HOT TOPICS IN REHABILITATION

INTRODUCTION:

As lawyers and health-care practitioners are aware, dealing with seriously injured persons is not easy. Often, we are dealing with a complicated and an intertwining constellation of injuries that can be physical, mental or psychological. With respect to those survivors with serious physical injuries, it is not uncommon for them to experience psychological aftermath in the nature of an adjustment disorder or sometimes more serious depressive symptoms. Moreover, it is common for those survivors with head injuries to suffer from psychological sequelae which may or may not be organic. In any event, assisting seriously injured survivors reach their potential is a journey which may take the rehabilitation team through several twists and turns which needs to be navigated which a view in mind to the final destination.

In this paper, we will discuss four difficult issues facing a rehabilitation team during which may complicate the team's ability to provide the services an accident survivor may require. We will also present some tips (both legal and practical) to assist the rehabilitation team deal with accident benefit adjusters and the survivor him or herself through the journey to recovery. These four areas are as follows:

1. Re-integration into the educational setting;

2. Alcohol/substance abuse;

3. Suicide/depression;

4. Leisure activities.

STATUTORY ACCIDENT BENEFITS SCHEDULE:

Pursuant to the *Statutory Accident Benefits Schedule* for accidents on or after September 1, 2010, the Accident Benefit Insurer has an expansive obligation to assist motor vehicle accident survivors overcome the effects of their accident-related injuries. In the new *Statutory Accidents Benefits Schedule for Accidents on or After September 1, 2010*, there are two main sections of this Regulation which speak to the Insurer's obligation to fund a survivors' rehabilitation. These obligations are set out in Section 15 (Medical Benefits) and Section 16 (Rehabilitation Benefits) of the new Schedule. While Section 15 and 16 are quite expansive with respect to the specific rehabilitation benefits an automobile insurer is responsible to fund, it is worth reminding everyone of the wording of Section 16(1) of the *Statutory Accident Benefits Schedule*. This Section reads as follows:

> "Subject to Section 18 (Monetary Limits) rehabilitation benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person in undertaking activities and measures described in sub-section (3) that are reasonable and necessary for the purpose of reducing or eliminating the effects of any disability resulting from the impairment or to facilitate the person's reintegration into his or her family, the rest of society and the labour market."

Section 16(3) goes on to identify some of the "activities and measures" which the Accident Benefit Insurer "may" be responsible to pay. These include the following:

> "3 The activities and measures referred to in sub-section (1) are:
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> (a) Life skill training;
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> (b) Family counseling;
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> (c) Social rehabilitation counseling;
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> (d) Financial counseling;
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> (e) Employment counseling;
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> (f) Vocational assessments;
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> (g) Vocational or academic training;
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> ….
>
> (l) Other goods and services that the insured person requires ... "

As can be seen above, the various rehabilitation benefits survivors of automobile accidents are entitled to receive are expansive and broad. It is also worth pointing out the generous wording of Section 16(3)(l) namely that an automobile insurer is responsible to fund "other goods and services that the insured person requires". This was this Section of the *Statutory Accident Benefits Schedule* that the Divisional Court on appeal (and the Arbitrator at FSCO) in *G* v. *Pilot Insurance Co.* (2008), O.R. (3d) 228 considered when they awarded an accident survivor the right to claim "nanny services" to assist her with a newly born child (born after the subject accident). However, it is also worth noting that since that the G v. Pilot decision was released, the Ontario Government amended Section 16(3)(l) of The Schedule to prevent survivors from claiming housekeeping and caregiving

expenses as Rehabilitation Benefits. Notwithstanding this amendment, survivors of motor vehicle accidents that occur before September 1, 2010 will continue to have these rehabilitation benefits available to them if “reasonable and necessary”.

Notwithstanding these amendments, it is important to keep in mind how expansive the accident benefit schedule can be with respect to providing rehabilitation services to a survivor which are “reasonable and necessary”. So long as the rehabilitation team can prove that that the funding is required to assist “the person’s reintegration into his or her family, the rest of society and the labour market” the only limit to obtaining this funding is one’s own creativity and the monetary limits available for medical and rehabilitation benefits.

EDUCATIONAL ASSISTANCE:

Providing assistance to survivors who have suffered cognitive, behavioural or neuro-motor impairments as a result of an accident often requires assisting the survivor return to school or a return to school for some retraining. However, obtaining funding for assistance with this goal is often more difficult to execute than one might think. Not only does the rehabilitation team need to get approval for funding for this assistance from the accident benefits insurer, you can also face a school or school board that is resistant to integrating private providers into its educational system.

With respect to the Public and Catholic School systems, it has been our experience that there is no coherent policy. Instead, each individual school seems to deal with the provision of privately funded educational assistance, a child youth worker and/or other assistance within the classroom quite differently. Prior to completing a Treatment and Assessment Plan seeking funding for assistance in the classroom, it is probably a good idea to first meet with the school and determine what is required by that particular school to obtain permission for a third party provider to enter the classroom and school setting.

With respect to the Toronto District School Board and Catholic District School Boards, usually there is some funding available publicly for this assistance. However, the funding for educational assistance is scarce and very difficult to obtain in a timely way. There is usually an evaluation that must first take place where the survivor is identified as a student with special needs. After the survivor is identified as such, the school itself must apply for IRPC funding from the school board. As such, it has been our experience that a survivor seeking public funding for an educational assistant must do so months in advance and then will be required to wait a significant period of time in order to determine whether funding is granted.

Some public schools are completely opposed to any third party funding of an educational assistant within that school. In these circumstances, it is difficult to

circumvent the individual schools position. Perhaps looking for a new school may be a good idea if public funding for an educational assistant is not prompt and moving the survivor out of the school is not too disruptive.

In the event that you are dealing with a school that is more open to third party providers in the classroom, it will necessary to execute a “Third Party Agreement” between the parents and the principle of the school setting out the terms and conditions for allowing the Third Party provider into the classroom. Attached to this paper are sample “Third Party Agreements” which you may consider presenting to the school’s principle or administrator when you are attempting to obtain permission for the Third Party provider to enter the school with the survivor.

The role of the educational assistant is quite broad. Sometimes, the educational assistant may be used to assist a student with the curriculum in a neutral space on a one-to-one basis. Other times, educational assistants are integrated into the classroom setting to help a survivor focus on the curriculum and to circumvent (to the best of their abilities) behavioural issues in the classroom. Sometimes, there is a mix of both one-to-one and assistance in the classroom.

Once funding and permission is received for a Third Party Provider to assist a survivor in the school setting, it is often a good strategy to reintegrate the survivor back into the full classroom on a gradual basis. For instance, it may be best to have the survivor attend a single course that the survivor continues to show some interest or a subject where there is some demonstrated residual strength. When the survivor is not is the classroom, the Third Party Provider may wish to spend time working one-to-one assisting the survivor with some of the more difficult parts of the curriculum for that student. Determining the residual strong suits of the survivor may be a good question to ask the team neuropsychologist. This gradual reintegration strategy is usually effective because is helps the survivor achieve some initial success in the classroom before moving forward. This approach may take additional time (and funding) to execute but is more likely to achieve better long term results for the survivor.

When dealing with children and youths, one should also keep in mind the difficulties the rehabilitation team may face dealing with puberty and other maturation issues. It is not uncommon for child and youth survivors who are making observable gains in the school setting suddenly take two steps backwards as puberty are some other life milestone intervenes. In particular, when dealing with a brain injury survivor with a frontal lobe injury, the arrival of puberty for the rehabilitation team is not unlike dealing with nitroglycerine. It is a very volatile combination and must be dealt with carefully to avoid a giant explosion. What must be kept in mind is that reintegration of a child or youth into the educational setting is not linear. There are many ups and downs and this should be considered very closely when completing Treatment and Assessment Plans and preparing reports for Insurers. Although in one given semester a child or youth may have performed quite well, this does not mean that removal of educational

support within a defined period of time can be predicted with any accuracy. We suggest a more cautious approach with respect to prognosis and estimates of the length of time support with be required when a child or youth is nearing an important life stage such as moving from grade school to middle school, moving from middle school to high school and while moving through the stages of puberty. This is particularly true with respect to survivors with frontal lobe injuries.

We have also found that the key to successful educational reintegration is routine and predictability. The more routine provided to the survivor, the more likely he or she will absorb the curriculum. Routine and predictability is also likely to reduce the number of behavioural outbursts which all too often divert a child or youth (and the whole classroom's) attention away from the teacher. Therefore, at the outset there should be some communication with the accident benefit adjuster regarding the importance of uninterrupted funding. As time goes by and gains are achieved, the educational assistance should be removed slowly and in a predictable way to maximize outcome.

ADDICTIONS/SUBSTANCE ABUSE:

There is a well known maxim in law that you "take your survivor as you find them". This rule of law should be considered closely when dealing with a survivor who is suffering from or has suffered from substance abuse or addiction which pre-dates the motor vehicle accident. A brain injury or other injuries engrafted upon pre-existing substance abuse or addiction issues usually make the team's rehabilitation goals extremely challenging. In fact, the rehabilitation team may have to deal with the addiction or substance abuse issues at the outset in order to ensure that meaningful rehabilitation is taking place.

When seeking funding for treatment to deal with substance abuse or addiction issues from an accident benefit insurer, it may be useful to consider the law of causation as it relates to claiming accident benefits. In the seminal Ontario Court of Appeal decision of *Monks* v *ING* (2008), 90 O.R. (3d) 689, the court finally laid out the test for causation as it relates to accident benefits. Please note that the law of causation with respect to cases against at-fault drivers is more strict and will not be dealt with in this paper except to say that it is based on a "but for" analysis.

According to the Ontario Court of Appeal, the Rule with respect to causation in Accident Benefit cases may be expressed as follows from *Monks* v *ING* at paragraph 94 where the Court stated the following:

> "At trial, ING argued that this was a "classic, unequivocal case of a crumbling skull Plaintiff" and, therefore, that ING need only pay for "those expenses for those injuries caused by our accident, being a cervical strain, which expenses have already been paid". The Trial Judge rejected this argument,

> holding at para 852: [T] here is no room for the crumbling skull theory in accident benefit cases.
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> I agree. There is no indication in the SABS of a legislative intend that an Insurer's liability for the accident benefits in issue in this case should be subject to discount for apportionment of causation due to an insureds pre-existing injuries caused by an unrelated accident. The SABS simply states, in clear and unambiguous language, that an Insurer "shall pay an insured person who sustains an impairment as a result of an accident "medical, rehabilitation and attendant care benefits".

Although the *Monks* v *ING* decision deals with pre-existing injuries from previous motor vehicle accidents, this decision appears to be equally applicable when considering pre-existing conditions such as addictions or substance abuse issues. In short, if a motor vehicle accident "materially contributes" to a need for rehabilitation funding then the Accident Benefit Insurer will be responsible for payment of this funding. The word "material" has been interpreted in other cases as meaning "more than *de minimus*" which means "a significant cause" or a cause that is more than trifling. The motor vehicle accident does not need to be the most significant cause to satisfy the material contribution test.

At the outset, there must be a distinction made between substance abuse and true addiction. For the purposes of this paper, we refer to substance abuse as a survivor using drugs or alcohol to excess when such activity is not deemed appropriate or is counter-productive to a survivor's recovery. Addiction is another issue. It involves a person's whole existence consumed with fuelling an unhealthy need, be it alcohol, drugs, gambling or as we learned recently with Tiger Woods, sex.

Addictions are obviously more difficult to treat with than substance abuse and require the assistance of physicians and perhaps an in-hospital stay. We recommend that when dealing with survivors with addictions that either pre-date or occur after a motor vehicle accident that the Case Manager contact the Addiction Research Foundation or the Centre for Addiction and Mental Health (CAMH) to seek out programs to assist survivors overcome their addiction issues. The problem with referrals to the Addiction Research Foundation and CAMH is the wait time for admission into the program. If addiction is a significant problem and you are waiting for CAMH or the Addiction Research Foundation to become involved, we suggest that you refer the survivor to a psychiatrist immediately in the interim.

Another option for dealing with a survivor with addiction issues (or while waiting for a public option to open up) is a private based facility. Private funding for programs that can provide 24/7 supervision with a live-in option should be considered. NRIO

is Toronto, PHABIS in Mississauga and PARADIGM in Hamilton are examples of such facilities which may provide assistance.

With respect to substance abuse, It is not uncommon for survivors with constant pain or impaired judgment to abuse prescription and non-prescription drugs or alcohol. Sometimes the survivor finds it difficult weaning themselves off addictive pain mediation prescribed after the accident. Other times, due to poor judgment related to a brain injury, a survivor will experiment with addictive drugs and then find it difficult to stop. Intervention by a parent, rehabilitation team or both will likely be required to keep the rehabilitation goals moving forward and to ensure the survivor's safety. Team members should report any instances of substance abuse to the case manager right away. Case managers should consult with the treating physicians and the psychologist for guidance.

There is a third scenario which became the subject matter of a lengthy Arbitration and eventual decision at the Ontario Divisional Court where a survivor who previously suffered with substance abuse relapses after a motor vehicle accident and then falls into some bad old habits. In the decision of *McMichael* v *Belair Insurance Company* (2007), O.R. (3d) 68, the survivor was an occasional cocaine user prior to the motor vehicle accident. After the motor vehicle accident, the survivor began to using cocaine more often. Over some period of time, substance abuse turned to addiction and began to take over the survivor's life. The survivor argued that he required funding for 24 hour per day attendant care to prevent him from engaging in cocaine use. He also argued that the substance abuse and/or addiction in and of itself entitled him to a catastrophic designation from the accident benefit insurer because he suffered from a Class 4 mental and behavioural impairment as defined by the *American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th Edition, 1993*.

After considering the facts of this case, the FSCO Arbitrator and Director's Delegate found that the motor vehicle accident "materially contributed" to the survivor's difficulties with substance abuse and agreed that his did in fact require 24 hour per day attendant care. The Arbitrator and Director's Delegate went on to find that his Major Depressive Disorder secondary to substance abuse was a legitimate DSM IV diagnosis and could therefore form the basis of a "Class 4 mental or behavioural disorder". Mr. McMichael was therefore found to have sustained a catastrophic impairment by virtue of the fact that he suffered from substance abuse secondary to the injuries he sustained in the motor vehicle accident.

When rehabilitation teams learn of potential substance abuse issues, there should also be some consideration of a referral to neuropsychiatrist to determine whether any prescription medications may assist to assist in the short, medium and long term.

If a member of a rehabilitation team learns of substance abuse while assisting children and youths, perhaps the best first step would be speaking to the parents in order for expectations to be laid out and for there to be an explanation to the child or youth of the dangers associated with this activity. If the parents are not able to deal with this swiftly on their own, there are several steps the rehabilitation team can then take to help. Family counseling can often prove quite useful making the child or youth aware of the problems associated with substance abuse. One-on-one psychological counseling may also be helpful depending upon the survivor and his or her ability to benefit from this modality of treatment. RSW support with guidance from the team psychologist may also prove to be effective

Often times, the best strategy for dealing with a survivor suffering from substance abuse is to divert his or her attention away from drugs or alcohol and instead focus their attention on more positive goals or tasks that are enjoyable to them. First the psychologist with the assistance of a Rehabilitation Support Worker should attempt to identify the survivor's area of strength. For instance a survivor with a brain injury struggling with substance abuse who is mechanically inclined may accept and benefit from a Rehabilitation Support Worker who works with them repairing cars or bicycles. While the survivor is otherwise engaged in an activity that is enjoyed, the hope is that his or her mind will be diverted away from using drugs or alcohol.

Often times, issues of substance abuse relate to or are exacerbated by the survivor's peer or social group. One strategy the rehabilitation team may consider adopting in this circumstance is diverting the survivor's attention away from his or her peer group and, once again, replacing it with activities the survivor enjoys. Immense benefits can be achieved by getting the survivor involved in groups, organizations or volunteer work where new peers and social groups will form. Initially, integrating the survivor into a new social group or volunteer position will involve close supervision by the Rehabilitation Support Worker. As more routine and predictability take root, the Rehabilitation Support Worker can reduce the level of supervision. It should be the hope and goal of the rehabilitation team, to get the survivor engaging in new activities independently thereby lessening the likelihood of the survivor engaging in harmful activities.

If these strategies do not work, the rehabilitation team should then re-consider registering the survivor in more formal programs that directly treat substance abuse such as programs offered at the Addiction Research Foundation, CAMH and of course, Alcoholics Anonymous.

In some circumstances, there may be a need for a Rehabilitation Support Worker to go with the survivor to an Alcoholics Anonymous meeting (or another similar program) to ensure attendance. Even if the Rehabilitation Support Worker is required to wait in a separate room while the meeting takes place, there may well be a tremendous benefit having the Rehabilitation Support Worker travel to and from this meeting with the survivor to provide some support.

SUICIDE/DEPRESSION:

Many survivors who have suffered significant injuries will also experience depression or other secondary psychological/psychiatric impairments such as an adjustment disorder. This commonly arises when the survivor begins to realize that his or her cognitive or physical abilities have been permanently compromised. As every member of a rehabilitation team knows, it is very difficult to treat the physical or cognitive aspects of a survivor's presentation without first addressing the depressive or psychological component of the injury. Psychological impairments usually affect the survivor's ability to initiate and engage in rehabilitation tasks and goals.

If the survivor communicates any indication of an interest in suicide (suicidal ideation), then the members of the rehabilitation team should immediately press 'pause' on their rehabilitation goals and get the survivor to the hospital for assessment. Reports of suicidal ideation should not be taken lightly. Any indication of this should result in an attendance at a hospital for evaluation. If the survivor is somewhat manipulative and communicating a suicidal ideation to garner sympathy or achieve some other goal, we believe that a visit to the Emergency Room is still the best course of action. A night in the hospital waiting for an evaluation by a physician or a psychiatrist will likely deter this survivor from playing this card in the future. Prescription medication may also be required which also requires an evaluation by a physician or psychiatrist.

With respect to survivors under the age of 18, there is a positive obligation on adults who learn of a child or youth's intention to commit suicide to report these findings to the Children's Aid Society.

If the survivor is suffering from depression without suicidal ideation, an excellent first step would be a referral for a neuro-psychiatric evaluation. When dealing with brain injuries or other injuries as well, it is possible that pharmaceutical intervention may be of great assistance. A regular psychiatrist would be the next best choice if a referral to a neuro-psychiatrist is not practical. If the depression can be treated with medication, that should be the first step.

With respect to depression, many of the same strategies set out above in our discussion on substance abuse may be of great assistance. Getting the survivor involved in interest based programs and diverting their attention away from their loss, over the long term, is usually the best strategy to employ along with psychological counseling.

One excellent strategy for dealing with depression is to introduce survivors to support groups. There are many support groups in the GTA that help both children and adults. Listening to other survivors speak about their own experiences and losses can be quite helpful in terms limiting the debilitating effects

of depression. In the Toronto area, support groups exist at Bloorview, West Park, March of Dimes and CHIRS. Local brain injury associations also organize support groups which include BIST and OBIA.

While putting survivors together with other survivors is an excellent first step, ultimately the plan should be directing survivors towards interest based programs. Survivors who are at first focused on “loss based” commonalities should slowly be diverted to programs where they are building relationships based on common interests. Survivors who enjoy stamps, trading cards, vehicles, motorcycles, playing billiards, working out at the gym and playing sports will likely benefit if from exposure to these activities and other people who share this similar interest. While it may not be possible to integrate the survivor into an interest based group immediately, it is an excellent second step in the rehabilitation process. Ultimately, creating enthusiasm towards an interest will hopefully have the effect of diminishing depressive symptoms because their focus will be on how they are the same as non-injured persons as opposed to how they are different.

Another excellent activity to engage a survivor with (when ready) is volunteer work. Survivors who have been through significant amounts of rehabilitation both in the public setting and in the community sometimes develop an interest in the rehabilitation process and think about helping others. There are many volunteer organizations that will accept survivors as volunteers because it is such a win-win combination. Other volunteer work that survivors often enjoy are working at animal shelters, with young children, with the elderly and with those who are chronically ill. By working as a helper, it introduces some structure and routine into the survivor’s day. The goal is also to assist the survivor garner some self-esteem through this process. Often times, a survivor will feel depressed thinking that that they are a drag on their friends, family and society. Engaging in volunteer activities and helping others tends to minimize the depressive symptoms which stem from this sort of hopelessness. In addition, volunteer work will hopefully lead to interest based relationships along with new peer and social groups.

One area of volunteer work which has proven to be quite effective is work with the elderly. Often times, survivors who have cognitive disabilities work quite well with the elderly who are still mentally sharp but are beginning to wane physically. The elderly are usually quite appreciative of the physical support they receive from the survivor and often enjoy the companionship. The appreciation a survivor usually receives from the elderly can be a great tool to minimize the effects of depression.

DRIVER RE-INTEGRATION:

Getting a seriously injured survivor driving a vehicle again is one of the more difficult rehabilitation goals the Rehabilitation Team may face. Whether the injuries are physical, psychological or cognitive, assisting a survivor get their driver’s license back must be dealt with carefully.

If a person is seriously injured in an accident, a letter from a treating physician from the hospital written to the Ministry of Transportation, Ontario which will automatically revoke the survivor's license. A survivor is entitled to apply to have his or her license reinstated but not until taking an on-road driving assessment.

Many survivors, particularly, survivors between the age of 17 and 24 are very anxious and determined to have their license reinstated. In less populated regions, not having access to a vehicle means extremely limited access to the larger community. Therefore, reintroducing a survivor back to driving a car is often related to issues of independence and self-worth.

From the lawyer's perspective, a survivor returning to driving a vehicle can be very difficult to the survivor's case. In those situations where the lawyer is claiming a need for 24 hour per day attendant care for the survivor, it is difficult to justify how it is that he or she is now permitted by the Ministry of Transportation, Ontario to operate a vehicle without any supervision. Also, it is not long after a survivor returns to driving a vehicle that surveillance is conducted by an involved insurer which lends the impression that the survivor is independent at least with respect to attendant care.

Before taking steps to introduce a survivor to the automobile, the first step should be a neuropsychological evaluation and a consult with the other physicians involved with the survivor to determine whether an attempt at reintegration would be safe.

A survivor suffering from a frontal lobe injury should also be assessed for their impulse control, anger management and ability to make decisions under stress or pressure before driver reintegration begins.

If a member of the rehabilitation team suspects that the survivor is unsafe to drive for some of the reasons stated above yet the survivor's license has not yet been revoked (or has already been re-instated), we recommend forwarding these concerns to the Case Manager immediately and a letter to the treating physicians should then be prepared by the Case Manger requesting that the survivor to be assessed with respect to their ability to drive.

There are many excellent programs available to assist survivors who have lost their license get the training they need to safely operate a motor vehicle and ultimately get their driver's license reinstated. One excellent program is at St. Elizabeth Health Care Centre where driver and assessment training programs are available. The program at St. Elizabeth Health Care Centre used to be organized at Bloorview MacMillan Driver Rehabilitation Services.

At St. Elizabeth Health Care Centre, an experienced team of experts are available to provide services to clients with disabilities and special needs to help them achieve driver independence. This program will also provide Ministry approved medical assessments and road evaluations for survivors with conditions that may be affecting their ability to drive safely.

An intermediate strategy that one might consider prior to enrollment in a more formal program would be to work with the survivor at the Nascar theme park in Vaughan, Ontario or simply playing driving based video games with the survivor simply for them to get a feel for driving with an acquired impairment.

No discussion of driving re-integration would be complete without discussing the Accident Benefit Insurer's obligation to fund a vehicle modification. Pursuant to Section 16(1) of the *Statutory Accident Benefits Schedule*, the Insurer is responsible to pay the following rehabilitation benefit:

> "(j) Vehicle modifications to accommodate the needs of the insured person, or the purchase of a new vehicle if it is more reasonable to purchase the new vehicle to accommodate the needs of the insured person than to modify the existing vehicle."

In order for a survivor to be entitled to funding for a vehicle modification, it is necessary that the survivor owned a vehicle prior to the accident. The accident benefit insurer may be responsible to purchase a "new vehicle" if modifying a vehicle does not make any sense. A classic example is a survivor who owned a vehicle with standard transmission and is now only able to operate a vehicle with an automatic transmission. Instead of paying excessive amounts to transform a standard transmission vehicle to automatic, it simply makes sense to buy a new one.

In some circumstances, an Insurer will indulge a request to purchase a new motor vehicle for a survivor or their family members if it is cost efficient to do so. The cost of taxis/transportation to and from appointments can often add up especially over a long period of time. If the survivor is able to safely drive a modified vehicle or there is a family member willing to drive the survivor to and from appointments the accident benefit insurer may consider purchasing a modified vehicle for the survivor even if the survivor did not own a vehicle at the time of the accident.

LEISURE ACTIVITIES:

It is difficult to emphasize the importance of integrating leisure activities into the client's rehabilitation schedule. Getting a seriously injured survivor involved in bowling, gym, shooting pool and playing video games is more than just diverting

the survivor's attention away from harmful activities. As stated above, establishing new interests with survivors is crucial to establishing a meaningful life after the accident.

With respect to leisure activities, it is important to question the survivor about their areas of interest. While it is great to involve a survivor in a support group or putting him or her together with other survivors with similar injuries, it may be even more effective, in the long run, to get these survivors involved in activities that emphasize how they are the same as the rest of society as opposed to focusing on differences.

By focusing the survivor's attention on activities that "non-injured people" engage in and creating opportunities for the survivor to build new social groups that focus on these new or old interests, hopefully many of the difficulties and pitfalls we see in so many rehabilitation cases can be averted or minimized.

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