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At times, we may not realize the impact that we have on others. It may be only a few words spoken, a limited interaction, or it may be a longer-term therapeutic or rehabilitation relationship.

RUTH’S DESK

Making a Difference

When one reflects on their work life, family life and involvement in the larger community what comes to mind? Is it prestige, is it impact, is it one’s likability or something else? For those of us who work in the brain injury community, or for those who volunteer, whether that be survivors of brain injury or caregivers, the importance of making a difference comes to mind. What does it mean to make a difference and how can we be difference makers? The Starfish Story that inspired the theme of the 2017 Provincial ABI Conference captures this sentiment:

While walking along a beach, an elderly gentleman saw someone in the distance leaning down, picking something up and throwing it into the ocean. As he got closer, he noticed that the figure was that of a young man, picking up starfish one by one and tossing each one gently back into the water.

He came closer still and called out, “Good morning! May I ask what it is that you are doing?”

The young man paused, looked up, and replied “Throwing starfish into the ocean”.

The old man smiled, and said, “I must ask, then, why are you throwing starfish into the ocean?”

To this, the young man replied, “The sun is up and the tide is going out. If I don’t throw them in, they’ll die.”

Upon hearing this, the elderly observer commented, “But, young man, do you not realize that there are miles and miles of beach and there are starfish all along every mile? You can’t possibly make a difference!”

The young man listened politely. Then he bent down, picked up another starfish, threw it into the back into the ocean past the breaking waves and said, “It made a difference for that one.”

At times, we may not realize the impact that we have on others. It may only be a few words spoken, a limited interaction, or it may be a longer-term therapeutic or rehabilitation relationship. It also may be through a talk we give, an article we write or something more removed such as supporting a bill in parliament that will enhance the lives of those living with brain injury.

Only a few short weeks ago, I gave a presentation to care providers on OBIA’s awareness campaign Concussions Hits Home – Domestic Violence and Brain Injury. One of the women who attended came and spoke with me. She shared that she was so moved by the presentation and that so much had

By Ruth Wilcock
Executive Director, OBIA
personally resonated with her. Quite a number of years ago, she was a survivor of domestic violence and sought safety in a women’s shelter. She had been knocked unconscious, hit in the head and only realized in the presentation that many of the symptoms she struggles with, including cognitive impairments, may indeed be because of multiple concussions. Up until this point, she really did not understand why she experienced these symptoms. It was an “aha” moment for her and made a difference as to how she understood herself.

We know that brain injury is not simple, it is complex and that it affects individuals and families. So many countless individuals make a difference, ranging from the medical personnel to those providing rehabilitation and home and community care. I cannot tell you how proud I am to be part of a community who makes a difference in individual lives and families. We know the need is great with almost half a million people living in Ontario have a brain injury. In many ways, it is not unlike the Starfish Story with thousands on the beach and yet the young man was making a difference one starfish at a time. We (the community who serve people living with brain injury) are making a difference one survivor, one family member at a time.

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When the Brain Goes Boom

By: Sharon Adams, Legion Magazine


The epic struggle to understand and treat the damaged brain takes place both at the frontiers of science and in the pharmaceutical Stone Age.

In April 19, 2006, Aaron Bedard’s brain changed forever.

That day the Princess Patricia’s Canadian Light Infantry combat engineer and five comrades were in a vehicle that drove over and detonated an anti-tank mine in Afghanistan. “My head was about six feet away from the point of detonation. My neck was rocked violently forward. I got a severe whiplash.”

At first Bedard thought he was lucky. The others suffered serious back injuries and ruptured ear drums and were medevaced back to Kandahar. But Bedard’s injury was invisible. “It was a typical ‘suck it up, soldier’ thing. I looked at myself and I don’t have a scratch on me and if I had said, ‘Oh, yeah, I’m hurt. I’m going to get on that helicopter and go back,’ I’d look like a faker and I didn’t want that. So I carried on.

“I took some painkillers and got on with the tour. I told them I had a really bad headache, but I’d be fine.”

He was anything but fine.

Explosions deliver a double whammy to the brain. First there’s the damage associated with any serious vehicle wreck. As soldiers’ bodies are thrown and jolted, their heads, weighted down by helmets, accelerate forward and jerk back, their brains sloshing around in their skulls like Jell-O in a container dropped on the floor. The brain bangs into the skull in one direction, then bounces back to hit the opposite side. The various layers—the cerebrospinal fluid, the white matter and the grey matter—are of different densities and accelerate and decelerate at different rates, so delicate structures connecting the layers stretch and shear and bruise.

And milliseconds after the explosion, a blast wave sweeps into the vehicle and bounces around, hitting the soldiers’ bodies again and again. These waves penetrate chests, constricting blood vessels, disrupting blood flow in the brain. They shift the bony plates of the skull, putting pressure on the brain. In response to these assaults, the brain swells, damaging more delicate structures.

Much of this damage takes place at the microscopic level, to axons, tiny projections on brain cells that transmit information. Just as it can take days for a deep bruise to make it to the skin’s surface, weeks and months can elapse between injury to the brain and when a soldier begins to notice things are awry.

That’s time enough for a new mission, to come within another blast’s radius, time for other injuries, for damage to be piled on damage.

Seeing Bedard nursing his neck, his comrades let him drive reconnaissance for the remainder of his tour. When he returned to Canada in August, he had 45 days of leave, and spent them in physical and psychological pain.
Shortly after returning to duty he was diagnosed with traumatic brain injury (TBI). The damage was not visible on a brain scan, but his symptoms were unmistakable. “The neurologist said ‘in four years this is either going to go away, or it’s still going to be there.’ That was the essence. They didn’t give me any treatment.”

The damage done to soldiers’ brains is not only hard to diagnose, it can be impossible to treat. Medical practices so far have not been completely up to the task, but scientists are working hard to get there.

In 2007, Bedard was also diagnosed with, and began treatment for, post-traumatic stress disorder (PTSD). He was medically released in 2010. He’s been in pain ever since.

“My whole head hurts. All the time. Like I’ve just been hit in the head with a frying pan.”

While diagnosis and treatment of other diseases and health conditions entered the space age, physical and psychological injuries to the brain have lagged behind. “In psychiatry, we’re still in the stone ages while the whole rest of medicine has moved forward,” said Colonel Rakesh Jetly, chief psychiatrist and mental health advisor to the Canadian Armed Forces Surgeon General.

There is as yet no simple diagnostic test for either TBI or PTSD. There are no cures. Cognitive rehabilitation is the basis of treatments for TBI, aimed at slowly rebuilding attention, memory, social and emotional skills. The cornerstone of evidence-based psychotherapies for military PTSD is recall of traumatic memories, a process so psychologically painful that up to a third of patients drop out. Drugs are used to treat symptoms of both injuries. “And there are side effects…people stop taking them,” said Jetly.

Traumatic brain injury and PTSD have been around as long as armies, but there has been no objective way to diagnose them, like the blood test for diabetes diagnosis. It’s common for doctors to prescribe drugs designed to treat other conditions—antidepressants, anti-psychotics, anti-anxiety drugs, anti-seizure drugs and sedatives—for treatment of PTSD. A century from now, people are likely to look at how we treat brain injury today with the same horrified fascination we have for the leeches and bleeding of centuries past.

Medics, doctors and psychiatrists have had to rely upon soldiers’ self-reports of symptoms for diagnosis. And not being able to see exactly what was injured or how, they often resort to trial-and-error to see which evidence-based treatment, or combination of treatments, works in each case. Although most TBI and PTSD patients recover, a significant minority do not and live with chronic symptoms.

But that is changing. Recent developments in computing power and neuroimaging have put us at a new frontier in the study of the brain.

Helping veterans was one aim of U.S. President Barack Obama’s BRAIN Initiative (Brain Research Through Advanced Innovative Neurotechnologies) launched in 2013, and backed by at least $1 billion funding. It has grown into an international effort to plumb—and solve—mysteries of the brain.

The brain has nearly 100 billion nerve cells and 100 trillion connections, making it “one of the greatest mysteries in science and one of the greatest challenges in medicine,” says the BRAIN Initiative website. Five U.S. federal agencies and half a dozen foundations are funding research at dozens of universities and clinics as well as a whack of private industries. The armed forces in Britain, Australia, Canada, the U.S. and other countries, as well as philanthropists and veterans’ advocates, are also investing in neuroscience research.

Brain injury is a signature wound of modern war, the result of bullets and blast. Many more injuries come from rollovers and falls. And millions of military personnel and veterans suffer from a myriad of psychological injuries rooted in the rigours of their service—depression, addiction and anxiety at the top of the list. For soldiers with a brain condition, breakthroughs can’t come too soon or too fast.

Progress is being made “at a staggering pace,” said Dr. Zul Merali, president of The Royal’s Institute of Mental Health Research in Ottawa. Research has already shown it’s not just that particular regions of the brain are damaged, but the way they communicate has been disrupted. “It’s actually the wiring within the brain that is not working well.

“Once we thought when brain tissue gets damaged, it’s gone permanently…never to be replaced,” said Merali. “Now we know new cells are being born every day, that circuits can reform, and the brain can find alternate pathways.”

The leader in military research is the United States, which has a quarter million serving military with TBI, where it’s estimated seven per cent of the nearly 22 million veterans have both PTSD and TBI, and 22 veterans die by suicide daily.

In Canada, about five per cent of serving military have PTSD, according to a 2013 Statistics Canada study. About five per cent of those who served in Afghanistan between 2009 and 2012 reported mild concussions—they were dazed or “saw stars”—and one in five developed post-concussive symptoms. But because concussions are vastly under-reported, nobody knows exactly how many of Canada’s 95,000 regular and reserve members have had concussions, let alone how many of the 600,000 veterans of all ages and conflicts.

There is no objective means to diagnose mild TBI (concussion) in the field. Symptoms can develop some time after the injury, be dismissed or put down to other causes. Treatment is more successful the earlier it starts. Risk goes up with combat exposure. After one TBI, risk of a second increases.

Not having a diagnosis at the time of injury (or having the record disappear in the fog of war or red tape) makes it harder
Jim Vigmond’s handshake is as firm as his commitment to helping his personal injury clients receive fair verdicts. This founding partner is also committed to his philanthropic pursuits. Among his many charitable organizations, Jim raises funds and travels to Cambodia every year to assist underprivileged women house themselves while giving them the opportunity to go to law school.

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to connect long-term symptoms to military service, raising the hurdle for qualifying for veterans’ benefits.

Scott Casey, who lives near Kamloops, B.C., developed PTSD after a tour in Croatia and Bosnia in the early 1990s. “I got out in 1994 and wasn’t officially diagnosed with PTSD until 2008. For that many years, I was a bloody mess.” Before he left the Forces, he was told he was suffering from anxiety. “That was probably a misdiagnosis.”

After he was finally diagnosed, PTSD treatment was painful and not effective. “I had to recount a lot of the horrible things that went on overseas. Reliving that stuff all over again was very difficult.”

Prescribed medication did not work. “I took to self-medicating, drowning my sorrows in alcohol.” He has strong opinions about drug therapy.

“Veterans are guinea pigs,” said Casey. “I think it’s safe to say if a soldier is prescribed a drug cocktail of 24 different meds every day, it’s probably not good for him.”

Bedard said, “They trialled me on 12 different ones and I had a nightmare experience.” He punched holes in walls, woke up “in pure rage.”

“The process took about three or four years. ‘Take some pills and go home. They didn’t work? We’ll try some different pills.’ The warnings all say they may cause suicidal thoughts.” Research shows one in two veterans with PTSD think about suicide and one in five attempt it.

He noticed flare-ups coincided with prescriptions meant to increase serotonin.

“Using drugs that aren’t designed for TBI, it’s playing with fire. They’re messing around with people’s brain chemistry.”

U.S. psychiatrist Dr. Peter Breggin agrees. “There is a strong probability that the increasing suicide rates among active-duty soldiers are in part caused or exacerbated by the widespread prescription of antidepressant medication,” he testified before the U.S. Congress veterans affairs committee. Breggin describes the “therapeutic effect” is to “chemically lobotomize” patients, an effect accepted by patients because apathy, indifference and loss of sexual function is an improvement over psychological pain.

“There isn’t a specific medication designed just for PTSD, so we’re borrowing from other areas,” said Jetly.

Confounding treatment is the fact PTSD and TBI have many symptoms in common—but the symptoms arise from different injuries, so need different treatments.

New technologies like PET (positron emission tomography), MEG (magnetoencephalography), fMRI (functional magnetic resonance imaging) and SPECT (single photon emission computed tomography) scans will allow amassing of information to tell which therapy works best for which injuries, said Jetly, the first to hold the Chair in Military Mental Health at the Canadian Military and Veterans Mental Health Centre of Excellence in Ottawa. Tailor-made treatment for each individual can then be checked by neuroimaging technology to see if it’s working.

It’s hoped neuroimaging will reveal exactly what structures have been injured and how they can best be healed, repaired, retrained or their functions augmented.

Research is establishing how brains affected by TBI and PTSD work differently from healthy brains, and from each other (“The Tell-tale Brain,” Legion Magazine, May/June).

Studies at Sick Children’s Hospital (SickKids) in Toronto sponsored by the Canadian Armed Forces and Defence Research and Development Canada compare brain activity of four groups: healthy civilians, combat soldiers who developed PTSD after trauma and trauma-exposed soldiers who didn’t develop PTSD, and civilians with mild traumatic brain injury (mTBI).

Early results reveal some regions of brains affected by PTSD are overactive, and that veterans with PTSD see threats everywhere. While all soldiers reacted to combat-related stimuli, the PTSD group had a markedly greater response. “Their brains are in a hyper-aroused state,” said Dr. Margot Taylor, director of functional neuroimaging in the Department of Diagnostic Imaging at SickKids.

Another study showed PTSD sufferers reacted more strongly to angry faces. Communication among regions of the brain controlling fear and emotion were overactive, while the part that inhibits fear was underactive, said Dr. Ben Dunkley, clinical associate in diagnostic imaging at SickKids.

“One of the problems in diagnosis is that mTBI or PTSD or psychological trauma don’t leave structural or anatomical scars that you can see on an MRI.” However, they do change the way regions of the brain communicate. MEG shows some brain waves of those with combat-related PTSD are hyper
synchronized and “talking to each other constantly,” said Dunkley. “Even at rest, they’re not silent.”

Why is not yet known—so neither is what to do about it. Yet.

**Captain Adrian Rizzuto** volunteered for the study to help find answers for comrades and friends.

After he returned from a tour to Afghanistan in 2008-09, he was unable to sleep more than four hours at a stretch. “I was barely functioning.” Worried it might be a harbinger of PTSD, he sought help. It turned out to be a transient sleep disorder relatively easily treated. But it reinforced the need for faster diagnosis. “It’s important we have a diagnostic test that says ‘this person is clearly suffering from PTSD, and here’s the brain scan to prove it.’ Right from the beginning, when they realize something is wrong and are figuring out how to treat it, right up to the end when they need help from Veterans Affairs Canada, a test will help.”

**Mark, who prefers not to be identified,** volunteered to help research tease apart PTSD from TBI symptoms. “I know the symptomology has a lot of overlap. A reliable diagnosis is important because people whose symptoms are from different causes will be able to have the proper care.” For instance, both TBI and PTSD cause sleep disturbances, but medication for PTSD sleep deprivation might over sedate someone with TBI.

“We know in 80 per cent of people with mTBI, problems with memory and attention spontaneously disappear in less than three months, but 15-20 per cent will have lingering symptoms that are chronic and really affect people’s quality of life. These head injuries are thought to damage the axons that send information between regions of the brain,” said Dunkley. “These injuries are microscopic and diffuse and can’t be picked up by MRI, but affect how neurons fire and talk to one another.” And that can be tracked by MEG.

Mark is lying on a bed at SickKids, his head inside something resembling an oversized, old-fashioned hair dryer lined with sensors called magnetometers that catch the tiniest changes in the brain’s magnetic field. The room has foot-thick walls. “The brain’s magnetic field is so minute, it would be completely invisible to the naked eye,” explained Dunkley. “These injuries are microscopic and diffuse and can’t be picked up by MRI, but affect how neurons fire and talk to one another.” And that can be tracked by MEG.

In the room outside, computer-generated images of Mark’s brainwaves play across a monitor, changing as his brain works when he’s given different tasks—matching colours or shapes or images. The machine is so sensitive that tiny blips appear in the regular oscillations whenever Mark blinks. Afterwards, he goes through similar mentally challenging tasks in an fMRI, which captures images of the brain as it works. “We meld the data from the two machines,” said Dunkley, to find out what is going on in the brain, and where it’s happening.

Mark suffered a concussion while cycling in Toronto when a passenger opened a door in front of him. He tried to carry on with his day, but was eventually persuaded to get medical help. “I actually didn’t believe the doc when he told me I had a concussion,” even though he had noticed everything on his right side looked brighter. “I didn’t get the full effect until the day after.” He had a whopper headache, and “really weird visual disturbances. Everything was jittery.” He found himself emotional, irritable and impulsive. He had suffered diffuse axonal injury. “The way the neuro optometrist put it, it’s like the cables that run from my eyes to the occipital lobe (in the brain) are frayed.”

Recovery has been a long process. “It’s really not up to you how fast you recover. I always thought my recovery was a week away, then two weeks away. And now it’s two years. You can have a good day, and the next day be down for two weeks.” He wears a mask and ear plugs, and still doesn’t get enough restful sleep. He has a headache that varies in intensity, but never goes away. He’s really sensitive to light. He can’t drive on bad days. He’s still not able to go back to his job.

Aside from helping with diagnosis, brain scans may eventually be used to determine when someone is able to return to work, and when they need more time to heal, said Dunkley.

Perhaps one day brain scans can be used not only to detect atypical brainwaves, but to help bring them back to normal by targeting areas for deep brain stimulation. Perhaps they will help identify subtypes of PTSD and TBI. “We’re really only scratching the surface of what we can do with these technologies.”

It’s early days yet.

A gene has been identified that appears to predict who will develop severe PTSD symptoms. It is linked to a thinner cortex in brain regions that help humans cope with stress and trauma and control strong emotions. “In future, it may be possible to use a genetic blood test to identify military personnel at risk for developing PTSD” in war zones, Naomi Smith Sadeh, a psychiatry professor and psychologist at the National Center for PTSD for Veterans Affairs in Boston, said in media interviews. The research has implications for prevention of PTSD, targeted intensive treatment and suicide prevention for those with the gene.

Research is showing more clearly what is damaged. University of Washington scientists found tiny leaks in the blood-brain
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Diagnostic tests for both PTSD and TBI are expected within three years.

Metabolomics—using a computer to assay minute chemical differences in blood samples—identified 95 per cent of concussions in a study of male hockey players, Dr. Douglas Fraser of the Children’s Health Research Institute in London, Ont., reported at the Canadian Institute of Military and Veteran Health Research Forum in 2015. Jing Zhang, of Royal Military College in Kingston, also reported that RNA (ribonucleic acid, which translates the genetic code for use by cells) might serve as a biomarker for TBI, based on studies showing micro RNA in rats’ hair follicles was silenced or degraded by blasts.

“I think it’s safe to say if a soldier is prescribed a drug cocktail of 24 different meds every day, it’s probably not good for him.”

PET/CT scans show pituitary glands of veterans with PTSD are working extra hard, report researchers at the St. Louis University School of Medicine studying the HPA axis—the interconnection of the pituitary gland and the hypothalamus in the brain and the adrenal glands, which sit above each kidney. The axis regulates stress response, mood and energy expenditure, and is suspected of playing an important role in PTSD. Damage to any of the three affects the others.

“This raises the possibility that some PTSD cases are actually hypopituitarism” and can be treated with hormone therapy, Dr. Thomas Malone, of the university’s neuro-surgery department, reported to the Radiological Society of North America in 2014. A study funded by the U.S. Department of Veterans Affairs found 44 per cent of veterans with blast concussions also had low levels of pituitary hormones. “If the possibility of hormone deficiencies in our veterans is not considered, appropriate treatment may not occur,” said lead researcher Charles Wilkinson, of the Veterans Affairs Puget Sound Health Care System in Seattle, Washington.

Developments in treatments may take longer.

Deep brain stimulation has dramatically reduced PTSD symptoms in the first veteran to undergo the procedure, barrier develop in the cerebellum of mice exposed to blasts, leading to inflammation of microglia, primary immune cells of the central nervous system. This damage may lead to later development of neurodegenerative disorders like encephalopathy and Alzheimer’s disease, connections being studied in Canada, Australia and the U.S.
doctors at the VA Greater Los Angeles Healthcare system reported in 2015. A pacemaker-like device was implanted in a veteran’s brain to stimulate his amygdala, which is involved in the fear response. After 10 months of treatment, the 48-year-old Gulf War veteran, who had not responded to years of other treatments, reported dramatic improvements in the ability to sleep, mood and emotional control and number of nightmares. But it will be years before the treatment enters the mainstream.

A few dozen volunteers have had small electrode arrays implanted in regions of the brain involved in recall, spatial memory and navigation to improve memory through electrical stimulation of the brain. Early results of the Defense Advanced Research Projects Agency (DARPA) project are encouraging, and researchers are now trying to determine whether stimulation is best used while memories are being stored or retrieved. “These early experiments are clarifying (such) issues and suggest there is great potential to help people with certain kinds of memory deficits,” program manager Justin Sanchez reported at the 2015 Wait, What? A Future Technology Forum.

DARPA hopes eventually to capitalize on brain plasticity, the brain’s ability to reorganize neural pathways to compensate for injury, to develop implants that can address neuro-psychological illness.

But eventually is not fast enough for the soldiers and veterans living with TBI and PTSD. Alarmed by the sheer numbers needing treatment, and the limited number of U.S. Veterans Administration facilities, the Intrepid Fallen Heroes Fund financed the National Intrepid Center of Excellence (NICoE), which opened in 2010 near the Walter Reed National Military Medical Center in Washington, D.C. And it is building nine Intrepid Spirit Centers, five of which have already been completed, to diagnose and treat serving military personnel and veterans with TBI, PTSD and other operational stress injuries. Centres, each located near a base, will cost $11 million to build and equip. While NICoE is devoted to research, Intrepid Spirit Centers focus on diagnosis and treatment.

**Medics, doctors and psychiatrists have had to rely upon soldiers’ self-reports of symptoms for diagnosis.**

In Canada, veterans’ advocates are pushing for the two veterans’ national health care centres of excellence promised by the federal government to be devoted to mental health care.

“There are hospitals already on the cutting edge of physical injuries,” said Bedard, who is on a VAC (veterans advisory committee). But there aren’t enough dedicated facilities addressing veterans’ mental health. Now veterans with PTSD are treated mostly by civilians who may have no concept of military culture, or in facilities that mostly deal with rehabilitation of civilians with addictions. Veterans have long advocated for treatments, programs and specialists sensitive to military culture, ideally in dedicated facilities. The two new centres could fill the bill, said Bedard. And they could be a focus for research on military mental health care, which is now spread out among a number of universities, hospitals, institutions and private industries.

“We could keep two mental health centres running full-time forever,” he said. “We currently have 1,300 members in Joint Personnel Support Units, and if half have PTSD, that’s about 750. Then you have to catch up for people who’ve been released. And then you could serve corrections officers, RCMP and first responders.”

Bedard hopes the full panoply of positive results of neuroscience research will play out, but diagnostic tests would immediately improve the lives of thousands of veterans.

Not only would it get them into treatment faster, but it would help overcome stigma.

“At the end of the day, we can’t cure anything,” said Bedard. “We can’t make symptoms disappear. The very least we can do is reach out to show these invisible wounds. Hand them proof they can take out onto the street or into the local [Royal Canadian] Legion branch, to the people who say ‘Well, you don’t look like there’s anything wrong with you.’ At least you have something in hand to say ‘Yeah, there is. Absolutely.’”

**How far can it go?**

Military brain research has a dual personality and purpose: to address health issues for serving members and veterans—and coincidentally, civilians—and add to the military’s technology arsenal.

Military research is leaping ahead in the quest to make stronger, faster, smarter troops with ultra human stamina—and the brain is a research destination.

Tens of thousands around the world now have brain implants that deliver tiny electric impulses to stimulate different areas of the brain, just as a pacemaker stimulates the heart. Such stimulation can be used to treat depression and post-traumatic stress disorder, stave off epileptic seizures, and allow people with Parkinson’s better control over their movements.

Research is also being conducted into use of implants on the battlefield, such as coupling implants to wireless communication so one day troops on the battlefield might be able to communicate by thought alone.

Transcranial magnetic stimulation, in which a tiny electric current is passed into the brain by a magnetic field, outperformed coffee in improving air force volunteers’ attention spans, alertness and accuracy in tests at the Wright-Anderson Air Force Base in Ohio. A helmet filled with electromagnetic coils has already been approved by the U.S. Food and Drug Administration for use in treating depression, and researchers hope to develop more user-friendly units that resemble music earbuds or can be used like a phone app. “We’re beyond
proof-of-concept phase,” biomedical engineer R. Andy McKinley said in a Boston Globe story. “We’re working on something that would be easy to apply and that you could potentially [use in the] field.”

DARPA’s Neural Engineering Systems Design Program is working on a brain/computer interface to convert electrochemical language of neurons into computer language. Capable of connecting with a million neurons, it’s only the size of the button on a man’s suit jacket. On one hand, it could improve thought-controlled prosthetics for amputees and allow doctors to monitor patients between visits, and on the other, allow troops to control equipment or help soldiers better detect danger on the battlefield. Brain implants could link pilots to computers to speed up reaction times when dealing with overwhelming amounts of data.

But while there might be wide public support for use of such technology to relieve symptoms of Alzheimer’s disease or dementia, enhancing brains of healthy people might cause some public concern. It’s one thing to stimulate brains of navy technicians so they can quickly synthesize information coming at them simultaneously from computer screens and telephones, but what about using such technology so an elementary student can master the times tables?

Neurotechnology “raises a lot of questions we’ve just not had to face before,” said Jonathan Moreno, a bioethicist at the University of Pennsylvania and author of Mind Wars: Brain Science and the Military in the 21st Century. “When existential survival is the issue, then people are generally more favourable to enhancement, because the stakes are so high, whereas with small children, your tolerance may be less.”

The United States is a research leader, partly because of President Barack Obama’s billion-dollar BRAIN Initiative, partly because of the duty to protect the health and safety of its 1.5 million citizens in uniform and nearly 22 million veterans. The U.S. also wants to avoid technological surprises that raise security threats, such as the 1957 launch of Russia’s Sputnik which sparked the space race.

The U.S. Department of Defense and DARPA are also spending billions on brain research to enhance performance of personnel and decrease effectiveness of foes. They are exploring technology and drugs that would allow soldiers to go a week without sleep, to suppress fear, extend alertness and ignore pain. And exploring neuroweapons, such as drugs that could be sprayed on the enemy during battle, causing them lose their fighting spirit (or consciousness) and lay down their arms. Where will it all lead…and where will it stop?

“I think you could get an international convention that would prohibit amputating limbs so you could put on better ones,” said Moreno. But an exoskeleton like the one that can help Trevor Greene, the Canadian soldier who suffered severe brain injury in an axe attack in Afghanistan, to walk, “that’s a different party.” (“A Mighty Big Bionic Step,” Legion Magazine, January/February 2014).

Expense will be carefully weighed against usefulness. “We’re so depleted in basic stuff like trucks and tanks [that] they’re not installing biosensors in helmets. The people buying this stuff have to be convinced it solves a problem better than something else. Why use a laser to blind someone, when you can just shoot them?”

And there’s fear of increasing dependence on technology. The last thing any commander wants is for pilots or infantry to become over reliant on technology that can be interrupted or fail on the battlefield.

“When I close my eyes and go to sleep at night I’m not mostly worried about this stuff,” said Moreno. “Some people think that anything I wrote about in Mind Wars is going to be done. Actually, very little of it will be done outside the laboratory.”

#IAmTheFaceOfBrainInjury

Do you have a story of survival? Do you have coping strategies to share? Are you a caregiver to someone with ABI?

To help spread the awareness of how brain injury impacts our lives, OBIA is pleased to share stories from our readership. The goal is simple:

Share • Inspire • Support

To share your journeys with our readers, email us at: stories@obia.on.ca
This past summer, the Minister of Health and Long-term Care, Dr. Eric Hoskins announced a three-year plan to give patients and their families more control over their home-based care. In early November, the CBC news discovered the provincial government has created a new agency to begin delivering self-directed home care services across Ontario. This new option, called Self-Directed Personal Support Services Ontario, is meant for clients with “complex conditions.”

After a public report was released, which identified the problems with access to community-based health care, Minister Hoskins replied with the proposed launch of a pilot program to offer self-directed care across Ontario. This will be a pilot program set to launch in the new year across a few unidentified sites. If this pilot is successful, it can help to address some of the longstanding concerns about patient access to Personal Support Workers (PSWs) in their homes. It is a regular occurrence to hear at OBIA and with other community agencies, how much of a struggle the current in-home health care system is. The number of hours received is limited and the staffing is inconsistent for many, causing frustration for the person receiving the service and their families. It is a great model for those high-needs patients who aren’t able to get out and shop around for their own PSWs.

Nearly 750,000 Ontarians receive home care each year. Most of those require care for only a few days or weeks after leaving a hospital, but many others require extensive, continual care. For years, these patients and their families have lobbied for self-directed care, where they can personally choose their own PSW and arrange a schedule that works best for the patient.

Direct Funding Ontario is an example of self-directed care in Ontario. It is a plan for individuals with physical disabilities who have the capacity to coordinate all levels of their care including the recruitment of their attendants along with completing all the necessary paperwork. In the plan being piloted by Minister Hoskins, the newly announced organization would manage the administrative tasks associated with retaining a PSW and allow for individuals to have more choice in selecting a PSW and more control in determining their care schedule. Patients with high-needs, such as adults with acquired brain injury, where some may require at least 14 hours of support a week, will be eligible to participate in the new program.

For years, individuals living with a brain injury and their families have been advocating for a system like this one. We hope that this new system will provide both flexibility for the patient in how and when they access their care, but also offer consistency with the staff that will be supporting them so that this new system can become a reliable source of support for those living with a brain injury.
My journey began on March 13, 1970. For years I did not understand why I was so slow learning anything. I asked my mom why and she told me that there had been complications during delivery and I had been deprived of oxygen, causing me to sustain a traumatic brain injury.

After delivery, I had to remain in the hospital in Thunder Bay for a month. I thank God for saving my life.

As I grew older, I was in special education classes all through school, from kindergarten through to grade 12. I almost quit school at the age of 16, but my dad told me if I quit, I would have to get a job. I thought about it and continued high school until graduation. I received an English award and graduated grade 12 with honours in the basic level in June of 1989.

My struggles continued after school as I dealt with bad relationships; was married at age 28, divorced at age 35.

I can now say that for the past 3 years I have given myself a better life and am happy again. Life is good!
Providing Services for Wounded Warriors

A Guide for Agencies

By Helaine Bilos, C.C.M. and Marilyn Lash, M.S.W.

TIP Card reprinted with permission, Lash & Associates Publishing

This article prepares staff of community agencies to...

• prepare for initial meeting
• gather information from all
• identify pitfalls and barriers
• be aware of cognitive issues

Introduction

Wounded warriors are returning to their homes and communities. Their needs for services and supports will vary widely. Their injuries are different than those seen in other wars, because the “weapons” are blasts, improvised explosive devices, chemicals and rocket-propelled grenades. Due to the advanced medical care in the battlefield and rapid transfer to trauma centers, the survival rates for wounded warriors are higher than ever seen before. This also means that their injuries are more complex. Some will recover. Others will have lifelong changes in physical, behavioural, cognitive, and emotional functioning. Some will need caregivers for assistance and support.

Traumatic brain injury and post-traumatic stress disorder (PTSD) are the signature wounds of the wars in Iraq and Afghanistan. Some symptoms are immediately apparent; others will emerge over time. Service providers face new challenges in treating wounded warriors. In preparation for their return, many providers in local communities are training staff, identifying resources, and developing veteran-centric services.

Before you Meet

Military culture

It’s important to understand military culture to appreciate the unique commitment made by service members and their families to our country. These recent conflicts have crossed all branches of the military as well as the reserve units. Each branch has its own identity, cost of conduct, culture, abbreviations and titles.

Tips on learning about military culture...

• Use the web to learn about the branch of service, e.g., Canadian Army, Royal Canadian Navy, Royal Canadian Air Force.
• Identify rank, e.g., trooper, sergeant, captain, etc.
• Know the person’s deployment history, e.g., number and length, sites, duties, etc.

Reading records

Reviewing records prior to meeting the individual and/or family provides diagnostic and treatment information. While very beneficial, records don’t tell the whole story. They often contain errors and conflicting reports that can be corrected through conversations with the wounded warrior and family. Many reports contain clinical information, but lack real life functional information. When working in the home and
community of a wounded warrior, it is the information on how the person functions and interacts that provides the most relevant and useful insights into challenges and abilities.

Tips on using information from records...

• Avoid having preset expectations; the person can be very different in person than on paper.
• After reviewing records, make a list of questions for the wounded warrior and family to determine their priorities and needs.
• Request the wounded warrior’s and family’s input about current functioning and status.

The record review sets the stage for an agency to conduct an in-house inventory of expertise and skills. This inventory serves as a critical self-analysis of the agency’s gaps in knowledge and experience. It helps identify areas where education and training are needed to provide services.

First meeting

Planning the initial meeting is more than simply scheduling. It is the first step in developing a relationship with the wounded warrior and family.

Tips on the first meeting...

• Ask what day and time is best before scheduling.
• Confirm the appointment 24 hours in advance.
• Be prepared to share information about yourself and your interest and experience in working with brain injury and wounded warriors.
• Have an interview or assessment tool to gather baseline information on needs and goals.

Get everyone’s perspective

Family dynamics are always complex. When you add the cognitive and behavioural changes due to a brain injury and/or PTSD, communication within families can be affected by emotions, stress, and anxiety. Communication patterns can range from extremes of talking about everything with everybody all the time to not talking at all. By identifying existing communication patterns, more productive and positive exchanges can be developed and supported.

The wounded warrior and family may have some agreements on their needs, but they may also have different perceptions about the challenges, stresses, and accomplishments in their daily lives. It is helpful to ask questions with everyone present, but it can also be revealing to talk with the wounded warrior and family separately.

Tips on communicating...

• Read nonverbal cues as well as what is being said.

• Know when to be assertive, when to negotiate and when to back off.
• Be alert for changes in emotions, moods and behavior when conversing.
• Observe the interpersonal dynamics between the warrior and family members.
• Offer to speak with each person separately if this is agreeable.

Brain Injury Overview

Neurological changes after brain trauma can directly affect the wounded warrior’s ability to engage in relationships and request help.

Insight and self-awareness

There may be denial of any changes in cognitive or physical functioning “Nothing is wrong with me” or “I don’t need any help.”

Tips...

• Teach about the effects of brain injury.
• Give feedback on tasks and improvements.
• Avoid arguing, reasoning, and power struggles in efforts to “make” the person more aware of difficulties (it’s not going to work).

Memory

Long-term memory refers to the recall of events and people long ago. This is usually not affected by a brain injury. Short-term memory is for recent events within minutes, hours, days, weeks, or months. Short-term memory is very commonly affected by brain trauma. A comment often heard is, “He can remember his little league coach, but he can’t remember what he had for lunch.” Short-term memory challenges can affect everything from recalling scheduled meetings to remembering therapy exercises to program goals.

Tips...

• Give reminders for scheduled activities.
• Use visual, verbal and auditory cues.
• Avoid multistep instructions.
• Ask for verbal feedback on what has been done and agreed upon at the end of each session.
• When information is given over the phone, ask the person to write it down and read it back.

Attention

This is the ability to focus on a given task or stimuli for a period of time. A brain injury often results in shortened attention spans and increased distractibility, and affects concentration and memory.
Tips...

- Minimize noise and distractions.
- Make sure the wounded warrior is ready before starting a task or activity.
- Schedule activities or visits during times of maximum cognitive alertness.
- Be alert to signs of cognitive fatigue and adapt.
- Identify other factors that may affect attention and concentration, i.e., headaches, pain, fatigue, personal needs (smoking, bathroom, and hunger).
- Do one task at a time; avoid overloading with multitasking.

Follow-through or task completion

Too often, the word “noncompliant” is used due to failure to keep appointments, complete therapy assignments, or finish tasks. Persons with brain injury often have difficulty with follow-through because of challenges with memory, attention, organization, initiation, and planning.

Tips...

- Post reminders and cues in all living areas.
- Structure activities; give day and time for completion.
- Follow-up to check progress and problem solve.

Initiation

Common comments are, “He just won’t do anything.” Or “She sits and watches TV all day long.” Decreased initiation is one of the most challenging and frustrating changes for family and caregivers. It is often confused with laziness. Instead, it is caused by the person’s inability or difficulty getting started in an activity. “The get up and go has got up and went.”

Tips...

- Teach families methods to jumpstart the wounded warrior by cueing the first step in an activity.
- Be consistent with activities and schedules.
- Post visible reminders of what to do and when.
- Avoid yes/no questions; give choices of time or place. Instead of, “Do you want to go to the gym?” ask, “Do you want to go to the gym at one or two o’clock?”

Egocentric

The person is often described as being selfish with no concern or thoughts for anyone else. Rather than selfishness, it is a loss of ability to empathize and relate to others that has been changed by the brain injury.

Tips...

- Revise your expectations of the person.
- Avoid becoming angry at what appears to be self-centred behavior.
- Encourage discussing reactions and feeling of others without being accusatory.

Judgment

This is the ability to assess a situation, weigh the pros and cons, evaluate risks and benefits, and make safe and sound choices.

Tips...

- Discuss safety risks for all situations.
- Offer safe alternatives.
- Process when and why a decision or action used poor judgment.
- Identify alternatives to avoid repeated episodes.
- Give close supervision as needed.

Emotions

Mood swings, crying spells and bouts of laughter are common and can be unpredictable. They can affect someone’s ability to establish and maintain relationships, work productively, be involved in community activities, and feel comfortable in social
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settings. It is normal for wounded warriors to experience a range of emotions after a brain injury as they grieve their losses and live with the effects of their injuries. However, some emotions may be more extreme and easily triggered, making the wounded warrior appear to be “out of control” and avoided.

Tips...

• Identify triggers for emotions.
• Prepare ahead for known triggers in social situations.
• Make a plan for the wounded warrior to remove him/herself when emotions feel overwhelming.
• Redirect the wounded warrior’s attention to less stressful thoughts and situations.

Social Skills

Everything discussed thus far affects social skills. Often the brain injury can result in the person making inappropriate comments or gestures, acting immature, missing social cues, and being socially awkward. Others may be perplexed and embarrassed by this behavior or comments and avoid the wounded warrior. The effect of a brain injury on social skills is especially difficult for others to understand when there is no visible disability.

Tips...

• Identify unsuitable or inappropriate behaviors.
• Know the triggers for behaviors and comments.
• Establish cues to alert the person to inappropriate social interactions.
• Educate peers and friends about the effects of brain injury on social skills.

What’s Next?

Developing a positive and supportive relationship with the wounded warrior and family is the foundation for providing services in the home and community. The warrior, family members and caregivers will each have unique strengths and challenges to consider in the development of a service plan.

Brain Fast Facts

DID YOU KNOW?

• 6% of the Canadian Military personnel deployed in Afghanistan have ABI as a result of their service - Canadian Forces Health Sciences Advisory Panel on TBI
• If you’re in the military, having a brain injury increases your chances of also having PTSD - US Dept of Veterans Affairs
• Most brain injuries acquired during military service are the result of blasts from improvised explosive devices (IEDs) - US Dept of Veterans Affairs

On behalf of the Board and Staff of the Ontario Brain Injury Association, we wish you the very best of the Holiday Season and a very Happy New Year!
Are you a caregiver?

Looking for one-on-one support after brain injury?

Our **FREE** Peer Support Program can connect you to a trained mentor who understands.
My name is Ria Koning and I was born on December 14th, 1941 as Ria Neehuis (my maiden name) in Oldenburg Germany. I tell everyone I am 49 and holding.

I came to Canada at an early age and eventually met my husband, Dirk Koning. He passed away years ago in 1986.

On August 1, 2001 I was walking to the local theatre where I live, a place where I used to volunteer. It was quite a hot day and about halfway there I was overcome from heat exhaustion and I fell, badly hitting the back left side of my head, suffering a subdural hematoma.

After being in the hospital for about four and a half months, including surgery and one month where I was in a coma, I was released to go home just in time for Christmas and into the care of my son and daughter. I also had a hospital outreach program follow me to my house with a holistic team that consisted of physical, speech and cognitive therapists.

I began going to the York Durham Aphasia Centre and continued going there for 13 years as they helped me with the progression of my speaking abilities. I also became a mobility plus service user as I was no longer able to drive a car.

In 2004 I became involved with the Ontario March of Dimes. I have a rehabilitation worker who comes to my home once a week and what we do is usually up to me. Sometimes we go to the library, the plaza or work on puzzles, write letters to friends and family or improve my computer skills.

Most of my days are filled with the March of Dimes program, including trips and special events, or attending the Acquired Brain Injury Adult Day Program through Mackenzie Health where I get to socialize with some of my peers, partake in exercise and games and offer support to newcomers. I no longer go to the Aphasia Centre.

The road to recovery for me has not been easy, but I believe my commitment to self-improvement, being able to laugh at myself, and remaining positive have greatly assisted me in my journey. With each goal I accomplish, I gain a little more confidence and independence.

I am the mother to two awesome ‘family’ social workers, my son and daughter, Mark and Amy. I am also a grandmother to two lovely grandchildren, Clara and her spirited little brother Lucas, both of whom refer to me as Oma.

Despite having a brain injury I live a very happy and full life. I have found new independence with enjoying the outdoors on both sunny and windy days with my scooter. And, I still enjoy doing a lot of the activities that have always been an interest to me; things like dancing, singing, photography, swimming, hiking, arts and crafts, puzzles and crosswords. I just take things at a bit of a slower pace. I also have fun from time to time hosting parties to celebrate the holidays with family and friends or getting dressed up to go out for lunch.

My advice to others out there that have survived through, and now live with, a brain injury, would be to not allow the things you can’t do stop you from doing the things you can do; to stay positive and support one another, and to never give up.
These wonderful people and their colleagues treated us with respect, dignity, and accountability...we also gained the help of kind, honest and able professionals that restored our faith in justice and humanity.

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- What is Second Impact Syndrome?
- Where can I get help?
- Resources

To receive a copy of this brochure, order online at: www.obia.ca
or if you need further information on concussion, contact:
1.800.263.5404 or support@obia.on.ca
Conflict: Catalyst for Change

Occupational Therapy: Reforms in Ukraine Triggered by Injured Soldiers of the Donbas Conflict

By Natalie Zaraska, BSc (OT), MSc (Rehab), Occupational Therapist, Reg (Ont)

Ukraine is a country of 45 million people situated in eastern Europe bordered by Poland, Russia, Belorussia, Moldova, Romania, Hungary and Slovakia. In 2014, Russian aggression resulted in the annexation of Crimea and armed conflict in the Donbas region. The country has received International support and NATO has been involved in providing support in five key areas, including “command, control, communications and computers (C4); logistics and standardization; cyber defence; military career transition; and medical rehabilitation. A sixth initiative on explosive ordnance disposal/counter-improvised explosive devices followed in 2016.” (https://www.nato.int/cps/en/natolive/topics_37750.htm)

As a past member state of the Soviet Union, Ukraine has a long history of oppression, mismanagement and cultural indoctrination. The medical system struggles to provide the most basic care and there exists a long-entrenched derisive attitude of imperfection and illness. “The disabled in Ukraine face both hidden and open discrimination in their daily lives, and they are stigmatized through popular stereotypes of disabled persons as inferior, deformed and even contaminating” (Phillips, 2002, page 1). The World Health Organization has examined the situation and has confirmed that the Ukrainian medical model of rehabilitation inherited from the Soviet Union is unable to meet the need for rehabilitation not only in response to soldiers of the current Donbas conflict, but for the population as a whole.

There is now a greater understanding of the need for a system of rehabilitation with thousands of soldiers returning from the front with life-altering injuries. It has been identified that extensive treatment is required for those soldiers, returning with spinal cord injuries, amputations, brain injuries and PTSD (post-traumatic stress disorder). A psychiatrist, Dr. Oleh Chaban states:

“We do not have national diagnostic protocols, treatment and rehabilitation systems for patients with acute reactions to stress and [post traumatic stress disorder] PTSD.” (CMAJ. 2015 Nov 17; 187(17): 1275.)

It has been reported that a typical Western soldier is deployed to a war-front for 35-45 days, while the Ukrainian soldiers may be deployed for 4 to 5 months. It has been reported that 2,027 combat deaths have occurred in 2 years with 597 deaths reported as non-combat related, most due to suicide. The military hospitals have been ill-equipped to handle soldiers with PTSD, spinal cord injuries and brain trauma. Staff have
been essentially untrained to manage the serious trauma victims and some soldiers have been sent to other countries for rehabilitation treatment, including military facilities in the U.S., while many others receive no treatment at all.

Occupational therapy, as a rehabilitation profession was non-existent in the country. As a Canadian Occupational therapist of Ukrainian heritage, I have felt drawn to assist in the process of introducing my profession. Due to the conflict, attention has been focussed on the need to improve services for wounded soldiers. On my many visits to Ukrainian military hospitals, meeting with soldiers and the staff providing care, it became quickly apparent that there was a great need for a structured rehabilitation program and that OT could play a significant role in assisting the soldiers with activities of daily living, cognitive therapy, as well as mental health treatment. The soldiers I met expressed concern for their future, unease about how they would survive financially, what jobs they could do and concern for their families. I spent time speaking with the soldiers and could easily identify a lack of therapy which would be of benefit. The attention that I could give as one OT was greatly appreciated by soldiers and staff alike. My initial visits to military hospitals has sparked my desire to get involved and assist in bringing OT to the soldiers.

I began visiting Ukraine and working with a private university in Western Ukraine, The Ukrainian Catholic University, in November 2015. My objective has been to raise awareness of the role of an Occupational Therapist in rehabilitation and assist in developing standards for education and practise of the future professionals. By June 2016, the university submitted an Occupational Therapy curriculum to the Ministry of Education. As a result of these systemic efforts, in August 2016, Occupational Therapy was recognized as a new profession in the Ukrainian health and education system, with the official name “Ergotherapy.”

In April 2017, this therapist together with a representative from the WFOT (World Federation of Occupational Therapy), Samantha Shann, and an OT from the U.S., Lisa Mason, travelled to Ukraine to promote OT education and advise the government and educational institutions in establishing the profession of Ergotherapy. We met with the acting Minister of Health, Dr. Ulana Suprun, and a Memorandum of cooperation was signed between the WFOT and the Ministry. Discussions with government representatives, both nationally and locally, identified recognizable needs for occupational therapy in the areas of rehabilitation for soldiers returning from the conflict and children with special needs. Our tour included visits to military facilities where staff identified their needs for therapy programming and professionals trained in rehabilitation. The next steps in this herculean task of creating a rehabilitation profession in Ukraine and ensuring its effectiveness and
success in a post-soviet health system will require the continued involvement of the international community. Needed is the provision of expertise in educating students in Occupational Therapy programs and providing both clinical and fieldwork experience to these students in accordance with the criteria and minimum standards developed by the WFOT. The universities will need out-of-country support from occupational therapists to teach the curriculum specifically pertaining to OT courses. The exposure to therapists trained abroad will further develop the concept and knowledge base of rehabilitation and assist in creating Ukraine’s own system of rehabilitation.
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November 1 - 3, 2017 saw more than 650 people attend the Acquired Brain Injury Provincial Conference in Niagara Falls, Ontario. On behalf of the participating community associations, OBIA would like to thank the knowledgeable keynote speakers (pictured below), the many concurrent speakers who shared their time and experience with the delegates, the sponsors, exhibitors, emcees Cheryl Scollard and Russ Davies, entertainers, our staff and many volunteers for making this conference a huge success. Together we do make a difference in the lives of persons living with acquired brain injury.

As requested by the delegates attending the conference, where possible, we have uploaded the concurrent and keynote presentations to the conference website for you to view and download: https://ontarioabiconference.ca/

**CONFERENCE HIGHLIGHTS**

Steve Noyes  
*My Story and the People Who Made a Difference*

Kim Gorgens, PhD, ABPP  
*Identifying and Treating the TBI-related ‘Superfecta’ in Justice Settings*

Keith Yeates, PhD, R.Psych, ABPP-CN  
*The Role of the Family in Recovery from Pediatric TBI*

Sheila MacDonald, M.Cl.Sc, SLP (C)  
*Managing Subtle but Significant Cognitive and Communication Deficits after ABI*

Eve M. Valera, PhD.  
*The Hidden Victims of Repetitive Traumatic Brain Injuries (TBIs): Women Subjected to Intimate Partner Violence (IPV)*

Angela Colantonio, PhD, OT Reg. (Ont.), FCAHS, FACRM  
*Intimate Partner Violence and Traumatic Brain Injury: A Canadian Perspective*
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PROUD SPONSOR OF SPINAL CORD INJURY ONTARIO AND THE ONTARIO BRAIN INJURY ASSOCIATION
OBIA Advisory Council (OAC) Report

The OBIA Advisory Council (OAC) met on September 16, 2017 at the Miles Nadal JCC in Toronto. There were 18 people in attendance as well as four via webcast. The first half of the meeting entailed discussions regarding plans for Brain Injury Awareness Month 2018.

Ruth Wilcock previewed information videos, produced for OBIA by summer student Elijah Lopez. These videos are available on OBIA’s YouTube channel (via the OBIA Website) and have been shared on OBIA’s social media platforms. After lunch, each association was given the opportunity to discuss their latest initiatives, fundraising and awareness campaigns.

Archived videos of past workshops can be found on OBIA’s Vimeo page:
https://vimeo.com/obia

BIA of Quinte District

The Brain Injury Association Quinte District has been very busy over the past few months. The members and staff have been working very hard to raise awareness about brain injury in the community.

The staff and summer students were joined by the members to host several bike rodeos in our area. They gave out literature on helmet safety, and spoke about the importance of always wearing your helmet. With the assistance of the Ontario Trial Lawyers Association, we were able to donate new helmets to children and adults so they could ride safely this summer.

The members have been working hard to give back to the community. This summer they spent time at the local food bank, and taking care of the community garden. They spent countless hours pulling weeds, watering the vegetables, and harvesting food so the members of our community could enjoy free, fresh produce.

The Artistic Expressions group got together with an experienced quilter from our community and made a beautiful one-of-a-kind Canada 150 themed quilt. They entered the quilt into the annual Quinte Exhibition Agricultural Fair and won several ribbons and acknowledgements. The quilt won 1st prize for the category “A Quilt Made by a Group”, as well as 1st prize in the “Canada 150” theme. It also won 1st prize in the “Quilt – Fair Level.” In addition to all the ribbons, BIAQD was presented with certificates from both Todd Smith...
MPP, and Neil Ellis MP for achieving 1st place at the Quinte Exhibition, and portraying Canada’s 150th with such creativity. We are very proud of their achievements!

**Upcoming Events**

On December 15th we will be having our annual Members Holiday Party. There will be food, entertainment, and an appearance by a special guest.

On February 13, 2018, BIAQD and Bonn Law will be hosting their first ever Comedy Night Fundraiser. Join us at the Signal Brewery in Codrington for a night of entertainment and support a great cause.

**BIA Waterloo Wellington**

We are pleased to announce that effective immediately, Lynda Abshoff has joined our team as Executive Director. The office has now re-opened and the “Restart” project is underway. Stay tuned for more details and a reworked website.

**BIST Toronto**

BIST has had a busy fall with the introduction of three new programs. This September BIST began running a 10-week Wellness Recovery Action Plan (WRAP) group for concussion survivors. We also hosted four Mindfulness and Art Sessions and began a monthly peer support group for caregivers. We also hosted a workshop with Dr. Hiten Lad and Dr. Milan Unarket on Behavioural Changes and Possible Medical Complications following an ABI. Communications Coordinator, Meri Perra, also staffed a BIST booth at the Movement to End Brain Tumours Conference.

Our members had the pleasure of spending a Saturday afternoon taking in an Argos game. Many thanks to Frank Bruno for getting the Toronto Argonauts Football Club to donate the tickets.

We kicked off October with our annual 5K Hero Run, Walk and Roll. We look forward to this event every year, and this year was no exception. We had great weather, amazing superheroes and (Toronto Radio Station) Indie 88 came out to support us! In addition to getting fresh air and exercise we were able to raise more than $40,000 for BIST’s programs and services - Superhero Success!

BIST loves Halloween and this year we got to celebrate it twice. Our Special Events Committee hosted a party for our members on October 30th, with costumes, food, fun and prizes. We were also very lucky to have Halloween Mavericks Joe Pileggi, Al Burton (Thomson Rogers), Lynne Harford (SWCG), Justin Kline (Anchor Rehab Support Services) and Tonya Flaming (Rehabilitation Planning Corp) organize a third-party fundraiser for BIST. This came complete with costumes, the best DJ this side of the graveyard, and a Sweeney Todd themed photo booth. We are already looking forward to next year!

We are gearing up for Giving Tuesday and are excited to once
again be hosting our Pop Up Thrift Shop. Last year, someone scored a laptop and a Gucci belt. We wonder what goodies people will pick up this year.

BIST would like to wish everyone a safe and happy holiday season and all the best in 2018!

Seizure & Brain Injury Centre (Timmins)

Another successful year of camping was held in early September. Everyone had a great time adventuring around the trails and lake. Unfortunately, the weather was too cold for swimming activities.

An afternoon Halloween Party was held for survivors of the New Beginnings Day Programming which included a pizza lunch and lots of treats. Costumes were worn and survivors played a number of games and socialized.

Staff participated again this year at the Ontario Brain Injury Association Bi-annual Conference and were able to network with other agencies, businesses and staff, plus learn more on the topic of acquired brain injury.

November 1 was the release of at the CD “Northern Ontario Rocks” for the Seizure & Brain Injury Centre at the Working Class Bar. It was a great evening with live bands and a packed house. All proceeds of the CD will be donated to the Centre. Newest Board Member Ryan Daly, a local radio announcer, pulled this event together for our agency.

The Board of Directors this September welcomed survivor Jessica West to the Board who will be sitting on OBIA's Advisory Committee. Jessica attended her first meeting in September and came back very excited about her participation on this Committee.

◊◊◊
Travelling to a foreign country to engage in combat. Witnessing injuries, death and destruction on a regular basis. Forced to endure tough living conditions. Is it any wonder members of the Canadian armed forces who see action return home not only with physical, but with mental and emotional trauma as well?

Broken bones and musculoskeletal injuries can be healed. More challenging however, are the emotional afflictions men and women in the armed services can suffer, and surely among the most devastating is Post-Traumatic Stress Disorder (PTSD).

Symptoms

Most people have been involved in a frightening situation at some point in their lives, and reactions vary from person to person. Some might feel nervous at times, while others might have a difficult time sleeping as they go over the details of the incident in their minds. Over time, symptoms usually decrease, and sufferers affected eventually return to their normal lives.

However, in the case of PTSD, the effects last a considerably longer time and can seriously disrupt a person’s life.

Doctors refer to three symptoms that define PTSD: intrusion, avoidance and hyperarousal. Intrusion is the inability to keep memories of the event that sparked it from returning. Avoidance refers to the attempt to avoid anything that may trigger those memories, and hyperarousal is the constant feeling that danger or disaster is imminent. These may also be accompanied by an inability to concentrate, extreme irritability or sometimes violent behaviour.

Those affected can experience recurring nightmares, flashbacks or recollections of the event or incident. They can feel “on edge” all the time, have difficulty in concentrating, be irritable and have problems sleeping. A common symptom among veterans is something known as nocturnal myoclonus, a sudden spasm of the whole body while sleeping or drifting off into sleep. It lasts for about a fraction of a second, but may occur several times in a single night. Often people with PTSD will sleep through such a spasm, but it can be extremely disturbing to their partner.
People suffering from PTSD may also feel disconnected from their thoughts and have a hard time expressing emotions. It can lead to depression, substance abuse and create problems in a person’s personal life. Suicide is often seen as the only way out.

Not surprisingly, those in certain occupations, such as policing, firefighting and the military have much higher rates of PTSD than those in other professions. And in some cases, trauma such as warfare can cause symptoms even beyond those commonly associated with PTSD, resulting in a state known as “complex PTSD.”

A study released by the University of Southern California, Los Angeles (UCLA), in February 2012, reported of a possible correlation between acquired brain injuries and PTSD, suggesting that people who suffer even a mild brain injury are more likely to develop an anxiety disorder.

UCLA professor of psychology Michael Fanselow found that this relationship was particularly prevalent among veterans who had returned from overseas. The reasons for the connection are not yet fully clear. Nevertheless, in an experiment with rats, scientists used procedures to separate physical and emotional trauma, training the rats by using “fear conditioning” techniques two days after they had experienced a concussive brain trauma, thereby demonstrating that the brain injury and the experience of fear had occurred on two separate days. As Dr. Fanselow explained:

We found that the rats with the earlier TBI acquired more fear than control rats (without TBI). Something about the brain injury rendered them more susceptible to acquiring an inappropriately strong fear. It was as if the injury primed the brain for learning to be afraid.

According to Boston's Mayo Clinic, the primary treatment of PTSD is psychotherapy but this is also frequently combined with medication. Psychotherapy can include any of the following types:

**Cognitive therapy.** This type helps patients recognize the ways of thinking (cognitive patterns) that are hindering the healing process.

**Exposure therapy.** This type helps patients safely face what is causing them such distress so they are able to cope with it more effectively.

**Eye movement desensitization and reprocessing (EMDR).** EMDR combines exposure therapy with a series of guided eye movements that helps patients react better to traumatic memories.

**New Treatment**

The Canadian military has come under criticism for its seeming neglect in both the recognition and treatment of PTSD in ex-soldiers who are still feeling the effects of combat.

November 2014, three veterans took their own lives over the course of a week, bringing the total to more than 22 since the mission in Afghanistan ended.

Nevertheless, a story from CTV News in March of 2014 reported a new treatment being tested that so far, is producing positive results. Developed by the Institute for Creative Technologies (ICT) at the University of Southern California, it involves the notion of virtual reality in which a sufferer affixes a device to his or her head which simulates the circumstances that brought about the trauma in the first place. The therapist can then talk the patient through the ordeal, thus helping them...
to overcome it.

The federal government is now in discussion with ICT in order to develop a Canadian version. The ultimate goal is not just to treat afflictions such as PTSD but to also train soldiers before going into battle, helping them to experience the sense of combat before they embark on the real thing.

PTSD can be both debilitating and life-threatening, but there is hope. If you know someone you suspect is suffering from PTSD urge them to seek help.

Those afflicted may find it difficult, for stigmas surrounding mental health issues continue to persist. Yet seeking help is the first step to recovery and it is readily available through such organizations as Canadian Mental Health Association. Suicide is most definitely not the solution. Those who have served in the Canadian armed forces have served their country well, and deserve whatever we can give them to continue leading happy and successful lives.

Resources

If you think you or someone you know has PTSD or needs other mental health supports:

• Members of the Armed Forces can contact Veterans Affairs Occupational Stress Illness (OSI) clinics
• For ABI services, call the ABI Network: 416-597-3057
• Call 211 – a free and confidential line for referrals to community and social services, available in most communities in Ontario
• Call the Canadian Mental Health Association in your area
• In a crisis situation call your local Distress Centre

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Neuro-Rehab Services Inc. Celebrates its 30th Anniversary by Supporting OBIA

On October 3, 2017, NRS was thrilled to have many of their community partners join them at Second City Theatre to help celebrate their 30th anniversary, and to pay tribute to OBIA as they too celebrated their 30th anniversary. All proceeds from the event were donated to OBIA, supporting the incredible work OBIA does in the area of awareness, advocacy and support.

The evening started with dinner, cocktails and networking. Master of Ceremonies, Patricia Howell began the evening sharing how NRS had grown over the years, from offering OT services to adults with brain injury out of Marie Hren’s home, to offering a full range of in-clinic and in-community services.

Marie Hren and Harriette Brown, Co-Directors of NRS, did a toast to the NRS staff, commending their compassion, skill and teamwork.

Ruth Wilcock, Executive Director, OBIA, then shared how OBIA had grown over the years, and gave thanks to NRS for choosing to celebrate their anniversary by supporting OBIA.

Munish Joshi, comedian and advocate for individuals with brain injury, shared some of his family's funny and touching experiences, evidence indeed that laughter is the best medicine. This was followed by the incredible Second City Comedy Show. A big high five to NRS's Ranjeet Hira and Marie Hren and OBIA's Katie Muirhead for getting on stage for the improv – you were awesome!

Tyler Stemmler’s Skate 4 the Brain

On August 27, 2017 Tyler Stemmler hosted his 2nd annual Skate 4 the Brain fundraiser for OBIA. Skateboarding was Tyler’s escape following a brain injury he sustained after being hit by a car at the age of nine. It was his way of regaining his balance and an outlet during the healing process.

This year’s event was bigger and better than ever. He had more sponsors and a larger turn-out.

OBIA would like to thank Tyler for his very generous donation to OBIA and giving back to the community. Tyler already has the 3rd annual event planned for August 25, 2018. See you there!
Congratulations to the 2017 Awards of Excellence in Brain Injury Rehabilitation winners. You are to be commended for all you do. Thank you as well to the award sponsor: PIA Law for your continuing support.
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Events Calendar

February 2, 2018
Toronto Rehabilitation Institute presents:
2018 Annual Brain Injury Conference
Location: Beanfield Centre, 105 Princes’ Blvd, Toronto, ON
Contact: Conference Coordinator
Phone: 416-597-3422 ext. 3448
Email: conferences@uhn.ca
Website: https://ers.snapuptickets.com/UHN/TBI2018/

February 20-23, 2018
OBIA and Brock University present:
Neurorehabilitation: Assisting Recovery & Function in Everday Life Following Brain Injury (Level 1)
Professors: Dr. Sherrie Bieman-Copland, Dr. Dawn Good and Deidre Sperry
Location: Brock University, Room TH325, St. Catharines, ON
Contact: Diane Dakiv
Phone: 905-641-8877 ext. 231
Email: training@obia.on.ca
Website: www.obia.ca

March 6-7, 2018
OBIA and Headwaters ABI Group present:
Brain Basics
Instructor: John Kumpf
Location: Dufferin Child and Family Services, Orangeville, ON
Contact: Diane Dakiv
Phone: 905-641-8877 ext. 231
Email: training@obia.on.ca
Website: www.obia.ca

March 21-22, 2018
OBIA and Seizure & Brain Injury Centre present:
Brain Basics
Instructor: John Kumpf
Location: Children’s Treatment Centre, Timmins, ON
Contact: Diane Dakiv
Phone: 905-641-8877 ext. 231
Email: training@obia.on.ca
Website: www.obia.ca

May 3-4, 2018
Hamilton Health Sciences presents
25th Annual Conference on Neurobehavioural Rehabilitation in ABI: The Evolving Landscape of Brain Injury Rehabilitation
Pre-conference Day: May 2, 2018 focusing on Mild Traumatic Brain Injury and Concussion
Location: Hamilton Convention Centre, Hamilton, ON
Contact: John Zsofcsin
Phone: 905-521-2100 ext. 40868

For more listings, check: www.obia.ca/events
Brain Injury Associations

**Ontario Brain Injury Association**
Phone: 905-641-8877 or 1-855-642-8877
Toll-free support line 1-800-263-5404
Email: obia@obia.on.ca Website: www.obia.ca
- www.facebook.com/OntarioBIA
- www.twitter.com/OntarioBIA
- www.instagram.com/OntarioBIA
- www.LinkedIn.com/company/Ontario_Brain_Injury_Association
- www.flickr.com/photos/OntarioBIA

**Belleville**
**BIA of Quinte District**
Phone: 613-967-2756 or toll free: 1-866-894-8884
Email: info@biaqd.ca
Website: www.biaqd.ca

**Chatham-Kent**
**New Beginnings ABI & Stroke Recovery Association**
Phone: 519-351-0297
Fax: 519-351-7600
Email: info@newbeginnings-cksl.com
Website: www.newbeginnings-cksl.com

**Dufferin County**
**Headwaters ABI Group (HABI)**
Phone: 519-215-1519

**Durham**
**BIA of Durham**
Phone: 905-723-2732 or toll free: 1-866-354-4464
Email: information@biad.ca
Website: www.biad.ca

**Fort Erie**
**BIA of Fort Erie**
Phone: 905-871-7789
Email: biafeoffice@gmail.com
Website: http://braininjuryfe.wixsite.com/biafe

**Hamilton-Wentworth**
**Hamilton BIA**
Phone: 905-538-5251
Email: info@hbia.ca
Website: www.hbia.ca

**London and Region**
**BIA of London and Region**
Phone: 519-642-4539
Email: info@braininjurylondon.on.ca
Website: www.braininjurylondon.on.ca

**Niagara Area**
**BIA of Niagara**
Phone: 905-984-5058
Email: pat@bianiagara.org
Website: www.bianiagara.org

**North Bay Area**
**BIA of North Bay and Area**
Phone: 705-840-8882
Email: contact@bianba.ca
Website: www.bianba.ca

**Ottawa Area**
**BIA of Ottawa Valley**
Phone: 613-233-8303
Email: contact@biaov.org
Website: www.biaov.org

**Peel-Halton**
**BIA of Peel & Halton**
Phone: 905-823-2221 or 1-800-565-8594
Email: biaph@biaph.com
Website: www.biaph.com

**Peterborough Area**
**Brain Injury Association Peterborough Region**
Phone: 705-741-1172 or 1-800-854-9738
Email: biapr@nexicom.net
Website: www.biapr.ca
Provincial Associations

Brain Injury Canada/Lésion Cérébrale Canada
Phone: 613-762-1222, Toll-free Line: 1-866-977-2492
Website: www.braininjurycanada.ca
Email: info@braininjurycanada.ca

British Columbia Brain Injury Association
Phone: 604-984-1212
Website: www.brainstreams.ca
Email: info@brainstreams.ca

Central Alberta Brain Injury Society (CABIS)
Phone: 403-341-3463
Website: www.cabis.info
Email: cabis@telus.net

Saskatchewan Brain Injury Association
Phone: 306-373-1555 or Toll-free (in Sask) 866-373-1555
Website: www.sbia.ca
Email: info_sbia@sasktel.net

Ontario Brain Injury Association
Phone: 905-641-8877 or 1-855-642-8877
Toll-free support 1-800-263-5404
Email: obia@obia.on.ca
Website: www.obia.ca

Newfoundland and Labrador Brain Injury Association
Phone: 709-579-3070
Website: www.nlbia.ca/index.php
Email: nlbia2011@gmail.com

Regroupement des associations de personnes traumatisées crânio-cérébrales du Québec
Phone: 450-575-8227
Website: www.raptccq.com
Email: info@raptccq.com

Brain Injury Association of Nova Scotia
Phone: 902-473-7301
Website: http://braininjuryns.com/
Email: info@braininjuryns.com

Brain Injury Association of Canada (New Brunswick)
Phone: 506-721-8003
Website: www.biacnb.org
Email: biacnb@icloud.com

Brain Injury Association of P.E.I.
Phone: 902-314-4228 or 902-367-3216
Website: www.biapei.com
Email: info@biapei.com

Sarnia-Lambton
BIA of Sarnia-Lambton
Phone: 519-337-5657
Email: info@sarniabiasl.ca
Website: www.sarniabiasl.ca

New Beginnings ABI & Stroke Recovery Association
Phone: 519-491-2668
Email: info@newbeginnings-cksl.com
Website: www.newbeginnings-cksl.com

Sault Ste. Marie
BIA of Sault Ste. Marie & District
Phone: 705-971-1050
Email: braininjuryssmd@gmail.com
Website: www.soobraininjury.com

Sudbury and District
BIA of Sudbury & District
Phone: 705-670-0200
Email: info@biasd.ca
Website: www.biasd.ca

Thunder Bay
BIA Thunder Bay & Area
Phone: 807-621-4164
Email: biatba@yahoo.ca
Website: www.bisno.org/brain-injury-association-of-thunder-bay.php

Timmins
Seizure & Brain Injury Centre
Phone: 705-264-2933
Email: sabicrl@eastlink.ca
Website: www.seizureandbraininjurycentre.com

Toronto (GTA)
Brain Injury Society of Toronto
Phone: 416-830-1485
Email: info@bist.ca
Website: www.bist.ca

Waterloo-Wellington
BIA of Waterloo-Wellington (office re-opened)
Phone: 519-654-0617
Email: info@biaww.com
Website: www.biaww.com

Windsor-Essex
BIA of Windsor and Essex County
Phone: 519-981-1329
Email: info@biawe.com
Website: www.biawe.com

York Region
Brain Injury Association of York Region
Office Voicemail: 905-780-1236
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Email: n/a
Website: www.biayr.org
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- Experts in cognitive rehabilitation
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- Experts in cognitive rehabilitation
- Experts in behavioural rehabilitation

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Holiday Inn & Suites 905.688.2324
Best Western 905.934.8000

Professors:
Sherrie Bieman-Copland, Ph.D, C.Psych
Dawn Good, Ph.D, C.Psych
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