



Canadian Paraplegic Association  
Association canadienne des  
paraplégiques  
(Manitoba) Inc.

**MPF** MANITOBA  
PARAPLEGIA  
FOUNDATION INC.

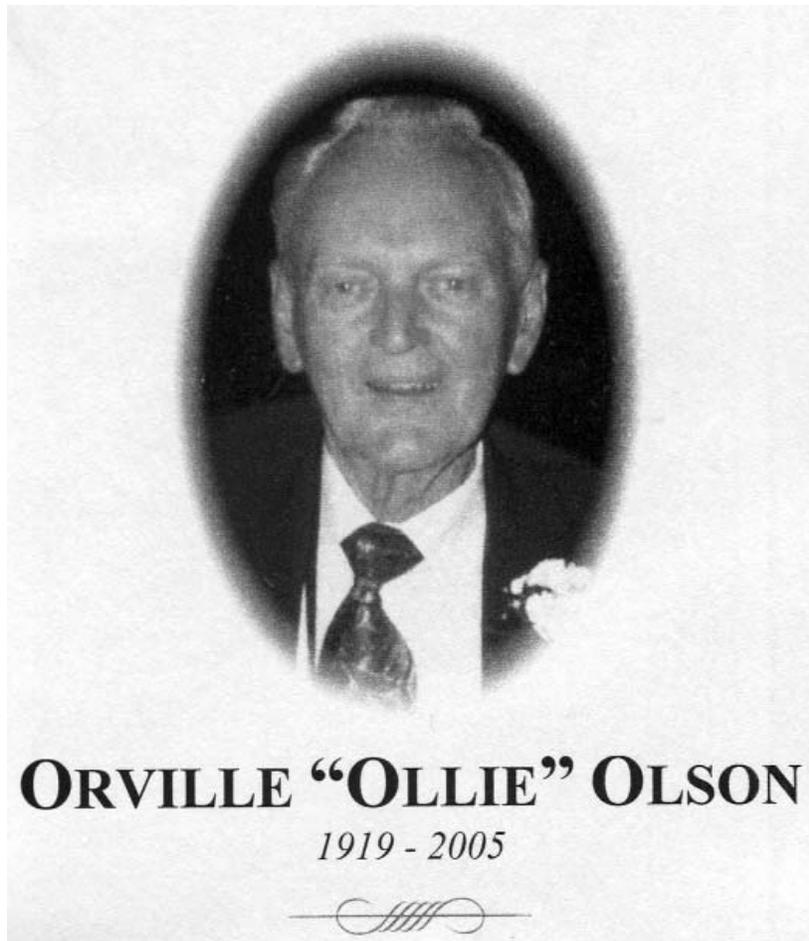
MARCH 2005

SPRING ISSUE

# *Para* Tracks

*Newsletter of the Canadian Paraplegic Association (Manitoba) Inc.*

## ‘Remembering Ollie’



### ***In this issue...***

*The Ceremonial Ways of the Ancestors: An interview with a Medicine Man*

*Wheelchair Seating - Is it time You Were Reassessed?*

*Part One: Understanding and Combating SCI, Diabetes and Heart Disease*

*"Domo Arigoto, Mr Roboto": Creating Your 'Smart' Home*



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**Meet Yvette...**

**H**olla! I'm Yvette Rivera-Colmant, Rehabilitation Counsellor, hired under the Opportunity Funds Project. I began working at CPA on November 15, 2004. I provide job search groups and individualized employment search services to those members interested in returning to the workforce.

I completed a Master of Clinical Social Work at the University of Oklahoma and a Bachelor of Social Work with a minor in Counseling and Educational Psychology at New Mexico State University. I have over seven years experience working in the field of vocational rehabilitation in several roles: job coach, job developer, employment specialist and vocational rehabilitation technician. I have facilitated job search groups in my past employment with the New Mexico Division of Vocational Rehabilitation in the United States of America.

I believe the best way to help some one with their career plans is to really get to know the person and find out



what they are passionate about. What I am passionate about is supporting people who are working toward their ideal job. I think it's important to take into account the whole person -physically, socially, emotionally, psychologically and spiritually and let's face it, if you are having problems with employment; all aspects of your life are affected. I am extremely excited about working with the members of CPA and I feel very welcomed by the staff here. If you are interested in working towards getting your dream job, I would love to help.

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## ***Back to the Future***

*by Lorne Chartrand*

**I**n today's fast-paced world it can be all too easy to forget the past as we try to move faster and more efficiently into the brave new world of the future. Sometimes, however, it pays to reflect on the past - understanding our heritage informs our decisions about the future.

Before I began as Communications and Public Education Coordinator for CPA Manitoba, I had very little knowledge about the history of the organization. I suspected that CPA, and mainly the counsellors who supported my rehabilitation, had done more for me behind the scenes than I really knew about. I've always been fiercely independent and like a lot of people had always felt that I had pulled myself through rehabilitation - both physical and psychological - on my own. Recent events, however, have caused me to rethink that perspective.

During my first days on-the-job, I was afforded the opportunity to delve into a vast number of resources about CPA. One of them was a story called just that, "About CPA." You can find it on the CPA National Web site. The piece talks about how a group of war veterans came home from World War II with spinal cord injuries and, thanks to their determination not to live out their lives in hospital, started the Canadian Paraplegic Association. Just like that.

We've come a long way since then. I've often wondered why we are called the Canadian 'Paraplegic' Association - the moniker seems to forget about an even more adversely affected group who, like myself are quadriplegic (there is a recent shift towards the term 'tetraplegic' - but I'm a creature of habit). I'll venture a guess that the survival rate for quadriplegia in 1945 wasn't that great, so the name reflects that reality (if anyone has more insight on this, please call me - I'll leave some space in the next issue for your story).

In Manitoba, we've recently lost-with the passing of founding member Orville "Ollie" Olson-a direct link with our past. In reading some archive material about Ollie, I realized that I had missed the opportunity to meet someone whom it would have been a privilege to know. Please see the story inside for all of the reasons why. I say that I "missed" the opportunity, because I'm certain that Darlene Cooper had dragged me over to Mr. Olson at more than one AGM and made the introduction - I just had no idea who, exactly, I was meeting.

Which brings me to my original point. Anyone who survives a spinal cord injury in Canada owes a debt to the founders of CPA. For many reasons; for having the wisdom to realize that the most important thing a "new injury" can experience is an introduction to someone who has overcome, survived and flourished despite their injury; for knowing that a few ingenious gadgets can significantly increase the independence of someone with SCI and finding a way to produce those gadgets (many of them conceived and constructed by Ollie Olson - leading to the development of what we now know as, "Rehab Engineering"); for pioneering a relationship with government to provide programs and systems and resources that contributed to the dignity of living with SCI. The work done by CPA goes a long way to ensuring success of people like you and me. I don't know if I would be here today without

hearing that voice in the darkness of my first days in the Rehab that said, "Hi, I'm from CPA." Now, however, I know where that voice comes from.

In this year, the 60th anniversary of the establishment of CPA, we need to acknowledge our heritage and celebrate the achievements of those who laid the groundwork that continues today as we strive towards a more fully inclusive society.

To that end, CPA will soon begin in awareness campaign recognizing our 60th year. Across Canada, a new 60th anniversary logo is about to be rolled out. Look for a promotional video with CPA Honorary Chairperson, Ron MacLean, in Famous Players Theaters and Cineplex Galaxy theaters in the month of May. There will also be print ads, radio ads and outdoor billboards designed to raise awareness and support for CPA programs and services. Increased public support means a better organization for everyone.

The reality is that CPA (Manitoba) Inc. is stretched to the limit in its ability to provide rehabilitation counseling, information and advocacy efforts - but with the help of awareness raising efforts like the 60th anniversary campaign and fundraising events like Wheels in Motion in Winnipeg and Walk 'N Roll in Brandon, we can increase resources available to continue what began 60 years ago. Please, call the CPA office for more details on how you can register a team in your area and join in the fun. The events keep getting bigger every year... and the weather's gotta be better than last year!

In January I was afforded my first opportunity to board an airplane as a 'wheelchair user' including loading onto a 40-seater prop-plane on the tarmac (at a balmy -29 C) in both Winnipeg and Regina. While the experience probably scared (and froze) a few years off of my life, it was entirely worth the effort. Saskatchewan celebrated its 40th anniversary in that province; hosted by the newest Canadian superstar, Brent Butt and featuring inspirational messages from Olympic curling champion Joan McCusker and national goodwill ambassador Bob Egan, it was a truly inspirational evening. In Manitoba, we can celebrate with the national organization this year and continue the party as CPA (Manitoba) Inc. enters its 60th year in 2006.

As for my normal editorial subjects, the world seems to have survived the reelection of George W. Bush. In fact, in the first hint that maybe the tragedy in Iraq will have been for the better was the huge turnout to elect a government that may, potentially, lead that nation back to independence, self-reliance and full community participation (sound familiar?). Nature asserted that she too could wreak a deadly havoc, while the world showed a great compassion for those left in the wake of the Tsunami in Southeast Asia. Perhaps there is hope for the global community to embrace its kin and treat their neighbors as such...

Like everyone else in this frozen land, I am fighting the horrible depression brought on by the gloomy, dark days of midwinter, I look forward to the summer that was withheld from us last year, and look forward to the Winnipeg Folk Festival, which will be where I recharge my spiritual batteries this year. Hope to see you there.



*Saskatchewan celebrates 40 Years of Excellence. From left to right: Clint Ellingboe, Brent Butt, Gord Dent and Yours Truly.*



## Remembering Ollie

by Arnie Schryvers

**O**rville Olson, better known to many of you as Ollie or OEO, died February 3, 2005, at the age of 85. Ollie was a paraplegic as the result of a war injury. He and other WWII Veterans with spinal cord injuries spent many years in “rehabilitation” at Deer Lodge Hospital. There was nowhere else for them to go. It was this group of pioneers, headed by Tony Mann, that decided that they did not need to live in an institution. They approached the government and were able to establish the Canadian Paraplegic Association in Manitoba. They became organized to provide accessible accommodation, transportation, equipment and support programs for people with spinal cord injuries. Ollie was one of the first individuals with SCI in Manitoba to live independently in the community, one of the first to marry, and one of the first to own a car. Hand controls had not yet been invented. He and his friends drove his car with one person leaning over and operating the brake, gas and clutch with their hands while another operated the gearshift and steering wheel. When hand controls were first invented it was Ollie who would install them for clients.

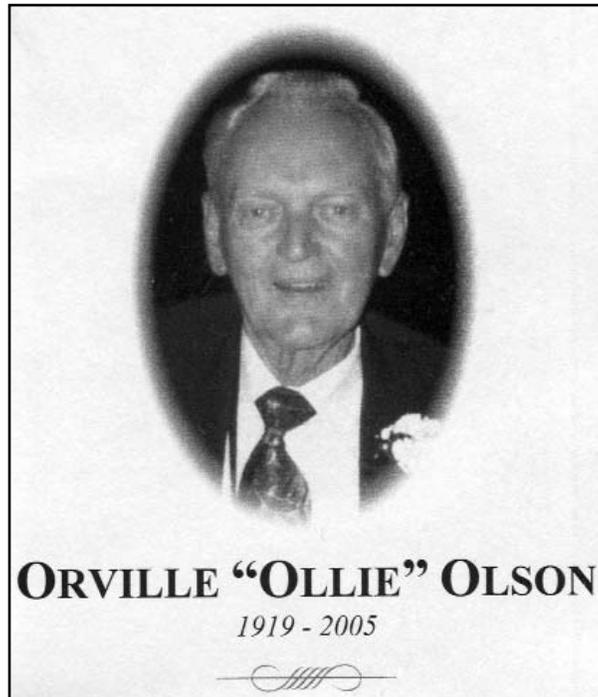
While still in Deer Lodge Hospital Ollie was the first person in Canada to receive penicillin. At that time, it was not in the form of the convenient pill taken orally. It came in an envelope in powder form that was mixed with water forming a thick brown liquid and administered intravenously over a long period of time.

Ollie was one of the first Rehabilitation Counsellors for CPA in Manitoba, from 1965 until his retirement in 1985. He provided counseling and advice on wheelchair accessibility, equipment, supplies, education and employment. Ollie was fiercely independent, something he tried to instill in his clients at CPA. He had a workshop in his basement, where he made many aids to independent living for his clients, even before the Rehabilitation Engineering Department was born. He also modified vehicles, designed hydraulic lifts for homes, baby change tables and many other items too numerous to mention. Ollie invented the Jiffy Biffy pads and when perfected, signed the rights over to the Health Sciences Centre so that the Orthotics

Department could make them available to any who needed them.

When I first met Ollie, I was in awe and in fear of him, but his generosity and good humor soon allayed the fear. His honest and forthright manner gained the respect and admiration of clients and colleagues. Ollie’s humor was legendary. He often said it was because of his Norwegian background. He loved to tell a story, con you in and then deliver the punch line.

Ollie worked long hours and felt that everyday of the week was a workday. Often on weekend trips and holidays Ollie would visit clients along the way to save the CPA the cost of his visit. Helping clients to live independently was Ollie’s life and not just his occupation. His wife Louise and his daughter Marina were very supportive of all of his extra visits and time spent with clients. Without their help, support and encouragement, Ollie would not have been able to accomplish all that he did.



*Good Bye Ollie. Rest in Peace.*

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## Spinal Cord Injury, Diabetes and Heart Disease: What are the risks?

by Kristine Cowley, PhD

This is part I in a two part series about diabetes and risk factors for heart disease after spinal cord injury. This installment will relate some of what is known about the statistics and possible contributing factors for adult onset diabetes and coronary heart disease for those persons who have sustained a spinal cord injury. Next ParaTracks, I will relate some of the studies that have looked at ways to reduce the risk of developing diabetes and heart disease, and whether they have worked.

But before we get into that, I thought I should make a few points about normal carbohydrate metabolism.

### **Insulin, blood glucose levels, and normal carbohydrate metabolism.**

When we eat a meal, our body digests consumed foods and absorbs various food constituents. Foods can be broken down into protein, carbohydrates and fats (and each of these can be further broken down). The main energy source for our bodies is glucose (carbohydrates break down into glucose molecules). So, we need carbohydrates, and our bodies have a system for checking to see how much glucose is in our blood (the blood sugar level), and for getting at our stored supplies of energy when the blood glucose level is too low, and also for removing glucose from the blood if there is too much blood sugar. If our bodies are working properly, this system keeps our blood sugar levels within an optimal range (an optimal blood glucose level hovers around 5 mM/L).

Insulin is the key to maintaining blood sugar levels. Insulin is released when blood sugar level rises and it helps glucose to be taken up by the liver, where it is stored for later release back into the blood (when blood sugar levels decrease). It also activates receptors in muscles that cause glucose to be taken up and stored by the muscle cells. Insulin does other things in the body as well, but for this discussion, think of it as the key to getting rid of too much glucose. If the insulin-glucose system is working properly, blood sugar levels are kept within a tight range. However, when the insulin-glucose system starts to malfunction it does not mean a person immediately goes into a state of diabetes. There is thought to be a 'pre-diabetes' stage, that may last for several years, during which a person has either impaired glucose tolerance (their bodies don't deal as well with glucose) or insulin resistance (when they have to release much more insulin than 'normal' to keep blood sugar levels in check). A person who has impaired glucose tolerance is not necessarily destined to get diabetes. Studies have shown that impaired glucose tolerance can be reversed with various interventions, which will be covered next Paratracks.

One final thing that is important to know about insulin is that it is also involved in processing free fatty acids, or lipid metabolism. The fats we eat break down into fatty acids and lipids. These are important for the body's normal functioning (for example, all of our cell membranes are made up of lipids), but if we have too much of certain fatty acids they can get into our arterial walls and cause 'plaques' that can narrow the blood vessel width and if these vessels are on or in the heart they can block the flow of blood to our heart muscle and cause a heart attack. So, we need to get excess, unhealthy fatty acids out of circulation and broken down by the body, and insulin helps to do this. But if you have a disorder involving carbohydrate metabolism, such as hyperinsulinism or insulin insensitivity, usually lipid metabolism is also impaired. In fact, impaired carbohydrate metabolism is considered to be an independent risk factor for heart disease (meaning

that by itself, if you have impaired carbohydrate metabolism, you are at greater risk for heart disease). The last thing I'll mention about heart disease here is the business of 'good' and 'bad' cholesterol - the good cholesterol is the high density lipoprotein (HDL) and it is believed these should be relatively high to minimize the risk for heart disease and the bad cholesterol is low density lipoprotein (LDL) and it is believed these should be low to minimize the risk for heart disease.

So now, how does the risk of developing diabetes or heart disease compare between the spinal cord injured population and the general population?

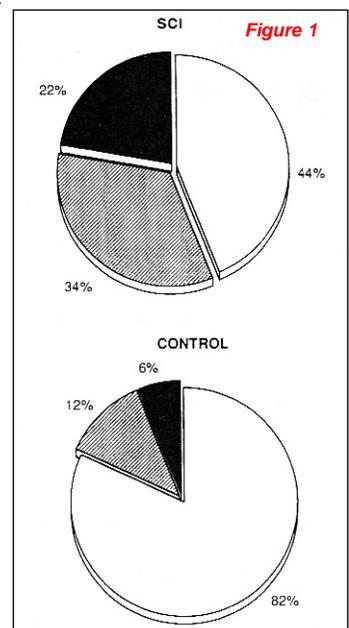
### **What are Diabetes, Impaired Glucose Tolerance and Hyperinsulinism?**

The type of diabetes we are concerned about in this article is the one called adult-onset diabetes, type II diabetes, or diabetes mellitus and is a disorder of carbohydrate metabolism. As I mentioned above, there are two stages to the disease: the pre-diabetes stage, in which a person displays impaired glucose tolerance (IGT) and full-blown diabetes, called diabetes mellitus (DM). In response to a glucose challenge (say drinking a sugar drink containing 75 - 100 grams glucose), a person with IGT will show a higher blood glucose level than a person who has normal glucose tolerance - a person with full-blown diabetes mellitus (DM) will show an even higher level of blood glucose. The reason those with IGT and DM show a higher blood glucose level after the glucose challenge is because their bodies are less effective at removing the excess glucose from the bloodstream, and, as we will see later, this is usually associated with increased insulin (or hyperinsulinism or insulin resistance). If a person has hyperinsulinism it means they have to pump out more insulin than others to get rid of the same amount of glucose.

### **Diabetes and impaired glucose tolerance occur more often in spinal cord injured versus able-bodied people of the same age.**

Figure 1 shows the percentage of persons showing normal, impaired and diabetic blood sugar levels in a group of spinal cord injured subjects and compares these percentages to those seen in an able-bodied control group.

As you can see in the SCI group 22% (black) would be classified as having DM based on their blood sugar levels, 34% have IGT and only 44% show a normal blood sugar response to the glucose challenge. In contrast, only 6% of the age-matched controls had DM, and a full 82% showed normal blood glucose levels. So, normal blood glucose levels were seen in only about half as many SCI subjects when compared to the able-bodied, age-matched, controls. Other studies have supported these findings and have examined this issue further. For example, studies



have looked at the impaired glucose tolerance in quadriplegics versus paraplegics to see if the percentage of normal and abnormal glucose metabolism differed.

**Table 1** Diagnostic Criteria for Disorders of Carbohydrate Metabolism From the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus

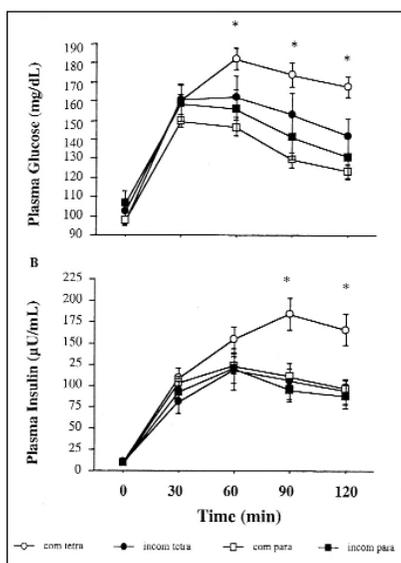
Serum Glucose	Fasting	At 120 min
Normal	<110 mg/dL	<140 mg/dL
Impaired	≥110, <126 mg/dL	≥140, <200 mg/dL
Diabetes	≥126 mg/dL	≥200 mg/dL

All values are for venous plasma glucose concentration (mg/dL). Reprinted with permission from *Diabetes Care* (11).

For your interest, Table 1 shows the blood sugar levels that relate to the various states of normal, impaired glucose tolerance and diabetes. I should note that many persons with SCI show normal fasting blood sugar levels (the one you get tested when you have your GU check up at the SCI outpatient clinic), and yet show impaired glucose tolerance when given the oral glucose tolerance test or OGTT.

So, in addition to showing a higher rate of DM and IGT when given an oral glucose tolerance test in comparison to age-matched able-bodied controls, people with SCI also show differences in their ability to deal with glucose depending on their degree and level of spinal cord damage.

**Complete Quadriplegics show higher blood sugar levels after an OGTT than incomplete quadriplegics, complete paraplegics or incomplete paraplegics.**



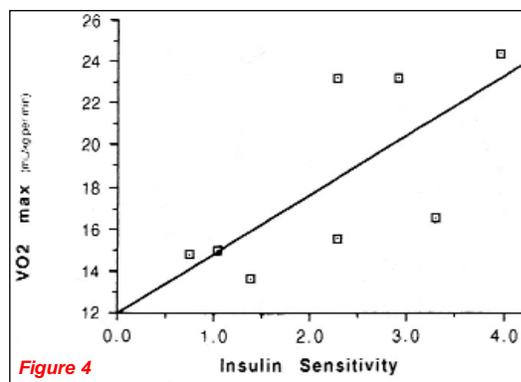
As you can see in this figure, complete quadriplegics (open circles), on average, show higher blood sugar as well as higher insulin levels for the two-hour period after drinking the same amount of sugary drink as the incomplete quadriplegics, as well as the complete and incomplete paraplegics in this study. What does this mean? Well, apparently, as a group, complete quadriplegics are less able to deal with glucose than either their able-bodied counterparts or those with less complete, or lower level

spinal cord injury. This does not mean that complete quadriplegia itself causes this impaired glucose tolerance - it may be that the reduced activity levels of complete quadriplegics leads to impaired glucose tolerance - this will be looked at further in next ParaTracks.

**Is it the spinal cord injury itself that impairs glucose metabolism or is it because of the reduced muscle mass, increased percent body fat, and a sedentary lifestyle?**

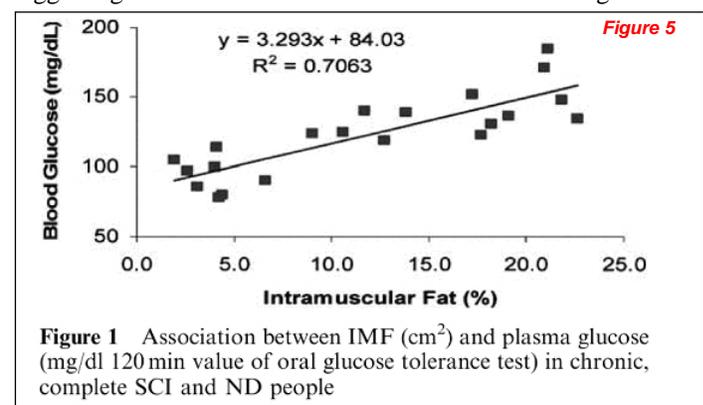
In the able-bodied population, the biggest risk factors for devel-

oping diabetes are obesity (particularly central obesity - those people who store their fat around the midline), a sedentary lifestyle, and a genetic predisposition. People who sustained a spinal cord injury are at a greater risk for becoming obese, and being relatively unfit.



There is some research that suggests that a person's level of cardiovascular fitness can be related to insulin sensitivity. In these studies, the amount of breathing per minute when a person is exercising at maximum capacity is used as a measure of cardiovascular fitness (called VO2 max), and the idea is that the more fit a person is, the more oxygen he or she will be able to use per minute at maximum effort. So, in Figure 4, the insulin sensitivity of people with SCI is plotted against their VO2 max and these authors concluded that there was a relationship such that the better the VO2 max, the more sensitive their insulin. Conversely, the worse their VO2 max, the more insulin resistance. However, this is a pretty weak relationship (you would want a line that was more steep if there was a clear relationship between these two variables). Also, a quadriplegic (say C7) who uses an arm ergometer 3-5 times a week with relatively little body fat will have a lower VO2 max than most paraplegics (even the most unfit) and yet the C7 quadriplegic may have less insulin resistance and better glucose tolerance than the unfit paraplegic.

Along this line of thinking, there was a recent research report suggesting that the amount of fat found inside the thigh muscle



**Figure 1** Association between IMF (cm<sup>2</sup>) and plasma glucose (mg/dl 120 min value of oral glucose tolerance test) in chronic, complete SCI and ND people

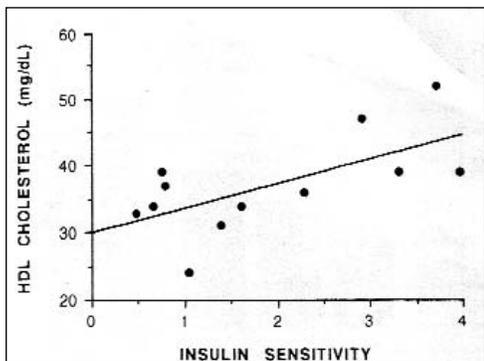
could be quite well correlated with blood sugar levels after an oral glucose tolerance test. In particular, Figure 5 shows the relationship between the fat inside the quadriceps (thigh muscle) with blood glucose levels and it is very clear that the more fat you have within your muscles, the worse your glucose tolerance is. In this figure it is interesting to note that the data for both chronic complete quadriplegics (C3 - C7) and the non-disabled controls were pooled because the relationship existed for both groups.

So, the more fat you have, the worse your diabetic profile. This line may not look that steep but when there is an R2 value over 0.7 it means that the percentage of intramuscular fat is very likely to predict that person's blood glucose level.

In summary, it looks as though the rates of diabetes and

impaired glucose tolerance are quite a bit higher in persons with SCI than their able-bodied counterparts, and that, as a group, the higher and more complete the lesion, the more impaired the carbohydrate metabolism. It also appears that the more fit, and the less fat a person is, the better their carbohydrate metabolism.

**Impaired Carbohydrate Metabolism is a Risk Factor for Coronary Heart Disease**



OK, so what about coronary heart disease? Is it a problem? Well, one retrospective study indicated that cardiovascular disease was the most frequent cause of death (46%) for those more than 30 years after spinal cord injury and

accounted for 35% of deaths for those more than 60 years old. When other studies showing 'silent' or asymptomatic signs of

heart disease, and lowered HDL in persons with SCI are taken together, it is thought that, as a group, persons with SCI are believed to have accelerated and premature coronary heart disease.

For example, in the group of spinal cord injured subjects shown in the above figure, the higher the insulin sensitivity the higher the HDL cholesterol (and conversely, the more insulin resistance, the lower the HDL).

In the general population, cardiovascular disease and complications due to diabetes are major contributors to death and health problems in North America. Some believe that the trend of increasing obesity and lack of inactivity in North Americans will lead to an epidemic of diabetes in the next few years, so the processes of these diseases are not unique to spinal cord injury. However, because of the nature of spinal cord injury and related lack of ability to easily participate in physical activities, the percentage of people affected (or potentially affected) is much greater than in the able-bodied population.

What, if anything, can be done to reduce the risk of developing diabetes or coronary heart disease for someone who has sustained a spinal cord injury?

*Tune in next installment...*

**Manitoba Paraplegia Foundation (MPF) News**

*MPF funds go to work in four main areas: special projects, product testing, research and direct aid to persons with SCI. CPA thanks MPF for its continued support to improving the quality of life of persons with spinal cord injury.*

**M**PF has approved several requests for financial support during the past few months. Some of the highlights follow.

During the month of September:

- » funding was granted to cover the cost of a rental damage deposit in order secure safe accommodation for a CPA member.
- » assistance was provided to cover repairs to a CPA member's wheelchair. These repairs are not covered through the government funded wheelchair program.

During the month of October:

- » an interest free loan was provided to a CPA member to cover the heating bill expense to ensure the member's home heat was turned on.
- » funding was granted to cover costs of obtaining medical records for the purpose of a legal consultation regarding a CPA member's injury.
- » funding was provided for the purchase of a stationary hand cycle for a CPA member who was required to switch to a motorized wheelchair after using a manual wheelchair for many years. The hand cycle was recommended by the member's doctor in order to main-

tain weight and cholesterol levels.

- » assistance was provided for the purchase of a custom backrest for a CPA member who uses a motorized wheelchair for mobility.
- » funding was granted to cover a portion of the cost of an electric wheelchair lift for a CPA member's van. The member's church contributed over half of the cost of the lift.
- » assistance was granted for costs of publishing and distributing the CPA (Manitoba) Inc. newsletter, Paratracks and the CPA National magazine, Total Access. This grant will assist CPA in continuing to meet its commitment to ensure that all of its clients and members receive this important information service.

During the month of November:

- » funding was provided for the purchase of appropriate clothing for a CPA member in hospital. The purchase of the clothing will enable the member to attend therapy sessions daily in clothing other than poorly fitting hospital clothes that provide little comfort or warmth.
- » funding was granted to cover the cost of an eye exam for a CPA member.

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## *Wheelchair Seating... Is it time you were reassessed?*

**O**ver the past 10 years, technological and rehab improvements have enhanced the lives of people with spinal cord injuries. Wheelchair assessments and seating products are among those improvements. More attention has been given to recognizing the importance of early seating intervention on maximizing life long function, comfort and independence.

### **Seating and spinal cord injury**

With a spinal cord injury, some of your muscles can no longer support your body as they were meant to. Your seating system must therefore provide the support. If the body is not well supported, pelvic obliquity (one side higher than the other), kyphosis (slouching) and scoliosis (leaning) can occur because gravity is pulling on the head, shoulders and body.

Balance is also frequently altered in persons with spinal cord injury. To gain a sense of balance, individuals may pull their buttocks forward in their seat and curve their shoulders over their thighs. This is a short-term solution for every-day stability and functioning but this posture may lead to long-term problems that are difficult to remedy.

Everyone ages and as they do their bodies change. Skin becomes thinner and loses its elasticity, joints become more worn and with less physical activity, muscles atrophy and become weaker.

Pain in the back or neck, sitting crooked in your chair, difficulties getting a full breath, and pressure sores may be some of the consequences of poor posture in sitting. Through a proper seating assessment, postural and age related changes can be addressed and with provision of appropriate equipment it is possible to reduce the risk of problems occurring in the future.

### **Prevention beats treatment...**

If you remember life in the rehab with halos, spasticity without Botox or if you have ever said to yourself, "Where will I ever find another Bye Bye Decubitis cushion?" then it is probably time that your seating be reassessed.

Individuals with spinal cord injuries often have their first wheelchair prescribed to them shortly following their initial diagnosis so they can begin to be independently mobile and learn to function at wheelchair level. We know that within a year or two after injury, weight changes as the body adapts to the injury, lifestyles change as the individual adapts to their new functional skills and a more permanent living environment established. This would be a good time for a seating and mobility reassessment.

As you may know, once problems such as pressure sores, pain and postural deformities occur, they can be very inconvenient to the individual and can be very costly to the medical system. In order to prevent problems *before* they begin, we recommended that a reassessment occur approximately every five years or when obvious concerns arise. Seating reassessments allow existing seating equipment to be assessed for wear and tear, ensures that discussion of technological seating advances occurs with a therapist and allows seating issues to be discussed and remedied sooner, rather than later.

### **Seating Myths**

#### ***Backrests are uncool***

Au contraire, monsieur... Do you think it is cool to be sitting with a curved back and a chin that pokes forward over your knees? Individuals who are supported by firm backrests are often sitting taller and can push themselves more efficiently. They often have less pain and fatigue at the end of the day. Because they sit taller, they may also breathe better and digest their food easier. You can sit more upright, too!

#### ***If I get a power wheelchair it means I'm getting weaker!***

Many people with spinal cord injuries have resisted the use of a power wheelchair because of the stigma associated with their use. People avoid power wheelchairs despite the fact that their shoulders are so sore that they can hardly transfer anymore or after a long wheel, they are fatigued for the rest of the day. Others have made the switch to a power wheelchair on a part time or full time basis to save their shoulders and their energy for the skills that help them maintain their community independence such as transferring into their bed, van or tub. Contrary to popular belief, individuals who choose power wheelchairs often have more community independence, have less pain and are more satisfied with their functional abilities and quality of life.

Some people also avoid power chairs because they want to get the exercise benefits of wheeling manually.

"Fitness is important for wheelchair users' mobility and cardio respiratory health. However, the risk of developing a degenerative joint disorder and the apparent lack of cardio respiratory benefits suggests that an alternative to standard wheelchair propulsion should be used for exercise." Cooper, R. and Boninger, M. (2003)

#### ***Arm pain cannot be prevented***

Arms were meant to lift and carry but were not meant to move us. Studies show that around 31-73% (Cooper et al., 1998) of wheelchair users suffer some sort of repetitive

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strain injury to their shoulders or wrists. Proper wheelchair set up, appropriate wheelchair selection and mobility training can help reduce the risk of repetitive strain among wheelchair users. Proper positioning in the wheelchair also places your body in a more efficient position for wheeling and can improve speed and performance.

### **We don't just use a measuring tape anymore...**

In the past, your therapist may have measured how wide your hips were and how long your legs were and sent you to your local vendor with a wheelchair prescription. These days, a seating assessment should be much more comprehensive. In Manitoba, Occupational Therapists are usually the ones to conduct seating assessments. In other provinces, physiotherapists may be the main assessors. Therapists work closely with the client, physician, rehab engineers, medical equipment suppliers, wound care nurses and other health care professionals as required. People with spinal cord injuries have unique seating needs and it is your responsibility to seek out a therapist who is able to complete this thorough assessment.

The assessment should include an evaluation of your functional abilities at home, work and fun; your environmental situation; as well as a detailed assessment of your medical history, physical status and postural issues. The physical portion of the assessment usually takes an hour or two to complete and involves an assessment of:

- » How you sit in your wheelchair at present
- » How your body responds when you are laying on a plinthe (a firm mat) or bed (so gravity is not making you slouch) and
- » How you sit when you are unsupported or supported only by a plinthe and the therapists' hands.

This will tell the therapist whether your pelvis, trunk and lower extremities are in flexible or fixed positions to help the therapist decide which types of equipment would best suit your needs.

For further information about your seating needs, the therapist may do a visit to your home or work, trial a variety of equipment with you; use a computerized pressure mapping system or other assessments specific to your particular needs.

### **If you are considering having a seating assessment done, ask yourself these questions...**

*When I view myself from the side, do my ear lobe, shoulder and hip joint form a straight vertical line?*

If you answered no, you may need a more supportive seating system.

*Is this cushion right for me?*

There may be new technology out there that may be more appropriate and may level out our pelvis and better reduce pressure on your skin.

*Is my back or neck sore at the end of the day?*

A firm, padded backrest or a new sitting position may lessen the pain and strain.

*Is my axle position ideal for wheeling?*

You may have a more efficient push and less shoulder pain if the axle position is changed.

*Is it time to consider a power wheelchair?*

A therapist can help you to identify the pros and cons and assist you in selecting the most appropriate equipment.

*Do I hook on the back of my wheelchair to maintain balance?*

Alternate solutions can be explored to help prevent permanent muscle tightening and pain.

*Is my seating negatively affecting my function in my home and/or work?*

A therapist can help you maximize your function through seating intervention and other related suggestions.

*Does my skin get red more quickly than when I was young?*

A therapist can help assess your current cushion and backrest to reduce the risk of pressure sores from occurring.

*Am I slouching or leaning more as I age?*

Kyphosis and scoliosis may intensify as you age but early intervention can prevent further problems.

Corinna Klassen, OTM and Angie Maidment, OTM together have over 20 years of seating and mobility experience. They have both worked at the Health Sciences Centre on the Spinal Cord Injury Unit and the Adult Seating Clinic. Therapy First offers in home occupational therapy, physiotherapy, massage therapy and recreation services. Along with their private practice, Corinna and Angie work as O.T.s at SMD – Wheelchair Services and the HSC Adult Seating Clinic, respectively.



**Therapy First**

Feel free to contact Therapy First with seating questions or for further information on options for seating assessments in your area. E-mail us at [TherapyFirst@shaw.ca](mailto:TherapyFirst@shaw.ca) or contact us by phone at Corinna (p) 204-612-0399 or Angie (p) 204-612-0398.

## The Ceremonial Ways of the Ancestors: An Interview with a Medicine Man

by Yvette Rivera-Colmant

[Excerpted from] Rivera-Colmant, Y. R. and Colmant, S. A. (2004). Integrating Native American Traditional Healing with Modern Health Care: An interview with a Medicine Man [On-Line]. Available: [www.PsychSymposium.com](http://www.PsychSymposium.com)

 Charles Scribe is a Medicine Man who lives in Winnipeg. One of the community programs that he works with is the All Nations Traditional Healing Center Inc. The All Nations Traditional Healing Center provides both Native American traditional healing and contemporary mental health interventions to assist residential school survivors and their families. This interview was conducted on 10/1/04 by Yvette Rivera-Colmant, MSW.

**Yvette:** Can you tell me how you use traditional healing to help people?

**Charles:** In what context are you referring?

**Yvette:** As far as healing emotional problems.

**Charles:** We use several methods actually to work with people. Most of them are methods that are passed down through the generations. A lot of them are related to the ceremonial ways of the ancestors. We deal with many types of ailments, physical ailments. When I started off working with a medicine man, I worked mainly with physical ailments. Things like diabetes, cancer, and high blood pressure. Things that affected people physically. But I soon learned that many of the ailments that affect people physically are related to their emotions. So we started getting into working with people's emotions as well as their spirituality. Generally what we utilize is our ancestral ceremonies to deal with the various sicknesses that people experience. Just as an example, with cancer we began having women that were suffering with breast cancer and cancer in their reproductive systems. After awhile, we began to realize that about nine out of every ten of these women suffered some kind of problem when they were young, in their early or late teens. A lot of times there was trauma related to sexual abuse or some sort of rape. They didn't seem to develop the cancer right away, not until they were older – in their late twenties or mid-thirties. Some of them even older than that and some didn't develop the cancer until their late 50's or 60's. In dealing with the cancer, we not only provided herbs but also dealt with their emotions and their spirituality. We had to educate them and help them regress by remembering the time that they experienced these situations. Once they dealt with the emotional issues that they held within themselves, the cancer began to clear up. In some cases it cleared up in several months. But, not all of them recovered. The success rate is about 60% depending how they themselves wanted to deal with these issues. A lot of these elderly people had these things so ingrained in them they couldn't release, they had difficulty releasing.

**Yvette:** Was it that it had become a part of them that made it difficult for them to let it go?

**Charles:** Yeah, it was harder for them to let it go because it became a part of their life. It became a normal way of living for them. It shouldn't have been. So they had difficulty releasing or letting go and they had difficulty finding forgiveness. That was one of the main ingredients in the cure; that they had to be able to forgive the individual or person that did them wrong, as well as forgiving themselves. Because a lot of times they held blame within themselves that really wasn't necessary... So that is one of the things that we did in terms of cancer. In working with people with diabetes it almost seemed like it was a similar situation. When people became emotional, they tended to overeat and they would



indulge in sugars and different types of high fat foods that caused blockages in their pancreases. When these blockages occurred, their pancreas could no longer produce the insulin that they needed to digest the intake of sugar so they began to suffer from different types of sicknesses. It began affecting their internal organs and they started suffering from high blood pressure and as a result started having heart problems. A lot of them started having problems with their livers or their kidneys. In the advanced stages of the diabetes, many of them started losing limbs, starting from their digits, their fingers. We found several herbs that we use that flush the pancreas. Medical science is unable to do that. They have no cure for it. Basically what they do is just replace the insulin that the pancreas is unable to produce or a derivative of the insulin. One of the more difficult areas that we continue to work with is the depressions and the anxieties that people suffer. Usually there are many after effects of these anxieties and these depressions... We have to educate them and try to get them out of their depressed state. It's very difficult because of the economic situation on the reserve. We let them know that as Indian people we have a sacred way of life... the ceremonial life. So we have to educate our own people as well, because many of them have been in the residential school system. Many of them have been told that their way of life is negative, that their ceremonial ways were paganism and that they were heathens. They were totally discredited and it made them depressed within their own community. So now they are trying to come out of that... The ones that seem to come out of it returned toward their traditional ways. They developed their self-esteem and their pride in who they are. Then they learn how to function in society, they learn how to balance their ancestral way of life and finally become successful.

**Yvette:** How did you become a traditional healer?

**Charles:** Well... my mother is the one that kept me informed about the traditional ways. She took me back to her reservation when I was six-years-old and I witnessed a Sundance. I didn't

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know what it was at that time. But, eventually I learned what it was about. My grandfather would talk to me quite a bit – her father. He would talk to me about the ceremonial ways but I wouldn't pay much attention to him when I was younger. It wasn't until I became older that I began understanding what he was talking about. One of the things that I learned in the 70's when I was listening to elders and spiritual leaders was that everyone has a vision and that everyone has a dream and that they should try to realize that dream, whatever it is. My dream was to become a pilot. Going by what the elders said, I pursued that. I became a pilot and spent a little over 10 years in the aviation business, flying for people, flying for myself, bush flying. In 1983 my father became ill with cancer and I spent the last month of his life with him. I watched him, I watched his suffering. I saw how his suffering went, some days it seemed like he was going to recover and then the next day he would be really sick. It seemed to be going like that up and down, up and down. Then finally he couldn't stand the pain anymore, just all of a sudden it seemed like he was fine one day and the next day he was really sick and then he passed away. That really made me angry, because at that time I had some faith in modern medical science. I had hope that the doctors that were working on him could cure him, but they were never able to. They never had a cure for cancer. They didn't know how to deal with it. Basically all they did was three things with cancer. The first thing they seem to do is give people a high dose of chemicals, chemotherapy. If that didn't work they radiated them and if that didn't work they took their knife and tried to cut the cancer out, but there was really never a cure. So when I watched my father die, the anger that I had, I was able to turn it around and seek an alternative way. I began seeking through our traditional ways; I began seeking an alternative cure. It took quite a number of years – he died in 1983 and it wasn't until 1986 I ran into my first medicine man. I was really impressed with what he was doing and he did a lot of strange things to me, emotionally, when I watched him work. My dad was a Christian and we understood that there was a healer that was able to make the blind see, the cripple walk and he was even able to raise the dead, he was even able to walk on water they said. We had that way of thinking and we didn't realize that we had people among us that were capable of doing things like that. I wanted to help him and I wanted to learn. So he was agreeable, I didn't tell him what my reasons were, but during my time as a helper he seemed to zero in on cancer.

**Yvette:** Do you work with Psychologists, Psychiatrists, and Social Workers?

**Charles:** Yeah, we do. We have clients with Child and Family Services that are under the care of Psychologists, so we did have some contact with Psychologists. General these types of people are reluctant to be with us. Our natural medicines are unorthodox... You can say that the doctors can't understand what the ailments are, probably because it is emotionally based. We do work with religious people, people that are ministers, psychiatrists – we do work with some indirectly. We can work together. Where we Sundance, we have a medical doctor, we call him Doc (laughs), he lives in Denver and he is a Sundancer too. I have

known him for 18 years. He not only practices modern medicine, he also works with Native and Chinese medicine- acupuncture.

So we do run across many professional people, Priests, lawyers, monks – all kinds of people Sundance. They come from everywhere; they don't have to necessarily have to be Indian to Sundance. We have had people come from Japan. We get people from Germany and South America- people come from all over the world to Sundance. It is interesting we get to learn the different cultures all over the world. We even have Druids come - indigenous people from England before the Roman Empire, so we have all walks of life. We also practice traditional medicines and it is very similar- the procedures might be a little different, but most the herbal medicines are the same. The Chinese people use Sage, but they use it in a different way but the effects- the cure is the same.

**Yvette:** I have kept you for a while now. Is there anything you would like to close with, something that you think needs to be said?

**Charles:** People need to begin understanding that nature needs to be respected. It's very important that anything that is taken from nature needs to be put back. Otherwise it's not going to last and our ancestors prophesized that. The society needs to begin to respect nature, how to use the resources more effectively, there is a lot of wastage, too much wastage.

To the people that will continue to live on Turtle Island, 500, 600, 700 years, they owe a lot, because the destruction that has taken place so far is immense, it's immeasurable... You can't measure the effects it has had on the inhabitants, the original inhabitants of Turtle Island. We deal with things, like racism for example, and all the time society doesn't understand why people are racist themselves, there is no need for them to be racist. It is something that is intergenerational from their forefathers. Their forefathers came here with a point of view they were looking for the American dream, they were looking for wealth, they were looking for prosperity, and it didn't matter how they got it. They pillaged and raped to get it, and it caused a lot of destruction. As a result the society today has this guilt and they don't realize that they have it... So, we are prepared to sit down and talk with people, we always have been, our people are always willing to share this land, that's the way they are naturally, they have been taken advantage of. The damage that has been caused can never be measured. There is no reason for Indians to continue to live on reservations in poverty, in despair, suffering from depression and anxiety. There is no need for them to be there at all. Some of us make it out of there- the prison, the concentration camp. We find our freedom by being able to balance the values of ancestors with modern day society. That is what it is, an everyday walk of life. That is what it is, so we can function any place.

CPA (Manitoba) Inc. sees rehabilitation counselling in a holistic light. We encourage members to consider their physical and psychosocial needs in their adjustment to SCI. CPA staff builds relationships with organizations that can guide members in their culturally relevant and spiritual pursuits. Interested members should contact their counsellor.



## Turtle Homes: Exceptional Accessibility in a Prefab Design

by Colin Mathieson

**A**s a barrier-free design specialist for CPA, I often find myself assisting people with decisions about homes and the cost associated with the ideas. I've found that every situation is unique and no two solutions are ever the same. Some might be looking to modify their existing home while others might consider purchasing or designing brand new and incorporating accessibility throughout. Over the past few years, a variety of options for accessible and economical houses have crossed my desk. Recently, I discovered a concept from Kansas called Turtle Homes that warranted a closer look.

What I found was an amazing Web site at: [www.turtlehomes.com](http://www.turtlehomes.com). Even if you're not in the market for a home, the site is well researched, with oodles of information about the pre-fabricated homes, including blueprints for the various sizes of Barrier-Free and Universally Designed homes. Recognizing that modifying an existing home may be impossible, Turtle Homes has even provided for the attachment of the prefab unit alongside an existing home with a corridor between the two.

An excerpt from the Turtle Homes Web site says:

*Turtle Homes are custom designed with double-layered non-flexing floors for heavy electric wheelchairs, reinforced walls and framing, integrating a wide range of assistive technology. A new home, or an accessible addition to your existing home can be designed to meet your needs. The Turtle assistive technology equipped, barrier-free factory built home is the first sectional home specifically developed to provide a fully accessible home for people with disabilities and their families.*

Turtle Homes have gone the extra mile to build a truly Barrier-Free home. Most of these features are normally found in totally custom homes and I am amazed that they are included in a pre-Fab unit.

There are many different designs and sizes. There is a 1300 square foot 2-bedroom design, all the way up to 2500 square foot 4 bedroom designs. You can have an attached garage and the modular design of extra features means you can customize the unit according to your personal care needs. There is an optional ceiling track system that goes from bedroom and bathroom to an optional walk-in closet.

Turtle Homes has also partnered with a company called HygieniCare to produce an ingenious "all-in-one" and bath which incorporates a bath, toilette and sink. (Check out the three-minute video on the Web site.) This timesaving device eliminates multiple transfers and virtually allows the user to

shower, shave and, uhm... shampoo... all from the same seat! This may, in fact, reduce time spent on personal hygiene and could make someone less dependent on care providers.

Now the disappointing part, in speaking with Turtle Homes they have indicated that they have not yet prepared to export these homes to the Canadian market. Anyone considering the prospect should check with the CSA and their lending institution; both would likely insist on an inspection to determine they would support importing such a home.

There are many differences between homes built in Canada from the ones, which are built in the USA. Canada has their own safety and building standards, as does the USA. The home inspectors and possibly CSA would have to go through the designs with a fine tooth comb and ensure that everything is consistent with our standards and our climate. On a positive note, the recent strength of the Canadian dollar makes the prospect of importing such a product of our more feasible idea that it was only a year ago.

Undoubtedly, Turtle Homes represents a new and exciting option in ultra-accessible housing. The beauty of the Turtle Homes design is that every square inch has been meticulously planned. By manufacturing a modular design the consumer can mix-and-match features but not have to

*The HygieniCare™ All-In-One Bath requires only a single transfer to access all bathroom features. Talk about a timesaver.*



*Roll in Shower with Grab Bars and Fold-down Bench*



pay the price for an individualized design. Modifying an existing home could be a costly trial-and-error undertaking. Hopefully, with enough Canadian interest either Turtle Homes will produce a model that meets our standards, or Canadian manufacturers will consider a similar project for our climate.



*Roll Under Lavatory In Accessible Bath*

Turtle Homes needs to consider three major items in assessing our market:

- 1) How much will it cost above average to bring them to Canadian standards?
- 2) Can they sell enough units in the north to cover the initial cost of research and development?
- 3) Would people want to live in one?

In the case of Turtle Homes, I think the answer is yes. Until the company produces a model for the Canadian climate, though, this remains untested. Anything is possible but someone would have to be the first to dive in. However, as the of new con-



*Bedroom and Walk-in Closet with Sure Hands Lift*

struction increases, alternatives designs like Turtle Homes are likely to become available.

This expansion of the market will follow the same path as hybrid powered automobiles. Honda was the first to mass-produce one in 1996 with the hope that it would attract a certain buyer. Now, with gas prices inching up to a buck a liter, there is a 6-month waiting list and every manufacturer will be producing one within a few years. Also, by producing more units - achieving an economy of scale - the price should come down as well.

I invite anyone having information or experiences in building a prefab home or living in one, to share their experience. Drop me a line at: [cmathiesen@canparaplegic.org](mailto:cmathiesen@canparaplegic.org). I'd like to take a look for myself.



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## Domo Arigato, Mr Roboto: Creating Your 'Smart' Home

by Regan Block

### Home Automation

So does anyone remember “The Clapper”? Yeah, the remote light switch that was activated by the sound of clapping your hands. Well that, as they say, is ‘old school’. Today many household devices can be turned on by a wireless remote control, by commands stored in your computer or even simply by your presence.

Now why would you want to automate your lights and appliances in your home? You have perfectly placed wall switches and it’s so easy to turn that fan off when you’re in bed, right? Aside from my obvious sarcasm, many people with limited mobility who do not live in custom made homes deal with the inconvenience of reaching for awkwardly placed light switches (try finding one in the darkness of night) or appliance every day. Some of us can’t even get that far.

Suppose that all your lights in your home could be controlled by remote control. Each light can be turned on and off or dimmed individually. Better yet, you could program your lights to turn on and off at certain times of the day. Going even further, you could have your lights turn on when you enter a room and then turn off after a set time. So you would like to dim all your lights in the living room to watch a movie – no problem...you can turn them all up remotely when the movie is over. And if you are ever annoyed when going to the kitchen for a late night snack only to be blinded by 200 watts of pure brightness, fear no more – there is a solution out there for you. (Refer to the section on programming and macros later on).

### Getting Started

Where do I get these wonderful toys? Well, the Internet of course. I recommend anyone wanting to start out, to go to [www.x10.com](http://www.x10.com), as this company basically started it all 30 years ago. Here you can find a home starter package, which usually consists of an assortment of modules and computer software / hardware. I went for the Ultimate Home Automation system which included 1 lamp module (dimmable), 1 appliance module, 1 (light) socket rocket which is non-dimmable, a master remote control, a key chain remote control, a wall mount remote control, a USB interface to a wall mounted controller, and software. The price was \$99.00 USD. For those of you that don’t deal regularly with US suppliers, credit cards or eBay, I also purchased some additional dimmable wall switches and socket modules from a Canadian retailer called Aarons X10 Heaven, in Edmonton. They stock most of the X10 modules and for a very good price too. You can also purchase hardware components through your local Radio Shack which all happen to be X10 compatible.

While you wait for your order, I suggest doing some homework to determine where the modules are going to go. For myself, I wanted to automate the lights that I found the hardest to reach (living room), used most often (master bedroom/bathroom/closet), lights left on for no reason (kitchen) and my front

house lights (security). Once I had my rooms planned I needed to determine which modules I would use to control my overhead lights, table lamps, & appliances. The method I used was based on House Codes. How this works is that each module can be set to 1 of 256 codes, which breaks down into 16 different X10 modules/commands by 16 different house codes. For Example, I set up my kitchen light with House Code B/Unit 1, my living room as House Code C and the lights were C1, C2, C3, Bedroom House Code D etc. This arrangement allows you to easily group rooms together in the automation software and saves the master controller’s 16 button interface to control macros set to House Code A. More on this later, under “macros”.



### Installation

If you’re lucky like me, you have a cousin taking an electricians course at Red River College and have a very smart uncle who can guide you with tips on setting up the commands. In other words, if you can find someone who has done household wiring and works cheaply and if you have done your homework beforehand, in an hour and or so your can have half a dozen modules installed and ready to go. Make sure you set the individual device codes up according to your plan.

The system I purchased had a USB interface that is also permanently plugged into the wall, which serves the purpose of saving all your settings, timers, and macros so that your computer does not have to be on in order for the automation software to run (it also has a battery backup to insure that your commands are not lost during a power outage). The software came as a link in an email from X10 and it installs as easily as any software does. Now to configure the automation software to your home. Remember that homework I asked you to do earlier? Here is where you’ll need it. The Activehome software is very user friendly:

- Step 1** – Create a room. Ex. Living Room
- Step 2** – From the module list beneath your room, drag exact model modules that were installed modules into the room
- Step 3** – Name the module (Ex. Left Lamp) and assign it the code from you plan
- Step 4** – Test the module (make sure it was switched to the ON position before) by clicking the ON switch in the screen. Another test would be to take the master hand held controller, set the House Code to that room’s House Code, and press the corresponding unit number. The light turns on.
- Step 5** – Repeat for the rest of the modules you installed.

Now that wasn’t too hard was it?



## Programming

Now the fun begins – setting up the times when your lights and appliances will turn themselves on and off. As I said, the Activehome software is very smart and easy to use. For example, you might like your living room lights to only come on when it is dark. Activehome has a Dusk setting where it always knows, based on your location, when it is dusk (or dawn for that matter). You will never come home to a dark home again. If your bedtime is 11:00 then you can set your living room lights to shut off at 10:55 (a reminder to ‘go to bed’). Some more advanced commands would be to turn on a light in the kitchen when you enter and then shut off when you leave. Simply set up an X10 Motion sensor to detect motion in that room and set a five minute delay to shut the light off automatically.

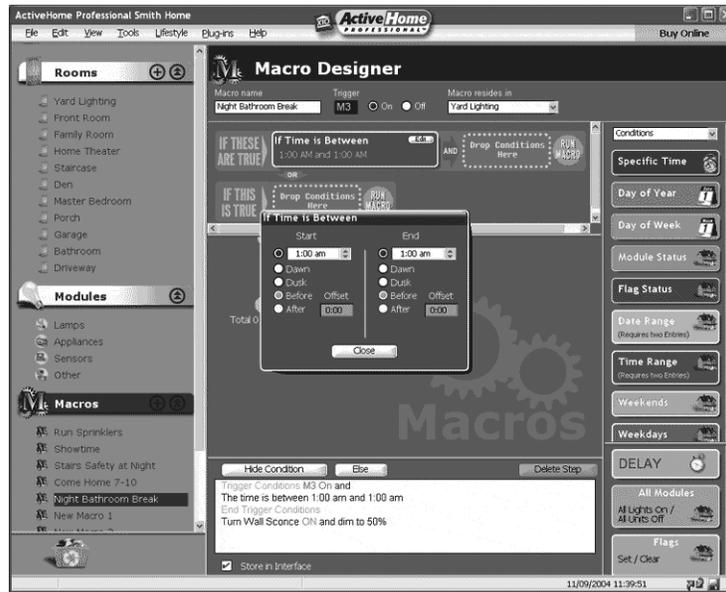
## Macros

Here is the WOW factor. Simply explained, a macro is a command that does several things at once. Very easy to setup and edit. Let’s do one called ‘Movie’ in your living room.

- Step 1** – Click Macro > New > and select the Living Room. The room modules will be displayed on the side.
- Step 2** – Name the Macro, drag all the room light modules into the macro screen.
- Step 3** – For each dimmable light, set the dimmer to 50% (or lower if it’s a scary movie).
- Step 4** – Assign a trigger code – this is where you would chose an ‘A’ code since you could theoretically have all your macros at your fingertips on the master controller. Let’s use A1.
- Step 5** – Test – from the Living Room view you will see the Macro for Movie. Click Run and watch all the room lights dim down - just like the movie theatre. This reminds me that I should make an ‘Intermission’ macro when I get home.

This brings me to another point about security. As I sit at my favorite coffee shop, pounding away at the keyboard, any crooks cruising down my street this evening will see that my front lights and my living room lights are on right now. For that reason, I believe that home automation is very good break-in deterrent.

The most powerful feature from X10 is something called Smart Macros. This is an additional piece of software for \$49.99 USD and includes two motion sensors, letting the user create



automation events to trigger based on specific criteria. My favorite is the ability to set the bathroom light to prevent it from blinding you when you’re making that late night trip. Setting this up is as easy as having an X10 motion sensor (and light dimmer module, of course) in your bathroom and then setting up a Smart Macro for a condition that says “Between the hours of 12:00AM and 6:00 AM turn Bathroom light ON at 50 %”. Smart Macros can be programmed with 2 different conditions such as (for all you programmers out there) AND, OR, NOT, and ELSE. Smart Macros may not be necessary for everyone but it wouldn’t it be cool to impress the father-in-law with that dimmed bathroom light at 4:15 AM!

## Tips and Tricks

If you hear creaks in the night and want to ‘bathe the house with light’, set up a macro to run all house lights ON. If you do this don’t forget to make a macro to turn OFF all the lights.

Have a hard time waking up in the morning? Try setting the timers on you bedroom

lights to full bright at 6:00 AM. For your bedroom, get a Slimline wall remote switch; control all your bedroom rights from a convenient switch right next to your bed.... it has dimmer control too – for those romantic moments.

## Conclusion

Well they say small things amuse small minds, and while X10 modules are definitely small (see picture), the power these little devices can deliver is impressive. Coupled with the software, remote controls, motion sensors, and cameras (I left that out for this issue) this package makes my life a little easier, saves money, make my place secure, and wows my family and friends when I need a pick-me-up. If anyone has any questions about X10 and home automation, send me an email and I will answer as best I can (I am still a newbie). Take care and see you all in a few months.



Direct link to ActiveHome Professional:

<http://www.x10.com/activehomepro/activehome-pro.html>

## Breaking Down Employment Barriers: The Manitoba Business Leadership Network

by Yvette Rivera Colmant

The Manitoba Business Leadership Network (MBLN) was established in 1999 and has been successful in breaking down employment barriers for qualified people with disabilities. MBLN is based on the United States BLN, and is a network of business leaders in our community who have partnered with the mission, "to engage the business community in promoting the benefits of hiring qualified individuals with disabilities and provide Manitobans with disabilities the opportunity to acquire meaningful employment." The MBLN strives to break down barriers for people with disabilities through initiatives such as an annual employment fair, an annual first job program, and an annual employer recognition banquet.

The Employment Fair occurs annually in late October or early November. The businesses that participated last year were: The North West Company, TD Canada, Scotiabank, The Public Service Commission, HBC (Zellers, The Bay, Home Outfitters), Great West Life, The Faneuil Group, Department of National Defence, Manitoba Civil Service Commission, City of Winnipeg, CIBC, Can/MB Business Service Centre, The Canadian Wheat Board, Bank of Montreal, Bison Transport Inc., Assinibione Credit Union, Cargill, Manitoba Hydro, Workers Compensation Board, RBC Royal Bank, MTS, and Manitoba Lotteries corporation. The 2003 employment fair initiated 25 new hires. The 2004 new employment-hiring placements are not available at this time. Greg Findlay, the Executive Director of the MBLN stated that the matches for employment were diverse, with the most being in office settings. This year Findlay is hoping to break that record

and stated, "Every year we have the employment fair, we have more businesses looking for qualified applicants. The first year we had 13 businesses at the fair and now five years later there are over 25 businesses in attendance." In 2005 the fair will be held October 26th at the Winnipeg Convention Centre.

Another flourishing project of the MBLN is the First Jobs, which started as a pilot project in 2001. This project gives high school students with disabilities, over the age of 16, their first paid work experience. The MBLN facilitates the matching of students with employers throughout the province that are interested in participating in this unique project. The pilot was very successful and has become an annual summer program activity.

When asked about the importance of a BLN in the community, Mr. Findlay stated, "We as business people understand the bottom line and can illustrate to other businesses the successes that have been achieved when hiring qualified people with disabilities. Sometimes I think businesses may not understand that accommodations really don't cost that much and can actually improve the site for not only people with disabilities but for all involved. It's not charity, it's good business sense."

Some near future plans for BLN are a Multi-sector forum, which brings businesses together to talk about solutions to break down hiring and employment barriers. Another plan is a website providing employers with information about reasonable accommodations and agency contacts for further advice. Findlay says that MBLN's plan is to level the playing field so that all Manitobans can participate in meaningful employment.

# Rick Hansen

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**Researcher:** Paul Falconer, Ph.D.(cand.)  
 Northcentral University  
 505 W. Whipple Street, Prescott, Arizona  
**Telephone:** (617) 983-2021

**Email:** [paulfalconer@comcast.net](mailto:paulfalconer@comcast.net)

**Online Survey:** [www.freewebs.com/mobilitysurvey](http://www.freewebs.com/mobilitysurvey)

*CPA extends its sympathies to the families of the following loved ones who recently passed away:*

- Barry Bell*
- Rene Vaningen*
- Christopher Guiboche*
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