



**BRAIN INJURY  
ASSOCIATION  
OF LONDON  
AND REGION**

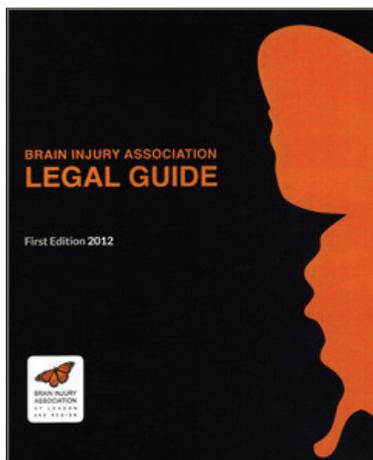
Spring Issue March 2015

# THE MONARCH

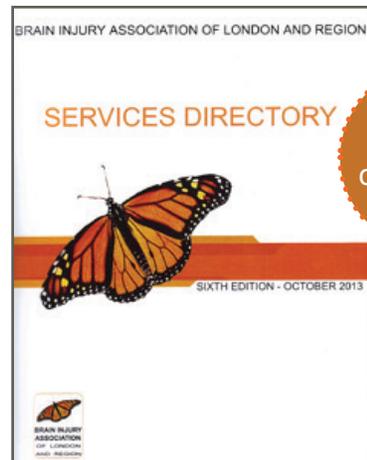
*Looking Forward*



# Check Out These Great Resources!

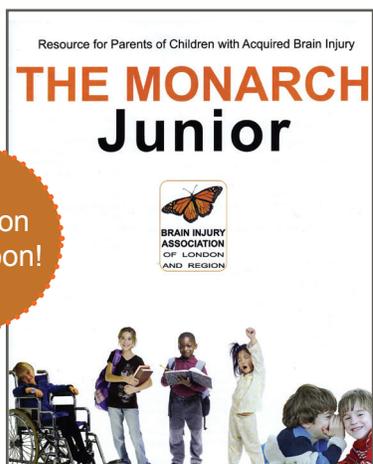


This legal guide is published by BIALR, in collaboration with Harrison Pensa, and is in its first edition. It is designed to provide straightforward accessible explanation of key legal issues and fundamental legal rights of those who have suffered brain injuries and their support teams. Print copies are available from the BIALR office and electronically on the website.



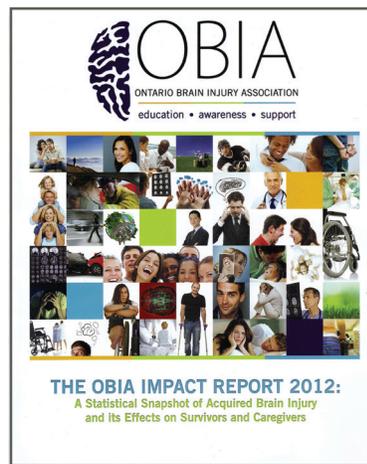
new edition coming soon!

This directory is published by BIA London and Region and is in its 6th edition. It is designed to help individuals suffering from the effects of a brain injury identify and locate the services in London and Region. (Print copies are available from the BIALR office and electronically on the website.)



new edition coming soon!

This resource is published by BIALR and is in its first edition. This compilation of articles is designed as an informational resource for parents of children who are suffering from the effects of an acquired brain injury. Print copies are available from the BIALR office.



The OBIA Impact Report 2012 is published by the Ontario Brain Injury Association (OBIA), with support and funding provided by the Ontario Neurotrauma Foundation. It is designed as an easy to read statistical snapshot of acquired brain injury and its effects on survivors and their caregivers. Electronic copies are available on the OBIA website.

## Online Resources:

- Brain Injury Association of London and Region - [braininjurylondon.on.ca](http://braininjurylondon.on.ca)
- Ontario Brain Injury Association - [obia.ca](http://obia.ca)
- Brainline.org, preventing, treating, and living with traumatic brain injury - [brainline.org](http://brainline.org)
- Brain Injury Association of Queensland - [synapse.org.au](http://synapse.org.au)
- National Resource Center for Traumatic Brain Injury ( Virginia Commonwealth University) - [www.tbinc.com](http://www.tbinc.com)

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# We Need Your Help!

## Volunteer Opportunities Available

If you or someone you know is interested in volunteering, we are looking for energetic people to join our team!

We are currently seeking volunteers to assist us with various support groups, charitable events and committees.

### London Nationals Hockey 50/50 Ticket Sellers:

-Wednesday nights at 7:30  
at the Western Fair Sports Center

### Support Group Leaders and Speakers:

-For all 5 counties: London/Middlesex, Perth, Elgin, Oxford and Huron

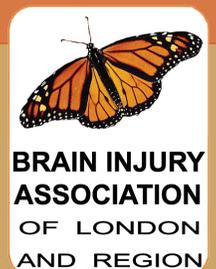
### Committee Members:

- Community Awareness
- Fundraising
- Support Services
- Conference
- Editorial



If you are interested in volunteering or have questions please email:

[volunteer@braininjurylondon.on.ca](mailto:volunteer@braininjurylondon.on.ca)





# Letter from The Executive Director

When the Association began nearly 30 years ago, knowledge about brain injury was quite limited. We have seen tremendous strides throughout the years with exciting research, varying approaches to treatment and increasing awareness of the effects of brain injury on those living with it. Although we are beginning to have a greater understanding about brain injury, we still have a long way to go. The theme for this issue of the Monarch is dedicated to the future of brain injury. A common question asked by family members is 'what should we expect for our loved one in the future?' You can help by participating in the Research Study conducted by the Ontario Brain Injury Association. Information about the survey can be found at <http://obia.ca/participate-in-research-survey/>. Your involvement in the Research Questionnaire will enhance our ability to provide a greater unified voice on behalf of people living with brain injury in Ontario. The Association is one of the founding members of Year of the Brain 2015. We recently held an exciting kickoff event at Parkwood Institute. You can find more details in the article on page 7. Be sure to check out the website, attend the Brain Fair on April 1 at the Children's Museum and sign up for monthly webinars provided by some of the 18 brain condition organizations that have come together. All of our monthly support groups are running well, with many thanks to our volunteer support group leaders for their efforts and to engaging guest speakers. Recent topics included food and safety, fire safety and Year of the Brain 2015. The Huron County group will be starting up March 9, 2015 and running until late fall. The Community Awareness committee has been seeking informative articles and topics for the revision of the Monarch Junior, a resource guide for parents of kids with ABI. We are hoping to have the publication ready for distribution at our annual conference. We are also in the process of gathering data for the Brain Injury Services Directory revisions. If your information has changed, or you wish to be listed, please contact our office. Also watch your email for the order form. The Conference Committee invites you to attend 'Journey through the Fog.. 18th Annual Conference June 17, 2015'. Engaging topics include: Mild ABI research, Latest treatments for ABI and PTSD and much more. Our board of Directors is currently undergoing strategic planning to determine what exciting new things the future holds for us. We encourage you to give us your input into what we do well, what we could improve on and what you feel is the most important function of the Brain Injury Association in your community. Please send your suggestions to [info@braininjurylondon.on.ca](mailto:info@braininjurylondon.on.ca).

Donna Thomson

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# Highlighting Our Volunteers

Just A Note To Say Thank You!



## Henna Butt

### Tell us a little about yourself?

I'm currently a 4th year Medical Sciences student at Western. I will be graduating this year and then going to medical school next year. In my spare time, I enjoy volunteering at a couple of places here in London, including the Canadian Cancer Society, and the Children's hospital. I am originally from Ajax, and moved here 3 years ago to attend Western.

### How long have you been volunteering with the Brain Injury Association?

I have been volunteering with the Brain Injury Association for about 3 years now.

### Why did you choose to volunteer with the BIA?

I chose to volunteer with the BIA because I had never heard of the association before moving to London. While searching for potential places to volunteer, I came across the website and decided to attend an interview for a volunteer position. Once I came in and realized what BIA is all about, I decided that I wanted to be involved in spreading awareness as well.

### What makes you come back to BIA year after year?

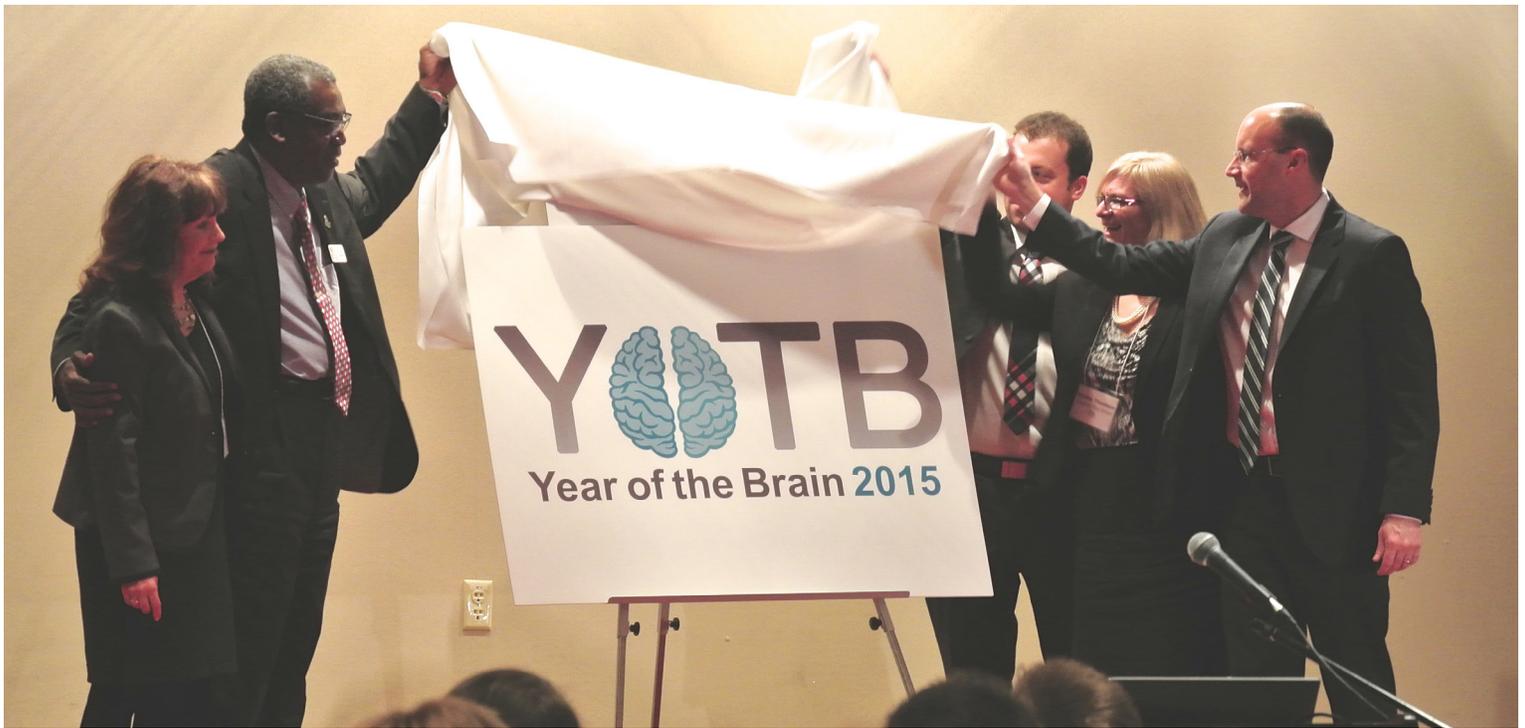
I choose to come back every year because of the people at the BIA. Donna, Stephanie, and Jessie along with the other members of the Fundraising committee are extremely inspiring, inviting, and dedicated. Their commitment to the BIA can easily be seen in all of the work they do and being able to help in any way I can makes me proud to say that I volunteer at the BIA.

### Do you have a favourite moment from your time here that you can and would like to share?

My favourite moment from volunteering at the Brain Injury association would be at my very first Casino Night. After running around all morning and evening, to ensure that everything ran smoothly it was nice to sit down and see that a very important cause was being recognized by a room full of people.

### What would you say to someone that is considering volunteering with BIA?

Volunteering at the BIA has been a very rewarding and interesting experience. Every week there was a different task to be done which kept me on my toes. I would highly recommend volunteering at the BIA since it has made me more aware and I have enjoyed my time here.



# Year of the Brain

As one of the three founding partners, Donna Thomson and the Brain Injury Association of London and Region, along with Brain Tumour Foundation of Canada and Dale Brain Injury Services, have officially launched the Year of the Brain 2015 in London & surrounding region. The focus of Year of the Brain 2015 is to provide a platform for all neurological and mental health based organizations in the area to come together to support people living with brain-related conditions.

A networking group from various organizations has been formed, called the Brain Health Network of Southwestern Ontario. One of the largest benefits to the London community will be the data analysis of the services that currently exist and the identification of gaps in services, as well as providing education and creating awareness throughout the area.

The official Kick-Off at Parkwood Institute on January 28th was a huge success, with members from all eighteen community partnered neurological and mental health organizations, Mayor Matt Brown, Ward 14 Counsellor Jared Zaifman and numerous initiative supporters were present. In addition, the initiative was thrilled to accept a donation of \$20,000 from The Sifton Family Foundation at this launch event.

Social media including a Twitter account, Facebook page, and official website have been launched. Also, a monthly 'Brain Health' webinar series will be held on the third Thursday of every month highlighting a brain-related condition or topic, with each webinar hosted by a different organization part of the Brain Health Network. An exciting and interactive Brain Fair is scheduled for April 1st from 4 – 8pm, to be held at the London Children's Museum. This event will include special guest speakers in the field of neurology and mental health, as well as caregiver's support and a chance to enjoy healthy brain food! With numerous partnered-organization events promoted throughout the duration of the Year of the Brain 2015 – it's bound to be an exciting and busy year ahead!

[www.yearofthebrain2015.com](http://www.yearofthebrain2015.com)

Follow us on twitter: @yotb2015

Find us on Facebook!

For any questions, please email [yotb2015@gmail.com](mailto:yotb2015@gmail.com)



## JOINT MEMBERSHIP PROGRAM

### Brain Injury Association of London and Region & The Ontario Brain Injury Association

Invite you to belong to both organizations for one low fee!

Further information and the application form can be found at

[www.braininjurylondon.on.ca](http://www.braininjurylondon.on.ca)  
under "How to help"



### Cornerstone Clubhouse

A Dale Brain Injury Services day and evening program for adults living with the effects of an acquired brain injury.



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## DISCLAIMER:

The Monarch is published by the Brain Injury Association of London and Region.

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All articles remain in their submitted un-edited form to preserve the original views and intent of the author.

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**Stephanie McGill**

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# Peer Support Coordinator's Report

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The Peer Support Mentor program continues to thrive with new mentors being trained and new partners realizing that they would like to speak with somebody else who really understands what it is like to have their entire world turned upside down by a brain injury. This month's theme of The Monarch focuses on the future of ABI and planning for your future. The Peer Support Mentor Program is making humongous impacts in the recovery of those whose lives have been impacted by an acquired brain injury, myself included. My involvement as a mentor at the very first mentor training way back on September 11, 2006 gave new purpose to my life. Here I was a brain tumour survivor and a recent assault victim helping out another brain injury survivor navigate the often turbulent road of brain injury by offering him support, sharing strategies with each other and sometimes just laughing and telling each other what's occurring in our lives. Now almost a decade later, I am London's Peer Support Coordinator. I guess you could say that the Peer Support Mentor Program was ahead of its time for being one of Ontario's first programs to offer support from people who have experienced brain injury themselves. There are many new and exciting initiatives currently being undertaken to improve the lives of those affected by brain injury. For example, this year has been labeled "the Year of the Brain", which you can read about elsewhere in this issue. I plan on holding the Association's 11th mentor training in a few months, so if you think you have what it takes to make an impact on someone who is struggling with the problems that brain injury inflicts, Don't be hesitant and call the office!



**Jamie Fairles**

Peer Support Coordinator  
519-642-4539

[editorial@braininjurylondon.on.ca](mailto:editorial@braininjurylondon.on.ca)

## Looking To Get Involved?

We are looking for individuals to become mentors in our Peer Mentor Program. Mentors provide support and share information and resources with partners who are coping with a similar ABI-related situation. We are in particular need of mentors who are family members and caregivers. Visit our website or contact our Peer Support Coordinator for more information.

[www.braininjurylondon.on.ca](http://www.braininjurylondon.on.ca)

# Brain Injury Support Groups

If you or someone you know has experienced a brain injury, you may benefit from participating in one of our many support groups. Groups meet either monthly or weekly and offer you the chance to learn more about living with ABI. Discuss common issues and problems or have fun in a positive environment.

 <p><b>Huron County Support Group</b></p> <p>Meets the second Monday of the month          OMAFRA Office          100 Don Street          Clinton ON          6:00 - 8:00pm</p>	<p><b>London Social Leisure Group</b></p> <p>Meets the first Thursday of each month          Cornerstone Clubhouse          781 Richmond Street          London, On          6:00 - 8:00pm</p> <div data-bbox="831 598 1057 705" style="border: 1px solid black; padding: 5px; text-align: center;">             Your logo could be here         </div>
<div data-bbox="94 932 319 1039" style="border: 1px solid black; padding: 5px; text-align: center;">             Your logo could be here         </div> <p><b>Perth County Support Group</b></p> <p>Meets the last Tuesday of each month          Zehrs Markets          2nd Floor Community Room          865 Ontario Street          Stratford, On          7:00 - 9:00pm</p>	 <p><b>Oxford County Support Group</b></p> <p>Meets the First Tuesday of each month          Dundas United Church          285 Dundas Street          Woodstock, On          6:30 - 8:30pm</p>
 <p><b>Perth County Social Leisure Group</b></p> <p>Meets every Wednesday of each month          Central United Church          194 Avondale Avenue          Stratford, On          1:00 - 4:00pm</p>	 <p><b>Elgin County Support Group</b></p> <p>Meets the second Wednesday every month          At the Real Canadian Superstore          2nd Floor Community Room          1063 Talbot Street          St. Thomas, On          6:30 - 8:30pm</p>
 <p><b>London/Middlesex Support Group</b></p> <p>Meets the last Thursday of each month          First Baptist Church London          568 Richmond Street (parking in rear)          London, On          7:00 - 9:00pm</p>	<p><b>Elgin County Social Leisure Group</b></p> <p><b>Cancelled</b>          We apologize for any inconvenience</p>



# Taylor's Story

Submitted By: Taylor Shappert

I used to be normal. I was a very active, social 21-year-old university student, working at the barn and riding horses almost every day. That's when brain injury struck: I was a passenger in a car accident that left me in a coma on life support in ICU for three weeks, nursing nine fractured bones, a punctured lung, and multiple skull fractures resulting in brain injury and a visual impairment (homonymous hemianopia). The doctors said I would never return to school. "The Taylor that left in the car that day," they told my parents, "is never coming back."

When I heard that later, I thought, "I was headed for success before; why shouldn't I still be?"

I am proud to say, five years later, I will be graduating on the honour roll from the Print Journalism program at Sheridan College this June and am back to many of my old activities. It wasn't without major effort: I spent two years adjusting to my new, different, strengths and weaknesses and limitations before I went back to school part time. Many things have impacted my success, all of which can be used by anyone else to improve their own success.

First of all, I had to learn to be deliberate and plan for the future, something that was foreign for someone who just winged it day to day. This meant using my calendar, being organized, and setting goals and sticking to them.

Use a calendar? I laughed at the thought. I never needed one before! I eventually accepted the fact that yes, being deliberate and planning my days, weeks, and months was a huge and necessary help.

So much mental energy is conserved for other things when I am not spending energy trying to remember if I have plans for

Thursday afternoon. It's so much easier and more efficient to look on the calendar.

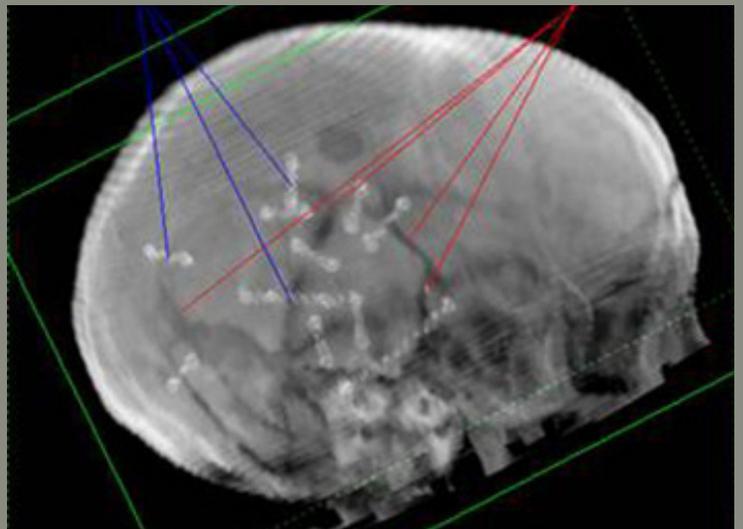
Mental energy has become a lot more precious to me. I see now that fatigue management and getting good quality sleep is the foundation for success in anyone. It's hard to employ good strategies if you're tired, no matter how hard you try.

Planning for the future also gave me a goal and something to work for. As I was "imprisoned," (so it felt) at home after the accident, I needed a light at the end of the tunnel, so I turned my thoughts toward school. This kept me motivated and kept me from becoming too depressed.

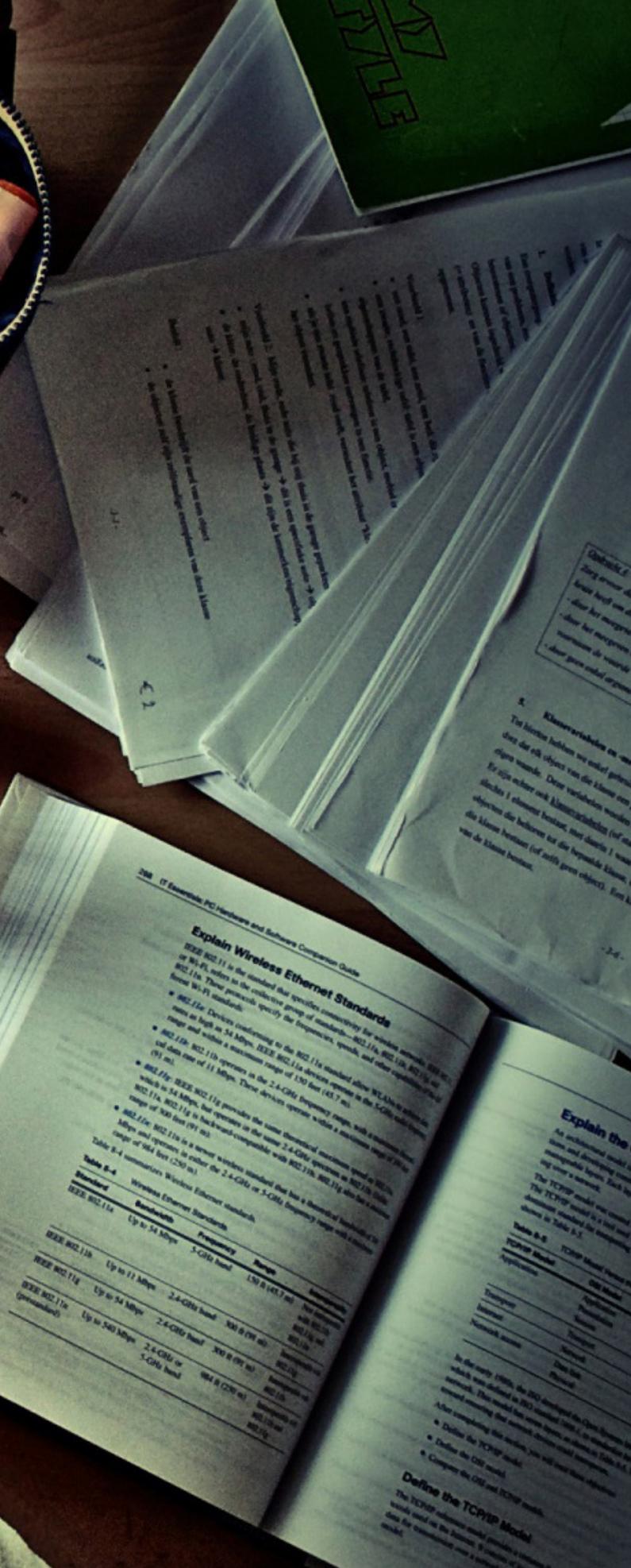
I wasn't going back to the same school or same program. As I became accustomed to my new strengths and weaknesses, I realized I probably couldn't go back to do what I had been doing. A major part of success is accepting what you can and can't do, and making the best of it. There's no shame in not being able to do something; the shame is in not doing something you can do. Being flexible is so important because the future is fluid and life changes – you have to grow with it, or it will grow without you.

Part of being flexible is being open to new strategies and employing them. This is essential to keeping up with life. Making time to keep yourself happy is so important. For me the biggest joy was getting my dog Dante and learning to appreciate my amazing family and friends. Having a hobby is a good way to keep yourself sane, too. Ironically, after acquiring a visual impairment I turned to photography as my pastime. The added challenge means I get even more satisfaction from knowing I do it well, and spurs me on to keep improving.

Last but not least, I had to learn that it's okay to accept help. I couldn't have gone very far without the help of others and I resisted that at first; going from being completely independent to being completely dependent on others was quite a change. But that's the beauty of being human: we're here to help each other be successful, and I'm lucky to have discovered that.







# Return <sup>2</sup> School

Submitted By: Stephanie Hutton & Penny Welch-West

Last year Speech-Language Pathologist, Penny Welch-West went back to school.

Was she looking to leave her post with the Acquired Brain Injury Program at St. Joseph's Health Care London to launch a career in law enforcement or basket weaving?

No. The visit was part of her mission, studying the classroom itself in search of a way to better serve those with mild traumatic brain injury hoping to get back to class.

Sitting in her office, barely large enough to contain her passion for helping patients with mTBI, she said her visit to the classroom of today opened her eyes like a new app freshly downloaded. She couldn't help put herself in the shoes of students recovering from concussion or mTBI. "Sitting in Psych 20 was like being in a Macbook commercial. How do they cope? How do they focus with so much going on?"

And so the creation of the Return to School (RTS) group program was birthed as Welch-West noticed a familiar pattern. "I sat with patient after patient attempting to answer the same question, "How can I get back to school?" Wading through an ever growing wait list of those suffering with concussion or mTBI in need of OHIP covered speech-language pathology with school as a recovery goal, she began to formulate the program that 2.5 years later continues to grow and change.



The program has seven modules starting with a two hour individual formal assessment session to identify the areas of strengths and weaknesses post injury in order to develop the proper treatment path, rebuilding those areas up again. Attention, comprehension, reading comprehension, verbal and visual memory, are among the areas tested to give Welch-West and the rest of the ABI team a complete picture of how the individual has been affected and will be further treated during group modules.

Welch-West aims to keep the group small enough so that she can intimately get to know each student keeping their assessments close at hand, but large enough to bring a real classroom feel. With the right balance she can swiftly change course when symptoms attempt to roadblock the learning that Welch-West believes each student capable of. She explains that learning styles can also change after an injury, auditory learners may become more visual for example, so identifying those changes are the key to success. "The problem is not articulation, these are bright, articulate individuals, but word finding and more often formulation/cohesion of thoughts is problematic. Many students struggle to organize thoughts leading them to be verbose, misplace words or be too unfocused to participate at all. What strategy, technology or treatment method can we use to allow the student to organize themselves in an efficient way?" As each learning hurdle is defined she has a tool chest of strategies at the ready to knock it down.

The students aren't the only ones learning as Welch-West says it was an early student in the course who really defined what it is that the program is doing "We take feedback forms from all students each week and one wrote, you are simulating a classroom, that's the best thing - my jaw dropped as I had never thought about it that way before"

This simulation is no cake walk. Students are encouraged to push themselves in areas they might have previously avoided, sometimes experiencing symptoms of their mTBI. This gives both sides the opportunity to identify the triggers and find ways to work around them. Welch-West does this with the use of SMARTboards, a slew of multi-media and forcing students to get involved and monitoring where and when symptom onset starts. When ringing in ears, brain fog or headaches do arise, Welch-West acts quickly to find a solution or way around the symptoms. "If someone starts with a headache I may call to other team members to trial acupuncture, review pacing and planning or even counsel depending on the source. It's not rare to walk by the room and see a few sitting with acupuncture needles poking up out of their heads." Aside from the expert treatment of the ABI team, technology looms closely to bring students back to the best possible state for learning. "We had one participant who was having a hard time staying awake during the sessions so with the Audiologist's guidance, I gave him an FM system he wore connected to a microphone I wore as I taught. We never heard from this guy and suddenly he said, 'Hey, it's like you're right' here pointing to his shoulder," she adds with a bright chuckle. Other symptoms such as forgetfulness, word finding challenges or inattention are met with a tool chest of solutions ranging from Livescribe Smart pens that record and playback notes to plain old rulers used to block the next line of reading materials.

While participants come away with individual strategies to deal with their mTBI, Welch-West says there is one lesson she broad brushes over the group who commonly try to sink into the background in the real world. "I am teaching them to be good self-advocates. How do you present yourself? Are you keeping eye contact? You will introduce yourself to your teachers and not just once at the beginning of the year so they will know why you need to have your head down sometimes. Many grades are based on 15% participation, get noticed. It's not probable to just accommodate a disability and have a successful back to school experience; this is about treatment, this is about understanding mTBI."

Modest about her efforts, she credits the team approach the ABI program operates under as the reason for an 80% success rate with the 80 plus students who have filtered through the program since its inception in October 2012. "I think what makes this program and the others we offer here so special is the team approach. I am constantly calling other therapists into treatment sessions. If I suspect that maybe comprehension problems are because the patient simply can't hear the material, I can access our Audiologist from next door. "Aside from speech-language pathologists the ABI program boasts experts in occupational therapy, audiology, behaviour/ anger management, physiotherapy, psychology and social work.

"I think this is what sets us apart. Some places may have massage and OT or speech-language and physio but our team has therapists to cover most things that patients with mTBI are dealing with, it's awesome!" Welch-West isn't the only one discussing the "awesome" of the RTS program as other clinics are taking note and picking up the phone. "I'm getting calls from all over the province, from parents who want to get their kids in, from places wanting to start a program like it, to speaking at different centres, the interest is huge." Her hope is to find time away from the SMARTBoard to get the program published in a concussion journal.

Despite its complexity, Welch-West boils down the RTS program, along with all the ABI team does, to this. "What we are really doing here is building people back up. It all comes back to confidence. Giving individuals the confidence to try a new way of doing things, to move through difficulties. We really try to provide a beacon of hope."

A tremendous task, however after just a few minutes with Welch-West it's clear to see that her beacon is bright enough to help any lost ship find its way.

### **For more information about the Return to School (RTS) Group or other ABI programs:**

<http://www.sjhc.london.on.ca/returntoschoolprogram>

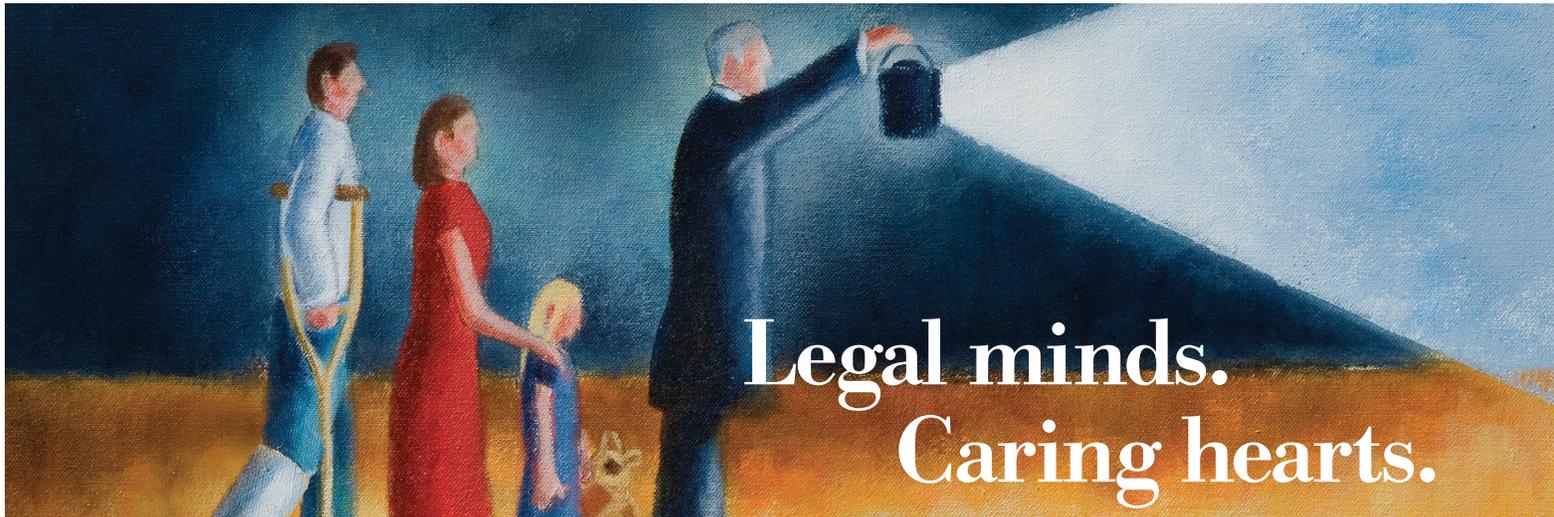
<https://www.sjhc.london.on.ca/acquired-brain-injury-program/outpatient-rehabilitation>

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# S.M.A.R.T GOAL SETTING

Submitted By: Stephanie Hutton

When looking to move forward after your brain injury or concussion it's time to get **S.M.A.R.T!** Your goals should be: specific, measurable, attainable, realistic and timely. Turn to this simple acronym before symptoms threaten to derail the next step in your life's journey.

**Specific:** Setting a specific goal will give you a much greater chance of success than having a general goal. To do this, ask yourself these five "W" questions: Who is involved? What do I want to accomplish? Where do I need to be to do this? When will I finish this? Why is this important to me? A general goal after brain injury might be "Get back to work" Now that you are "**S.M.A.R.T**" you would set out "Attending my workplace for one hour three times a week without fatigue"

**Measurable:** You must be able to track how successful you are at achieving your goal. To do this set out criteria for measuring progress toward the attainment of your goal. Using our example of the workplace, you might use a calendar to log when you do attend work, along with the amount of time you were able to work without fatigue. When you look back seeing the minutes of work without fatigue will motivate you through the days when you need it most. Remembering that you can't control the symptoms, only your effort.

**Attainable:** When you identify goals that are most important to you, you begin to figure out ways you can make them come to life. Breaking your larger goal into manageable chunks will have you working toward something that something you really want in a way that will make it tangible, providing hope and promise for the future.

**Realistic:** Perhaps the most important step for setting out goals after brain injury is to define realistic goals. That is not to say that you should not aim high, only to keep in mind what you are willing and able to do. Consult with your therapists when addressing the realism in your goals, but feel free to dream big! A higher goal is more likely to keep you motivated and interested because it will challenge you and become a labor of love.

**Timely:** Give your goal a defined time frame. With brain injury there are too many unknown factors that threaten to derail large goals with stanch deadlines. You can avoid those roadblocks with mini goals. Take our example: if you want to get to work three times a week but aren't yet going at all, start with attending work once a week for one month. At the end of that month you can reassess and set a new mini goal such as "Attend work twice a week". Each time you reassess keep the larger goal in mind.

Lastly, turn **S.M.A.R.T** into "**S.M.A.R.T.R**" with a reset when needed. Give yourself the grace and understanding you would give anyone else in your position. If you don't make it to work one day because symptoms have you unable to stand up, you must not get down on yourself. Understand that your motivation is not your symptoms and that being **S.M.A.R.T** means doing what is best for your brain. Reset when symptoms derail you, record it in your log and move on to the next step as determined by you. Define your success as progress, not perfection. Remember always that



# 6 Unexpected Health Benefits of Gardening

Sure, that succulent produce improves your diet by leaps and bounds... But your endless labor of love may also strengthen you in some surprising ways.

## 1. Stress-relief and self-esteem

A Dutch study asked two groups to complete a stressful task. Afterwards, one group gardened for 30 minutes, while the other group read indoors. Not only did the gardening group report better moods than the reading group, they also had measurably lower cortisol levels. Cortisol, “the stress hormone”, may influence more than just mood: chronically elevated cortisol levels have been linked to everything from immune function to obesity to memory and learning problems and heart disease. It may be more than brain hormones causing higher self-esteem scores for gardeners: there’s no more tangible measure of one’s power to cause positive change in the world than to nurture a plant from seed to fruit-bearing.

## 3. Hand strength and dexterity

As we age, diminishing dexterity and strength in the hands can gradually narrow the range of activities that are possible or pleasurable. Gardening keeps those hand muscles vigorous and agile without oft-forgotten exercises such as a physiotherapist might prescribe. Related research has inspired rehabilitative programs for stroke patients involving gardening tasks as a satisfying and productive way of rebuilding strength and ability. But don’t push your hands too far: gardening can also set the stage for repetitive stress injuries, tendonitis, and carpal tunnel. Practice hand-healthy gardening by using a few simple warm-ups, positioning your body comfortably and ergonomically, and changing tasks frequently before strain becomes evident. Alternate use of your right and left hands to balance your body — using your non-dominant hand is one of many exercises to keep your brain functioning well as you age.

## 5. Immune regulation

This one is a wild card. Not only does the Vitamin D you’re soaking in from the summer sun help you fight off colds and flus, but it turns out even the dirt under your fingernails may be working in your favor! The “friendly” soil bacteria *Mycobacterium vaccae* — common in garden dirt and absorbed by inhalation or ingestion on vegetables — has been found to alleviate symptoms of psoriasis, allergies and asthma: all of which may stem from an out-of-whack immune system. This particular organism has also been shown to alleviate depression, so go ahead and get your hands dirty. Researchers are still speculating how our immune system may interact with our brains and play into a variety of mental health issues in addition to our ability to fend off infection: inflammation may provide the key link.

## 2. Heart health and stroke risk

Gardening may be just one way to achieve your target 2.5 hours of moderate-intensity exercise each week — but gardening provides a rewarding motivation that makes it happen, unlike a treadmill, which invites associations with hamsters in wheels. Raised beds can save the joints and extend possible gardening years for seniors, or for anyone wishing to garden more comfortably. Make sure to expose your limbs (without sunscreen) for just 10 minutes during midday gardening: this will give you enough vitamin D to reduce risks of heart disease, osteoporosis, and various cancers. Try for 30 minutes of gardening a day: if your schedule won’t let you fit in half an hour at a stretch, try a quick 15 minutes in the morning, and another 15 after work.

## 4. Brain health and Alzheimer’s risk

One long-term study followed nearly 3000 older adults for 16 years, tracking incidence of all kinds of dementia and assessing a variety of lifestyle factors. Researchers found daily gardening to represent the single biggest risk reduction for dementia, reducing incidence by 36%. Another study estimated the risk reduction at 47%! Why does gardening make such a difference? Alzheimer’s is a mysterious disease, and the factors influencing its incidence and progression remain poorly understood. However gardening involves so many of our critical functions, including strength, endurance, dexterity, learning, problem solving, and sensory awareness, that its benefits are likely to represent a synthesis of various aspects. Researchers found daily gardening to represent the single biggest risk reduction for dementia, reducing incidence by 36%.

## 6. Depression and mental health

Plenty of your friends and neighbors have probably mentioned what a “lift” they get from a morning’s sweat amongst the lettuces and radishes. To add professional legitimacy to anecdotal claims, the growing field of “horticultural therapy” is giving proven results for patients with depression and other mental illnesses. The benefits appear to spring from a combination of physical activity, awareness of natural surroundings, cognitive stimulation and the satisfaction of the work. To build the therapeutic properties of your own garden, aim for a combination of food-producing, scented, and flowering plants to nourish all the senses. Add a comfortable seat so you can continue to bask in the garden while you rest from your labors. Letting your body get a little hot and sweaty might also have hidden benefits: as devotees of hot baths and saunas can attest, elevated body temperatures are also correlated with increased feelings of well-being. Don’t forget to drink plenty of water and know your limits.

# Spring Cleaning



## The Basics

- Find or create a checklist for Spring Cleaning your house. Put it somewhere noticeable.
- Start small, and don't try to do too many things at once.
- Go one room at a time. It is easier and you see results faster.
- Don't rush yourself. Set reasonable goals to accomplish certain tasks.
- Take frequent breaks and don't over work yourself.
- Once you are done cleaning your home, find ways to keep it tidy
- Look through your fridge once a week and throw out anything expired
- Spend 15 or 20 Minutes a day cleaning. Time yourself, you'll be surprised how much you can get done
- Plan some easy meals for while you are doing your Spring Cleaning

## Tips

- Do one room, even one area of one room, at a time to avoid unfinished jobs. The satisfaction of seeing one room sparkle will make the hard work feel like it's worth the effort.
- Do two things at once. While laundry is going, scrub the shower stall.
- Invest in good rubber or vinyl gloves to protect your skin and nails.
- Dust before vacuuming or cleaning the floor.
- Don't stand your brooms on their bristles. It will destroy their shape and diminish their effectiveness.
- Use microfiber cloths. When wet, they sanitize and clean floors, counters, glass and tile, and eliminate the need for other cleaning products. They're reusable (machine-wash, hang to dry) and cost about \$5 for a two-pack.
- Get rid of things you haven't worn in a year and vow to put away your clean laundry each week.
- If you actually time how long it takes to do certain chores, you won't mind them as much, says Cilley. Believe it or not, most chores only take 10 minutes.
- Do a 5-minute sweep through each room, taking a laundry basket with you. Place in it anything that doesn't belong in that room, then put away the stuff that does belong there.

## All Natural Cleaning Products

**Lemons:**  
removes dirt and rust stains, and is especially effective when mixed with salt

**Borax:**  
when added to a laundry wash, it makes detergents more effective

**Vinegar:**  
can wipe out tarnish, soap scum, mineral deposits and more. Not to mention it is a great window cleaner

**Baking Soda:**  
great for ovens. Make a paste with water and spread on the bottom of the oven. Wipe away after a few hours

**Dishsoap:**  
great for getting small oil stains out of clothes





**Brent T. Hodge**  
Legate And Associates

# Ask A Lawyer

## How Much Care Is Enough?

In cases involving catastrophically injured clients, the cost of future care is often very high. One of our primary goals as lawyers is to make sure that our clients are properly compensated for their losses. Part of achieving this goal includes speaking to our clients about the real cost of future care, which must account for contingencies and associated costs.

The vast majority of litigation ends in settlement. Prior to entering into settlement negotiations, we meet with our clients to discuss the value of their claim. The goal of this discussion is to avoid our clients becoming awestruck by seemingly big numbers. One million dollars may sound like a lot, but fully considered, may not be enough to ensure a seriously injured person receives all the future care they require.

We begin our analysis by breaking down the future care costs into their component parts which often include major blocks for housing modifications and attendant care. Housing decisions tend to guide other costs, so we start there. To determine how much to allocate to housing, we turn to realtors and housing modification experts to develop a plan that suits the needs of an individual client. Next, we look at attendant care. There are many factors that go into this analysis, as these needs tend to change over time. We consider the daily needs of an individual, forecast over a lifetime. We also consider government-funded services which may or may not continue to be available and significant life events, such as when a child completes his or her school-based programming. We also look at who is providing care to the injured person. For example, we know that parents often prefer to care for their own child; we also know that they will not be around forever and at some point, the child must look to other caregivers for support – there is a cost associated with this change.

Another consideration is counsel fees, which must be paid on any settlement or judgment. The net amount, after deducting fees, is the figure we use to determine whether a proposed settlement will be enough.

The numbers, variables and considerations can seem overwhelming, which is why we are here – to guide our clients through the process and give them the tools to make informed and educated decisions on whether to settle their case or go to trial. While, in many ways, injured persons can never be fully compensated for their losses, we try, inasmuch as the law allows, to achieve results which afford them the care and comforts they deserve.

**Please e-mail any questions, comments, or suggestions for future articles to the writer,  
Brent T. Hodge, at [b.hodge@legate.ca](mailto:b.hodge@legate.ca).**



# Environmental Barriers

**The severity of a TBI is a key factor in determining how well someone does after his or her injury. That’s almost a “no-brainer.” Medical care and rehabilitation play a role too. So does the person’s motivation and attitude.**

However, there are also things, separate from the person with the TBI, that make a difference. For example, there are things like:

- **Support from other people:** What if family or co-workers are not supportive and don’t help?
- **Discrimination:** What if people are prejudiced toward the person?
- **Physical barriers:** What if buildings are not accessible? What if the environment prevents the person from doing things he or she needs to do?

Any of these things can make it harder for a person with a TBI. They can make life much more difficult and much less satisfying. When things like these create problems, they are called “**Environmental Barriers.**”

## Five Kinds of Environmental Barriers

People with disabilities can face many Environmental Barriers. These barriers depend on the person, the type of the disability, and many other things. There are five broad types of barriers:

- 1. Physical barriers:** Is your home accessible? Does it let you move around easily? How accessible is work or school, and the public places you go? Physical barriers can be caused by things like buildings, stairs or hills, doorways, or even the weather and climate.
- 2. Attitude barriers:** These have to do with prejudice and discrimination. Do negative attitudes and prejudice from people you come in contact with keep you from being as productive and successful as possible?
- 3. Assistance barriers:** Does lack of transportation keep you from going where you need to go? Does a lack of good information or medical care keep you from doing what you need to do? Are people in your home and community helpful enough?
- 4. Policy barriers:** Do government rules make road-blocks for you? Can you find the educational, employment, and service programs you need? Do rules and regulations stop you or get in your way?
- 5. Work and School Barriers:** Are people you interact with at school or work positive and helpful? Do they support you? Does how they act prevent you from doing the things you need to do?



**Check the barriers that are big problems for you: ones that you experience often, or ones that are severe problems:**

- The availability of transportation
- Design and layout of your home
- Design and layout of buildings and places you use at school or work
- Design and layout of buildings and places in your community
- The natural environment — temperature, terrain, and climate
- Aspects of your surroundings — lighting, noise, crowds, etc.
- The availability of information you want or need
- The availability of education and training you want or need
- The availability of health care services and medical care
- Lack of personal equipment or special adapted devices
- Lack of computer technology
- The availability of someone else to help you in your home
- The availability of someone else to help you at school or work
- The availability of someone else to help you in your community
- The attitudes of others in your home
- The attitudes of others at school or work
- The attitudes of others in your community
- Lack of support and encouragement from others in your home
- Lack of support and encouragement from others at school or work
- Lack of support and encouragement from others in your community
- Prejudice or discrimination
- Lack of program or services in your community
- Problems with rules and policies of businesses and organizations
- Problems with education and employment programs and policies
- Problems with government programs and policies



**Now, go back and look at the ones you checked. Ask your self: What can you change to make these barriers be smaller or less frequent?**

- Do the people around you know what kind of support you need from them?
- Could you move to a different place that is more accessible?
- Could equipment like a cane or a wheelchair, or even a wheelchair lessen your barriers?
- Could you find new people to be with -- ones who are more supportive and positive?
- Can you change what you do so you are less bothered by your environment? For, example, if noise bothers, could you avoid noisy places?
- Can you change things about yourself so other people perceive you differently? This could improve their attitudes.



# *Life Care Planning*

## Introduction to Life Care Planning

When individuals have suffered an injury, full recovery is not always possible. Some individuals are left with long term health care requirements. A life care plan is requested to assist in determining the individual's long term needs and the costs associated in the provision of their care and services. This may include, but is not limited to: medications, assistive devices, therapies, attendant care assistance, housekeeping/ home-maintenance assistance, home accessibility and transportation.

A life care plan includes items or services that will allow the client to maintain/ promote independence, maintain good health, reduce medical complications, increase function, and to maintain a reasonable quality of life.

Based upon a thorough assessment of the client, a detailed review of the documentation, and consultation with the rehabilitation team, a life care plan is prepared providing a comprehensive overview of their current and future health care needs. The plan is specific to a given client with the purpose of aligning the client as close as possible to his/ her pre-injury quality of life and functioning. Each life care plan is unique, reflecting current and anticipated developmental changes as well as current medical status

and anticipated complications associated with the injury. The International Academy of Life Care Planners has defined the life care plan as “ a dynamic document based upon published standards of practice, comprehensive assessment, data analysis and research, which provides an organized, concise plan for current and future needs with associated costs for individuals who have experienced catastrophic injury or have chronic health care needs”.

For clients who have sustained serious or chronic injuries (resulting from motor vehicle accidents, slip and falls, medical malpractice for example), these plans may be utilized within settlement/ or pre-trial meetings to assist with settling the individual's file. During trial, a judge or jury may use the life care plan to better understand the long term effects of these injuries and the associated costs of the care required. It may also be utilized post-settlement by the individual, to determine and plan for their medical and rehabilitation needs over their life-time.

## The Role of the Rehabilitation team and client in Life Care Planning

Inclusion of the rehabilitation team in life care planning is crucial to help identify and quantify future care needs. As part of the life care planning process, the professionals

are consulted to further understand what goals have been addressed throughout the rehabilitation process, obtain an update on progress and to identify recommendations for current and ongoing treatment. Therapists and rehabilitation workers may include occupational therapists, orthotists, case managers, physiotherapists, prosthetists, psychologists, rehabilitation and technical assistance, vocational counsellors, social workers, speech language therapists and registered dietitians. Deciding who to consult with depends on the stage of the client's rehabilitation, ongoing limitations/challenges and the specific goals of the client.

An individual's access to and participation in rehabilitation in a timely manner following an injury, is key to identifying future care needs. Through this process, the individual's goals are identified, helping the person to achieve optimal function. Additionally, access to rehabilitation services promotes better understanding of what strategies, supports, rehabilitation and/or assistive devices are important to plan for their goals.

The client is also an integral part of the life care planning process. Through a comprehensive interview, information is obtained about his/her injuries and how they have impacted on each area of their life: employment, activities of daily living, leisure and family. This interview is scheduled at their home and significant others can also attend the interview and/or contacted at a later date. It is essential that the life care planner has an understanding of the client's goals to ensure that they coordinate with the recommendations from the rehabilitation team and are consistent with the documentation.

## Life Care Planning for the client with an Acquired Brain Injury

An Acquired Brain Injury (ABI) has a significant impact on a person's life. The effect of a brain injury can include cognitive, behavioural and/ or emotional difficulties, with each individual's challenges and recovery quite unique.

Thus, special consideration is given to the unique needs of the client with an ABI within the life care plan. Several factors impact the long terms needs of the individual with an ABI, including the location of the brain injury, the age of the client, access to rehabilitative therapies, the progress with treatment and rehabilitation efforts to date, and potential complications with aging. Evidence based practices/ guidelines for ABI are utilized to provide rationale and support for the recommendations outlined within the life care plan. Collaboration with the client's treatment team, including rehabilitation professionals and medical

specialists is an essential component to the plan. Of note, ABI is prevalent in younger clients, and thus, the life care plan with the younger client must consider a full life span. However, all life care plans must consider changes in the client over time, throughout developmental stages and the aging process. Due to the uniqueness and variability of a person's recovery following an ABI, different scenarios may need to be identified to address potential outcomes.

In considering future needs for the individual who has sustained an ABI, one must look at the long term sequelae and complications of ABI. There are indications in the research that people with severe ABI are more strongly represented in populations of persons with Alzheimer's disease than the average population. There are also numerous other potential complications such as increased risk of seizure disorder, mood disorders (anxiety and depression), personality changes, risk behaviours, addiction, re-injury, sleep disturbance, post-traumatic headaches, and the development of arthritis. These potential complications are considered in long-term planning for the ABI client.

## Conclusion

Certified Life Care Planners prepare a comprehensive report on the client's behalf, taking into consideration the unique needs of an individual with an ABI and collaboration with the client's rehabilitation team and physicians/ specialists in order to provide an overview of their current and future needs. It is dynamic in nature and a life care plan that covers the lifetime of an individual can undergo several modifications based on complications that have occurred, improvements in medical care and technology, and other factors that affect the cost of care.

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The authors are all Canadian Certified Life Care Planner, having completed the required 120 hours of comprehensive post-graduate training and having passed the certification examination set by the Commission on Health Care Certification.

If you wish to learn more about preparing Life Care Reports, please note that DMAREhability is pleased to announce the 3rd Rehabilitation and Life Care Planning Symposium is scheduled for April 23, 2015. Please visit our website ([www.dmarehability.com](http://www.dmarehability.com)), for details.

# Research To Shape the Future

Submitted By: Laura E. Gonzalez-Lara, Ph.D.  
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Consciousness is “the state of being aware of and responsive to one’s surroundings” (Oxford Dictionary).

Dr. Adrian Owen’s research group at Western deals with questions such as: What if someone is aware, but cannot respond? Or what if they can, in fact, respond to a command, just not in a way we can easily detect? There are two different components of consciousness: wakefulness and awareness. We are usually able to determine when someone is conscious when they appear to be awake (i.e. eyes are open) and are able to respond to a command.

Dr. Owen’s group studies the brain’s residual cognitive function after injury in patients who have been diagnosed with a “disorder of consciousness”, patients who may have been diagnosed as being in a Vegetative State or a Minimally Conscious State. These patients who will have sustained a severe brain injury, spent some time in a coma, have recovered some brain function, but have not yet regained full consciousness. The acute brain injury may have been a traumatic event (e.g. a blow to the head) or a non-traumatic event (e.g. a loss of oxygen to the brain, known as an anoxic brain injury).

Vegetative state is commonly defined as ‘wakefulness without awareness’. Patients with a vegetative state diagnosis may appear to be awake, but will show no evidence of self awareness, awareness of others, or awareness of the environment. These patients have preserved brain function that allows them to breathe on their own and maintain sleep and wake cycles. However, regions of the brain responsible for language comprehension and expression, or sustained, reproducible, purposeful and voluntary responses to external stimuli, have been damaged. Minimally Conscious State patients also have sleep/wake cycles and preserved brain function that allows unassisted breathing. These patients differ, however, in their ability to show reproducible behaviour indicative of some level of self awareness, and awareness of the environment, albeit inconsistently. In short, there is sufficiently preserved brain function for the patient to show that he/she has some level of awareness, but not enough preserved function for the patient to communicate reliably.

Dr. Owen’s group seeks to get a better understanding of the different degrees of consciousness by probing the presence of self-

awareness, awareness of others, or awareness of the environment. We also aim to understand the specific brain damage that is causing the loss of consciousness in these patients. Disorders of consciousness are caused by many different types of injury and little is known about the key brain areas that are responsible for these deficits. Understanding how the brain functions after severe injury will help us to improve the accuracy of diagnosis and to estimate prognosis (the likelihood of recovery) more precisely. We study both automatic and non-automatic responses using Magnetic Resonance Imaging (MRI) and Electroencephalography (EEG). Over the years we have studied different aspects of brain function, including automatic responses such as vision, hearing, speech perception, and comprehension; as well as non-automatic responses such as the ability to follow verbal commands and communication.

MRI is a powerful non-invasive imaging technique that generates high quality images of the brain, and different body parts, without harming the patient. A powerful magnetic field generated by the scanner allows us to obtain images of the brain in different planes and generate three-dimensional reconstructions. MRI does not use radiation and we do not use contrast agents in our research. Functional MRI (fMRI) is a technique that allows us to monitor brain activity through the blood oxygenation level-dependent (BOLD) signal. This technique is used to observe, in a non-invasive fashion, changes in the brain’s blood flow in response to various kinds of stimulation (e.g. visual stimulation, auditory stimulation). The areas activated in the brain during an fMRI examination will need more oxygen and thus draw more oxygen-rich blood to that part of the brain, which appears, in our data, as red/yellow ‘blobs’.

EEG is a technique that uses sensors placed on the scalp to measure brain activity and has been used in hospitals for many more years than MRI. Each sensor measures changes in the brain’s electrical activity in response to a variety of stimuli, including verbal instructions and passive stimuli, such as listening to sounds and words without being asked to do anything. EEG is widely used in clinical applications; however, the systems that we use are research-dedicated with a different set-up and tests. While our EEG setups are not commercially available, they are more readily available and are a first step to a portable system that would potentially allow some of these patients to communicate in the future.

***“we are a research group, not a therapy facility. What we are trying to establish is the basis for communication that will allow these patients to have a voice in making their life as comfortable as possible.”***

There are many different processes in the brain that are fully automatic. Facial recognition is one of them. For example, you cannot decide not to recognize somebody you know. If a familiar person’s face appears in front of you, your brain will automatically respond to it. You cannot make the choice not to recognize it, because it is an automatic brain response. Understanding language is another example. No matter how hard you try, you are not able to not understand what you are hearing if you listen to speech in your native language—it is processed by your brain, whether you like it or not. These types of automatic brain processes have been shown to occur in healthy individuals even when they have been heavily sedated with drugs. If you give an individual a light anaesthetic and play a recording of speech, their brain will still respond to the stimuli as though they were aware, even though the individual will later report being unaware of the recording. For this reason we know that responses to stimuli like speech and faces in patients who appear to be vegetative are not necessarily signs that they are aware – they may simply be automatic responses that occur in the absence of awareness, just as they do in healthy participants who have been sedated.

While many of our brain functions occur automatically, we do have control over some aspects of brain function, including our ability to physically move our body or imagine certain activities. For example, we can decide to imagine playing a game of tennis if somebody asks us to do so. Even if we were asked to imagine playing tennis, we can freely decide to imagine a game of chess instead, or perhaps nothing at all. Similarly, if someone was asked to raise their arm, they could choose to follow the instruction or choose to ignore it. In this sense, engaging in these activities is not an automatic brain response. Rather, it is a decision that we make and we have conscious control over what that decision is. Because choosing to move our body or imagine activities when instructed to do so requires a decision on our part, it is safe to say we must be aware, and therefore conscious, to make such a decision. If we were unaware, and therefore unconscious of these instructions, it would be very hard, if not impossible, to explain how it is that we can engage in consistent and predictable behaviour – whether raising an arm or imagining an activity—in response to commands to do so. It is this type of intentional, non-automatic brain response that we believe is indicative of awareness. Finding this type of brain response in patients who are otherwise unable to follow commands through visible behaviour is our primary interest. For patients who are unable to display behavioural responses to instructions, such as “raise your arm in

the air,” we ask them to imagine particular activities, which generate predictable brain activation associated with a deliberate, conscious response. We ask patients to imagine certain activities that we know are associated with activity in specific regions of the brain. If a participant is able to imagine certain activities in response to the questions we pose, we infer that more sophisticated networks responsible for understanding questions, remembering instructions, and following tasks are intact. Responding to questions through the imagery task remains the best evidence we can provide of some level of hidden awareness in our participants. These imagery tasks have been used to establish a simple form of yes/no communication with a few of our patients. This is done by asking them to imagine one activity (e.g. playing tennis) if the answer they wish to convey is ‘yes’ and a different activity (e.g. navigating around their house) if the answer they wish to convey is ‘no’.

It is very important to understand that awareness and recovery are two different things; detecting consciousness will not necessarily translate into functional recovery. Furthermore, we are a research group, not a therapy facility. What we are trying to establish is the basis for communication that will allow these patients to have a voice in making their life as comfortable as possible.

The clinical applications in the future could be in different aspects. First of all, we think this research may have a substantial impact on the accuracy of the diagnosis after brain injury. In some cases, we can show that there is a higher level of awareness than can be deduced based on standard clinical examination alone. Providing physicians with the necessary tools to get an accurate diagnosis is the most important objective of our research. Second, these neuroimaging techniques may soon be used to provide a more precise prognosis. Currently, patient outcome after acute brain injury is very uncertain. For example, the precise reasons why some patients recover well while others do not are poorly understood. Finally, the end goal of this research is to develop a true brain-computer interface or a type of communication tool that will allow some of these patients to actually communicate on a routine basis. The basis for such a system might be the yes/no communication. However, that is still some years away, but it is something we are working very hard to get to.



# Handling the Surge of Concussion Referrals:

***Innovative Group Treatment Models Result in Better than Expected Outcomes***

Submitted By: Becky Moran & Shannon McGuire

## Recent Trends:

Tune into any sports broadcast, and concussion is talked about frequently. In recent years, there has been an increase in public awareness about concussion, and the lingering symptoms associated with this injury. Many interchange the words concussion with mild traumatic brain injury (mTBI); and while 80 per cent of all TBI's are considered mild, most research indicates this is an underestimation. Those who live with the ongoing symptoms state, "There is nothing MILD about a mild traumatic brain injury"--it can be a life altering and devastating injury."

Many people who have experienced a mTBI/concussion are now seeking treatment and help for their ongoing symptoms such as persistent headache, ongoing fatigue, difficulties with concentration and focus, issues with memory and problem solving, significant dizziness, loss of balance, and difficulties with coping with the life changes that come along with this injury. They are looking for help from a variety of health care professionals including physiotherapists, chiropractors, osteopaths, craniosacral therapists, psychologists, social worker, speech language pathologists or occupational therapists.

Many of these services are not covered by provincial health care plans, so out of pocket expenses are incurred at a time when income may be greatly reduced, if not non-existent, because the person seeking help is unable to work. Therefore, services can become quite costly, and there are no guaranteed results with the treatment being offered.

If the head injury was minor, some people never seek medical attention, or those who

do seek attention may receive conflicting or inaccurate information. Research targeted to treatment strategies and best practices is still ongoing, so there is a lack of strong evidence about the best way to rehabilitate people with mTBI after the acute stages of this injury.

With increasing awareness comes increasing demand for services. Health care professionals are trying to figure out the best way to handle the increasing number of referrals and provide the best possible services in the quickest amount of time. The public sector has not traditionally provided services to this population, but many people are unable to work and unable to afford self-pay options.

Over the past several years, Parkwood Institute's Outpatient Acquired Brain Injury (ABI) team has seen the number of referrals for mTBI patient go from 0 per year to over 150. This drastic increase in the number of patients awaiting services has led to the team developing innovative treatment solutions without a significant increase in funding for staffing. Creativity was key for this team in figuring out effective treatment strategies, such as: pacing and planning with a points system, using weighted compression vests for balance, vision rehab and group treatment models. An increased demand for services has also motivated the team to create community linkages, sharing information across the spectrum of care (i.e., Fowler Kennedy Sports Medicine Clinic, and the Pediatric Acquired Brain Injury Outreach Program) and improving the expertise of the team members providing services to these patients.

Group treatment models are another new approach the ABI team at Parkwood Institute

is taking, with the main focus to serve more patients in a timely manner so the intervention is the most impactful and valuable.

The first group developed was **ABI 101: Steps to Success**. This group meets the demand for education around management strategies so patients can start helping themselves while waiting for treatment. This education-based group allows patients to attend immediately following their initial triage appointment with the team. The group consists of six sessions, meets on a weekly basis for 90 minutes, and is facilitated by a member of the team. Sessions include Occupational Therapy (OT) for pacing, planning, and organizational techniques; Speech Language Pathology for memory & attention strategies, and social communication; Social Work for coping strategies and anger management; and Physiotherapy for exercise, vision rehabilitation, and balance strategies. The entire team meets with the group in the final wrap-up session to answer any outstanding questions people may have. This group runs continuously, and a new group of patients starts approximately every six weeks.

Following the success of the ABI 101 Group, the **Return to School Group (RTS)** was developed to address similar needs students have with returning to their studies, and to reduce their wait times for assessment and strategies to manage school demands. Designed like a classroom setting, the RTS group covers seven modules over seven weeks. Each module is 120 minutes in length. Patients are assessed prior to initiating the group; therefore, treatment can be specifically tailored to the needs of the patient despite being in a group setting. Many patients in the RTS group require academic accommodations, such as increased amount of time to complete exami-

nations. Being assessed prior to starting with the group allows for specific and customized accommodations to be put in place to allow for a successful return to school.

While the RTS group was very successful for the student population, it was becoming increasingly obvious that other non-student patients also needed more timely services. Within the ABI Team, Physiotherapy (PT) and Occupational Therapy (OT) shared common goals and treatment strategies; therefore, an idea was born to combine OT and PT treatments together into one group format. **BrainEx 90** begins group treatment with OT and PT as part of a 90 minute circuit training program. There are 14 five minute stations which address balance and core, vision rehab, cognition, self-management, cardio exercise, vestibular therapies, interspersed with cognitive puzzles, logic games and rest breaks. 20 minutes of education is also included as part of this treatment.

The feedback from patients who have participated in BrainEx 90 is that the shift to group treatment, that was initially implemented to decrease wait list times,, has actually led to a better method of treatment. Patients report that being in a room with six other patients who are struggling with the same problems is enormously beneficial and often leads to social networking outside the group treatment environment. Although it is very challenging when patients first start with the group, they inevitably rise to the occasion and find

an increase in their stamina that translates to other aspects of life. In our exit survey over 76 per cent of patients felt they achieved their goals, 96 per cent would recommend it for other patients and 87.5 per cent felt that participating in the group enhanced the rehab process. With **BrainEX90** patients attend 90 minute sessions over the course of either eight weeks (two sessions a week) or sixteen weeks (once session per week) and complete an assessment with both OT and PT prior to and upon completion of the groups.

Lastly, the **Psychosocial Support Group** is a nine week program facilitated by Social Work, which has also been hugely successful in meeting the needs of patients struggling with coping, managing their emotions, accepting a 'new normal' and making the necessary adjustments to life to develop meaning once more. While created to decrease waiting times for patients, once again patients develop social relationships and network together during the group times, which helps them feel less alone with this struggle.

The group education and treatment models have been such a resounding success that the participants find it difficult when the sessions are completed. Maintenance programs to help patients continue with the gains and successes they achieved in the groups, and to allow for ongoing connections with other group members, therapists, and the team are being initiated now for Return to School and BrainEx90 groups.

## Future Outlook

Although mTBI is gaining in awareness and advocacy, there is still a need for greater understanding about how the brain works both normally and when injured. There need to be more targeted therapies to help people recover. As well, better guidelines need to be in place to improve early management of TBI, so fewer people develop persistent symptoms.

With this age of knowledge and technology, people are taking brain recovery into their own hands with brain training apps and websites, and they are seeking help from a multitude of different sources. Ideally there needs to be increased public funding for management of persistent symptoms, so as many of these patients as possible can maximize their potential to return to employment and other activities.

Our hope is that other facilities will begin adopting a similar model of care using groups to help meet the growing demand for rehab, and to increase the knowledge sharing and expertise of therapists treating those with mTBI.



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Parkwood Institute (formally Parkwood Hospital) invites those who have survived a brain injury, their partners, parents, family members, and friends to their

## 2015 Acquired Brain Injury Survivor and Family Education Series

The goals of this series are to share information, provide opportunities to meet other individuals and family members affected by brain injury, and to encourage peer support.

The sessions are held on Tuesday evenings from 6:30-8:00 p.m. in the Parkwood Auditorium on the main level of the Main Building at Parkwood Institute. See dates and topics of sessions below.

The sessions are also video-conferenced each Tuesday evening to participating sites throughout Southwestern Ontario, including:

- Grand Bend    Grand Bend Area Community Health Centre
- Hanover        Hanover & District Hospital, Family Health Team Office (2<sup>nd</sup> Floor)
- Owen Sound    Home and Community Support Services office
- Sarnia          Community Living Sarnia-Lambton
- Stratford        Stratford General Hospital
- Windsor        Windsor Regional Hospital – Oullette Campus
- Woodstock     Woodstock General Hospital, Althone Ave. entrance

Please note: Additional sites may be added prior to the beginning of the series

<b>March 24<sup>th</sup></b>	<b>Brain Injury 101 – Part 1</b> Speakers: Kelly Williston Wardell & Lisa McCorquodale
<b>March 31<sup>st</sup></b>	<b>Brain Injury 101 – Part 2</b> Speakers: Kelly Williston Wardell & Jill Bowen
<b>April 7<sup>th</sup></b>	<b>Practical Strategies for Managing Your Life</b> Speaker: Susan Rice
<b>April 14<sup>th</sup></b>	<b>Social Communication &amp; Auditory Issues Following ABI</b> Speakers: Connie Ferri, Stephanie Muir Derbyshire & Patti Hinton
<b>April 21<sup>st</sup></b>	<b>The Importance of Nutrition, Physical Activity &amp; Sleep Following ABI</b> Speakers: Chris Fraser & Laura Graham
<b>April 28<sup>th</sup></b>	<b>Managing Fatigue After ABI</b> Speaker: Becky Moran
<b>May 5<sup>th</sup></b>	<b>Coping with Anger &amp; Frustration Following ABI</b> Speakers: Dave Furac & Dan Pettapiece
<b>May 12<sup>th</sup></b>	<b>Survivors' Stories</b>

You are welcome to attend, one, some, or all of the sessions.

If you have any questions regarding the series or the locations, please contact Wendy Davis at 519-685-4064 or toll-free at 1-866-484-0445.



# Up Coming Events

**YOTB Brain Fair**  
April 1, 2015

**Annual Mike's Walk**  
May 25, 2015

**Annual Conference 2015**  
June 17, 2015

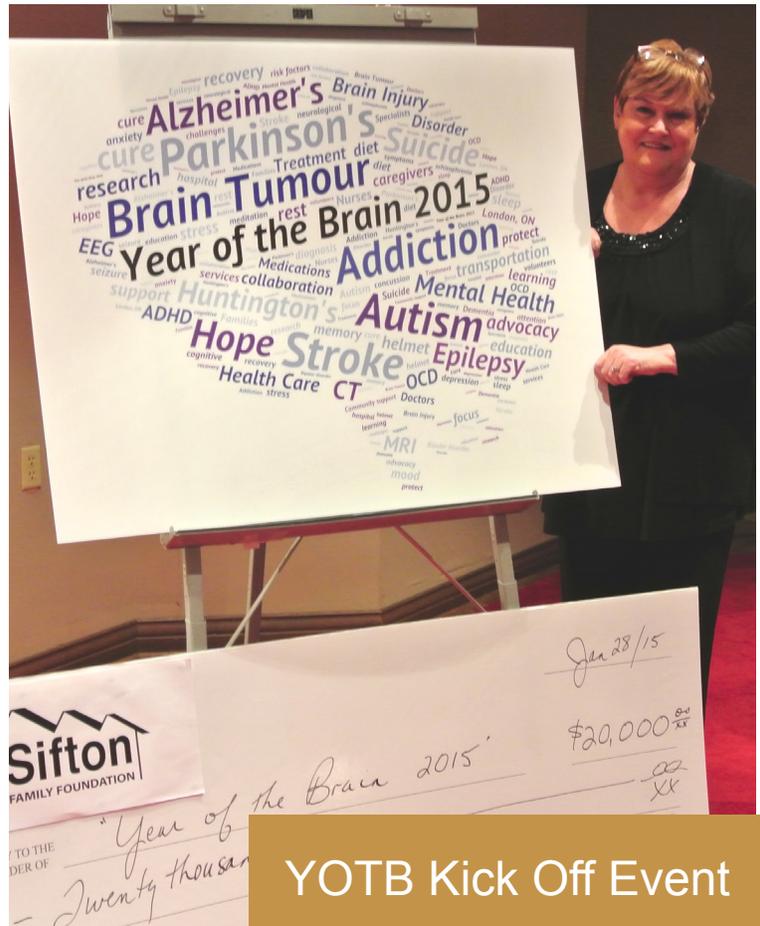
**Annual General Meeting**  
June 17, 2015

**Helmets On Kids Kick-Off**  
June 18, 2015

**Camp Dawn**  
September 17 - 20, 2015

**Annual Golf Classic**  
September 17, 2015

**Provincial Conference**  
November 11 - 13, 2015



**YOTB Kick Off Event**

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## Brain Fair!

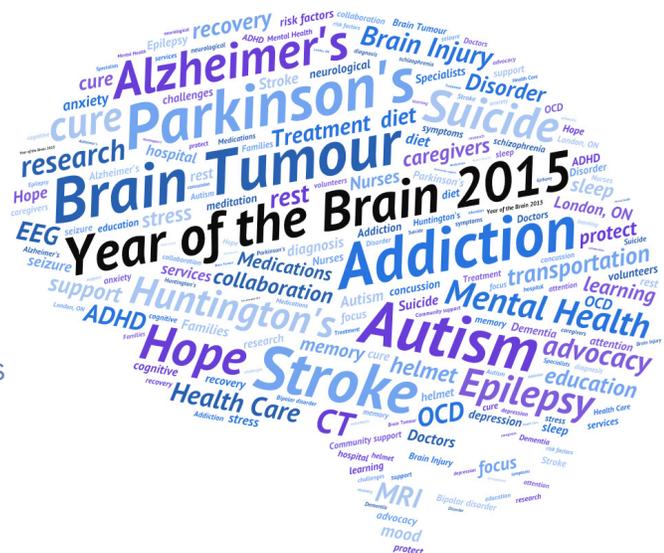
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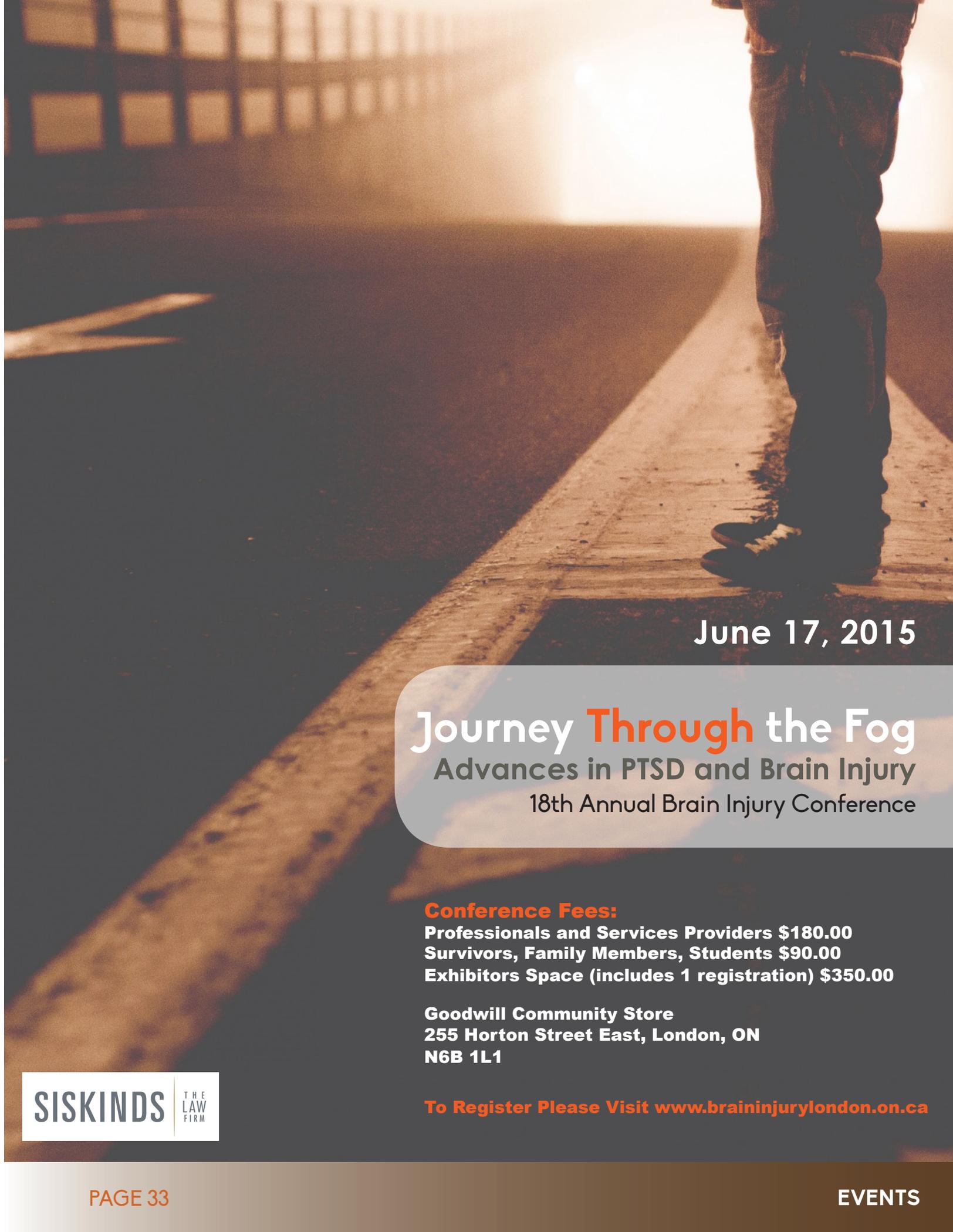
Keynote Speaker: Dr. Jog  
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