

February 2018

Winter Issue

# PARATRACKS

Newsletter of the Canadian Paraplegic Association (Manitoba) Inc.



*Flor Marcelino, MLA-Logan and CPA Member Scott Coates*



*CPA Member Darci Epp and Hon. Cameron Friesen,  
Minister of Finance, MLA-Morden-Winkler*

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

*William Brown*

*Samuel Cabigas*

*John Dodds*

*John Dyck*

*Paul Gilbert*

*John Kathler*

*Manjit Kaur*

*Walter Kiryluk*

*Moe Lerner*

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**WE NEED YOUR FEEDBACK**

**What would you like to see in future issues of  
ParaTracks ?**

We try our best to publish articles and stories that are of  
interest to you, our members. To ensure we continue with  
this practice, we need your help. Without feedback from  
CPA members, we can't always be sure that we're provid-  
ing you with the information you require.

Please take a moment to provide us with your feedback.  
Was there an article that was of great interest to you?  
What did you like about this issue of ParaTracks? What  
didn't you like?

Please send your comments by email to Adrienne at [aconley@canparaplegic.org](mailto:aconley@canparaplegic.org) or give her a call at 204-786-4753  
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# The Accessibility for Manitobans Act is Now in Play

By John Wyndels

**A**lmost four years ago, the Manitoba government made a commitment to make Manitoba more accessible for everyone. Proclaimed in 2013, The Accessibility for Manitobans Act (AMA) had the support of all parties. The main goal of this legislation is to identify, prevent and remove barriers to participation.

In consultation with businesses and the community, AMA standards lay out who has to do what, and by when. These standards focus on five areas of daily living:

- Customer Service (enacted November 2015)
- Employment (give us your feedback on the proposed standard)
- Information and Communication (in development)
- Transportation
- Built Environment (Public Spaces)

Rather than focus on disabilities, the AMA is about removing barriers that may result from inaccessible structures and spaces or how information is delivered. Barriers can be created, increased or reduced through technology. Policies and common practices also can create systemic barriers, but negative attitudes are often the greatest barrier of all.

## Update on Customer Service Standard Implementation

As of November 2018, accessible service is the law in Manitoba and businesses, small municipalities and non-profit organizations must have policies in place to reflect the requirements of the Customer Service Standard under the Accessibility for Manitobans Act. These requirements include:

- meet the communication needs of clients
- allow assistive devices
- welcome support persons
- allow people with service animals
- review physical barriers to access
- let customers know when accessible services aren't available
- invite customers to provide feedback

- train staff on accessible customer service

If you want more information about the Accessibility for Manitobans Act and the Customer Service Standard, visit [www.AccessibilityMB.ca](http://www.AccessibilityMB.ca). This website has information and resources for everyone, whether you provide customer service or receive it.

## Next Areas of Accessibility Standard Development

The final phase of public comment in response to the proposed accessibility standard for employment recently ended. All submissions will be reviewed, and if the Minister considers it appropriate, the standard will be amended before sending it on to Cabinet for approval.

Employment represents an area where long-standing barriers in the recruitment, selection and retention practices have disadvantaged persons with disabilities, resulting in their disproportionate underrepresentation in the workplace and labour markets.

The goal of an accessibility standard for employment is to identify the steps that employers should take to remove barriers at all stages of employment for persons with disabilities.

Work has already begun on the third accessibility standard, information and communications. The Information and Communications Standard will outline requirements for organizations to create, provide and receive information and communications in ways that are accessible for people disabled by barriers. This encompasses information and communications, whether in person, in print or electronic.

The Information and Communication Standard Development Committee has been meeting on a regular basis for several months. It is expected a proposed accessibility standard for information and communications will be available for comment and public consultation in the spring of 2018.

For more information on The Accessibility for Manitobans Act, we encourage you to go to [www.accessibilityMB.ca](http://www.accessibilityMB.ca)

While there, you can also subscribe to Accessibility News, a newsletter sent out every second month with tips, updates and examples of good practices.



## Take Your MLA to Work Day

By Scott Coates

In October 2017 I was able to participate in the “Take Your MLA to Work Month”. I was honoured to meet with the MLA for Logan, Flor Marcelino. Flor and CPA staff met at my workplace and we discussed the roles and contributions that individuals with disabilities make in the workforce. I believe these types of initiatives are important to inform and educate our members of government of the importance of hiring individuals with disabilities. As a result of the initiative, we can all develop a more inclusive workforce in Manitoba.

Meeting with Flor Marcelino heightened awareness of individuals with disabilities successes and struggles in employment on a daily basis. With the support of agencies like CPA, a message is spread on the importance of hiring individuals with disabilities and the supports that can be provided to its members to be productive, valuable members of society.



*Laurence Haien, CPA Sr. Rehabilitation Counsellor, Vocational Services, Scott Coates, CPA Member, Ron Burky, CPA Executive Director, Flor Marcelino, MLA-Logan*

guest on behalf of Flor Marcelino.. Flor had made a Member Statement to her colleagues to inform them of the role CPA services play to support, guide, and advocate for individuals to return to work. I am thankful to CPA to be one of the individuals who has participated in a vocational plan, that allowed me to obtain a professional degree and return to employment with the federal government. The recognition from Flor to her colleagues and the media coverage involved in the project. will raise awareness to businesses in the community to hire individuals with disabilities to create more inclusive workspaces.



*Flor Marcelino, MLA-Logan, CPA Member Scott Coates, CPA Rehabilitation Counsellor, Vocational Services Melanie White and CPA Director of Rehabilitation Services Darlene Cooper*

I would encourage other employees with disabilities to participate in Take Your MLA to Work day because not only are we able to provide feedback to MLAs like Flor Marcelino, but she was able to provide our message of a more inclusive workplace to members of government. The continued support of this initiative, the word of mouth experiences of the MLA’s participating in this event, and sharing of work experiences from the CPA membership allow everyone to become a voice of change in an inclusive Winnipeg and Province of Manitoba.

I was invited along with CPA to the legislature to be a



## MANITOBA LEGISLATIVE ASSEMBLY MEMBER'S STATEMENT

### **Disability Employment Awareness Month Flor Marcelino, MLA for Logan November 22<sup>nd</sup>, 2017**

Madame Speaker, The current employment rate for citizens with disabilities is 17.9%. However, once hired, employers have a 72% retention rate for citizens with disabilities. Studies have shown that 90% of people with disabilities can work just as productively as or even more so than their colleagues. In the month of October, we celebrated Disability Employment Awareness Month. And as part of the celebration, I was invited to "Take Your MLA to Work Day".

We take this time to recognize the barriers that peoples with disabilities face in the workforce. "Take your MLA to Work Day" celebrates the contributions that Manitobans with disabilities are making and are capable of making to healthy, productive, and inclusive workforces in Manitoba.

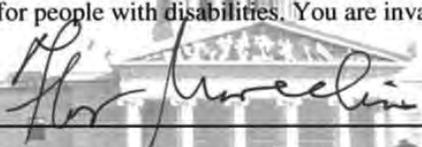
In honour of Disability Employment Awareness month, I have invited Scott Coates, rehabilitation case manager at Canada Pension Plan Disability. He was supported by the Canadian Paraplegic Association of Manitoba, an organization that works every day to ensure that people with disability are living a life that meets their potential and ensure that employers are providing inclusive workplaces. It was inspiring to hear Scott's story and learn about the remarkable recovery he has made after the accident and to witness the meaningful life he lives now.

This year alone, The Canadian Paraplegic Association of Manitoba is providing services to 1374 members whom similarly to Scott, are being assisted with attaining employment opportunities and live a productive life of meaning. The Canadian Paraplegic Association's employment rate is 25.3%, which 10.2% than the national average of employed people with disabilities.

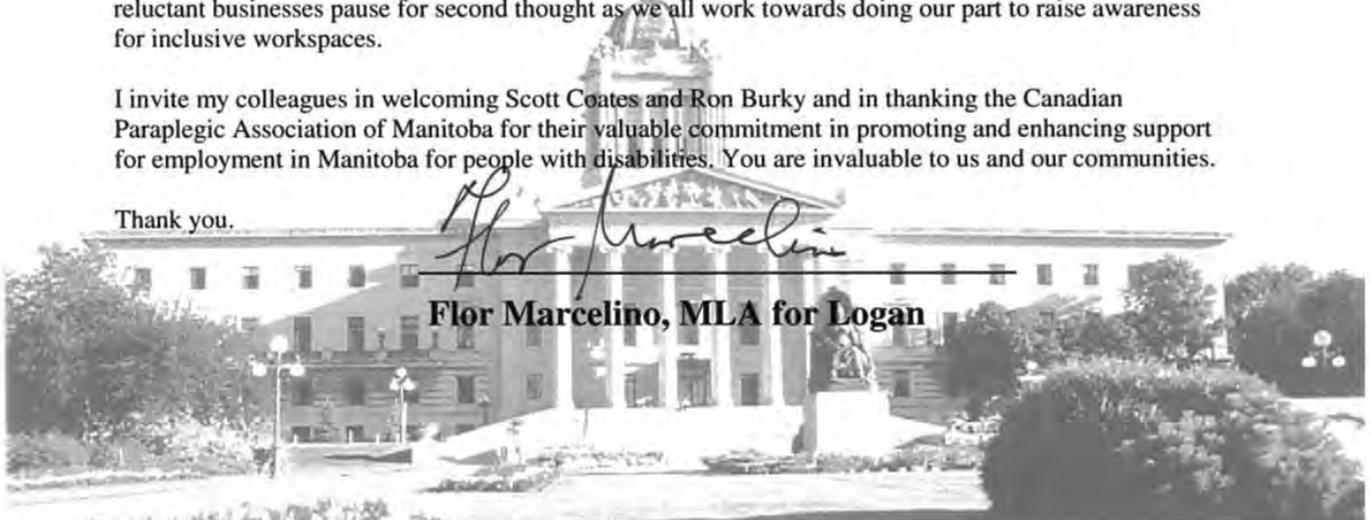
In 2013, BMO conducted a study and it shows that only 3 in 10 small businesses in Canada hired people with disabilities. There are still barriers and stigmas. "Take your MLA to Work Day" will hopefully give reluctant businesses pause for second thought as we all work towards doing our part to raise awareness for inclusive workspaces.

I invite my colleagues in welcoming Scott Coates and Ron Burky and in thanking the Canadian Paraplegic Association of Manitoba for their valuable commitment in promoting and enhancing support for employment in Manitoba for people with disabilities. You are invaluable to us and our communities.

Thank you.



**Flor Marcelino, MLA for Logan**





# Electrical stimulation shows promise in healing otherwise hard to treat pressure injuries:

## An interview with Daryl Dyck and Cara Windle of Deer Lodge Centre

By Kelly Tennant

I had the opportunity to sit down with Daryl Dyck, Clinical Nurse Specialist, and Cara Windle, Clinical Service Leader in physiotherapy, who have been getting some recent attention in the field of wound treatment after having great success using electrical stimulation (e-stim) to help close a Deer Lodge resident's pressure injury that had resisted treatment for 2 years.

**CPA: First, I thought I'd start with having you both explain your roles here at Deer Lodge Centre.**

Daryl Dyck: I'm one of two Clinical Nurse Specialists in the building. My role is a clinical one, but it changes from time to time. It's providing some clinical nursing support for difficult cases. It's also research, policy and procedure development, and some work with supporting systems. I'm a certified wound care specialist, so if I'm going to do some clinical consultation, it's primarily skin and wound issues.

Cara Windle: I'm the Clinical Service Leader in physiotherapy here, and my role is to support and supervise practice throughout our inpatient and outpatient programs. Regarding electrical stimulation, we are always looking for new and innovative approaches to care. This is a new area for physiotherapists in Manitoba. We're the first place in the province, that we know of, to try this.

**CPA: What made you give electrical stimulation a try for this particular patient?**

DD: That was a good question because it wasn't as easy as "Oh, there's a patient, let's go try this one." Looking at the research that's out there and establishing criteria was one of our big challenges. Who would qualify? Who wouldn't qualify? The patient that we

chose was agreeable and had the type of wound that responds best to electrical stimulation and had had it for quite some time, so it seemed to be quite a natural fit. Nothing else we had tried had worked, so why not?

**CPA: So when you say that he had the wound type that responds best to electrical stimulation, what are the characteristics of the wound?**

DD: A pressure injury was the cause of his particular wound, and it was a chronic wound. He didn't have some of the other contraindications: no bone infection, no cancer process at all, the area was well off-loaded. It perhaps just needed a little electricity to get it going.

**CPA: How does electrical stimulation work to heal wounds?**

CW: One of the ways that it works is to improve the circulation that occurs to the area. Impaired circulation is one of the reasons that the wound doesn't heal. At a cellular level, there are a number of things that happen. It restores the electrical flow across the skin. All of us have a normal electrical flow across the skin, and with a chronic wound, that electrical flow is impacted in a negative way.

**CPA: Does it have any germicidal ability? For example, if there was an infection or surface colonization would it help with that?**

DD: A chronic wound *will* be colonized with bacteria, and so there is some research with electrical stimulation that does show that it has a little bit of an antimicrobial effect. That's not the primary way in which it works. That's not what's going to heal or close the wound.

**CPA: Do the parameters of the stimulation change based on the type, the size, or the location of the wound?**

CW: We hired a physiotherapist with a Masters in Clinical Science in Wound Healing. She was able to guide us about appropriate parameters based on the research. The intensity of the treatment depends on the reaction of the client as far as their sensation or observed muscle twitch. It doesn't have to be an intense feeling, and it should never be painful. The parameters themselves are complex and that's one of the reasons why physiotherapists are helpful in treating a wound like this, because we are used to dealing with electrical stimulation. We use it for pain control and for muscle stimulation. Understanding how the nerves work, and what kind of stimulation will be most effective is important to appreciate.

**CPA: So you deliver it at that threshold where they can feel it or they're getting a little bit of a twitch?**

CW: If sensation is reported, the intensity is deemed to be appropriate. If a muscle twitch is observed, the intensity is typically reduced slightly. Settings are individualized.

DD: A challenge for our client was that he had poor sensation due to multiple sclerosis, so we consulted our e-stim expert who suggested a starting point for our parameters. We started at lower settings to begin with, just to make sure there were no ill effects from that, and there weren't, so we gradually increased the settings and monitored the response.

CW: We're always looking for irritation to the skin. That would be another way that we would know that there was too much stimulation.

**CPA: Do the treatment parameters vary day to day, depending on things like how the person slept that can change pain thresholds?**



CW: What made this case challenging was that the patient had impaired sensation, so we didn't adjust the settings because the patient never felt uncomfortable. We would adjust the parameters as needed or would discontinue the treatment if the patient found it uncomfortable.

DD: Because we saw no muscle twitch in the treated leg and there were no reports of pain and no skin irritation was seen, we continued the treatment. We were there every day, Monday through Friday. Everything seemed to go smoothly with the parameters that we had set. We were seeing improvement.

**CPA: Was that measurable on a day to day basis?**

DD: No, week to week, for the first 8 weeks. Then we hit a bit of a ceiling in terms of wound size reduction. We kept the treatment going a little longer, but when no more improvement was observed, we discontinued the treatment and returned to some of our more conventional treatments that previously had not been working. The e-stim protocol seemed to have 'kick-started' the wound repair, such that the conventional treatments, were now able to take the wound to full closure.

CW: It might be helpful for you to understand the background of the wound. It was a 2 year old wound. Many different treatment interventions had been tried. There were many consultations that were done with specialists, medications that were provided, and different wound dressings trialed, but yet, over 2 years, it never closed. Our initial goal was for a 30% reduction in size over 4 weeks. We achieved that and ultimately a 98% reduction by week 15.

**CPA: Are there any downsides to the treatment?**

CW: From the perspective of the health care professionals involved, it's time consuming. The treatment itself takes 60 minutes, but in preparation for the treatment, we cleaned the wound and applied the electrodes and cover dressing. There is some cost associated with the treatment, but over time if the treatment is successful, the cost would potentially be less than the ongoing stand-

ard wound care. I think one of the main barriers that people find is that to start something new, that you've never tried before, is a bit of a leap. You have to have the right people to get it going. I would say those would be some barriers, but there were no significant negative consequences for the patient.

DD: I don't think so. I think the positive outweighed the negative. Working collaboratively on this project was great, and I think our patient benefitted from this as well psychologically. When was the last time we were able to give such dedicated quality time to our patient? He enjoyed the interaction as well, apart from what we were doing to his leg.

**CPA: Why do you think you're the first group in the province to try this technique?**

CW: I would say that, for me, it would be because it's not the realm of any one discipline to do it. It has to be a team approach, because you need the nursing side, you need the physio side – potentially. You need somebody that understands the electrical stimulation; it doesn't have to be a physiotherapist. Everybody's feeling so overloaded with time that it's difficult to have the foresight to think if we do this short-term and really put intense resources into it, that it will pay off in the long run.

DD: Though the research is out there, there are currently no procedural guidelines in the Winnipeg region for how to do this. The lead up time before we started on this client was a couple of months of preparation, of reading, of putting some kind of protocol and care plan together related to this gentleman and the e-stim for his wound. Part of our goal now is to have a clinical practice guideline written for the region.

**CPA: What would it take to get this treatment into the hands of more clinicians?**

CW: We're working on trying to find some partners in the community. We know that might be a source of appropriate clients. You do have to find a client who is appropriate for this, because we want it to be successful. In this case, we weren't sure that it would work, but it did. Our region has been

supportive of this endeavour. There's been a lot of interest in it.

DD: We presented it about a month ago at Nursing Leadership at WRHA and Home Care is particularly interested in getting it going. We know that our group will probably have to do some mentoring and perhaps participate in the early stages of implementation by other health care partners.

CW: And we're willing to be part of that, as much as our time allows. We're limited in that we have a commitment to our own clients and own facility. There are some treatments that are being used, like the VAC [vacuum assisted closure], that aren't as well supported in the literature; and so part of it, I imagine, might be making sure that the other health professionals, who might suggest the implementation of wound treatments, are aware of it as an option.

**CPA: Would this be something that would be feasible for people to do at home with a Home Care nurse, or would they have to go into a clinic to receive treatments?**

DD: No, I think the vision is to have it available to be done in people's homes.

CW: It's a portable unit, so there's no equipment that couldn't be taken to somebody's home.

DD: We trained one of our Rehabilitation Assistants to help us do some of the take down, so if we can't be there when the treatment's done, they could take the equipment, remove it, clean it, and finish up the wound. Caregivers could learn the technique too.

Cara summed up their work nicely by stating "We like to say that e-stim is one tool in the tool box, and that it's not the only thing. So just because you use e-stim, doesn't mean you're going to heal the wound. There are lots of factors including nutrition, offloading, circulation, and other comorbidities that might affect how you heal."

Thank you to Daryl and Cara for talking to me about your work. CPA will be paying close attention to the future of e-stim as a treatment with the hope that it will eventually be the go-to for healing chronic pressure injuries and getting our members off of bedrest and back to their normal lives!



The Grief Recovery Method®

by The Grief Recovery Institute®

By Gail Burnside

**W**hat is Grief?

- 1) Grief is the normal and natural reaction to significant emotional loss of any kind.
- 2) Grief is the conflicting feeling caused by the end of, or change in, a familiar pattern of behavior
- 3) Grief is the feeling of reaching out to someone who has always been there, only to find when you need them again, they are no longer there.

While death and divorce are obvious, many other loss experiences have been identified that can produce grief. Among them are:

- Major health changes
- Loss of a career
- Retirement
- Financial changes – positive or negative
- Legal problems
- End of addictions
- Death of a pet

Grief will tend to control your ability to enjoy any fond memories of your lost relationship as long as you let it. By that I mean that unless you take personal action to effectively deal with the emotional pain of your loss, that pain will persist. No matter how you try to suppress those feelings, you find your fond memories are swept away by all the things that you wish might have been different, better or more in that relationship. When this occurs, it is a sign that you have unresolved grief issues, no matter how much time has actually passed since that loss.

“Time” is not a factor in recovery. Many people have heard people say that “grief just takes time,” or that a certain amount of time needs to pass before they can feel better. In truth, time just goes by, but has nothing to do with recovery. The passage of time, more than anything else, simply makes them used to feeling bad, but offers no real relief.

People say you have to let go and move on in your life, but they don’t tell you what you need to do to accomplish that.

Taking action to deal with those things that are still “incomplete” in that relationship will allow you to be able to remember those joyful memories without that deep sadness. Taking effective action is the cornerstone of The Grief Recovery Method®, and is spelled out in *The Grief Recovery Handbook*. The Grief Recovery Method Outreach Program not only makes this possible, but provides partnerships and guidance to ensure that happens.

CPA Manitoba offered The Grief Recovery Method Outreach Program in the fall of 2017. The following article is a group member’s personal experience of her involvement in the 7 week program.

If you would like to participate in a Grief Recovery

Method Outreach Program or have any questions about the program, please feel free to contact: Darlene Cooper, Director of Rehabilitation Services @ 204-786-4753 ext. 225 or Gail Burnside, Rehabilitation Counsellor @ ext. 229.

### Comments on the Grief Recovery Program

I was asked if I would share commentary about the Grief Recovery Program that I participated in last fall. The program has been developed and refined over the decades by Grief Recovery Institute founders, John W. James and Russell Friedman. Darlene Cooper, CPA Director of Rehabilitation Services and Gail Burnside, CPA Rehabilitation Counsellor, delivered the program weekly to a small group over seven weeks.

At the outset I feared opening up even to myself; but I needed to do something. I was crying frequently and too easily. Remembering lost relationships was painful and others close to me were at a loss when something triggered my tears. I was feeling emotionally and socially isolated. The pain of unresolved grief is cumulative (which the program acknowledges) and I was facing another significant life change—retirement.

Meetings were structured, interactive and sometimes we worked in pairs. People were friendly and I felt at ease shortly into the first meeting. We each received a copy of the Grief Recovery Handbook<sup>1</sup> and the starting premise was that “all relationships are unique—no exceptions”. We were free to say what we wanted to say about our own experiences and the importance of respect and confidentiality was emphasized. We were provided with guidelines and information that helped us to be respectful and better listeners.

We stuck to **Grief** and **Recovery** except towards the end of each meeting when we moved to a more casual discussion. Below are a few excerpts from the handbook describing these terms:

**Grief (is) “normal and natural, and clearly the most powerful of all emotions, it is also the most neglected and misunderstood experience, often by both the griever and those around them. .... (it) is the conflicting feelings caused by the end of or change in a familiar pattern of behavior ... We grieve for the loss of all relationships we deem significant whether they are romantic, social, familial or business or other.” “...is about a broken heart not a broken brain.”**

**Recovery means feeling better and “acquiring the skills that should have been taught in childhood”... “skills will heal your heart if it gets broken and in turn will allow you to participate 100 percent in all of your relationships.”**

Looking forward to participating in each meeting was the last thing I expected; but progress felt good and I



looked forward to more relief. New ideas and accurate information refreshed my perspective and cleared space for new insights. For example, well-meaning people had advised “Don’t worry, time heals all wounds” But time *had* passed and I was not feeling better. In the program, we learned to recognize this and many other of society’s beliefs and expectations as incorrect/inaccurate. My questions like, “Why can’t I get over this? What’s wrong with me?” were mostly erased.

A premise of this program is that communications in relationships that are lost or changed are almost always incomplete. This can include a loss of faith, trust or belief. When we look back we often wish aspects of relationships had been “better, different or more”. Reading, discussion and exercises methodically showed us how to recognize these aspects of loss and address them. I am still surprised at the simplicity of the process.

Homework involved about 60 minutes of reading and the few other assignments usually took about 45 minutes. These assignments, by the way, were not ‘marked’. We shared, usually in pairs and again, confidentiality and privacy were important.

Hearing others’ stories made me aware I was far from

alone. In-class and homework exercises guided examination of losses. By session four, my thoughts were organizing themselves better and I completed an exercise that helped me recall some great memories which in turn helped me realize a truer perspective. We had plenty of opportunity to ask questions. Discussion was careful and constructive.

James and Friedman say, “(W)hen a loss occurs, our brains begin a review, searching for whatever was never communicated or completed”. The Grief Recovery program’s exercises methodically prompted grievers to complete emotional work, while preserving memories. Once learned, the steps to feeling better can be repeated for each or any loss a person has experienced.

I highly recommend this program to anyone who wants help finding their way through the quagmire of grief. I found the facilitators to be non-judgmental and skilled at safely applying the proven techniques specific to this program. They guided us through a process to complete unspoken or incomplete communications. Facilitators were gentle and respectful and well prepared. I came away from the process much unburdened and I have the tools to address other past or future losses.

<sup>1</sup>James, John W. and Friedman, Russell. *The Grief Recovery Handbook, The Action Program for moving Beyond Death, Divorce and Other Losses including Health Career and Faith, 20<sup>th</sup> Anniversary Expanded Edition.* Harper Collins, New York. 2009.

## Brandon Wheelchair Sports and Leisure

By Ryan Sturgeon

**B**randon Wheelchair Sports and Leisure has taken off (visit [www.brandonwheelchairsports.ca](http://www.brandonwheelchairsports.ca))!!

I am very proud to have been involved with the Maiden Voyage in a recent Wheelchair Curling Clinic held here in Brandon on November 25, 2017. CPA’s own Mark Wherrett and Olympic Gold medalist Dennis Thiessen instructed a wonderful turnout of 13 people from the Westman Area.



The Mayor of Brandon attended the event along with reporters from the Brandon Sun and CBC. It was a huge success and we had 8 people sign up to continue curling. We now practice on Thursdays from 6:30 – 8:30 p.m. with all costs being covered. We wanted it to be as accessible as possible so we will pay for transportation, ice time and equipment. There are wheelchairs as well as

volunteers onsite.

The exciting news is that we are striving for an ongoing curling team or two and that is only the first step. Please look for us in the following months as we eagerly plan a summer sport!!

If you’re interested in curling or future summer sport in the Brandon and Westman area, please register at [www.brandonwheelchairsports.ca](http://www.brandonwheelchairsports.ca) or by email to [brandonwheelchairsports@gmail.com](mailto:brandonwheelchairsports@gmail.com).





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## **FREQUENTLY ASKED QUESTIONS REGARDING TRANSITIONING TO CITY LIFE**

**By Maria Cabas**

### **Where do I look for housing for rent in Winnipeg?**

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- ◆ Kinew Housing Inc. 201 424 Logan Ave. Winnipeg MB R3A OR5 ph.: 204-956-5093
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- ◆ Kanata Housing Corporation Riverwood Management 202 -2055 McPhillips St. Winnipeg MB R3E 3E8 ph: 204-338-6261
- ◆ Dakota Ojibway First Nations Housing Authority Inc. 100 -11 Arden Ave. Winnipeg MB R2M 2J7 988-5380
- ◆ Winnipeg Housing Rehabilitation Corporation 60 Frances St. Winnipeg, MB R3A 1B5 204-949-2880. [www.whrs.ca](http://www.whrs.ca)
- ◆ Manitoba housing ph.: 204-945-4663
- ◆ <https://www.gov.mb.ca/housing>
- ◆ Rental guide: <http://nexthome.yip.ca/corporate/online-publications/WINNIPEG-Renters-Guide/Manitoba/>

- ◆ [www.winnipegrentnet.ca](http://www.winnipegrentnet.ca)
- ◆ [www.marketplace.winnipegfreepress.com](http://www.marketplace.winnipegfreepress.com)
- ◆ [www.kjjjj.ca/winnipeg](http://www.kjjjj.ca/winnipeg)

### **How I apply for Employment and Income Assistance (EIA) ?**

Manitoba Family Services Employment and Income Assistance - Phone: 1-877-812-0014.  
[www.gov.mb.ca/fs/assistance/eia.html](http://www.gov.mb.ca/fs/assistance/eia.html)

### **Where can I get my ID?**

- ◆ Eagle Urban Transition Centre provides a one-time offer for a Birth Certificate to a CPA member who has no other means or can't afford the application fee. Eagle Urban Transition Centre is located at 275 Portage Avenue, Winnipeg, Manitoba, phone number (204) 956-0610, <http://eagleutc.com/contact-us/>. Other agencies that offer free Birth Certificate identification support are S.E.E.D. and Citizen's Bridge.
- ◆ Medical Card: In-person you can receive a card at Manitoba Health 300 Carlton Street, Winnipeg, Manitoba - Mon-



day to Friday 8:30 am– 4:30 pm. You can also call them at 1-800-392-1207 (toll free #) to have one mailed to you.

- ◆ Manitoba Public Insurance Photo Identification: Gather all the necessary original documents you need to meet the application requirements. Take your documents to any Autopac agent or a Manitoba Public Insurance Service Centre. The agent will take your photograph and will capture your signature digitally. The card costs \$20.00, including the photograph\*. It's good for up to five years and costs \$20 to renew. A valid card may be replaced for \$10 if it is lost, destroyed or damaged. \*This fee may be waived under certain circumstances. See an Autopac agent for details.

#### Where can I get my treaty card or status card?

- ◆ Secure Certificate of Indian Status card: Currently there is no drop- in service; only accepting appointments. Call 204

-983-5910 to arrange an appointment. You must have all supporting documents when attending the appointment.

#### Where can I find cheap furniture with small budget? Free furniture (for those who qualify)

- ◆ Hands of Hope Ph. 204-261-8607
- ◆ Centre Flavie-Laurent Ph. 204 233-4936

#### Buy used furniture

- ◆ Salvation Army Thrift Store - Phone. 1-899-757-4483
- ◆ Goodwill Stores - Phone 204-943-6435
- ◆ Mennonite Central Committee (MCC) furniture thrift store – Phone 204-694-3669.

If you have more questions or you need more information, please contact Maria at 1-800-720-4933 or 204-786-4753, ext. 228 or by email at [mcabas@canparaplegic.org](mailto:mcabas@canparaplegic.org)

## Pregnancy and Woman with SCI

By Maria Cabas

The Spinal Cord Injury Model System website in the USA has a very comprehensive fact list which helps women prepare for pregnancy, labour and delivery after a spinal cord injury. It also gives tips on how you can work with your health care team to keep you and your baby healthy.

Women with all level of injuries have had children after their injury. Your decision to have a baby is made by you and your partner the same way as anybody else. Consider the demands and challenges of parenting and how you may manage them; but usually the positive aspects of parenting usually outweigh the difficulties.

There are some things that need to be done when you are pregnant: get a complete gynecological exam, talk to a rehabilitation doctor who knows about women's health after SCI, get your medicines checked (many prescription and over-the-counter medicine are not to be taken if you are pregnant), and get a urology check-up. During the pregnancy there are lots of changes in your body. Your baby will develop as all babies do, so your injury does not impact your baby, but you may have the same common discomforts of pregnancy that other women have such as: headache, numbness or tingling, fatigue, nausea and vomiting, dizziness, body aches and pains, need to urinate often, heartburn and indigestion, hemorrhoids, swelling in the feet and ankles, congestion or nose bleeding, constipation and so on. This means you have to follow the advice of your obstetrician to take steps to prevent the risk for secondary condition related to your SCI like: autonomic dysreflexia (AD) if your injury level is T6 or above, urinary tract infection (UTI), impact of the bowel management, skin care (prone to pressure ulcers), changes in muscle spasms, breathing (baby pushes on your diaphragm), blood flow (pressure from baby can slow the flow of blood

to your legs and feet causing them to swell).

Women with SCI need to plan for labour & delivery in the same way as other women and they may have many of the common signs of labour like: water breaks or mucus leakage, usual pain or backache, strong, regular contractions, tightening in your abdomen, breathing easier, pressure in the pelvis. A full pregnancy is 39-40 weeks, but it is best to start watching for signs of labour at about 28 weeks. Women with a T10 level of injury or above may not feel labour pain. With injuries below T10 women may feel their uterus contracting.

Although AD is more common for people with a T6 level of injury and above, AD can occur in women with any level of injury during labour. The best way to prevent AD during labour is to use a continuous epidural anesthesia. This provides a long-lasting numbness during labour. There is no need to have a Caesarian Section simply because you have an SCI, in fact, most women can deliver vaginally no matter what their level of injury. Talk with your obstetrician about the type of delivery that is best for you.

After delivery, congratulations on your new baby! Most women with SCI can breastfeed, but you need to watch for problem issues like: bladder spasticity as you breastfeed and producing less milk if you have a loss of feeling in your nipples because nipple contact is the trigger for breasts to produce milk.

Now that you know some more facts about having a baby after a spinal cord injury, you can make an educated decision whether or not you want to have children. CPA Manitoba has at least 4 new babies delivered by our members in the past 3 years and the number is only growing.

For more information please go to <http://www.msktc.org/sci/model-system-centers>



# Indigenous perspectives: The Grieving Wheel and Seven Sacred Teachings In Recovery

By Melanie White

The medicine wheel represents all things connected in the circle of life. There are more than one-hundred traditional teachings of the medicine wheel, with each having its own meaning and purpose; the details may differ from tribe to tribe but the basic teachings remain the same. These sacred teachings can lead us down the path towards *mental, spiritual, emotional and physical* enlightenment. The medicine wheel can also be used to help us understand and deal with special life circumstances such as the breakdown of a relationship, the passing of a loved one, and illness/injury. This framework allows us to look at our experiences in a new way, one that is easier to understand because it relates to our experience of the natural world.

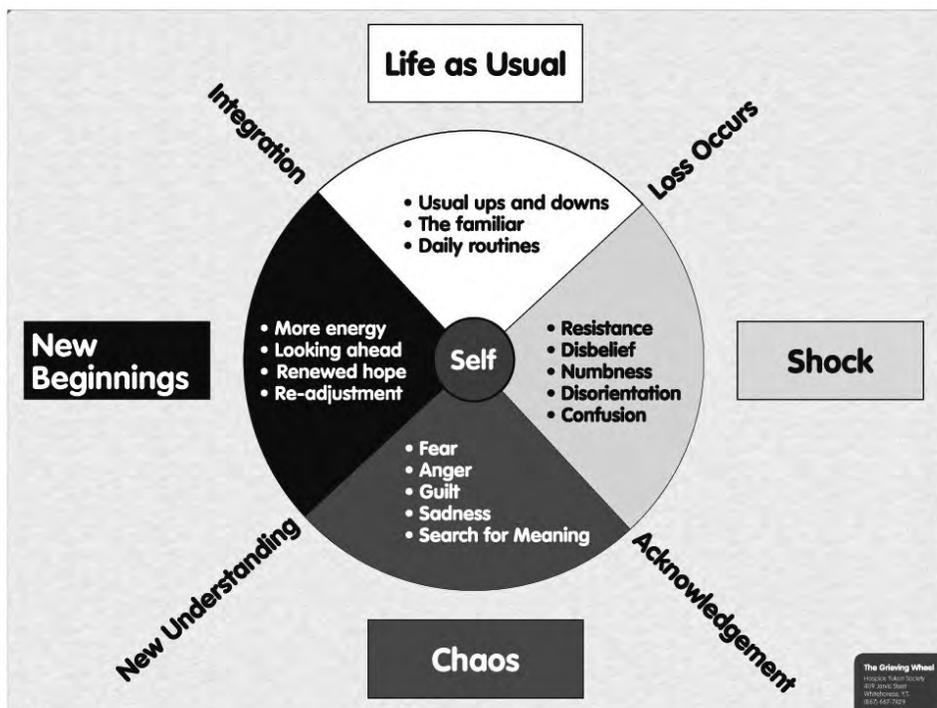
A loss/injury can turn a person's world upside down. Serious physical changes are often accompanied by emotional shock. Each person processes and comes to terms with these changes in their own way; sadness, grief and depression are common responses.

The Grieving Wheel consists of 4 parts or phases, all revolving around the self. During the initial phase of 'Shock' (after the loss/injury occurs) an individual may experience any combination of the following: resistance, disbelief, numbness, disorientation and confusion. They are not ready to accept that the loss/injury means a new reality and may detach from their emotions in an effort to protect the self from this realization.

As the shock of the injury dissipates, an individual moves onto the next phase of grief which is known as 'Chaos'. While the loss/injury is acknowledged and a person becomes aware of the permanence of the loss during this phase, a wide range of emotions can rise to the surface, such as: fear, anger, guilt, sadness and search for meaning. For example, fear of the unknown (*where will I live, how will I support*

*myself and my family*) or anger directed toward self or others such as a friend/family member who was driving at the time of a motor vehicle accident and walked away unscathed (*why me*).

As a person transitions beyond the second phase of grief, they enter the third phase of 'New Beginnings'. The individual comes to a new understanding of the loss and they begin to look ahead toward the future with a renewed sense of hope. Although they will still experience feelings of sadness, anger or fear, these emotions tend to be less intense and happen



less frequently over time. The individual experiencing the loss/injury enters a period of readjustment as they begin to rebuild their identity and learn new skills as they re-examine their relationship to the world around them.

The final phase of grief in relation to the medicine wheel is known as 'Life as Usual'. This is a period of integration in which an individual has established new routines and coping strategies to deal with the ups and downs of daily life.

In dealing with the spiritual and emotional compo-



nents of loss/injury, there are **Seven Sacred Teachings** (aka Grandfather Teachings) that can be used to help guide us in the recovery process. Each of the seven teachings is represented by a different spirit animal and provides practical and positive traits for use in our everyday lives:

(Image from Winnipeg School Division)

### **LOVE (Eagle)**

*The eagle is a reminder of our own ability to soar to great heights.*

### **WISDOM (Beaver)**

*Beaver reminds us to act our dreams and make them reality. Wisdom is given by the Creator to be used for the good of the people.*

### **RESPECT (Buffalo)**

*All of creation is to be treated with respect. You must give respect if you wish to be respected.*

### **TRUTH (Turtle)**

*Slow down the pace of your life. Faster is not always the best way to reach your goals. Speak truth, do not deceive yourself.*

### **HUMILITY (Wolf)**

*Wolf brings inner power and strength. You are equal to others but you are not better.*

### **HONESTY (Kitchi-Sabe aka Bigfoot)**

*In facing a situation is to be brave. Always be honest in your word and action.*

### **COURAGE (Bear)**

*Just as the bear hibernates during the winter, the bear reminds us that we must awaken and seek whatever opportunities are around us, to do what is right.*



**Reference list** Bouchard, D., Martin, Dr. J. (2009). *The Seven Sacred Teachings of White Buffalo Calf Woman*. Vancouver, BC: More Than Words Publishers., Hospice Yukon. *The Grieving Wheel- A Model of the Grieving Process*. Retrieved 15 Jan 2018, from [http://www.hospiceyukon.net/L\\_G\\_Wheel.html](http://www.hospiceyukon.net/L_G_Wheel.html), Laframboise, S. & Sherbina, K. (2008). *The Medicine Wheel*. Dancing To Eagle Spirit Society. Retrieved 15 Jan 2018, from <http://dancingtoeaglespiritsociety.org/medwheel.php>

## **Client Needs Survey**

**By Delcy-Ann Selymes**

**F**or the past eight months, the Canadian Paraplegic Association (Manitoba) Inc. has afforded me the privilege of offering a “Client Needs Survey” to 50 CPA members. For those who participated in the survey, I want to thank you for sharing - either through telephone conversations or by welcoming me into your homes. Without exception, your patience was outstanding as you allowed me the time needed to work through

the lengthy 13 sections of questions. I gratefully thank the CPA staff who guided me to each of the survey participants; they seemed to know just the right people I should approach.

Please know the information gathered is now in the process of being reviewed and I can assure each of you that it will be utilized to improve the service to Manitobans with a spinal cord injury.



# What can we expect in terms of quality of life and medical ‘issues’ as people age with a spinal cord injury?

By Dr. Kristine Cowley

This article focuses on two types of issues related to aging with a spinal cord injury. The first can be called general health and employment and ‘getting out’ and the second focuses on the rates of more common health conditions that occur as people age after SCI. The first is longitudinal, following the same people over time. The second is cross-sectional, taking information at little ‘snippets in time’ in more people with SCI.

**Meet James Krause, a longstanding researcher interested in aging after spinal cord injury.** The longest running study to date of those living with spinal cord injury began in 1973 at the University of Minnesota. James Krause, who is a Professor currently located at the Medical University of South Carolina, now spearheads it. James Krause also happens to be a clinical psychologist and power chair user with cervical SCI who has written a ton of papers on a variety of topics related to life satisfaction, pressure ulcers, adjustment and aging with spinal cord injury, to name only a few topics.

**Longest running study of those with SCI to date.** The study in 1973 began with its first group of 256 people with SCI, and has grown to include an overall total of over 2000 people with SCI surveyed several times each, leading to close to 6000 surveys. You may be surprised to find out that a full 20% of that original group of 256 were still living and responded to the survey of 2013. These 48 people are the longest surviving group with SCI that have been repeatedly queried about their life situations, and how their life situations and satisfaction has changed over time after injury.

**Life is better at 10-20 years post injury than it was for the first five years or so.** I remember Arnie Schryvers, the long-standing in-hospital Rehab. Counsellor commenting on the need for more research on aging with an SCI. At that time, I was newly injured, and I couldn’t fathom the idea of spending the rest of my life in a wheelchair. I figured there would have to be some advance or ‘cure’ in the near future that would remove me from that fate. Then I went back to school, started wheelchair track, and was able to socialize with friends and family; and things got better. It has now been just over thirty years living from a wheelchair and as time passes, I have become more and more interested in whatever ‘keys’ there may be to age successfully with SCI. It seems that if you are fortunate enough to be able to figure out how to manage pain and pressure ulcers, a common trend for those surveyed is that life gets better for the first decade or two. Krause reported that at the 11-year time point after injury there was an increase in life satisfaction, as well as employment, the number of outings per week, and sitting tolerance, when compared to within the first 5 years of injury.

**Employment is related to level of life satisfaction.** In terms of employment, the percentage of people employed at baseline (study start) was 49% and this number increased to about 70% at 11, 20 and 30 years after the first survey. It is encouraging that it has been possible for some people with SCI to remain in the workforce for so many decades. So, given that the youngest age in the first study would have been around twenty, 30 years later most of those surveyed would be over 50 years old, and some would be older. Further, on average, they reported working over 37 hours per week, so they were employed full time. Ten years later, less than 30% were employed, but most of these people would be over 60 years in age at that point. Anecdotally, I have noticed a number of full-time employed people with SCI who, starting in their early fifties, began to experience significant health issues that interfered with their ability to work, and often led to their early retirement by about age 55. Krause’s studies don’t comment on this, so we don’t know what the average time of retirement is and whether the retirement was really due to deteriorating health status or if it was a free decision to retire for personal, rather than SCI-related health reasons. In terms of the high employment rates at twenty years or more post injury, there is an obvious bias in the study, in that those that manage to survive longer (and be surveyed) are also the most likely ones to be able to maintain employment. Krause points this out in his articles and calls it a ‘survivor effect’.

**The survivor effect:** “Those individuals who are more active, employed, and have better overall psychosocial adjustment are also more likely to live to subsequent follow-ups.” Krause also indicated, “that those who had greater psychosocial and vocational adjustment, more so than medical adjustment, were more likely to have survived”, and, “Participation in social activities outside the home and sitting tolerance were important protective factors for mortality, whereas self-reported physical and psychological health problems, dependency, and economic barriers represented significant risk factors.” It would be of interest to find out if there is a link between the number of hours of sitting tolerance and employment status. Regardless, Krause’s research draws a clear link between vocational factors and longevity after SCI.

**Number of weekly outings decreases when aging with SCI.** The percentage of people who very infrequently left their homes (1-3 times per month or less) increased from 8% at the 20 year follow-up to 16% at 30 years and 26% at the 40 year follow-up. Those who go out at least once per week declines from 92% at 20 years follow-up to 83% at 30 years and then down to 74% at the 40-year time point. The good news is that 74% are still getting out of the house at least



once per week after age 60.

**Sitting tolerance decreases as people age with SCI.**

Overall, the majority of those that survived to the 40 year follow-up were able to spend more than 8 hours a day in their wheelchairs. However, a small number (12%), were only able to sit between 0 and 7 hours per day. Sitting tolerance declines with aging, such that 68% could spend at least 12 hours per day in their chairs at 20 and 30-year time points but only 48% could do so at the 40 year mark.

**Non-routine physician visits and days in hospital can remain low for many decades but increases after long-standing (>30 years) of injury.**

Over 76% of study participants reported seeing a doctor unexpectedly less than three times in the previous two years at the 20-year follow-up. This number dropped to just under 60% at the 30-and

40-year time points and then to 40% at the 40-year time point. Over the same time period, there was an increase in the need to spend time in hospital. Only 16% had spent at least one day in hospital in the two years preceding the study at the 20-year mark, which rose to 43% at 30-years and then to 63% at the 40-year time point. The reasons for the doctor visits and hospitalizations were not explored in these studies.

I am going to end this installment with the chart below, which summarizes some major medical ‘issues’ that occur increasingly after SC, and is taken from a recent review of aging with SCI at:

<https://emedicine.medscape.com/article/322713-overview#a4>.

Item	Rate	Comment	Can anything be done to prevent this?
Shoulder arm or hand pain	70% common overuse syndromes include rotator cuff injury, bursitis	This is the percent that reported having at least one episode of pain that needed some form of treatment.	Use weights or band resistance exercises to correct for imbalances in strength of rotator cuff muscles.
Nerve compression (e.g. carpal tunnel syndrome)	2/3 of those with SCI	Percentage treated surgically wasn't provided.	Most people with carpal tunnel syndrome can be treated with decompression surgery successfully, but the needed rest can require temporary home support for ADL.
Osteoporosis and increased risk of low impact leg fracture	100% if motor complete		There is increasing evidence that therapies using electrical stimulation or passive standing may slow the decline.
Cardiovascular disease	2x rate of general population		Reduce body fat, exercise.
Hemorrhoids	74% of those with SCI		?
Difficulty with bowel evacuation	20% of those with SCI	Multiple causes including needing to take medicines that interfere with bowel motility.	Alter medications taken.
Sleep apnea	40% of those with SCI		May be related to long-term use of baclofen for spasticity.
Obesity	>75% of those with SCI		Strict attention to Calorie intake, exercise, physical activity.

*The two articles discussed here by J. Krause are “The natural course of SCI: changes over 40 years among those with exceptional survival” Spinal Cord 2017, Vol 55, p502-8 and “SCI longitudinal aging study: 40 years of research” Top Spinal Cord Inj Rehabil 2015, Vol 21, p189-200.*

Hopefully you found this compilation of research about aging with SCI useful.



## MANITOBA PARAPLEGIA FOUNDATION INC. (MPF) NEWS

**M**PF funds go to work in four main areas that are not supported by any other sources in Manitoba: special projects, product testing, research and direct aid to persons with spinal cord injuries who do not have the necessary financial resources for equipment and/or services. All requests for direct aid are initiated through CPA. Individuals must provide information on their financial status, explain why they cannot meet the expense within their own budget, and identify any other potential sources to support the request including potential for contribution from family.

CPA thanks MPF for its continued support to improving the quality of life of persons with spinal cord injury.

MPF has approved several requests for financial support during the past several months. Some of the highlights follow:

- ◆ Funding was granted for the purchase of a platform lift for a CPA member whose home was an inaccessible bungalow with four steps to enter the home. The member required a safe, independent egress into the home which the platform lift provided.
- ◆ Financial support was provided for the purchase of a backrest for a CPA member. This backrest will provide the member with the support they require while seated in different positions, reduce their experience of pain and increase their seating tolerance.
- ◆ Financial assistance to attend the International Seating Conference in Vancouver, BC in March 2018 was granted to two occupational therapists that provide services to persons with spinal cord injuries through their employment at the Health Sciences Centre. Attendance at

this conference is anticipated to result in multiple, direct benefits to individuals with spinal cord injury, specifically through the translation and application of evidence-based seating and mobility practices to client care, in the areas of seating/mobility and pressure management.

Visit MPF's website at: [www.cpamanitoba.ca/mpf](http://www.cpamanitoba.ca/mpf). Applications for assistance are available through the website or by contacting the CPA office at [winnipeg@canparaplegic.org](mailto:winnipeg@canparaplegic.org) or 204-786-4753.

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# HUNTING: AN INTERVIEW WITH RICHARD WASSING

By Bernie Gaudet

**CPA: When did your interest in firearms and hunting first begin?**

Rick Wassing: That was a long time ago, when I was 10 or 11 years old in Fort McMurray, Alberta. At that time, in the late '60s, early '70s, it was a small town – one grocery store – so we survived on wild meat. Dad was a big outdoorsman, still is, and taught us about hunting and fishing. It would be nothing to spend weekends up the Athabasca River hunting.

**CPA: How about you, Tracy?**

Tracy Wassing: My interest started when I moved out to Manitoba with Rick and we moved out to our acreage.

**CPA: Do you remember your first hunting trip?**

RW: We were up the Athabasca River at a camp we had set up. My dad started calling for a moose – and one actually called back. He managed to call the moose right into our camp. As it was coming into the camp through the brush, he picked up his rifle and nailed it on the spot. I was just awestruck. It was me, my dad and my two brothers. It was phenomenal to see that kind of ability.

**CPA: Have you two ever hunted together?**

TW: We've hunted together the last four years.

**CPA: What were you hunting?**

RW: Deer. We hunt at the back of our property and have managed to get a few deer. In the seven years we've been there we've got three. Tracy got her very first deer on our property.

We'd gone to the Remembrance Day Ceremony in the morning, got home, and wondered if we wanted to go out or not. We decided to make some coffee and go sit in the blind. We were sitting there for a short while having our coffee when we heard some noise and out popped this doe, not 15 feet away from us. It looked at the blind, ran out to the middle of the field, stopped and looked the blind again, then took off. Well, we thought, cool, we'd seen something. Then we heard some rustling behind us again. To me it sounded like somebody was coming through the bush. I figured somebody was after the doe. And then, not even 5 feet from the blind, out came this beautiful 5-5 point buck. I looked over at Tracey and she looked over at it. Then he walks out to

the little field, 30, 40 yards from the blind. He turned sideways, a perfect kill shot. I looked over at Tracy and she said, "I'm taking it." She took the shot, it ran about 20 feet then fell. I don't know who was more excited, me or her.

TW: You were more excited. I was still – reality didn't hit yet.

RW: It was phenomenal. Then we got into a little bit of an argument about how to field dress him because I wanted her to have him as a mount, as trophy, because it was her very first deer. She said no, I just want the horns, I don't want to mount him. She didn't like the look of them looking at her. I finally convinced her that, no matter what, he was going to get mounted. If she didn't like it, well, he could sit in a closet. So I called a friend of mine who owns Wild North Taxidermy, out of Lorette. I took it down to him. It took about a year. Tracy was getting antsy about seeing it. She said, "Where's my deer? I want to put it up."

TW: The more I thought about it the more I wanted it.

**CPA: Do you still have it?**

TW: We put it in our living room in last February.

RW: A friend of ours came over and mounted just above our brick fireplace.

TW: It turned out really nice.

**CPA: As a member of the Armed Forces you must have been exposed to a number of different types of firearms. Do any of them stand out or have special significance to you?**

RW: I've always been partial to the SIG 226 pistol. In the Navy we used the 225 for the boarding team, as well as the MP 5, which is a submachine gun. Both are 9mm and are the weapons of choice for boarding operations because they are compact. They are close impact weapons where we don't have to worry about metal penetration and so on. I like the SIG so much I actually bought one. I own the 226 for on the (firing) range.

**CPA: Are those German made?**

RW: Some are made in Germany, but most are made in the U.S. now.

**CPA: You are currently the proprietor of a small business, in partnership with your spouse Tracy,**



---

**Ranger Firearms Training. When did you start this business?**

TW: November 2015 you started it.

RW: It got to a point that, within about three months, I couldn't keep up. It was so crazy doing bookings, talking payments and doing the courses. Tracy was working part-time but the business took off. We had to decide whether to close the business down or get some help. We sat down and talked about it and decided to make the company a 50-50 split. She quit her part-time job and came to work for us full-time doing all the bookings and all the work behind the scenes. So all I'd have to do is pick up my briefcase and she'd tell me where I'm teaching.

TW: I would handle all of the correspondence, scheduling and administrative stuff. It can be 6 to 8 hours a day easy.

**CPA: You've already answered my next question which was, what are each of your roles within the company. Tracy handles the bookkeeping, scheduling, correspondence, etc., and you, Rick, just go to wherever Tracy tells you to go and teach the appropriate course for that particular class.**

RW: Right. We teach the Restricted and Non-Restricted Firearms courses. As well, both Tracy and I teach the Hunter's Education courses for the Manitoba Wildlife Federation. We've been very lucky to teach out of their location for the Hunter's Education course, as well as for some of the firearms courses we do.

**CPA: So, going forward, your courses will be accessible for anyone, of any level of disability, is that correct?**

RW: Yes.

TW: That was one flag that I see for teaching, Rick, for someone with your level of disability. I don't know how that's going to work because there is a practical part to the course.

RW: There is a practical that has to be completed as part of the course.

TW: We're still working on that. There has to be a way to do it.

RW: We have to check with the Chief Firearms Office. They've been pretty good in getting back to us on things. We've had people with disabilities take the course before, people who have difficulty with reading and writing. We've had to give verbal exams but the hands-on portion is fine. But as Tracy was saying, this is the only thing that could potentially be a glitch. We have to check with the Chief Firearms Office to see what would be involved in delivering the hands on part

of the course. There are special regulations for people with disabilities to hunt. For example, if you can only walk 50m, I'd have to check the regulations to be sure, you can get a permit from Water Stewardship that allows you to hunt from a motorized vehicle. So, for example, a quad, a side by side, a truck, you are allowed to shoot from that vehicle. The actual regulations can be found in the hunting guide for Manitoba.

**CPA: Can you speak a bit about the injury you sustained?**

RW: I was on my farm – we have a 40 acre hobby farm – I was up in my shop working. We both do chores together so I went down to help do chores. At that time we were putting our ducks in for the winter. I was walking over to the barn to get some straw and my feet came out from underneath me and I hit the ground and that's all it took. From then on I lost feeling from my neck down. One of my best friends, Chris, came over when Tracy called him. He knelt in the snow and held my head for forty-five minutes. He wouldn't get up and wouldn't switch out with anybody. I went to Concordia Hospital and from there to Health Sciences Centre. They have a phenomenal team there. I sustained a C4 incomplete spinal cord injury.

**CPA: What modifications are available for you to continue as an instructor? To operate a firearm?**

RW: I'll be getting a mount on my chair so I will still be able to do some demonstrations. We had to talk to the Chief Firearms Officer because there are a couple things that have to be done as an instructor. One of them is a four page form with carbon paper that needs to be submitted. But because I can't sign my name, we had to talk to them about it. Another thing was the answer key for the exam marking template needed to be lined up over the exams to quickly mark the multiple choice exams. When we first talked to the CFO he said no, can't see it happening. We told him what we wanted to do. We told him what had happened and what we were prepared to do. Tracy would line up the overlay template and I would simply tell her which were correct and which not. Then, to sign off on it, we suggested getting a signature stamp to stamp all the pages of the exam. The CFO he said he would look into it. The next day he called us back and approved it. The only thing they asked was that they attend the first course to see how we were going to do things.

TW: Everything in the course is coming from Rick. He delivers the material as the instructor. I'm just there physically marking the papers or stamping his signature on the papers. Hopefully they'll see how we're doing it and recognize it's legitimate.

RW: And, of course, the course itself is delivered using



PowerPoint. I've got enough movement in my hands that I can press the toggle to change slides. The only thing that might be difficult is changing the pages of my book.

**CPA: When do you plan on holding your first course post injury?**

RW: Hopefully this month (January), or early February. I need to do a course within a year to retain my instructor qualification.

**CPA: How about the practical side – teaching people to shoot?**

RW: We've talked about that but that is not what we have done so far. The courses we deliver are in the classroom, that's it.

**CPA: I remember when I took Hunter's Safety many years ago, we had to shoot; it was a requirement of the course.**

RW: That was the same for me. We took a course in junior high school – a survivalist weekend. We would camp out and our parents came out with us. They would all stay in tents. But we were doubled up with another student. We had to make a lean-to and survive

on the basics; snare rabbits, build fires, etc. One of the things we did was shoot .22 and shotgun rifles. It was pretty neat for the kids who had never done that before. The big thing for me was just the survival weekend part.

**CPA: How do you picture going forward with Ranger Firearms Training post injury?**

RW: Hopefully everything will work out and we will be as busy as before.

TW: Maybe a little less busy, to start with anyway. We'll see how the first few courses go. Things have changed with scheduling care and Rick's resilience at this point. They can be very long days teaching these courses.

RW: We are still doing a lot of advertising and we will have a booth at the Outdoor Show. We are advertising through Cabela's webpage, Manitoba Wildlife Federation webpage have a Facebook page of our own and if you Google firearms training in Manitoba, we are there as well.

You can find out more about Ranger Firearms Training at: <http://www.rangerfirearmstraining.ca/>

## CPA Kicks Off Their 2017 Employee Campaign

On November 28, 2017, CPA held their United Way Employee Campaign Kick-off Event which consisted of a United Way Guest Speaker, a staff lunch and silent auction. This year's United Way speaker was CPA member Kevin Black.

Thank you to Campaign Co-chairs Kelly Tennant and Aison Balajadia organizing this year's event! A huge thank you to everyone who supported us by purchasing tickets for the silent auction.

CPA would especially like to thank the following donors for their generous support:

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# WHEELCHAIR SPORTS 70-50-40 Celebration

By Mark Wherrett

I was lucky enough to attend the Canadian Wheelchair Sports Association [CWSA] Anniversary Gala on December 15, 2017 in Ottawa. It was a great weekend of seeing friends I hadn't seen since the mid-eighties and meeting some athletes who I had only read about.

This weekend was an event planned by CWSA to commemorate 70 years of wheelchair sport. The first wheelchair sport competition was held at Deer Lodge Hospital in Winnipeg in 1947. The second celebration was about the development of wheelchair sport and its incorporation in 1967 - 50 years a sport organization. The third celebration, and the most exciting, was the 40 years since the creation of wheelchair Rugby or "Murder Ball" as it was first called by a group of young Winnipeg men. The men developed a game in the Big Gym at HSC Rehab. which developed and grew from a sport played by quadriplegics in Canada to a worldwide competitive sport played by many. It is also a Canadian Heritage Sport as it was "born" in Canada. 70-50-40 was the theme of the weekend.

They had on display the changes of equipment that took place over the 70 years of wheelchair sport, from the 50 plus pound hospital chairs used to the 12 lbs of a three-wheel race chair.

It was a real walk down memory lane for me as I was in that gym watching Murder Ball be developed – this was during the time when I was in the Rehab. Hospital learning to take care of myself. I still remember Paul LeJeune running into me and bending a pile of spokes on my hospital loaner chair and then the OT and PT departments questioning me on how that could have happened to my wheelchair! Gerry Terwin, Duncan Campbell, Randy Dueck and Paul LeJeune were the men who first developed the game and they were joined by Chris Sargent in the second year. As participation grew, so did the rules. Officiating was led by Ben Harnish of Winnipeg, along with Larry Jones, Bill Wiseman, Alf Blackaby and Sue Mount. Physiotherapists Sue Mount and Sue Russell, along with Dr. Dubo and Dr. Rush, were instrumental in helping with the first classification system. In 1978 they introduced "their game" at the National Games in Edmonton. The Manitoba "Winged Wheelers", later to be called 'Prairie Fire", awed fellow

quads with their play and this then started the spread of "Murder Ball" across Canada.

Toronto and New Brunswick were the first teams to be formed after the demonstration at Nationals. The sport grew quickly as neighbouring states picked up the sport and they too soon developed teams. With the best efforts of Barb Montemurro promoting the sport in 1984, an exhibition game was held at the Stoke Mandeville World Wheelchair Games. The efforts of Barb and the Canadian quads paid off and "Quad Rugby" (new name) became the first Wheelchair Rugby tournament that was held at the Stoke Mandeville games as a World inclusive game.

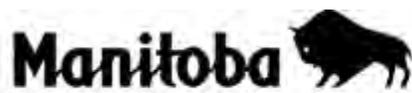
This is just a quick note on the development of Murder Ball to Wheelchair Rugby, but it is so nice to know that this game was first started in the same gym at the Rehab. Hospital where most of us did our rehab. in, and it's where we still go for treatment from PT. The same gym, just no room to play Murder ball or Basketball anymore as the room is filled with Physio mats and workout equipment.

CPA Manitoba was instrumental in the development of Wheelchair Sport in Manitoba, and one of the presenters of the weekend read from an archived CPA Board meeting that the Vocational workers "should spend more time advocating for sports and not just vocational interests".

I totally enjoyed my time at the celebration and wished more of my teammates from Manitoba could have been there. It was very nice to see Diane Hrychuk get inducted into the Canadian Wheelchair Sports Hall of Fame. No surprise there as Diane dominated the Basketball court and played on Team Canada for many years. She also was a strong competitor in field events as back-in-the-day a person did not just compete in a single sport.

One thing I noticed is that a lot of the athletes from the past were still busy with their lives; some still competing in a different sport, but most seemed to be leading active lives. Everyone had a sore shoulder or a pain but all were smiling from the memories of all the FUN we had competing in our glory day of wheelchair sport.

—#23 Mark Wherrett



January 16, 2018

## **PROVINCE SELECTS PUBLIC SECTOR EXPERT TO CONDUCT MANDATORY REVIEW OF THE ACCESSIBILITY FOR MANITOBANS ACT**

Manitoba Families advises a Manitoban with a long history in the public sector has been selected to perform a comprehensive and mandatory review of The Accessibility for Manitobans Act.

Theresa Harvey Pruden will conduct the review, report on the findings and make recommendations to improve the effectiveness of The Accessibility for Manitobans Act and its regulations. As well, the review will include consultation with the public and in particular those with disabilities.

The Accessibility for Manitobans Act became law in December 2013, and provides a clear and proactive process for identification, prevention and removal of barriers. Physical, communication and systemic barriers prevent a significant portion of Manitobans from fully participating in society. The act is aimed at eliminating barriers through development of accessibility standards for government, public and private-sector organizations including municipalities, business and not-for-profit organizations.

The mandatory, four-year review will focus on initiatives already taken under the act and the structures that support it. It is anticipated the review will begin in March and the final report, with recommendations, to be completed before the end of the year.

Harvey Pruden, of Winnipeg, has 30 years experience in the provincial public sector and has volunteered for numerous organizations including the Canadian Association for the Advancement of Women, Sport and Physical Activity, Go for Green and Coalition for Active Living. She is the recipient of a Governor General's Award for Volunteerism and has worked as a consultant on a women's heart health initiative with St. Boniface Hospital Foundation and St. Boniface Hospital and Research Centre.

More information on The Accessibility for Manitobans Act can be found at [www.accessibilityymb.ca/](http://www.accessibilityymb.ca/).



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## MEMBERSHIP APPLICATION

**YES!** Count me in as a member of the Canadian Paralegic Association (Manitoba) Inc. All members receive "ParaTracks" CPA (Manitoba) newsletter and voting privileges at the Annual General Meeting. Members also receive discounts at various health care supply stores – Stevens Home Health Care Supplies (special pricing for supplies & 10% off equipment), The Access Store (10%), Northland Home Health Care (10% off medical supplies) and Disabled Sailing membership (25%).

I wish to select the following category of Membership:

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*All Monies donated remain in Manitoba to support CPA (Manitoba) Inc. An income tax receipt will be issued for any amount over \$15.00. Sustaining, Charter and Patron Members will receive recognition of their generous contribution in the context of events such as our Annual General Meetings or in the programs of other CPA (Manitoba) Inc. functions.*

**\*\* IMPORTANT \*\*** According to Canada's Personal Information Protection and Electronic Documents Act, commencing January 1, 2004, all businesses and organizations are required to obtain an individual's consent when they collect, use or disclose their information. **Unless you indicate otherwise by checking the box below, signing and returning this form to CPA, you are providing a form of consent that permits CPA to use the information you provide on this membership form for the purposes of sending out membership receipts and cards, reminder notices with membership applications and newsletters as noted above. You are also consenting to having your name listed in CPA's Annual Report (Sustaining, Charter and Patron members).**

**CPA (Manitoba) Inc. does not sell or trade personal information and does not rent out mailing lists. Personal information is provided to a third party only for the purpose of sending out CPA's newsletters.** If you have any questions, please call the CPA office.

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