an example. I'm seeing the police doing a lot with very little, but they still need the time to do the work properly, and there may be need for more resources there. I don't know if it's going to produce the efficiency. I'd be afraid that simply focusing on efficiencies without really looking at things more comprehensively way would divert people from what I'd call the meat of the issue. We get diverted to looking at how we can cut rather than at how we can do a good job.

● (1615)

Ms. Wai Young: Given our current fiscal realities, do you think it's wise for us to just throw more money at things without looking at whether we are doing the best we can given that so many of our systems and processes and services were developed some 40 or 50 years ago—since the fifties and the sixties and the seventies?

The Chair: You have ten seconds, Ms. Wahl.

Mrs. Judith A. Wahl: I really can't give you a good answer one way or the other. I just don't know enough about the funding.

The Chair: Thank you very much.

Now we'll turn it to Ms. Sgro.

Hon. Judy Sgro (York West, Lib.): Thank you very much.

My apologies for being a few minutes late.

Dr. Armstrong, I missed your presentation.

I assume we will get these presentations in written form, Madam Chair?

The Chair: Yes, we have a copy ready.

Hon. Judy Sgro: Certainly I have followed the work that SSHRC has done and the investments they have made into so many different areas, and their pressure to continue to fund things is difficult.

You said your study was for two and a half years—

Prof. Hugh Armstrong: It's seven years.

Hon. Judy Sgro: Oh, I'm disappointed if it's seven years; it will be a long time before we hear what your results are and hopefully come up with something significant.

As a more pressing issue, from what you have seen in the period of time that you've already been doing this study, is there any one thing in particular that stands out?

Prof. Hugh Armstrong: The first thing I'll say is that we're not waiting for seven years to issue a report. We're talking with people as we go along.

One of my colleagues and I were at the Council on Aging of Ottawa last week. There were 35 or 40 people, all of whom work in this area, and we were exchanging views and ideas with them. We will continue to do that. We have a website and all the sort of standard stuff. So we're not waiting for seven years.

That said, towards the beginning of the project we were trying to map what exists in these various jurisdictions. You may not have heard, but we were talking about California, Texas, five Canadian provinces, Scotland, England, Germany, Norway, and Sweden. There are a lot of interesting things to do in terms of making sense of the comparisons among these jurisdictions.

One thing that seems to have come out—and this would speak to the efficiency argument—is that for-profit seems to be less efficient in that for the same dollars you get fewer good results. This is difficult to measure, and we sometimes measure it in a surrogate fashion by looking at staffing levels, but that's not the only way we can measure it. I'll refer you to Margaret McGregor's piece for the IRPP released last January.

Hon. Judy Sgro: Thank you very much.

Ms. Wahl, on the issue of abuse amongst the elderly, you referred to those in hospital being charged a per diem. Could you elaborate a bit on that? I'm hearing that a lot in my particular area.

Mrs. Judith A. Wahl: I'm going to talk about the Ontario situation, but it's comparable in other provinces. I don't know the details on other provinces. So the senior goes into hospital with an acute episode. She's at the hospital and has now gone through the acute episode. Now she's ready to leave the acute care but she can't go back home, because there isn't sufficient home care to meet her continuing needs.

The hospital under the Ontario health insurance can charge a per diem, but that per diem is limited to $53 a day, approximately, with rate reductions. Most hospital policies say if you don't take the first available bed in any home for long-term care anywhere, usually within 200 kilometres, you may be charged between $600 and $1,800 a day. That charge is illegal under OHIP. You can only charge the $53, and seniors have the right of choice. They can choose up to five homes offering long-term care. They do not have to put on their list of choices places that the hospital is directing them to. Often the hospitals will say they must choose from a short waiting list.

Please understand, I'm not naive. We encourage people to look closely at all the different alternatives, but this illustrates, first, that we don't have the home care supports for some of these people at home, and second, that we are ending up telling people they have to go 200 kilometres away from their home base, away from family and friends. This is to me systemic abuse.

● (1620)

Hon. Judy Sgro: I've had several constituents come in to my office. I'm an Ontario MP. I've had to contact the hospital and at that point they have backed away from charging. But these people knew enough to come to me. I've had to put out some outreach so people know that you can't just let the hospital do that. I think they're now backing off that hospital policy because of what I did.

You mentioned 43% violence against caregivers, Dr. Armstrong. Would you elaborate a bit more on that?

Prof. Hugh Armstrong: We asked a question similar to what had been asked in the Nordic countries—namely, have you experienced physical violence from a resident or a resident's relative, and how often? The highest answer was daily or almost daily. The next answer was weekly. The next was monthly. It was seldom never. The 43% is daily or almost daily.

Hon. Judy Sgro: Do we have something that oversees the caregiver? We're talking about elder abuse and it works both ways. I've seen that happen too.

Frankly, other than the Labour Code, when it comes to a caregiver there really isn't anything that helps to go in and work between some of these people who are having these issues; there's no go-between who's going to go in and try to settle these things.

Prof. Hugh Armstrong: I think that's quite accurate. One of the difficulties is that the workers are reluctant to report, for a number of reasons—the paperwork, the blame that gets assigned to them, a desire to protect the residents, and a culture that suggests that this is normal, that if you sign up as a PSW in long-term, you're going to get bitten, scratched, punched, or whatever.

Mrs. Judith A. Wahl: I can tell you that in the Ontario legislation, there are supports for the workers, but I totally agree with Dr. Armstrong that they can't really use it. The legislation provides for supports for them; it's just not implemented because of the culture.

Hon. Judy Sgro: But in both ways, it can be a difficult relationship—for both people.

Prof. Hugh Armstrong: Yes.

Hon. Judy Sgro: Thank you.

The Chair: Thank you.

We'll now move on to Ms. Truppe.

Mrs. Susan Truppe (London North Centre, CPC): Thank you, Madam Chair.

My thanks to Mr. Armstrong and Ms. Wahl for attending. I have a couple of questions here.

In 2008 we launched the federal elder abuse initiative, a successful, $13-million, multi-departmental, three-year initiative to help seniors and others recognize the signs and symptoms of elder abuse and provide information on available supports. This has gone to great lengths to raise awareness of elder abuse across Canada.

Can either of you explain the impact of awareness campaigns concerning reporting elder abuse crime?

Prof. Hugh Armstrong: I'll take the first run at it.

Until a year ago, I was on the board of the Council on Aging of Ottawa, joined by, among others, Vern White, the chief of police in town. At the initiative of the council, we established an elder abuse network that involved the police and a number of agencies.

I think it works well. It has had some public money. I'm not sure, but I think it was Ontario money rather than federal money. In a sense, that doesn't matter much.

One of its difficulties for it is a difficulty so many social agencies face. I teach in a school of social work, and some of my students tell me about this all the time. Much of the money comes in on a project basis rather than as core funding. The agencies, including the elder abuse network in Ottawa, spend so much of their time justifying their existence, writing grant proposals, sending in interim and final reports, hoping they get the next one, and worrying about whether they have to lay off staff because they haven't heard yet.

This is incredibly inefficient. It's what the economists sometimes call “transaction” costs, but it's also a human cost for the people who work in this sector and who receive services from it.

So I welcome initiatives of the sort you describe. It is all too often a hidden issue. Judith and her colleagues occasionally find out about it—or MPs find out about it—because somebody happens to know a number to phone. A lot of it is hidden. It's partly a cultural thing; we have to bring it out into the open and make sure that it's not a matter of stigma. We also need more secure, stable places where people can go.

● (1625)

Mrs. Susan Truppe: Sorry, I only have five minutes, and I'm trying to get in a couple of questions.

Regarding the $13 million that we spent, you said it works well, but you feel, based on your comments, that there could be more awareness raised.

Prof. Hugh Armstrong: I'm sure there could be more awareness. I wish that kinds of funding were somehow more stable, more regularized.

Mrs. Susan Truppe: Okay. Thank you.

Mrs. Judith A. Wahl: My problem with the awareness campaign is that it has raised some awareness, but it's more focused on having others report somewhere rather than helping seniors and supporting seniors to reach out to get the support.

So it's not what I'm going to call the “talk to the senior” program, and I think that's where the next round of things needs to focus more on rather than concentrating on others reporting it to someplace where.... That's not going to help the senior, in the way it is, because some of those people doing the reports are, in fact, the people who need to be doing the helping. They're not talking to the seniors.

I encourage the federal government to shift the focus, to be more senior-focused rather than portraying seniors as all vulnerable and unable. Most of my clients out there are capable, able seniors, and they are vulnerable, but not in the way that's portrayed in some of the awareness campaigns, as being incapable or unable to speak up. We need the supports for them to speak up.

Mrs. Susan Truppe: Thank you.

With all the different funding we've been providing to help combat elder abuse, we hear from you and some of our other witnesses that everybody wants money to help with the problems. We're also looking at other options that could be done from the ground up, from a grassroots level.

Does anyone have suggestions on what else we could do as a federal government, in addition to the funding?

Mrs. Judith A. Wahl: I personally want, as I mentioned in the proposal I'm making to you about amending the bill that's amending PIPEDA, to really look at how these players can better support the seniors and get them, as the customers or victims, to be heard more. Instead of the banks reporting off to the family, how do the banks deal with their customer service? How are they helping the individual seniors?

My own mother was told that if she didn't do a banking power of attorney, the government was going to get all of her money. Well, that's not true in law; I know that.

The Chair: Thank you.

We'll wrap it up there. We have two minutes left for Ms. Freeman.

Ms. Mylène Freeman (Argenteuil—Papineau—Mirabel, NDP): Thank you, Chair.

Thank you so much, Professor Armstrong and Ms. Wahl, for coming.

I would like to hear from Professor Armstrong. Am I right to think that you said standardizing and equalizing seniors health care will positively affect the reality of senior abuse?

Prof. Hugh Armstrong: I'm not sure I said exactly that, but I would certainly sympathize with that as a perspective.

One of the problems with long-term residential care is that it's below the radar. It's below the radar in part because it's not part of what we call medicare—the things that are covered under the Canada Health Act.

So I would welcome minimal national standards in this field. As to how to achieve them, I'll leave that to you politicians. I know there are federal-provincial-territorial issues involved.

I think more federal leadership to provide more recognition, less stigma, and less a sense of failure in long-term residential care would be most welcome.

Ms. Mylène Freeman: Thank you.

Could you also briefly elaborate on how funding is being cut in social sciences, and how there is virtually no research being done on long-term care facilities?

● (1630)

Prof. Hugh Armstrong: Well, I won't say there isn't any being done. Some researchers are creative enough to have a proposal accepted for consideration by SSHRC, despite the fact that it's really about health care, because they call it something else.

I know that CIHR, the other more prosperous funding agency, does support some social science in this field. It's a matter of how much. I know from my colleagues who work in studying health care that there are enormous frustrations at having to go to CIHR.

I should say that this survey we conducted was with CIHR money, so it's not that it never happens; it's just that there are more roadblocks for social scientists and humanities scholars.

The Chair: Thank you very much.

That wraps up our time.

I'd like to very much thank Dr. Armstrong and Ms. Wahl for joining us here today.

We'll break for a few minutes and then be back to carry on our discussion.

Thank you.

[*Proceedings continue in camera*]

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