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Handbook for Mortals: Controlling Pain

By Joanne Lynn, M.D. and Joan Harrold, M.D. Publication date: March, 1999.

You, like many people, may be especially afraid of being in terrible pain at the end of your life. You - and the people caring for you - should know that even severe pain can be brought under control. However, to do this, you may need to rethink some of your ideas about pain and pain medication.

Pain can almost always be managed well enough so you can be comfortable and life can be meaningful. If pain gets to be overwhelming, usually it is because available treatments are not being used well.

Some people hesitate to take medications because they fear becoming dependent on - or even addicted to - pain relievers. Others are worried that, if they take medicine "too soon" in the course of their illness, then there will be no medication strong enough later if the pain gets really bad. And still others are afraid that side effects will interfere with their thinking, concentration, or energy level. The fact is, good pain management can usually control your pain throughout the course of your illness without lots of side effects, without addiction, and without keeping you too tired to enjoy the things you want to do.

Effects of pain

Pain is more than "just" hurting. Pain decreases your physical, emotional, social, and spiritual well being in a variety of ways. It affects you physically, mentally, and emotionally. With pain, you may:

- Be less able to function
- Feel tired and lethargic
- Lose your appetite or have nausea
- Not be able to sleep, or have your sleep interrupted by pain
- Experience less enjoyment and more anxiety
- Become depressed, anxious, or unable to concentrate on anything except pain
- Feel a loss of control
- Have less interaction with friends
- Be less able to enjoy sex or affection
- Have a change in appearance
- Feel that you are more of a burden on family or other caregivers
- Suffer more

Types of pain

The only way your doctors will know about your pain is if you tell them. How you describe your pain will guide your doctors' plans to relieve your pain. Understanding and using these descriptions may help you get the relief you need more quickly. There are different types of pain, and you may experience none, one, or several of them depending on the diseases you have.

To choose the best treatment for pain, doctors usually classify pain according to duration, cause or location, pattern, and severity.

Questions your doctor will ask about your pain

When you talk to your doctor about your pain, be prepared to answer these questions about new pain and changes in your pain, too. You might want to make notes before you see your doctor so that you don't forget to mention something important.

- Where is the pain?
- What does it feel like? (Describe the pain - is it throbbing, aching, burning?)
- On a scale of zero to ten, with zero being no pain and ten being overwhelming pain, how bad is your pain now?
- When do you get this pain?
- What makes the pain better?
- What makes the pain worse?
- What does the pain mean? How is it affecting other parts of your life?

Words for Pain

- Sharp
- Aching
- Throbbing
- Pressure
- Burning
- Shooting
- Stabbing
- Taking other medications for the pain, such as Tylenol™?

Duration of pain

Your doctor will ask about the duration of your pain.

- Acute pain is usually sudden or caused by a specific event such as surgery or injury. It lasts for hours or days and may cause increased heart rate, increased blood pressure, and anxiety.
- Chronic pain may exist for months or years, often from diseases such as arthritis and cancer. Chronic pain rarely causes changes in heart rate or blood pressure but can cause loss of appetite, sleep disturbances, and depression. Many patients have trouble labeling chronic pain as "pain" at all. Instead, they use terms such as "discomfort," "ache," or "troubles." This is fine, as long as patient, family, and caregivers all understand one another. Many people with chronic pain don't look like they are in pain - it has gone on too long.

Cause or location of pain

Your doctor will ask about the location of your pain.

- You can locate pain which occurs in bones and muscles. It is usually described as sharp, aching, throbbing, or pressure.
- Some pain comes from internal organs. It is usually spread out and not easy to locate in one place. Internal pain may be gnawing or cramping, or it may be sharp, aching, or throbbing, depending on what internal organ is the cause of the pain.
- Pain sometimes comes from diseases affecting the nerves. These are the same nerves that help us know when things are hot, cold, sharp, or dull. Neuropathic pain is really a variation of these sensations - burning, tingling, shooting, and stabbing.

Some pain does not have an easily identified source. Such pain is very real - just because you can't quite describe it doesn't mean it is "all in your head."

All pain is part physical and part psychological. The physical part is the irritated tissues and nerves. The psychological part is how pain affects the rest of your life. And, just as pain affects your appetite, sleep, mood, social activities, and sense of well being, these things affect your pain.

Pattern of pain

Your doctor will ask about the pattern of the pain you feel. Try to recognize the pattern of your pain. It will help the physician decide which types of pain medicine are right for you: long-acting, short-acting, or a combination of the two.

- Do you have pain all the time? Even if your pain relief is good most of the time, does pain occasionally come unpredictably and intermittently? If so, you have what doctors would call "breakthrough" pain.

- Does it occur predictably when you do certain activities, like taking a bath, changing wound dressings, getting out of bed, or traveling? If so, you have what they would call "incident" pain.
- Does the pain increase just before the next dose of medication is due? Doctors call this pattern "end of dose" pain.

The pattern of your pain may be like one or more of these, or it may have its own pattern. It is important to describe all your pains for your doctor.

Severity of pain

Your doctor will ask how severe the pain is. Pain is often described as none, moderate, severe, or excruciating. Pain can also be measured on various scales (including picking a number between zero, for none, and 10, for excruciating). You are the only one who can determine the severity of your pain. How much pain anyone else has in similar circumstances is not important in figuring out what you need. However, you might feel comfort knowing that others have been through similar experiences and have found ways to cope. You might find some people to talk with about severity of pain, medications, or activities that affect pain in order to share experiences - just don't expect that things will be the same for you.

People experience pain differently and need different doses of medicine to relieve pain. Using more or less medicine than someone else doesn't reflect on your character or ability to tolerate pain. While some people, including doctors, may express surprise at your medications, it is usually because they do not understand one of the most important rules of pain control: The right dose of pain medicine is the dose that relieves the pain.

Choosing the right pain medicine

Over-the-counter medicines

You may have already taken non-prescription, over-the-counter medicines: aspirin, acetaminophen (Tylenol™), ibuprofen (Advil™, Motrin™, etc.), or similar medications. These are the same medications your doctor is likely to suggest for mild pain.

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Opioids

If these over-the-counter medications are not relieving your pain, tell your doctor. The doctor needs to know that you are in pain, where the pain is located and how it feels, what medications you have tried and in what doses. Your doctor will probably add a medication called an opioid (sometimes called a "narcotic").

These medications are often given in pills that also contain aspirin or acetaminophen. These combinations of medicines have a synergistic effect - that is, they work together to relieve pain better than either drug could do alone.

For example, people with cancer that has spread to their bones (bone metastases) might try a non-steroidal anti-inflammatory agent (ibuprofen or similar drug) in addition to an opioid. However, these drugs have many side effects and patients should always check with their doctor before taking them. People with a history of stomach ulcers, internal bleeding, or liver or kidney disease are especially prone to side effects.

If these opioids or combination medications do not relieve your pain, or if you are having severe pain, other opioids should be prescribed. Although there are many such medications, the commonly used ones include morphine, oxycodone, hydromorphone, methadone, and fentanyl. One older opioid called meperidine (Demerol™) has too many [side effects](#) and too short a period of activity and should rarely be used. If your doctor prescribes any opioid, ask if you should add an over-the-counter medicine to your

Common opioids

- Codeine
- Oxycodone
- Hydrocodone
- Morphine
- Hydromorphone
- Fentanyl
- (but avoid meperidine)

schedule.

Other medications that relieve pain

Pain that starts in the nerves themselves, "neuropathic pain," is best treated with antidepressants and anticonvulsants, often in combination with opioids. These are often used in doses lower than the doses used to treat depression or seizures. However, if someone has neuropathic pain and also has depression or seizures, these medications may be prescribed in traditional doses to treat both conditions at the same time.

Steroids (prednisone, dexamethasone, and others) also help relieve pain when used with opioids. The steroids reduce inflammation that can exert pressure on an already painful area. They also reduce cerebral edema (fluid in the brain tissues) associated with tumors or metastases in the brain, thus improving pain and some neurological symptoms. Steroids can also improve appetite and overall sense of well-being. Side effects of steroids usually depend on the dose and how long someone takes them. Most of the short-term side effects, such as elevated blood sugar, swelling of the legs and arms from fluid, difficulty sleeping, and confusion, can be managed. Because steroids can cause stomach ulcers, your doctor might prescribe an anti-ulcer medication whenever steroids are taken.

Finally, when pain is coming from a specific place, but is difficult to manage with the usual medicines, nerve blocks may be performed, usually by an anesthesiologist. A nerve block is performed by injecting the area of the nerve with an anesthetic to keep the nerve from transmitting painful impulses. This is just like anesthesia for dental procedures, but it can be longer lasting. Other nerve blocks can be performed by placing a catheter in one of the spaces around the spinal cord and instilling small amounts of opioids and anesthetics. If such a catheter is placed, a pump may be used to deliver small quantities of medicine continuously to maintain pain relief.

"I am taking opioids. Should I keep taking the medicine I used to take, too?"

If your doctor writes a prescription for a pain medication, ask if you should continue to take your over-the-counter medications. Do not continue to take over-the-counter medications unless your doctor tells you that it is safe to do so.

Common opioids

- Codeine
- Oxycodone
- Hydrocodone

- Morphine
- Hydromorphone
- Fentanyl
- (but avoid meperidine)

Different ways to take pain medicine

Pain medicine can be taken in a number of ways. There is always a reasonably convenient and effective way to take pain medications.

- Most of the time, you will take pain medicine orally, by mouth, as pills or liquids. Over-the-counter medicines are usually taken regularly every four to eight hours, depending on the medication. Opioids are usually taken regularly by mouth every four to twelve hours. Morphine, hydromorphone, and oxycodone are available in long-acting forms that may be taken every eight to twenty-four hours. Doses of opioids for breakthrough pain may be taken as often as every thirty minutes, depending on the dose and the specific medicine. Be sure you know your schedule for taking medications. Write it down and review it with your doctor.
- For pain that is difficult to control, or for patients who are having trouble swallowing, various options are available. Pain medicine can be given subcutaneously, through a thin catheter attached to a very small needle placed just under the skin. A small battery-operated pump (PCA pump or CADD pump) can deliver injections continuously or on a regular schedule and allow patients to take extra doses for breakthrough pain.
- Patients having trouble swallowing for a short period of time may be given rectal medications. This is especially useful if swallowing becomes difficult or a pump malfunctions and it is the middle of the night. Most oral medications, but not all, can be given rectally with good results. However, many people would not want rectal medications for a long period of time. Rectal medications are not very useful for patients having diarrhea.
- Some people treat their pain with a transdermal ("across the skin") patch. The opioid fentanyl is the only one you can get in a patch right now [as of 2001]. The patch is placed on the chest or back and changed every three days. The patch is an effective method of controlling pain because it keeps the dosage at a fairly constant level. But, because it takes medicine in the patch twelve to eighteen hours to reach a useful level in the bloodstream, a quicker acting (oral, sublingual, rectal, or injectable) medication must be used during the first few days of wearing a patch and should be available to treat breakthrough pain.
- Many medications can be administered intravenously (IV), through a catheter in a vein. While this works in a hospital setting when an IV may be placed for other reasons, it may also be used at home. Some people

will have had "permanent" catheters placed in order to give other medications. These are easy to use for pain medications, but patient and family have to learn some routines to use in caring for the catheter.

- Pain medications can also be given by injections into muscle or into the space around the spinal cord.

Doses of pain medicine

Over-the-counter medications are taken in the same doses as recommended on the label. When medications such as aspirin, acetaminophen (Tylenol™), ibuprofen (Advil™, Motrin™, etc.) are included in prescription medications, the total dose of these should still not exceed the maximum recommended daily dose on the over-the-counter labels, so be sure to ask your doctor or pharmacist what the maximum dose would be.

"What is the usual dose of morphine? Isn't mine too high?"

The right amount of [opioid](#) medication is the amount that relieves your pain with minimal or tolerable [side effects](#). There is no usual dose. Some people need small doses of opioids, while others need much larger doses. The amount of medicine that you need for pain relief is not related to how well you tolerate pain or how well you are coping with your disease. It is not a weakness to take large doses of medicine if that is what you need to relieve your pain.

Just as there is no usual dose, there is no maximum dose of opioids. This is unlike over-the-counter medications, which do have a maximum dose (and have serious side effects if you take too much). For opioids, you increase the dose if your pain increases. Also, there is no ceiling effect - no point when increasing the dose won't work anymore to reduce the pain. Some people worry that they will get so used to the medication that it will not relieve their pain anymore. There is always a dose which will overcome any tendency of the body to be "used to" opioid drugs.

"My husband says he won't take more pain medication - he feels like he's giving in to his disease."

Some people do not want to take medication for pain because they feel that doing so is giving in to their disease. Remember, though, that living well is often the best revenge. Trying to ignore your pain will not make your disease go away. Ignoring pain will only make you even more aware of your disease, and will detract from the time you have left. Treating your pain will keep your disease from controlling your life more than it already does.

Some people look at the amount of pain they are in as a measuring stick. They judge whether their disease is getting worse by how much pain they are having.

Although pain may worsen as some diseases worsen, it is not a reliable indicator of disease activity. Sometimes a small injury or change hurts a great deal. Some people have a lot of pain with less disease; others have little pain with advanced disease.

How often to take pain medicine

Usually, you must take opioids around the clock to relieve and prevent pain. Some people try not to take opioids too often for fear that they will become [addicted](#) to the medicine. But waiting until you "need the medicine" or "can't stand the pain anymore" is not an effective way to take opioids. First, it means that you will have much more pain. Second, when your pain becomes extreme, it will take more medicine to relieve your pain. To get good pain relief with the least amount of medicine, take your medications, especially [opioids](#), on schedule. Try to prevent pain rather than to have to treat it.

A few rules about pain management

There are some general rules about pain management that are helpful to know.

If you have more pain after having had no pain on a stable dose of an [opioid](#), your regular dose will generally need to be increased by at least one-half (50%). For example, if you are taking 10 milligrams (mg) of morphine every four hours, your doctor will usually need to increase your dose to 15 mg every four hours to get pain relief again. This is just as true if you were taking 100 mg every four hours; the new dose is likely to be about 150 mg.

The dose of medication needed to treat breakthrough pain [[see definition](#)] is determined by the dose of pain medicine that you take regularly. The breakthrough dose is usually equivalent to one to two hours' worth of your regular dose. So, your breakthrough dose should increase as your regularly scheduled dose increases. This is not because you are taking too much medicine. It is because the breakthrough dose has to be calculated as a percentage of the regular dose. Again, the person taking 10 mg every four hours will need 3 to 5 mg for breakthrough pain, and the person taking 100 mg will need 30 to 50 mg. These larger doses often cause some anxiety for professionals who are not used to using them. Talk to your doctor about the dose of medicine you should take for breakthrough pain, and have your doctor talk with people in your family or care team who need to understand how the dosing works.

Because incident pain [[see definition](#)] is predictable, the best treatment is to take a dose of medication before starting the activity that produces pain. The dose may or may not be the same as your breakthrough pain dose. Work with

your doctor and use your own experience to determine what dose best prevents pain before specific activities.

You can treat end of dose [[see definition](#)] failure in one of two ways, depending on your medicine and your medication schedule. You can increase the dose of medicine, or you can decrease the amount of time between doses. Also, if you are using pills that are not long-acting, you might switch to long-acting versions that "smooth out" the transition time between doses. Talk with your doctor about the best choice for you.

The amount of medicine that you take will be very different depending on the route used. If you switch from morphine tablets to injections, [[see ways to take](#)] for example, the dosage usually needs to be cut to about one-third.

It is usually better to take one kind of [opioid](#) at a time, although you will need to take two if one is a transdermal patch. Taking only one opioid limits the [side effects](#) and makes it easier to calculate dose changes. However, there may be times when you need to change opioids. When this happens, your doctor may prescribe a slightly lower dose than the "equivalent dose" to your previous opioid. This is because equivalent doses are not exact and because your body may need less of an opioid that it is not used to having. Use your breakthrough medication for pain while you and your doctor adjust your new medicine.

[Opioids](#) are really very safe drugs; used as described, they are very unlikely to speed up dying even if you end up taking very large doses. Some people feel that opioids must kill - they are so often in use at the end of life. But this is not the case. They provide a great deal of comfort and are quite safe when used appropriately.

Fear of addiction

Many people are worried about addiction to pain medicine. Unfortunately, as our society has battled illegal drug use, people have become discouraged from taking legal medications when they really need them. But you should not "just say no" to good pain relief. And you will not become an addict by taking your medicine as prescribed.

Addiction is a psychological disorder of drug craving and compulsive drug use when taking drugs is harmful to the user. Addiction is really very rare in people who take opioids for illness. It is not the same as taking medicine because you have pain. It is not the same as tolerance or physical dependence, either.

Tolerance means that increasing doses of an opioid are needed to maintain the effects of the medicine. In treating pain with opioids, tolerance is a useful feature. It allows most [side effects](#) to wear off a few days after a dose is increased.

Physical dependence means that the body becomes used to having an opioid present. Physical dependence happens to everyone who uses opioids for more than a few days, but all it means is that opioids should never be stopped suddenly. They should be weaned over a few days if they are going to be stopped. If they are stopped suddenly, you may have withdrawal - a very uncomfortable flu-like syndrome including muscle aches, nausea, diarrhea, and sometimes vomiting or even muscle spasms. If a person suddenly cannot take opioids by mouth, the weaning needs to be done by some [other route](#) (by rectal suppository or intravenous infusion). Side effects of pain medications)

Opioids do have side effects

Constipation

The most troublesome side effect of opioids is [constipation](#). Almost everyone needs stool softeners and laxatives to prevent constipation. You may also need an occasional enema. Keep in mind that you will not develop tolerance to the constipating effects of opioids. As you increase the amount of your dose of pain medication, you should increase your stool softeners and laxatives.

Drowsiness

Opioids can cause drowsiness. Usually, however, your doctor can prescribe a dose of medication that will relieve your pain without causing confusion or excess sleepiness. Do not be alarmed by increased drowsiness for a day or two after increasing your dose of medicine. Some of your drowsiness may be from not sleeping well because of your pain. You may be exhausted and need to "catch up" on your sleep. Or you may need a few days to develop tolerance to the drowsiness, which will then lessen. Very sick people can have somewhat diminished response times even when they are not feeling drowsy. However, if you generally feel well and you are taking a stable dose of medications, you probably can drive safely. Talk with your doctor before you drive a car or do anything else that might be dangerous if you were slowed in response to an emergency.

If your drowsiness does not go away in two or three days, ask your doctor if another medication might be responsible or if you might benefit from taking a stimulant to counteract the sedating effects of the opioid. Remember that patients should not have to accept sedation or coma in order to be comfortable unless they are very weak and near death, when the tradeoff is often welcome. If you are much stronger and active, there is probably something more that could be done for your pain.

Confusion or delirium

Some people experience confusion or delirium when they take certain opioids. This usually limits the use of the specific opioid to a few doses because no one

wants to take a chance that the confusion will continue or get worse. This is not the same thing as an allergy, although people are often told to say they are allergic to the medication to avoid it being given to them again. Allergies to opioids are actually very rare. However, just because someone becomes confused taking one opioid does not mean that he cannot try a different opioid. Usually there is a dose of opioid which avoids this problem, at least most of the time.

Nausea

If taking an opioid causes [nausea](#), then you should consider trying another opioid or taking an anti-emetic, which is a medication that stops nausea. Often the nausea disappears as tolerance develops. Do not let an easily controlled side effect such as nausea keep you from taking your pain medicine.

Muscle twitching (myoclonus)

A few people taking high doses of opioids develop muscle twitching (myoclonus). This occurs mostly when a person is in and out of consciousness prior to death. When that is the case, the tremors and twitching are more likely to bother family, friends, and staff than they are to bother the person having them. If, however, you are having myoclonus that interferes with your activities, then a muscle relaxant or change in medication may be helpful.

Effect on breathing

If you have lung disease or congestive heart failure, you may experience both pain and shortness of breath. Conveniently, opioids are used to relieve the feeling of breathlessness that people with heart and lung disease often experience. Nevertheless, extra care should be used when treating your pain with opioids. When you are very close to death, the opioids that provide comfort by relieving severe pain could cause you to breathe a little less effectively and therefore slightly hasten your death. If this tradeoff is acceptable to you, you should make it clear to your doctors and nurses that being comfortable is more important to you than living a little longer.

Relieving pain in other ways

Although pain medications are useful, there are other methods that help to relieve pain effectively, often in addition to pain medications. Most are pretty harmless, so feel free to try them out and see if some work for you. These include:

- Heat and cold
- Massage
- Electrical stimulation (TENS unit)

- Exercise
- Meditation
- Relaxation
- Imagery
- Acupuncture/acupressure
- Hypnosis
- Peer support groups
- Pastoral and spiritual support

"... he was moribund and screaming... I had no morphine... I finally instinctively sat down on the bed and took him in my arms, and the screaming stopped... He died peacefully in my arms a few hours later. It was not the pleurisy that caused the screaming, but loneliness."

-- Archie Cochran, from "One Man's Medicine".

What Are Assistive Devices and How do they Improve the Quality of Life for Persons with a Disability?

Assistive Devices refers to equipment, devices and services that may improve function and quality of life for individuals who have special needs due to a physical disability. Assistive technology enhances the natural abilities of individuals living with disabilities, enabling them to increase their level of independence, increase mastery of their environment, communicate and interact with others. It makes use of devices and services to reduce barriers and enhance independence for those living with disabilities.

Such aids and adaptations allow individuals with disabilities to function independently in recreation, education and vocational activities. Other terms that are used in describing assistive devices and assistive technology are assistive technology products, assisted living products, adaptive technology and aids to daily living. Assistive devices can be cross-used – meaning some that are "intended" for a person with one type of disability can be useful for people with other types of disabilities.

An assistive technology device is any item, piece of equipment or product system, whether acquired commercially modified or customized that is used to increase maintain or improve the functional capabilities of individuals with disabilities. Assistive technology services provide a comprehensive process of assessments, strategies and adaptive equipment to benefit a person with a disability. Examples of assistive technology devices include: **Aids to Daily Living (ADL)** (equipment used to aid with eating, bathing, cooking, dressing and

home care); **Mobility Aids** (equipment that assists people to transition from place to place such as wheelchairs, powered or manually-operated) three-wheeled scooters, canes, crutches, walkers; Architectural Items (structural modifications made to the home, school, or workplace that reduces physical barriers, including ramps, elevators, lifts, and special door handles); **Communication Aids** (devices used to augment or substitute the natural voice such as electronic or hand-operated pictures, gaze systems and prosthetics - also known as Alternative and Augmentative Communication Devices (AAC)); **Computer Applications** (Alternative input devices including voice recognition, headsticks, light pointers, alternative keyboard and switches and alternative output modes such as Braille and speech); **Environmental Control Systems** (electronic systems or switches that help a person control appliances, electronic equipment, lights, telephones and security systems in their home, workplace or elsewhere); **Prosthetics and Orthotics** (equipment to augment or substitute natural body parts such as braces (prosthetics) and artificial arms, hands, legs or feet (orthotics)); **Seating and Positioning** (changes made to wheelchairs or other seating systems to provide postural alignment and optimal access to the environment, including cushions, back and head supports, wedges and boosters); **Sensory Aids** (devices used by persons with visual and auditory deficits including eyeglasses, hearing aids, telecommunication aids and magnifying devices); and **Transportation Adaptations** (modifications made to vehicles such as hand controls, lifts, ramps and keyless entry).

The assisted technology department is responsible for the design, construction and fitting of specialized equipment that is not commercially available, such as frames that enable someone with a disability to stand, specialized seating modules, mobility aids, and specially adapted recreational devices that provide additional support for the child with a physical disability. Mechanical assistive technology helps individuals with standing, seating, mobility, or provides assistance with tasks of daily living. Examples include standing frames, seating modules, walkers, bath seats, adapted bicycles and sleds. Types of assistive technology services include: **information** about various services and equipment that are available; **referral** to specialized programs or individuals associated with delivering/providing the technology; **assessment** of a person's need for modifications or a piece of equipment based on their physical functioning capabilities; **recommendation** for a modification or specific aid or device to help meet the need; **ordering** the equipment from a manufacturer, commercial vendor or other source; **fitting** the device, perhaps with some modifications, to the consumer; **fabrication** of a custom piece of equipment or a modification that meets the needs of the consumer; **evaluation** of how well the proposed solution helps solve the original problem; **training** on the device; and **maintenance/repair** of equipment or modifications.

The Health Services Division of the Ministry of Health and Long-Term Care (MOHLTC) has the responsibility for administering the Assistive Devices Program (ADP), which provides financial assistance to people with long term

physical disabilities to obtain basic, personalized assistive aids and devices appropriate for the consumer's needs and essential for independent living (those devices listed earlier in this article). In order to obtain funding for the purchase of equipment through ADP, one must go through an assessment in order to determine the level of need for the actual assistive device. ADP does not cover the assessment fee. However, for those receiving ODSP, upon receipt of an approved ADP invoice for an assessment fee, ODSP will cover the cost if there is no other source of funding available. The fee may vary depending on the type of device and the complexity of the assessment.

Initial access for a consumer is often through a medical specialist or general practitioner who provides a diagnosis confirming the consumer's type of disability. During the assessment process, in most device categories, an authorizer (i.e. an occupational therapist) assesses the specific needs of the consumer and recommends appropriate equipment or supplies. Finally, a vendor of the consumer's choices sells the equipment or supplies to him/her.

Examples of professionals who may perform the assessment are physiotherapists or occupational therapists for mobility devices; audiologists for hearing aids, speech language pathologists for communication aids; and optometrists and orientation and mobility instructors for visual aids.

All Canadians need access to appropriate assistive technology. This will allow them to engage in and achieve their desired potential in life's occupations. Appropriate use of assistive technology can promote independence and health.

Council of Canadians with Disabilities

March 2, 2006

Open Letter

Re: Disability Community response to CBC Interview with Robert Latimer

Once again, we are made to suffer Robert Latimer's claims of righteousness in murdering his vulnerable 12 year old daughter. He has had his day in court. The Saskatchewan Court of Appeal upheld his life sentence without parole for 10 years. Finally almost 8 years after the crime, he lost his last appeal to the Supreme Court of Canada and began to serve his sentence. Since he was first arrested he has had ample and repeated access to the courts and, through a sympathetic media, to the court of public opinion. How often do Canadians with disabilities have to be subjected to the fact that some part of the public assert and believe our lives are not worth living!

The CBC television and other media outlets have given this unrepentant murderer a prime time platform from which to persuade the public to excuse his crime. I believe those of us that are most put at risk by the broadcast of Robert Latimer's dangerous rationalizations should have similar opportunities to share our perspective with the public.

The 2001 Supreme Court of Canada decision in *R. v. Latimer* has much to commend it. The public would benefit from knowing the balanced approach of the Court in weighing aggravating circumstances against any mitigating circumstances in the case. The following from the decision illustrates this approach:

On the one hand, we must give due consideration to Mr. Latimer's initial attempts to conceal his actions, his lack of remorse, his position of trust, the significant degree of planning and premeditation, and Tracy's extreme vulnerability. On the other hand, we are mindful of Mr. Latimer's good character and standing in the community, his tortured anxiety about Tracy's well-being, and his laudable perseverance as a caring and involved parent. Considered together we cannot find that the personal characteristics and particular circumstances of this case displace the serious gravity of this offence. (*R. v. Latimer* paragraph 85)

Very importantly, the decision recognizes the denunciatory value in sentencing:

Denunciation of unlawful conduct is one of the objectives of sentencing recognized in s. 718 of the Criminal Code. As noted by the Court in *R. v. M. (C.A.)*, [1996] 1 S.C.R. 500, at para. 81:

The objective of denunciation mandates that a sentence should communicate society's condemnation of that particular offender's conduct. In short, a sentence with a denunciatory element represents a symbolic, collective statement that the offender's conduct should be punished for encroaching on our society's basic code of values as enshrined within our substantive criminal law. [Emphasis in original.]

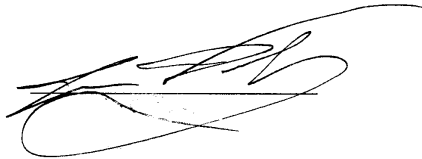
Furthermore, denunciation becomes much more important in the consideration of sentencing in cases where there is a "high degree of planning and premeditation, and where the offence and its consequences are highly publicized, [so that] like-minded individuals may well be deterred by severe sentences": *R. v. Mulvahill and Snelgrove* (1993), 21 B.C.A.C. 296, at p. 300. This is particularly so where the victim is a vulnerable person with respect to age, disability, or other similar factors. (*R. v. Latimer* at paragraph 86)

Robert Latimer's only chance to avoid serving the remaining 5 years of his life sentence before being eligible for parole is a rare use of the "royal prerogative" to grant a federal pardon. This can be done by the Governor in Council or the Governor General. There are probably some Members of Parliament in each party that will support such an idea. We are confident that wiser heads and hearts in Prime Minister Harper's new government will prevail.

To overturn the wisdom and proper role of our courts to reflect Robert Latimer's twisted views would be completely bizarre and wrong. After all, through his deeds and words, he asserts that some persons with disabilities are so difficult a burden for the rest of us to endure that they should be deprived of their lives without any legal consequence. Why should we nullify the operation of our laws to sanction the outrageous justifications of Robert Latimer's deluded criminal action?

We do not believe our Canadian justice system will be stood on its head to permit the murder of children by their parents.

Marie E. White

A handwritten signature in black ink, appearing to read "Jim Derksen", with a large, sweeping flourish at the end.

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