

# Moving On

A Semi-Annual Newsletter for our Families, Partners and Donors

*issue two - volume one*

## *Celebrating 25 years of Success!*

On October 6, 2008 at the Lamplighter Inn, Dale Brain Injury Services celebrated its 25th anniversary. We have certainly grown from our early days in the farmhouse at Wonderland and Southdale supporting 6 clients with 12 staff to today where 140 staff support over 250 clients. So far 144 people have 'graduated' from Dale Brain Injury Services, moving on to independent living, living with their family, or making other community living arrangements - achieving our goal of community integration.

Over this 25 years we have introduced new support services, including:

**Outreach services** - staff support individuals in their home setting, whatever form that takes, and provide client-focused service, doing whatever is required to maximize the participant's independence and ability to maintain their living arrangement.

### **Day Services at Cornerstone Clubhouse**

- an internationally accredited program based on a very successful member-driven model where members help members, and staff facilitate and encourage members to flourish. These two services have grown significantly over the years and we continue to invest new resources into these programs.

Our Residential programs have grown over the years as well, and we have added new residences on an ongoing basis. Our mandate over the past 25 years has focused on transitional rehabilitation, moving people on once they have achieved their goals. What many of the applicants for our residential programs are telling us now is that

they are looking for long-term living supports. As we plan for the future of our programs, we need to look at facilities with that in mind. You will see in another article in this newsletter that we need some community investment in new facilities to help us continue our work and to meet the long term living support needs, as well as the rehabilitation needs of adults living with the effects of an Acquired Brain Injury.

Thanks to our tremendous staff and supporters for helping us reach 25. We look forward to continuing on with our work, 'building futures'!

years of service

**Dale  
Brain  
Injury  
Services**

*We build futures.*

# Capital Campaign Launched!

At our Annual General Meeting and 25th Anniversary Celebration on October 6, 2008 DBIS launched our Capital Campaign. In order to meet the changing and expanding needs of our clients over the next few years we will need to invest in several capital projects such as new residences and program facilities. Provincial funding is extremely limited so we need the community's support to provide funds to renovate, furnish and equip new and expanded residences and program facilities.

This exciting new initiative offers the community an opportunity to contribute whatever they are able to. Every bit helps! Donors will be recognized in a variety of ways, depending on the nature of their contribution.

The first project that requires funds is the Riverside Project, an 11 unit apartment building that we are building in partnership with SDI Builders. More details will be available in the New Year, so check out our website for information.

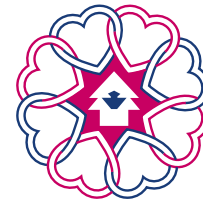
We are looking for Fund Development Committee members, and we would be pleased to have you join us. If you are interested please contact Sue Hillis at 519-434-8544 X101.

## Managing Pain

Pain, seen as the "fifth vital sign", is best understood from a biopsychosocial point of view. The experience of pain is an individual matter, as we can't really see, touch, hear, taste or feel another person's pain. A person can have perceived or real pain; both can interfere with adaptive functioning and well-being. When we don't "get" someone else's pain, it can leave them feeling unsupported, misunderstood, punished, picked upon, helpless, hopeless, angry, overwhelmed and sometimes, guilty about their health condition. These feelings can create or increase chronic anger, depression, anxiety, hopelessness, and grief. It can sometimes trigger symptoms of post-traumatic stress. Pain experienced by individuals living with ABI varies from post-traumatic headaches, neck pain, and tension pain to a range of other physical, behavioural, emotional, psychological,



## Dale Brain Injury Services Capital Fundraising Campaign



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*Capital Campaign Launch Guest Speakers*

psychosocial and cognitive symptoms. Pain can make it hard for people to sleep, leaving them tired and irritable.

For someone experiencing pain, the first step is to report the pain in a way that lets someone else have an idea about what is happening. A person can use a scale of 1 to 10 to describe how much pain they are experiencing. Or, they can use a picture of a human body to mark the specific areas where they are experiencing pain. A third method of reporting pain is by telling another person, such as a family member, friend, or staff.

It is helpful to see a physician, who can make referrals to professionals such as social workers and psychologists with pain management expertise, physiatrists, neurologists, physiotherapists and occupational therapists,



chiropractors, massage therapists, and acupuncturists. Medication, prescribed and monitored by physicians, can reduce pain. Some of the stronger painkillers can be addictive and may have other damaging side effects, so it is extremely important to work with your doctor to monitor your pain medication.

There are many things you can do to manage your pain. You can keep a pain log to track 1) the times you have pain, 2) for how long, 3) in what parts of your body, 4) the intensity (using pain scales), 5) what you were doing when the pain occurred or got worse, and 6) what you did to manage your pain. This helps you to know what to change to better manage your pain. Research has shown

that when we are in a poor mood state or stressed out, our brain's pain gates open wider to receive more signals, and we experience more pain. If we can relax and improve our mood, our pain gates get smaller, allowing fewer pain signals through, and we have less pain. Getting help (individually or in groups) to manage depression, anxiety, hopelessness, sleep problems and stress are helpful for managing pain. Various relaxation and motivational pain management strategies, including hypnosis, can also be helpful. At Dale Brain Injury Services we have a Pain Management Group to support our participants living with pain. We need to support them!

*Carl R. Lokko*

## *Outreach has some new programs!*

Over the last few months the Outreach staff at DBIS have been working hard on making the program more exciting for the New Year. The Christmas Season is a very busy time with many activities. We have our annual Outreach Christmas outing to Harmony House. We look forward to having this yearly Christmas lunch where all the participants and staff have the opportunity to connect with and enjoy each others' company. We offer an annual Christmas shopping trip to a mall of the participants' choice where they can gather any last minute gifts. We are all looking forward to making some Christmas crafts and cards at our next Loblaws Social, and attending the Holiday Lights tour with the Glen Cairn Community Resource Center.

Starting in January we are looking at introducing some new programs into the already busy repertoire of activities offered. Starting the first week of January we are adding another monthly Community Kitchen on Friday mornings. The current Community Kitchen has had such a huge response that this additional opportunity will reach out to more participants. We are looking at offering a monthly education series around Addictions and the effects of Addictions and ABI. Starting in the New Year we will be gathering donations of food and clothing for a centre that can be accessed by participants in need.

All Outreach Program participants and staff wish everyone the best for 2009.

*Renee Penner and Becky Coward*



*Community Kitchen*



## *Right to Risk vs. Need for Protection: a Dilemma*

As we know, acquired brain injuries can result in impairment in judgment, reasoning and problem-solving in many individuals. Often, individuals with an acquired brain injury act in impulsive ways that can get them into difficulties at home and in the community and can engage in high-risk behaviours, seeking out or gravitating toward activities where they may get hurt

There is a natural tendency for care-givers to want to protect their family members, friends or clients from getting into trouble. At times there may be a perceived need to protect other members of the community from harm (e.g. in situations where the individual with a brain injury is likely to engage in aggressive or sexually inappropriate behaviour). In fact, the more severe the deficits, the more we may want to protect the individual.

While the need for protection is often obvious, it is sometimes difficult to distinguish between protection and control. In our concern for the people we support and care about, we may become more controlling than we would like to be and the protection that we provide may extend bit by bit to areas where the individual might not, in fact, need it. What starts out as protection – keeping the individual (and other members of the community) safe – may turn into control to try to ensure that nothing bad happens to the person. This is especially likely if we engage in “what-if” thinking, e.g. “What if something terrible happens when he/she does ...?”

We can frame the problems relating to protection and control as representing a dilemma: the right of an individual to have experiences that people without a brain injury have (“right to risk” or “dignity of risk”) versus the “need for protection” (for the individual and the rest of society). Without the right to risk, people cannot achieve growth and independence. Without risk, people cannot learn to problem-solve, to exercise judgment and to correct their own errors. Individuals who have lost a great deal of their independence as a result of a brain injury may not be able to regain or re-learn some of the skills necessary to become more independent without experiencing some risk. Things may go wrong but if we are there to provide support, we can limit harm as much as possible.

Without protection, individuals with a brain injury might get into dangerous situations or place themselves in harm’s way. Being aware of the right to risk does not mean that we abandon the people we are supporting. We do not believe that it is ethical to let people suffer unnecessarily. We may need to intervene to keep people safe.

Is there an absolute way of resolving the right to risk vs. need for protection dilemma? I don’t think that there is. We do have to try to consider all sides of an issue. Is there really a great risk of harm to the individual? Based on past experience, what is actually likely to happen even if things do go wrong? Are there opportunities for growth and progress that make taking a risk worthwhile? What is the worst-case scenario? Would it be so terrible? What is the best-case scenario? Is it important enough to justify the risk?

We have to be mindful of the fact that many individuals with an acquired brain injury have suffered a loss of self-esteem along with the deficits that they experience. Many people feel dependent and powerless – as if they have returned to a childlike state. People who have not suffered brain injuries often make poor choices, some of which have serious consequences. Do people with an acquired brain injury have the same rights?

*Dr. Alan Lawrence*