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Chair

Mr. Bryan May

Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities

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● (1540)

[*English*]

The Chair (Mr. Bryan May (Cambridge, Lib.)): Good afternoon, everybody.

First of all, happy Halloween. I hope everyone is looking forward to trick-or-treating later. We'll try and get through this as quickly and efficiently as we can so everyone can get home to do that.

Pursuant to Standing Order 108(2) and the motion adopted by the committee on Thursday, May 4, 2017, the committee is resuming its study of advancing inclusion and quality of life for Canadian seniors.

Today is the third of three panels that will be held on the subject of inclusion, social determinants of health and well-being.

Thank you, again, to today's witnesses for accommodating the change in the meeting date. We're going to get right into the introductions, and then everyone will have seven minutes for comments.

From Dying Healed, via video conference from Chilliwack, B.C., we have Natalie Sonnen, executive director.

From Seniors First BC, also via video conference, from Vancouver, B.C., we have Mr. Kevin Smith.

Appearing here as an individual, we have Birgit Pianosi, associate professor, gerontology department, Huntington and Laurentian universities. Welcome.

Appearing from the Canadian Federation of Nurses Unions is Linda Silas, president. Welcome.

From the National Association of Friendship Centres, also here in Ottawa, we have Vera Pawis Tabobodung and Sonya Howard. Welcome.

As I said, everyone will have seven minutes and, when I make a signal, it means you have one minute. You have lots of time. We usually try to get everyone to stay within seven minutes, and they do a pretty good job of that. However, when you see me make a signal, you'll want to start to wrap it up.

We're going to start with the video conferencing.

Natalie Sonnen, the next seven minutes are yours.

Ms. Natalie Sonnen (Executive Director, Dying Healed): Thank you very much.

I want to quickly start off by talking about Dying Healed. What I would like to bring to bear on this committee is the importance of volunteerism and its crucial role in our society, especially concerning matters of elder care and end of life care. I think a spirit of volunteerism in this regard would and should relieve pressure on governmental bodies, especially at the federal level, to spend tax funds on expensive programs that could be better run at a grassroots level. Let me give you some background.

In 2015, I began to put together a program called Dying Healed. The name of the program came from something which Dr. Margaret Somerville, formerly the head of the centre for law, medicine and ethics at McGill University, said at a conference that I attended. I will paraphrase her words here. She said that we have to rediscover the value of life at the end of life and that we must impress upon people the importance of making use of this time, not so much to heal our bodies, but to heal our souls, our relationships, our regrets, and our sorrows.

The term “dying healed” is a concept that explains how a person can use the later stages of life to perhaps accept their physical limitations, but use the wisdom of their lifetime to heal their past wounds and become mentally, emotionally, and spiritually healthy. In practice, however, it became manifestly clear to me that human beings are not islands unto themselves and that the process of finding peace in old age or at the end of life is integrally tied to the other people who inhabit our world. I then realized that to really deal with the looming crisis of an aging population, volunteerism had to be at the very core.

That is why we designed the Dying Healed program. The program seeks to reach out to potential volunteers of all stripes and inform them in concepts around the end of life. It seeks to empower everyday people and give them an awareness of the problem and the confidence to do something about it. However, the doing part is more about being than doing, and this is very key to the dying healed program.

To quote directly from our training manual:

> The purpose of the Dying Healed Program is not to create professionals but educated lay people confident in the fact that their presence at the bedside of a lonely or dying person is an invaluable service. If a person is alone, suffering in any way or at the end of life Dying Healed volunteers can simply be there with the conviction that their presence can bring love, hope and a sense of belonging to those who suffer.

I want to be very clear here that this program is not intended to replace any currently existing volunteer training program that is being held in our institutions across Canada. Think of this as a preparatory training and volunteer recruitment program, reaching out through churches, mosques, synagogues, community centres, and home-based visitation programs, to give people a first taste of what volunteerism like this might be like, how incredibly important it is, and most especially, how vital the power of human presence alone is to changing the life of an elderly person struggling with social isolation and all that it entails.

In a 2016 study by the U.S. National Institutes of Health, it was found that a majority of people who died by euthanasia in the Netherlands for so-called psychiatric reasons had complained of loneliness. The researchers found that loneliness or social isolation was a key motivation behind the euthanasia requests of 37 of 66 cases reviewed, a figure representing 56% of the total.

● (1545)

A tireless advocate for the vulnerable members of our society, Jean Vanier, wrote:

> To be lonely is to feel unwanted and unloved, and therefore unlovable. Loneliness is a taste of death. No wonder some people who are desperately lonely lose themselves in mental illness or violence to forget the inner pain.

As we know, Jean Vanier set up homes for the disabled in Canada and around the world.

Dying Healed volunteers are given training and formation in the issues surrounding palliative care, medical aid in dying, the meaning of human suffering, and the power of human presence to heal and bring dignity to others.

I want to share with you my own personal experience of visiting a young man from Algeria who had been a child soldier and prisoner of war from the age of nine to the age of 16. He lived in Downtown Eastside, in a filthy hotel room. I worked with a group of volunteers who went every Saturday morning just to sit with him. His isolation was so severe that at first he could only stand facing the wall, with his back to us, while a colleague and I would sit, barely saying a word. But he wanted us to be there. Over a period of two years, he slowly began to talk to us, and soon, through our regular visits, he began to share his story, and then seek advice and help. Eventually, he got a job and became a functioning member of society. It all began with us simply being there, through the power of human presence.

We must reach out to those who feel that life has no value, to the elderly and the dying, those most at risk of giving up and most susceptible to the new ideas that have come with the advent of assisted death. I am particularly concerned about suicide contagion in nursing homes where one person makes a request for medical aid in dying. How does that affect the others who are struggling with loneliness and its attendant sense of despair?

I feel that society must cherish our elderly, who have done so much for so long for society, yet elder abuse is definitely on the rise. The elderly live longer. With demographic challenges that result in fewer family caregivers than in previous generations, the future may easily tend toward an ever more precarious situation for those most vulnerable people.

The Dying Healed program was launched officially in June of this year and is now in 15 communities across Canada. We are just now getting feedback on the training program itself and the experiences of the volunteers who have gone on to spend time with those most in need.

In short, I want to emphasize that the reliance on grassroots programs such as the Dying Healed program, already working in communities to identify and meet the needs of seniors, will be much more effective than a government-sponsored project. With more funding for our own work, we could, for example, hire a director of outreach and get this program into tens, if not hundreds, of communities across Canada. I do believe that this is a more reasonable and responsible use of our tax dollars.

Thank you.

● (1550)

The Chair: Thank you very much.

From Vancouver, B.C., we now have Mr. Kevin Smith from Seniors First BC.

Mr. Kevin Smith (Representative, Seniors First BC): Thank you, Mr. Chair and members of the committee, for the opportunity to address this important and timely issue.

As noted by the International Federation on Ageing, the number one emerging issue facing seniors in Canada is keeping older people socially connected and active. An estimated 30% of Canadian seniors are at risk of becoming socially isolated. Seniors First BC is a non-profit agency serving the people of British Columbia. We work to prevent elder abuse, to provide assistance and support to older adults who are or may be abused, and to those whose rights have been violated. Our programs include an information referral support phone line, a victims services program, free legal advice and representation, and public education outreach programs. Our staff are from various professional fields, allowing us to offer a mix of supports, with expertise about elder abuse issues from a unique, holistic, and multidisciplinary perspective.

Social isolation is a recurring issue in our work. Elder abuse, neglect, and financial exploitation of seniors can result from or be exacerbated by the social isolation of the older adult. The likelihood that an older adult will not accept help, and whether that help is easily available, is also in part determined by how socially connected that older adult is. There has been much research and reporting on the dramatic ways that these forms of elder mistreatment can affect the health, safety, and quality of life of older adults. We do not intend to review this material. We understand this committee wants to look at advancing inclusion of seniors, keeping them socially connected and active. This requires an active action plan or strategic plan. We agree with the brief from the Coalition for Healthy Aging in Manitoba in supporting the use of the framework from the global strategy and action plan on aging and health of the World Health Organization.

Strategic plans require an aspirational vision. We want to suggest a vision for how inclusion may play out for one of our socially isolated clients. We will call him Dave. We have chosen an example of a very isolated rural senior. We recommend the brief from our sister organization S.U.C.C.E.S.S. regarding a culturally sensitive and linguistically appropriate way to advance inclusion for diverse urban populations.

While Dave's situation is perhaps extreme, we believe choosing an extreme example can be informative and the solutions may have broader application. Dave's living situation displays many of the risk factors associated with social isolation. He lives alone in a semi-remote cabin. He's 80 years of age, has multiple chronic health problems, no children, little contact with other family members, recently lost his spouse, recently lost his driver's licence, lacks access to transportation, is of low income and low education. Dave is socially isolated, potentially exposed to exploitation, vulnerable to financial abuse, to frauds and scams, to self-neglect, but let's look at what Dave's situation might be five years hence.

Dave is awakened by his alarm and the smell of coffee brewing. After a few sips, he speaks to Connie. Connie is his personal digital assistant developed by the connecting Canadians program and the private sector. Connie functions as Dave's connection to the outside world through a free broadband connection and a hands-free interactive speaker hardware provided to low-income seniors by connecting Canadians. Connie is more than just a hands-free browser, search engine, and scheduler. Connie provides specific curated information from the community and the Internet for Dave and functions as an e-health adviser, and through Dave's Fitbit bracelet, monitors Dave's health with connections to a community nurse practitioner, occupational therapist, and pharmacist.

While interacting with Dave, Connie is monitoring his cognitive functioning. Connie monitors his browsing, warns Dave about potential phishing and online frauds and scams. Connie monitors his finances, warns about shortfalls or questionable transactions, simultaneously warning his attorney. Connie learns what Dave likes, recommends activities based on its learning, and interacts with "body language" and subtle expressions to simulate emotion.

Dave has made informed decisions about these various ways Connie is monitoring his life and has, to his surprise, developed a bond with Connie. As it is Monday, Connie goes through the coming week with Dave while he eats his breakfast. The self-driving community bus, a school bus used between school hours, will be coming by today to take seniors to the seniors centre for various programs.

● (1555)

The Government of Canada developed these self-driving buses in a public-private consortium with Bombardier and BlackBerry. Canada is now a world leader in the development of these buses. They display public service announcements on the side, in this case the federal government's latest anti-ageism campaign.

The Canadian government and the provinces also subsidize self-driving cars and "taxi-bots" for low-income seniors who have lost their licences and have traded in their cars, and for those who have a disability that's preventing them from driving.

Tomorrow the medical home self-driving bus will come by for Dave's monthly checkup. On board is a nurse practitioner, occupational therapist, pharmacist, dentist, and dental hygienist. A doctor is available by teleconference. Dave will get his prescription refills. Connie will be advised to set up an appointment with a heart specialist in town and schedule a taxi-bot so that Dave can attend the appointment. Tuesday afternoon a Better at Home volunteer, accompanied by the self-driving firewood supply and splitter truck, will come out to help Dave split and stack cords of wood. Wednesday the social club on wheels comes by. Friday the grocery bus comes by.

After this, Connie leads Dave through his calisthenics and reminds him of an upcoming online meeting of his circle of support to help him make a supported decision about a request by his nephew for a loan. Connie talks about other possible events to consider attending in town—a widower peer support meeting, a lunch gathering of the blues society, a community kitchen event—and about an incoming call from his neighbour Doug about travelling to the seniors centre together.

That's our presentation. Thank you, Mr. Chair.

The Chair: Thank you very much.

We now have, appearing as an individual, Birgit Pianosi, an associate professor in the gerontology department at Huntington and Laurentian universities.

You have seven minutes.

Dr. Birgit Pianosi (Associate Professor, Gerontology Department, Huntington and Laurentian Universities, As an Individual): Thank you very much. Excuse my accent. I'm German, so if you don't understand me, please ask.

I thought of talking about aging and older adults from a different perspective. I thought it important to point out that the majority of older adults today are healthy and that has an impact, of course, on how we view and what kind of policies we introduce to older adults that we will have in the next couple of decades. As a professor, of course, that also includes education in gerontology, so I will split my presentation into two parts, healthy aging and education gerontology.

My two main thoughts, as I just said, are really to look at the generations today of older adults. They are very different from previous generations and we need to increase our education of the public and the people working with older adults about the current issues of aging. I will talk about the demographic reality, the status quo of health and social service education, and then some consequences and solutions, and the summary. I will try to do that in seven minutes.

Today is different from the past. Older adults of today and the future will be much healthier, wealthier, and better educated than those of previous generations. Declining fertility has led to greater female labour force participation. Fewer children mean healthier, smarter, and better educated children. Demographic projections indicate further gains in longevity, including gains in healthy life expectancy, so we really need to look at older adults from a very different perspective. Also, the increase in legal retirement age and change in pension policies will also entice older adults to work longer because they are healthier.

I thought of giving you an imageto have in your head. When we look at older adults, 65 years and older—I use older adults on purpose as a term, not seniors, as seniors implies frailty and, as you can see, over 90% of our older population today in Canada live independently and therefore are healthy enough not to have to move into long-term care or in any assisted facilities. So please remember, older adults and not seniors. That's what I tell my students anyway.

The graph that I found quite interesting indicated that almost 80% of older adults today are feeling quite healthy. However, some of the older adults do feel lonely, as we have heard in previous presentations, and their life satisfaction might not be as great. Their concern about life satisfaction is almost 20%. Most older adults participate in social activities, but many older adults would still like to be more involved, and I think that really has to reflect the policies that we introduce, such as age-friendly environments, age-friendly communities, and such.

Many healthy older people represent not a liability but a great asset of experience, skills, drive, that the country should learn how to exploit. We really have to make use of these older adults and that is what they want, as you have seen in the previous graph.

What is our status quo now in education? What do we really know about older adults? What does the public know about older adults, and especially our social and health care providers? Health, social and community human resources need to be better prepared and supported to meet the needs of our aging population. The fact that we don't require any of our schools that train our future health, social and community care providers to formally teach content related to caring for older adults is concerning. Youths who are not exposed to caring for or working with older adults will be less confident in their knowledge and skills working with these patients and less prepared to meet their needs or even to choose these areas as a career.

A strategy that provides the right education and training opportunities will ensure that Ontario and Canada gain an informed workforce that will have the necessary knowledge, skills, and confidence to identify issues of need amongst older adults while delivering them the right care, in the right place, at the right time. That is not only care, but also services. I always include this because, again, we're not only talking about frail older adults, but the majority who are healthy and are looking for services rather than care.

What is the status quo? We know that most of our older adults are cared for by people who are not educated properly. That is a global issue. It's not just a Canadian issue. It's a worldwide issue.

● (1600)

We have different health and social service programs. They are very different from each other. There are no real guidelines about what should be part of the education.

Research shows that 70% of respondents feel that gerontology content in their programs should improve, so any kind of health and social service programs in Canada. Programs do not have sufficient gerontological expertise. Even the teachers and faculty who are teaching gerontology issues are often not educated in the area.

In 2012, seven Canadian universities offered specific three- to four-year undergraduate degree programs in gerontology. I'm teaching at one of those programs at Laurentian and Huntington universities. The consequences are that those who work in the field with older adults often have negative attitudes toward older adults. They don't really know what older adults are, because they haven't learned the realities of aging during their course content.

Ageism is a barrier in curriculum development. We need more applicable and practical applications of gerontological knowledge, competencies, and training. Providing relevant, ethical, safe care, and services to older adults is paramount not only in creating and maintaining their quality of life but also in the development and changing of attitudes toward health, aging, and end of life care. I also think to create policies.

Movement toward professionalizing gerontology and gerontologists, aging specialists, like myself, may well aid the continuity of aging services both in the health care and social care domains.

I would like propose some solutions. We need to have better education that includes health promotion, financial security, and so on, but I'm focusing here on education. We need to encourage students at an early age to specialize in gerontology, and that shouldn't start at the university age. That starts at a much younger age, often at the elementary school age. We must enhance capacity of existing faculties, making use of train-the-trainer approaches for increasing faculty capacity. Both older adults and their care partners must be integrated into the team, and provided information and training. Education includes all older adults and their care providers. We need to initiate social change by introducing new ways of thinking.

We need to have special knowledge if we want to care for older adults, and provide services to them. It is important that we adjust our curricula in social services and health sciences. Gerontologists do have special knowledge they can provide, creating age friendly environments, and so on. Many jobs require registration with professional bodies. Gerontologists at this time do not. Registration has now started in the United States. Actual programs are now being accredited. We need to include the expertise of this profession in our policies to move forward.

Thank you very much, Mr. Chair.

● (1605)

The Chair: Excellent, thank you.

From the Canadian Federation of Nurses Unions, we have Linda Silas, president.

The next seven minutes are yours.

Ms. Linda Silas (President, Canadian Federation of Nurses Unions): Mr. Chair and committee members, thank you for inviting the Canadian Federation of Nurses Unions to present to this committee. On behalf of close to 200,000 nurses who I represent, I'm very pleased to be here. As mentioned, my name is Linda Silas. I'm president of the federation and a registered nurse.

Congratulations for undertaking this important study, and congratulations especially to those presenting via Skype. It is quite hard to present to these committees.

As all of you know, in the last census, for the first time in history, the share of seniors in our population exceeded the share of children. What does it mean for society? We know that most seniors want to stay in their home as long as possible. That means that the demand on continuing care services within the community will continue to increase. You have all read the studies and you know that by 2026 it is expected that the number of seniors needing continuing care will increase by 71%.

Our Canadian health care system needs to recognize the new realities of the home, especially looking at hospitals without walls. From the front-line nurses' perspective, staying in one's home might present many challenges, both for the client and for the caregiver. Assessing all the necessary medical and social services while ensuring clients' safety can be difficult. Rather than recommending a home-first policy, CFNU is calling for a safe-at-home policy.

What are the elements of a safe-at-home policy? We tried to answer this just two weeks ago at the annual meeting of the provincial and territorial health ministers on this topic. We highlighted “Safety at Home”, a pan-Canadian home care safety study. The report identified many things in the home environment that put the safety of the clients, caregivers, and health care providers at risk. For example, initial assessments of the clients might be done, but they might not be reassessed in a timely manner, and the coordination of their care is also an issue. What emerged is that many of these home care challenges were overcome when one primary provider, usually a nurse, was given the job of having the complete picture of the client and family situation and coordinating timely care, communication, and teamwork. The role of the primary provider can be effectively performed by a nurse practitioner or registered nurse. Ultimately, system failures led to adverse events and increased use of our health care resources, such as increased use of hospital beds, as well as increased risk of disability and death.

CFNU recently conducted a poll to confirm some of the safety-at-home observations. That poll was conducted just this September. Nine out of 10 home care nurses surveyed said the acuity of clients at home has increased. Nurses reported that the main reason for the decline in the quality of care was an increase in the client population. Current staffing was reported as insufficient to do the job. About 90% of home care nurses said their workload has increased over the last three years. The majority who reported frequently work overtime, and despite this, necessary work is being omitted. About half of home care nurses said essential tasks, such as reassessing clients and families, are not being done. Around 50% said that the service coordination is also left undone from the previous month.

The message is clear: there is not enough staff, not enough training for both paid and unpaid caregivers, and not enough time in the day to provide essential home care services. These numbers are from one poll, but what we are talking about are real people, real seniors, and real families whose care is not met.

To add to the complexity of home care, most seniors are taking multiple medications. Nearly two-thirds of seniors take five or more prescription drugs. About 40% of them take a drug from the Beers list that is potentially inappropriate for use by seniors.

Last week, you heard from our colleagues at the Canadian Medical Association, when Canada's doctors presented before this committee. CFNU is also supportive of expanding discussions to include income security, affordable housing, and other related issues, but for now, as Canada's nurses, we believe we need to stay focused on the health services that the seniors of today and tomorrow need.

● (1610)

To reiterate CMA's presentation on October 26, we are also long-time supporters of a national pharmacare program. A national pharmacare program would allow for improving, monitoring, and evaluating prescribing practice. It would do so much to eliminate inappropriate prescribing to seniors. It would also help ensure that seniors would have equal access to the necessary and safe prescription.

CFNU's recommendations, which we have distributed to the committee members along with the backgrounder, are as follows. First is a safe-at-home policy; second, senior patient appropriate and timely nursing assessments and interventions supported by the full health care team; third, continuity of care provided by primary nurses to ensure timely and seamless access to care providers; fourth —and you've heard it from different presenters today—education and support for all members of the team, including unpaid caregivers; and fifth, a national pharmacare program.

I will be pleased to answer questions.

[*Translation*]

Thank you.

[*English*]

The Chair: Thank you very much.

Now we'll go to the National Association of Friendship Centres, with Vera Pawis Tabobondung, senator, and Sonya Howard, policy officer.

The next seven minutes are yours.

Ms. Vera Pawis Tabobondung (Senator, National Association of Friendship Centres): I want to give my greetings and thanks to the Creator for this wonderful day today, and I want to acknowledge the peoples whose traditional lands I am privileged to be a guest in today.

Mr. Chair, I recognize the valuable work that you and the committee have done, and I am grateful for the opportunity to bring a message from the National Association of Friendship Centres. We're working on what we believe to be very important work; work that's been very much a part of the being of the friendship centres for the past 50 years. We know there's a difference between an elder, a senior, and a nice old lady. I have presented before about seniors and inclusion and exclusion, and on having accessible programs and services. I'm going to talk about some of the the things that we brought forward before.

We still have a great population of seniors. They are very much the biggest component of our communities across the nation, in all of 117 communities where there are friendship centres. We know we're matched in size by the young people, and that we have real work to do in terms of how we make that match work. How do we ensure that the young people are going to be able to look after their grandparents?

We know that in the world in which we live today...housing, access to water, having food, and the quality of life that is, I guess, all-Canadian. There have been great gaps in our society and in our history, and in the development of our friendship centres to address those gaps. We hear and understand all of the words from our colleagues, but most certainly, in the community that I come from, and the ones I have worked in, and that I participate in now as a senior, they're very vocal. They're very confident in being able to say what it is they want, what strategy they would like to design that's going to be community-based and able to address their needs, because it's not all the same. From my community to Sonya's community or any other community.... We must know the importance of having to work together to ensure that there is a quality of life that is most acceptable to the indigenous people and the friendship centre movement.

I wanted to share those words so you know that it's important to have an understanding of the work that we do in the friendship centres, that the programming and services are culturally appropriate and designed by seniors, and that they have a say in what they want. It's not something that I think is good for me; it's something that we collectively agree on. I know that's going to be a hard task, but I think as an organization and as community-based friendship centres, we need the capacity to bring people together as we do now in a social setting—weekly, monthly, and daily.

Some programs are designed to be in-house, in the friendship centres, and some of them are outreach. I think we can be a little more collaborative in terms of how we work on addressing the isolation, the disability, and the social well-being of indigenous communities. We know for sure that we have success. We know we can help in terms of culturally sensitizing people who are going to work in the programs and deliver the services, whether it's an institution, another program, or a collaboration and partnership in looking at these issues. We understand that we're very diverse. Across the country, we know there are many that.... When I first started this work, the average life expectancy of an indigenous person was 47 years, so we've come a long way. That's a recognition of our resilience, and being able to live a good life and understand what that good life is.

● (1615)

We want to be able to ensure that our young people understand what that good life is...that we can overcome all of that, like the low-income population and the food insecurity, and that we will thrive. In doing that, we're asking that there be continued support for friendship centres, the programs that are run by friendship centres, and of course, always collaboration in how we can do that.

As diverse and as wonderful as we've gotten to be, there are still seniors who look after seniors. There are grandparents who look after and are raising their grandchildren. It's a whole different spectrum from maybe what I thought I was being brought up to be. It was more than just kindness and understanding the role of grandparents in our communities. Some of us are fortunate to have grandparents. Some of us are fortunate, today, to have grandparents.

I still bring that forward. We do need those kinds of programs. We do need to continue to look at the housing, water, food, and the culturally appropriate programming that's designed and delivered by indigenous people in the indigenous communities. There still has to be accessibility. We still have to be able to hold people's hands and be human beings, so that this loneliness that kills us all...it doesn't matter our colour or stripe, that loneliness is there at the end of everybody's day. If we don't learn how to co-operate, collaborate, and build partnerships, it doesn't matter....

It's not a cellphone that's going to keep me company, but it is. I can attest today that I can call home tonight and see my grandchildren and great-grandchildren in their Halloween costumes. It certainly isn't going to be the human touch. That would be different because then you're there to hear them say “trick or treat”.

Thank you for listening. I wish you well on all of the work. *Meegwetch*.

● (1620)

The Chair: Thank you for that wonderful holiday note.

We're going right into questions. First up, we have Ms. Wong.

Hon. Alice Wong (Richmond Centre, CPC): Thank you very much to all of the witnesses who came all the way from different parts of our nation. Hello to those I've visited and worked with. I personally have witnessed many of the things mentioned. Thank you, senator, for coming.

I still remember the time when I went to Nunavut, Yukon, and the Northwest Territories to meet elders and listen to them. It is definitely important that we be very much aware of the sensitivity of the culture and also the kind of supports in these rural communities, especially in the first nations, that require a lot of our attention. Thank you to all the friendship centres. You've been coordinating. We definitely appreciate that.

Also, to our two witnesses from B.C., we appreciate all the great work you've done. Again, I think I've met some of you before and worked with you.

I would like to ask some of the organizations about the new horizons program. With all the priorities that you've been looking at, we definitely understand that the original purpose of the new horizons program was to encourage seniors to be volunteers and to have them stay active and engaged. Healthy, active aging is part of the work which the former government had been promoting. Hopefully the current government can move on with that as well.

Do you see the need for a sharing of experiences with other organizations so that we are not reinventing the wheel? The testimony of these witnesses is really hopeful.

Professor, what do you think of the need for sharing the experiences and making them part of your curriculum?

Dr. Birgit Pianosi: Do you mean including the adults in the curriculum?

Hon. Alice Wong: Yes.

Dr. Birgit Pianosi: We do that already. I think it's very important because we need to ask all the adults what they want. We can't just assume we know what they want and how they age. I'm not sure what your question is. I'm familiar with new horizons, but....

Hon. Alice Wong: Should it also focus on helping volunteers, especially senior volunteers, to stay active? A lot of our services depend heavily on seniors. Then we have seniors helping seniors. I just wanted to hear your thoughts.

Dr. Birgit Pianosi: Yes, for sure. I think that older adults today want to be involved. They want to be asked to provide whatever they can, and they often don't need to be paid. However, especially when they are caregivers for their loved ones, there needs to be some kind of help for them so they can do that volunteer work.

When it comes to curriculum, there are really good ideas from other countries, especially the Netherlands where they do include older adults in all the decisions they make at the university and college level.

I think there are a lot of different opportunities where we can include older adults, and we should. I love older adults. They are there to provide their services and help younger generations.

Hon. Alice Wong: We understand that when we look at seniors we are looking at those who are the most frail and vulnerable. That is why we wanted to make sure prevention of elder abuse is very important. Then, of course, family and unpaid caregivers are also important, because they play such an important role. It's culturally needed, or it's for some other reasons. Even friends who are looking after other seniors do need our support.

I would ask our witness from Seniors First BC how much he sees the need for programs that do exactly what I just mentioned.

● (1625)

Mr. Kevin Smith: I certainly agree that volunteerism is a big part of advancing inclusion for seniors. There's the new horizons program. In B.C. we have, as I mentioned, the Better at Home program, which is through the United Way. It's being expanded around the province. It's a way to coordinate volunteers to help older adults with tasks like shopping, cleaning the yard, maintaining the house, etc. I think there's a huge opportunity there as more seniors come into their retirement years and are looking for ways to contribute. As was said earlier, this is a rich resource we have to tap into.

Hon. Alice Wong: You also mentioned the story of an elderly person and all those techniques. I believe it's your vision that in the future, support for these seniors should go along that way using technology instead of just the human touch. Is that what your presentation was about just now?

The Chair: That's time, but I'm going to leave it open for just a very brief answer there.

Mr. Kevin Smith: Very quickly, I'm not saying that's in place of human touch. Absolutely, human touch is much better than any robot, AI, computer interface, or Skype call, etc.

Hon. Alice Wong: Thank you.

The Chair: Thank you very much.

We'll go to MP Fortier, please.

Mrs. Mona Fortier (Ottawa—Vanier, Lib.): Good afternoon, everyone, and thank you so much for being here this afternoon and for appearing today.

As you know, we are looking today at advancing inclusion and quality of life for seniors. I had the opportunity last week of hosting two consultations in my community of Ottawa—Vanier on this very issue. I must say, this is a very interesting and enlightening exercise to do, because what you are sharing today resembles a lot of what was said in my community. I must say, Mr. Chair, that we have great witnesses today, and I want to thank the committee for identifying these great witnesses. I've heard many ideas and suggestions, and I think we have to look at these as being results in our study.

I would like to dive a little bit further into the topic of indigenous friendship centres, because I know in Ottawa, and especially in Ottawa—Vanier, the work these centres do is absolutely incredible and critical in our community.

Senator, you mentioned that we have to address those gaps. What are the resources you need to be even more successful in supporting seniors in your communities?

Ms. Vera Pawis Tabobondung: For sure we have engaged and we're negotiating for continued funding for the friendship centres so that we have core dollars.

We know that across the nation many people and many of the friendship centres have accessed programming, the new horizons for seniors program, and in some places we're in a competition for those dollars because there is great need. We know that.

However, in order for our seniors to be engaged and to have those community consultations that you talk about, we need the person, we need Vera Pawis Tabobondungs who I can get to volunteer. We also need somebody who has the ability to bring people together whether they come by public transit...and in some communities we can't do that. We still want to do outreach, the whole thing about picking up the phone and calling because we care. I think we need that kind of capacity in the friendship centres.

We're trying to put our centre programs together so that we have wraparound service, with a bus that could bring the doctor and everybody else on the team along, and so we could still address what the seniors identify as the priorities in the community of their friendship centre.

Mrs. Mona Fortier: You were saying that you have 117 friendship centres in the country. I would like to better understand, and maybe you can give us an idea, how services of a friendship centre might vary between an urban setting, a rural setting, or a northern setting. Can you maybe explain to me a couple of challenges for each type so I can better understand the need?

● (1630)

Ms. Vera Pawis Tabobondung: The challenge is that not all governments understand friendship centres. Not all governments, whether in the north or elsewhere across the country, give us the same credit that you and other members of the panel who have an understanding of the kinds of work and the people who we work with do. Some of us can work with 10, yet some of us have thousands. It's all about access. It's all about equality and ensuring that communities create their own vision. We know what the basic premise of a friendship centre is, but they're all designed and put together according to the priorities and the cultural grouping of where they come from.

Yes, you have to have an open-door policy and be status-blind at a minimum, but there is no minimum for us. It's always that one shoe doesn't fit all friendship centres. That model doesn't work, and we know that.

It's all about governance. It's all about creating, being creative, having one dollar and making it stretch into $9. I think we know that pretty well.

Mrs. Mona Fortier: You know how to work through it.

Ms. Vera Pawis Tabobondung: We'd like to have the capacity to continue to design the programs, deliver the programs, and still do policy work and help with what the policy should look like and make sure we feel we're included in the design and delivery.

Mrs. Mona Fortier: Very quickly, I understood and I'm glad you mentioned youth as being of key importance in the approach you're suggesting. If we could make one investment in youth in your friendship centres, what would we do? Where would we put our money?

The Chair: Be very brief, please.

Ms. Vera Pawis Tabobondung: I would say a youth worker. It's the same. They're 24-7 just as seniors are 24-7. I wish I could say that nobody has a need on Saturday and Sunday.

Mrs. Mona Fortier: Thank you very much.

The Chair: Thank you.

Now we'll go to MP Rachel Blaney.

Ms. Rachel Blaney (North Island—Powell River, NDP): Thank you.

Thank youso much for being here with us today. I would like to start off quickly by asking everyone to answer "yes, no, or abstain" to a question. Do you believe the government should implement a national seniors strategy?

Dr. Birgit Pianosi: Yes, please.

Ms. Vera Pawis Tabobondung: A national indigenous strategy, yes.

Ms. Rachel Blaney: Can I get you to answer, Kevin? Yes, no, or abstain?

Mr. Kevin Smith: Yes, based on the WHO framework.

Ms. Rachel Blaney: Thank you.

Finally, Natalie.

Ms. Natalie Sonnen: Yes, I believe so.

Ms. Rachel Blaney: Thank you so much.

Linda, I would love to start with you today. Again, thank you so much for being here. As the seniors critic for the NDP, sadly I'm all too familiar with the cost barriers to medications in our country for our most vulnerable people.

In the report "Down the Drain: How Canada Has Wasted $62 Billion Health Care Dollars without Pharmacare", you demonstrated the need for pharmacare today. Can you share with us why this is so important? Also, what are the next steps the government should be taking?

Ms. Linda Silas: There are two prongs here. If we look at pharmacare, it's, one, having a formulary that's based on the evidence. I'm scared every day to hear reports—and that's not a CNFU report, that's the Beers report—that 40% of the prescription drugs prescribed to seniors are inappropriate for them. They end up in hospitals and in long-term care facilities, where they should not be. We would have the science behind the formulary and better prescription habits.

For seniors, it is about looking at safety. I often say that we all want to be 92 years old and play racquetball, but some of us will be sick, and some of us will need secure home care services and secure long-term care services.

I was very impressed with all the volunteer organizations. They all talked about volunteers, but trained volunteers. We're not trained to take care of a sick senior in our homes, or of a sick baby either, but with the seniors, they'll be there 24-7. It's about safety training.

Also, pharmacare not only will save money, but it will save lives, and it's time we get to it.

● (1635)

Ms. Rachel Blaney: Yes, I agree. I've had too many health professionals come to me and talk about giving people medication or prescriptions for medication and people not filling or taking half a dose when they really need to take the full dose.

We've heard loud and clear how very hard the work is for health care professionals. Can you expand a bit on how labour practices can impact care? Also, is there an issue in retention around this sector?

Ms. Linda Silas: There's no issue on retention. It's almost the ghetto of where we go in health care, which is kind of sad, because as you heard from many of the speakers, seniors and the aging population are a richness in our country. We need to mix the professional help that is needed from doctors, specialists, and personal care workers with help from volunteers and family caregivers and make sure that everyone is working in a coordinated team—of course with the family and the senior leading the team—regardless of the cultural appropriateness of what is needed.

It's about working as a team and making sure that if they have medical or health care needs, they're filled. We cannot push seniors and their families into their homes if it is not safe. As I said earlier, some of them are very sick and need support 24-7. Sometimes the volunteer or the aunt can't do it. We have to guarantee our seniors of today and tomorrow that our health care services will be there.

Ms. Rachel Blaney: Thank you.

We're hearing a lot about the need for training. We're hearing a lot about the fact that attracting people to work with seniors is a challenge. We know there's an intensified focus on the need for clinical data standards and the interoperability of clinical information systems across all the provinces. Do you see other needs that would fulfill something like a national standard?

Ms. Linda Silas: Yes. We had Dr. Pat Armstrong from York University do a paper for the council of the federation two years ago. It was all about building national standards for seniors care and having it be legislated.

Let's be clear. The federal government will never deliver the care, but the federal government can deliver the standards that will be in each province and territory and can also have the clinical data available for everyone. The federal government could easily build a training program for all the volunteers and caregivers, paid or not, that would be appropriate in every setting for seniors. That can be an EI program. There can be so many programs that can be led by the federal government to ensure that all older Canadians are taken care of.

Ms. Rachel Blaney: Thank you so much. I see my time is winding up, but I will be coming back to the friendship centres soon.

I wanted to say that one of the elders in our community taught me that if we were traditionally appropriate, all of our magazines would have elders and seniors on the covers because they would be the people who we respected and followed.

I look forward to having a conversation with you in the next little while about what we need to do to support friendship centres in our communities. Thank you.

The Chair: Thank you very much.

Now we'll go to MP Robillard, please.

[*Translation*]

Mr. Yves Robillard (Marc-Aurèle-Fortin, Lib.): Ms. Silas, the nurses you represent are in the best position to see the aging of our population and its consequences. What can you tell us about the needs the people you represent observe? Also, what needs do the nurses you represent observe among seniors?

And, more important still, what do you recommend as a federal solution to help meet these needs, as the Canadian Federation of Nurses Unions?

Ms. Linda Silas: Thank you, Mr. Robillard.

The reassessment of clients and their families is probably the greatest need observed by the country's nurses. All of the seniors are medically assessed and sent home, and then they are forgotten for weeks, months, or longer. That is when accidents happen, loss of balance, falls; people forget to take medication or are sent to emergency or readmitted to hospital, and the families scramble constantly.

The nursing profession asks that there be more continuous reassessments and coordinated care, whether we are talking about physical, mental or social health. You have heard it in other presentations; people cannot live in isolation, and even truer for the elderly, as this weakens their physical and mental condition.

As I mentioned several times, care has to centre around the person's safety, and not only on what the system permits, home care.

● (1640)

Mr. Yves Robillard: Our government's 2017 budget simplified and improved the tax credit system for family caregivers. The Canadian caregiver credit now provides better support for those who need it the most, and it applies to family caregivers, whether they live with a family member or not; the eligible income threshold has also been raised.

As president of the Canadian Federation of Nurses Unions, can you tell us about the impact of these changes for caregivers and for those in the nursing profession? Do you see more people claiming this tax credit?

Ms. Linda Silas: Yes and no. Caregivers are often those who would naturally help the family or the elderly person. Any support in the form of tax credits helps them personally, but they do not decide to become caregivers in order to benefit from the tax credit.

The key is making sure these caregivers have the training, education and support they need to take care of their family members. That is what is missing, and that is what the caregivers, nurses and social workers ask us for. The would like us to provide them with the training they need to take care of the elderly in their homes.

Mr. Yves Robillard: Do you see a real change thanks to the tax credit we provided?

Ms. Linda Silas: Honestly, I can't tell you. We hear positive stories, but are they representative?

Mr. Yves Robillard: Mr. Smith, your organization has set up a telephone information line and helpline for abused seniors.

Can you tell us what you hear, and what solutions you provide to those who use the helpline?

[*English*]

Mr. Kevin Smith: I'm sorry. If I understand your question, it's what have we heard for problems and solutions?

Mr. Yves Robillard: From the elders.

Mr. Kevin Smith: My presentation was based on some of what we hear on our line in terms of people who are isolated, and in rural situations where they lack communication and transportation. We also see abuse and neglect in various forms of seniors accommodation, assisted living, residential care facilities, where the seniors, even though they're in a social setting, are isolated. They feel like they have no social connections and they have been exploited.

We hear, in a number of different places, where people are being exploited. We think, in terms of advancing their inclusion, there needs to be more done in terms of providing opportunities for seniors to get together with other seniors in those situations.

Mr. Yves Robillard: Thank you.

The Chair: Thank you very much.

Now we'll go to MP Sangha, for six minutes.

Mr. Ramesh Sangha (Brampton Centre, Lib.): Thank you to the team for giving this valuable info today.

I'm giving you a very new scenario. I'm talking about one group of seniors. These seniors are not in my riding. They are living all across Canada. These people are over the age of 65. They are not entitled to CPP, GIS, or OAS. They are not entitled because they do not qualify, so they are living in poverty. They are undergoing financial hardship. Generally, they don't have a good standard of living. They cannot go for employment because of barriers due to age and obligation.

Do any of you know that this type of group exists in our communities? Anybody can answer.

● (1645)

Dr. Birgit Pianosi: Yes, I think it's especially women, older women more than men.

Mr. Ramesh Sangha: Mostly they are immigrants who were sponsored by their children or grandchildren, but they have not completed any years and are not entitled to these benefits.

Besides those benefits, what else do you suggest to improve their standard of living to get them out of poverty? What are your suggestions for that?

Dr. Birgit Pianosi: Well, it depends on whether they are dependent on their family members or not, from a physical perspective. If they are unhealthy and they have family members who can take care of them, through the tax benefits, they would have an option that the younger generation can take care of them.

If not, I think it's quite difficult, especially as you probably also have problems with language. They might not speak English or French as their first language. I see an opportunity to especially make them feel that they are still needed and are part of the community, that they can be involved in some ways.

Those are my thoughts.

Mr. Ramesh Sangha: Most of them are taken care of by their families, the people who have sponsored them. Some of them are unlucky, those who are not getting a good response from their families. They deserve some sort of help in the community or by the government.

What type of suggestions can you give?

Dr. Birgit Pianosi: There are volunteers who do home visits and could provide home visits to those older adults.

I think that also an opportunity might be, now I forgot the name, but the centres—I am an immigrant too—when someone can meet with people from their own background, for instance. For me, it would be someone from Germany to speak to. This is especially if language is a problem. It would be to have them volunteer to come and meet with them, because I think the biggest problem probably is for them becoming lonely and isolated at some point.

Mr. Ramesh Sangha: Madam Senator, you had something—

Ms. Vera Pawis Tabobondung: At friendship centres we ensure that there's a drop-in or there's a place for them to come. I know from my work that family members would bring them to the friendship centre during the day so that they had a place to socialize, whether it was sitting by the desk and reminding people about their Ojibwa language that they could use for the telephone, or reminding us of our language, that we had a role to play. There's always room for one more in our homes. We know that doesn't work sometimes.

Some of us have outlived our own children, and we do have people who remember who we are because we're an auntie or we come from an extended family. We always add more water to the soup so that people are being fed. We try to have community kitchens and community socials and potlucks so people can get together and share. They would be able to ask for or identify somebody who will help them. They pick someone who they trust will come and help them find a home so they don't have to continue to live on the street.

We also try to ensure that we go past being a volunteer. You will compensate me for my knowledge that I'm sharing with you; then it goes beyond being just a volunteer. We're running and trying to further develop community conversational Ojibwa language programs so that we can be partners in the way that we can design something. We could supplement their incomes.

● (1650)

Mr. Ramesh Sangha: Do you think that...?

The Chair: Ramesh, sorry, that's it.

Mr. Ramesh Sangha: Thank you very much.

The Chair: Thank you.

We're now going to MP Warawa for six minutes.

Mr. Mark Warawa (Langley—Aldergrove, CPC): Thank you, Chair.

Thank you to the volunteers. I really do appreciate the testimony and expertise that you are providing to our committee.

There's not enough time to ask all the questions and hear all your inputs. Some of you have provided a brief. We would encourage each of you to provide a brief with recommendations on how we can better care for our seniors.

I have highlighted a couple of things here for some questions. Repeatedly, we heard the importance of the human touch. Isolation is a huge problem. Along with isolation comes shortness of life, depression, sickness. It's quality of life and the importance of potlucks. I grew up as a young boy enjoying potlucks, the good food and the pies. It keeps the community together. You get to spend time with your friends, of course, but you get wisdom from the seniors. The human touch is so important.

I also wrote down the suggestion from Linda that the federal government could provide training and standards for senior home care. I thought that was extremely important. Health care is provided by the provinces but where does the federal government step in? Well, it's providing that training. A couple of weeks ago we heard from CARP. CARP said, regarding caregivers, that an estimated $25 billion, or 80%, of care is provided annually by eight million informal, unpaid caregivers.

CARP is urgently calling for action to reduce the devastating emotional impact on caregivers nearly a half of whom have experienced stress and depression. CARP wants a refundable federal tax credit, expandable EI coverage for compassionate care benefits, a caregiver's allowance for low-income caregivers, and a significant expanse of respite care. I think those are all good suggestions.

We'll start with Natalie Sonnen. You said there are fewer caregivers now, and we have a growing population. Did I hear that correctly that there are fewer caregivers?

Ms. Natalie Sonnen: Yes, I would say fewer within the family because the nuclear family is much smaller these days. Oftentimes, in our experience, we don't have the core family members there to take care of their parents, for example. That was what I was referring to.

Mr. Mark Warawa: The cost of $25 billion annually for the value of that volunteerism that is already happening, which is often provided by family members, is a savings to our country, and it provides that human touch.

You also mentioned that loneliness and isolation are major contributors to people getting thoughts of life not being worth living: “I'm not feeling well”, or “I'm lonely”, and “Just give me the shot. Put me to sleep. Goodbye, I've had enough.”

Could you expand on the importance of meeting that need of depression and isolation through volunteerism?

Ms. Natalie Sonnen: Yes. It obviously has been a concern of ours.

One of the things I did want to quickly mention is that the program we run is available and being utilized most especially by older adults themselves. In terms of giving people incentive to get involved with their community, this program, we found, has been excellent, not only in terms of the visitation and the visiting of those who are dying, but older adults themselves are the ones who are taking the program and volunteering themselves. It's really giving them a way to connect with their community. What we've found is that it's been extremely valuable for them.

The statistic, again, that was quite concerning is that, when people are lonely and don't feel that they have meaning in their lives, they are definitely more susceptible to the notion of an early exit and—

● (1655)

Mr. Mark Warawa: I'm going to have to interrupt you. My apologies. I'm running out of time.

I think it's so important that we deal with this issue, and the study that we have right now is a national seniors strategy on M-106.

I'd like to move a motion that the Standing Committee on Human Resources, this committee, undertake a study on caregivers in Canada—basically what's being asked for by CARP— immediately after this study, and that the committee hear from witnesses at 10 meetings and report the findings on the status of caregivers in Canada, including recommendations on federal changes needed to assist caregivers in the House. I think it's very important, after this study, that we move on to caregivers.

The Chair: Thank you, Mr. Warawa.

I just want to remind everyone that we have carved out the last probably 20 minutes of today for committee business, if you'd like to wait. Otherwise, we're going to have to ask everybody to leave.

Mr. Mark Warawa: Can we deal with this at the end of the day?

The Chair: Absolutely, 100%.

Mr. Mark Warawa: I'd be glad to do that. Thank you.

The Chair: Thank you very much.

Now over to MP Ruimy for six minutes.

Mr. Dan Ruimy (Pitt Meadows—Maple Ridge, Lib.): Thank you very much, everybody, for coming.

I've said this before, and I'll continue to say it. This is a problem that's been ignored for decades, which is what has brought us to where we are today. There's not going to be one magic bullet that's going to solve the problem. It's going to involve funding, absolutely, but it's also a cultural mindset that needs to change.

Before I got elected.... Well, I still own a little coffee shop in my riding, and we've been doing, for about four years now, something called the death café. It sounds morbid, but it's a place where people get together to talk about death in a non-threatening, life-empowering way. It's one of the reasons I decided to run for Parliament. I started seeing 15-year-olds engaging with 88-year-olds and the magic there. Nobody's getting paid. This is just starting to take back what we've lost, because we used to be able to take care of our own. We used to be able to engage each other.

I think, Natalie, you said that the nuclear family has changed dramatically, and we don't have that number of people there. From what I see, that's a great opportunity.

I think it's very similar to your Dying Healed program, because you are dealing with end of life. You're having those conversations. Am I correct in that?

Ms. Natalie Sonnen: Yes.

Mr. Dan Ruimy: Can you quickly tell me, Natalie, how you are growing this part of your program?

Ms. Natalie Sonnen: We have a network of groups across Canada. We have about 112 groups. These are very small grassroots organizations. I think they're concerned with what they were seeing happening within their communities in terms of elder abuse and the social isolation of elders, so they wanted to really get involved. They're the ones who are taking this program and running it in their local communities. Often it's through a church, a synagogue, or a mosque, where there's a community already established. They're coming in and saying, “Here's this program. Let's get together; let's first learn it.” There's an education component. It's also confidence building for volunteers. It's giving them a sense of ownership, and then empowering them to go out. We're teaching them concepts about the power of human presence, that there's meaning in human suffering. We don't want to suffer, but—

Mr. Dan Ruimy: I'm going to jump in here. Is it a non-profit organization?

Ms. Natalie Sonnen: It is, yes.

Mr. Dan Ruimy: Have you been taking advantage of the new horizons for seniors program to fund it?

Ms. Natalie Sonnen: No, we haven't. I'm learning a lot sitting on this panel today.

Mr. Dan Ruimy: It's a good program. You should look into that.

Ms. Natalie Sonnen: Yes, I've written it down.

Mr. Dan Ruimy: Are we doing partisan things now?

Thank you. I'm going to move now to Ms. Pianosi. Do you see an uptick in people who want to study gerontology?

● (1700)

Dr. Birgit Pianosi: I think it's a catch-22. Most of the programs internationally actually have problems surviving. That's just reality because of the fact that right now they are not accredited programs. They're not considered to be health care professionals, so it's very difficult for graduates of the programs, three-year and four-year programs, to find employment in long-term care and so on. So it has to do with professionalization of the field.

Mr. Dan Ruimy: The number of medical practitioners who specialize in gerontology—

Dr. Birgit Pianosi: No, that's a different story. Medical professionals who study aging are geriatricians. They are social science programs, gerontology. It's not a medical program. It's a social science, usually, so the graduates would learn about what the aging process is, except for diseases. I mean, they learn them but they're not medical—

Mr. Dan Ruimy: Where do they go on from there? You get a graduate program. What do you do with that?

Dr. Birgit Pianosi: Many go into long-term care, not-for-profit organizations of aging, ministry offices, Statistics Canada, private—what do you call somebody who creates their own kind of company, I can't think of the word—entrepreneurships.

Mr. Dan Ruimy: Entrepreneur, right.

Do you see a demand for their services?

Dr. Birgit Pianosi: Yes, there's a demand. Everybody says we need more people who have knowledge in gerontology, but then on the other hand, many people can't employ them because they're not registered. They're not regulated. It's very difficult for employers to see what a gerontologist or graduate of a program can do. It's not an accredited program so all programs are not the same. It depends on, really, where you're studying gerontology.

Mr. Dan Ruimy: I'm running out of time, but very quickly, with what you've experienced, having more people certified in this, how do you think that would help our system?

Dr. Birgit Pianosi: There are two different things. One is we need to educate specialists, people who are, for instance, nurses, social workers, and so on, more on gerontology and geriatrics. That's one point. The other point is that we do need more specialists, gerontologists, who can provide services other than the ones offered by health care providers. They have the knowledge. They know about aging. We really need to look at how we can provide these programs.

Mr. Dan Ruimy: Very quickly, do they collaborate with doctors?

The Chair: Dan, we have to.... A very quick answer.

Dr. Birgit Pianosi: No.

Mr. Dan Ruimy: They don't collaborate at all with doctors.

Dr. Birgit Pianosi: Doctors don't collaborate. It's not the gerontologists' fault.

Mr. Dan Ruimy: No.

The Chair: Okay.

Now, for five minutes, we'll go to MP Falk. Welcome to committee, sir.

Mr. Ted Falk (Provencher, CPC): Thank you, Mr. Chairman.

I would like to start with Senator Pawis Tabobondung.

Simply as a point of curiosity, you said there's a difference between an elder, senior, and a nice old lady. Can you very briefly tell me what the difference is? I'm curious.

Ms. Vera Pawis Tabobondung: Well, I'm the nice old lady sitting here and telling you what I'd like to see in a program that's designed for seniors that's going to help me stay in my home. We're pretty vocal about those kinds of things. After a while we get to be a senior citizen and we're able to get our old age pension and a number of programs that are designed for us, and sometimes we'd like to be able to sit together in our communities and design our own...and establish what the priorities are and how to evaluate those.

An elder is when.... Well, it's the recognition and the respect that comes from the life you've lived, the experience you've had, and the ability to share that and mentor young people on those things that they're going to expect or see in their seven stages of life—

Mr. Ted Falk: Thank you.

Ms. Vera Pawis Tabobondung: —that I should be able to share what end of life ceremonies are, end of life teachings, and have the responsibilities that all of us have to do and participate in.

Mr. Ted Falk: Thank you, Senator. We need more elder seniors.

Ms. Vera Pawis Tabobondung: Thank you.

Mr. Ted Falk: I'd like to ask Ms. Sonnen a few questions.

You alluded in your comments to individuals...and I think you used the term “check out early”.

I'd like to follow up a little on that. With the physician-assisted suicide legislation that has been passed, I'm sure you see an impact with that legislation among the people you work with.

Can you tell me if there's any impact, or how it impacts the seniors that you or your organization work with?

● (1705)

Ms. Natalie Sonnen: I think there is a risk of lack of confidence in the medical system, so they may not be as likely to reach out when they're in need. There's also the issue of suicide contagion, in terms of the quality of.... You know, we talk about assisted death being something that a person gives their consent to, and that there are safeguards around the consent, but the quality of that consent I think is jeopardized when there are issues of other people in the care home who may be committing suicide or having medical aid in dying. That kind of influence and culture within that care home then is affected.

I do see it affecting confidence levels. There is a certain amount of fear. Those put up barriers between seniors who need care and the people who should be providing it.

Mr. Ted Falk: If I can interpret what you said there, you're saying there is a degree of peer pressure in nursing homes and among the elderly with this program.

Ms. Natalie Sonnen: Yes, absolutely.

I think medical aid in dying can affect the culture within a care home, for instance, so there are undue influences or pressure there that might even be unspoken. It does affect the quality—

Mr. Ted Falk: Another thing I'm curious about is that your organization is based on volunteerism.

Do you go out and recruit volunteers? Is there a pool that you can draw on? Where do your volunteers come from?

Ms. Natalie Sonnen: We have a network of about 112 groups across Canada. These groups are very grassroots. They're on the ground. A program like this gets passed out from group to group to group.

The program itself is recruiting volunteers. That's the point of the program, to provide education and volunteer recruitment. It's trying to raise awareness of this issue, raise awareness that we have a lot more older adults who are needing care, and the importance of the issue and all that it entails, such as the knowledge of aging, as one of the panellists spoke about.

The program itself is actually recruiting, and the vehicle is our network of groups.

Mr. Ted Falk: Thank you. I think I'm out of time.

The Chair: Thank you.

For three minutes, we have MP Rachel Blaney.

Ms. Rachel Blaney: Thank you so much.

I have two friendship centres in my riding, Sacred Wolf and Wachiay.

I'm asking both of you this, whoever wants to answer.

Last year, I received an extensive package with all the concerns around the lack of funding or the changes to funding. They were petitions from the Wachiay Friendship Centre, in which people specifically spelled out each service they were receiving and each service they had received.

As a service provider, I know that you both do a lot, and you see first-hand the needs of elders. Issues like food security and housing were both in high need in the information that I received. I'm wondering if you see the same and can tell us what the government can do, because this seems to be a systemic problem.

Ms. Vera Pawis Tabobondung: For me, on what we can do, I think we have to work together on designing the community strategy, because in some places it's housing, and yet in other communities, it's not.

However, where do we study? How do we design the study so that the information we need today is what we're going to be able to action in five to 10 years, because that's how long things take? We talk about needing housing, needing housing that's appropriate for seniors. We need to have programs, whether it's the home care, the transportation that brings them to the service or to the dentist to have their health care needs met.

That's what I have right off the top, without doing a whole bunch of research and looking at what our recommendations were before.

● (1710)

Ms. Rachel Blaney: When Statistics Canada officials came to committee, they shared with us the 2012 aboriginal peoples survey. We heard that a higher percentage of aboriginal seniors lack social support.

Do you have any ideas as to why this is happening, and what can we do to remedy it?

Ms. Vera Pawis Tabobondung: When we start to understand the identity, we can bridge the gap between young people and old people. I believe that I have done my job by raising my children to understand their roles and responsibilities.

We come back from the city to our communities, and sometimes we have to relearn the things we didn't get. It's fun to sit down and relearn your language. You haven't used it for so long, because you worked in an economy that just didn't allow that. We went to institutions where we could study all kinds of things, but never learn about ourselves.

At the friendship centre program I go to when I have time, that is where they talk about so-and-so moving over there, or so-and-so bought a new e-bike and is getting around quite well. You can hear the community conversations. If we had time, and made a priority of all the things that have been mentioned around the table, we would get there. It's important.

The Chair: Thank you very much for your testimony today.

Thank you to all of you for being here and contributing to this study. I will echo Mr. Warawa's sentiment. If there are things you still want to share, please feel free to submit a brief to the committee, and of course it will be considered.

We will suspend for a moment while we get ready to do some committee business.

[*Proceedings continue in camera*]