the HEADLINER

Fall 2008
Vol. X Issue 4

The Newsletter of the Brain Injury Association of Oregon

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Sports Session Has Started: Are Your Children Safe?

Any athlete knows that part of playing a sport is getting injured. From a young age, children are taught by coaches to play through their injury unless it is unbearable. The problem with this coaching philosophy is sometimes children don't know when they are pushing their injury too far, and this is when the injury can become life threatening. The most recent example of this is when a Montclair, New Jersey, football player died in October after suffering a brain hemorrhage during a game. The brain hemorrhage was later found to be caused by playing after suffering a recent concussion. The junior varsity player had recently been cleared to begin playing again after being "okayed" by his primary care physician. If the young boys doctor had more thoroughly examined him this death may have been prevented. This situation has become eerily familiar to families across the country who have had children severely injured or die as the result of a poor decision made by a doctor or a coach.

Many of these could be avoided with effective helmets and annual training on concussion for coaches and trainers. Currently, neither students nor coaches are required to have training in either concussion or in how to play the game. In other words, the art teacher with no sports experience may also be the football coach. Equipment is not tracked and older helmets may have been repaired dozens of times. Many of these helmets are twenty years old or older. How can we track these older helmets? Using a tracking system which consists of software similar to a spreadsheet, a bar code reader and bar code sticker can track whether a helmet has been used, what was done when it goes to the re-conditioner etc. Information can be noted in the spread sheet right down to which player or players used it in any given year. This is what the Brain Injury Association of Oregon's sports concussion bill will cover.

Under the bill, when helmets are sent in for refurbishing, the pads are removed, the number is noted and a tracking system with a permanent bar code sticker is put into place.

The helmet manufacturers do not serialize their headgear. They are given lot numbers. While this helps to identify the year a helmet was manufactured it would provide no way to track what was done to individual helmets. This is important because helmets are returned to the schools rather than being destroyed. Schools are known to keep sending the headgear to different refurbishers until they find one that looks the other way and OKs the helmet. (In Max Conradt's case Riddell sent a letter to the Lincoln County School district advising them that Riddell would no longer be bidding on the refurbishing because as in the words of Riddell rep Mark Elmblade as stated to Waldport coach Donald Kordosky "Your helmets are a brain injury waiting happen".)

The bill will also require the helmet refurbisher to destroy the helmet and return all parts to the schools. Returning the parts is important since it is well known that some unscrupulous refurbishers, like the one that re-certified Max Conradt's 20 yr old helmet, after rejecting a helmet shell, will strip the faceguard and other parts and then install

(Sports Concussion page 13)

Coaches and parents must be aware of methods to best protect athletes and prevent long-term problems:
- Insist safety comes first.
- Ensure athletes always wear the right protective equipment for their activity.
- Make sure their youth sports league or administrator has a concussion action plan in place.

If a concussion occurs or is suspected, coaches and parents should:
1. Remove the athlete from play.
2. Ensure that the athlete is evaluated right away by an appropriate health care professional.
3. Allow the athlete to return to play only with permission from a health care professional with experience in evaluating for concussion.

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Headliner DEADLINES

Issue	Deadline	Publication
Spring	April 15	May 1
Summer	July 15	August 1
Fall	October 15	November 1
Winter	January 15	February 1

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A: Business Card	$100	$ 350
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C: 1/2 Page	$300	$ 1,000
D: Full Page	$600	$ 2,000

Policy

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We invite contributions and comments regarding brain injury matters and articles included in *The Headliner*.

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* Support Group Facilitator p. 22-23

To become a supporting professional member of BIAOR see page 21 or contact BIAOR, biaor@biaoregon.org.

The Lawyer's Desk: A Look at TBI Legal Representation

By David Kracke, Attorney at Law
Nichols & Associates, Portland, Oregon

I have learned over the years that the practice of law has within it a significant educational component. I routinely teach people about legal facts that they then apply to their own lives in what is essentially a preemptive manner. As I wrote in an earlier column, I advise clients to increase their insurance coverage in anticipation of the unexpected auto collision, or I will help a client prepare estate documents that will create the framework for an orderly transfer of assets upon a person's passing. Occasionally, however, the law, and the reason why I volunteer with the Brain Injury Association, hits me from another direction.

Along with being a lawyer, I am an old soccer player from my college days, and I am now coach of my eleven year old daughter's soccer team. Before a practice a couple weeks ago, I was reading the paper and there was an article about a girl from Portland who hit heads with another player during a soccer game. The girl suffered a concussion, but unfortunately, she was allowed to participate in a practice shortly after suffering that head injury. During the practice she headed a strong corner kick and immediately suffered another concussion. I couldn't believe that she was allowed to take part in that practice and I hope that her recovery isn't hindered by the apparent willingness of her coach to expose her to the risk of a second concussion in such a short time period.

I was relaying this story to a friend of mine and he told me about a concussion he received while playing youth football thirty years ago. As he staggered off the field, dizzy, about to throw up, and with a stinging headache, the first thing that happened was that his coach grabbed him by the helmet and started shaking him violently complaining that my friend didn't make the tackle. As my friend says, "If I didn't have a concussion coming off the field, I sure did after the coach got through with me." My friend was playing in the next game as if nothing had happened.

Thankfully, we have more information now about head injuries in youth sports. I knew that the soccer incident with the Portland player provided me with an opportunity to teach my players about the dangers of head injuries and what to do if they ever end up with their bells being rung on the playing field, or anywhere else for that matter. I started with a discussion about the symptoms of a head injury; the dizziness, the pain, the nausea. From there I discussed what the players should do in the event that they receive a head injury during a game or a practice. The bottom line, I explained, is that I, or their parents, need to know about it immediately. Little did I know how timely this advice would be?

In the next game one of my players was hit in the head by a hard kicked ball from just a few feet away. She staggered under the force of the blow and fell to the ground. Play stopped and the girl was escorted off the field. With my head injury lecture in her thoughts, she immediately told me that she was dizzy. I advised her that her game was over and that we need to tell her parents to watch her and take her to the doctor if the symptoms persisted. Thankfully, by the end of the game she was up and running around without any dizziness or head pain.

The incident taught me firsthand the importance of teaching our kids about the symptoms and dangers of head injuries. My player had just been educated, and as a result, she didn't complain when I informed her that her game that day was over. I know this is a lesson that she will remember, and one that she may have to visit again in the future. I may teach the players how to score on a penalty kick, but just as importantly, I have taught them what to do if they ever suffer a head injury on the pitch or otherwise.

Much is happening right now with regard to youth sports and head injuries. It is great to see advancements in the design of football helmets, proposals for head protection for soccer players, youth bike/ skateboard helmet laws and a general awareness that our kids are at greater risk of head injuries when they participate in these sometimes violent sports. The Brain Injury Association of Oregon is focused on these issues and is hoping that Oregon's laws will reflect this increased awareness. I urge any interested BIAOR supporters to call Sherry Stock and volunteer to help with these issues.

Ultimately, though, it is up to us adults to teach our kids about prevention and recognition of head injuries. We need to let them know that they will typically recover from an initial concussion, but if they receive a second concussion shortly after the first the chance of a more serious injury increases significantly. We need to insist that they wear protective head gear when appropriate and we need to tell them to tell us when they are hit in the head. Take the time to talk to your kids, or grandkids or relatives or friends about head injuries. The days of the coach smacking around a player are hopefully behind us, but the risk of head injuries is still a clear and present danger.

David Kracke is an attorney with the law firm of Nichols and Associates in Portland. Nichols & Associates has been representing brain injured individuals for over twenty two years. Mr. Kracke is available for consultation at (503) 224-3018.

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2008-2009 BIAOR Calendar of Events

For updated information, please go to www.biaoregon.org
Call the office with any questions or requests

Nov 17	Managing Critical Decisions to Obtain Cost-Effective Outcomes in Brain Injury Rehabilitation—Free Seminar (call 503-528-6729)
Dec 7	Fundraiser—Holiday Brunch with Music & Balloons—Portland See page 15-16
Dec 16	TBI Training for Service Providers in Washington County 503-740-3155 for more information or registration form: http://biaoregon.org/docetc/trainings/training%20registration.pdf
March 6-7	7th Annual NW Brain Injury Conference Living with Brain Injury: *Identifying the Problems - Finding Solutions* Sheraton Airport Hotel, Portland OR See registration on pages 11-12

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United Way Campaign

As a 501(c)3 tax-exempt organization, the Brain Injury Association of Oregon is eligible to receive United Way funds. When donating to United Way, you can specify that all or part of the donation be directed to the Brain Injury Association of Oregon .

On the donor form, check the "Specific Requests" box and include the sentence, "Send my gift to Brain Injury Association of Oregon, PO Box 549, Molalla OR 97038-0549, Tax ID # 93-0900797"

If your employer has a policy of matching United Way donations, you can take advantage of that.
BIAOR Tax ID #: 93-0900797

A Wound Obscure, Yet Serious

Consequences of Unidentified Traumatic Brain Injury Are Often Severe*

Soldiers returning from war with visible head injuries are easy to spot, but what about soldiers—and civilians of all ages—who have brain injuries but no external wound? Wayne Gordon, Ph.D., notes that these cases of unidentified traumatic brain injury are far more prevalent than we realize and offers suggestions for better awareness and treatment.

John, at age 3, was hit on the head by a swing at the playground. His mother called her pediatrician, who told her that she need not go to the ER because John had not lost consciousness. Immediately, her happy-go-lucky son seemingly became a different child: anxious and clingy. For a few years thereafter, John would occasionally shake his fists up and down, out of the blue, then stop; such episodes were later recognized as undiagnosed seizures. Initially, he did well academically but not socially. He became the butt of jokes and was labeled by his teachers as unmotivated and inappropriate.

Over many years, John's mother sought help from the schools he attended, his pediatrician, several neurologists, tutors and the like. No one was able to help. Finally, when John was an adolescent, a tutor told his mother that his reading problems were not typical and that he should be seen by a neurologist. The mother tried again. The boy was sent for a type of brain scan called single-photon emission computerized tomography, or SPECT, which showed major damage where the swing had hit his head 16 years earlier. However, the neurologist told her that there was nothing to be done; he was mistakenly of the opinion that it had been too long after John's injury for any intervention to be of use. John's mother persevered and found a program for him that could help address his cognitive and behavioral difficulties.

Unfortunately, he was so emotionally damaged by so many years of being misunderstood—not only by everyone around him but also by himself—that despair won out. His traumatic brain injury ultimately ended in his suicide.

The brain injuries we see on the evening news, when soldiers return from war with visible, grievous wounds, are clearly evident: this is *known* traumatic brain injury, or TBI. Then (both in military and in civilian life) there are cases such as John's, where injury to the brain is relatively mild, with only a brief loss of consciousness or a period of feeling dazed and confused. Because the person appears physically unharmed, the "bump to the head" may easily be forgotten. This is appropriate in most cases, because the majority of people who experience mild brain injuries recover with no lingering effects. However, it is not appropriate for the large numbers of people who experience substantial post-injury cognitive, behavioral and/or emotional problems that do not go away.

Unidentified TBI occurs when these problems are not understood to be a consequence of the head injury; they may be misattributed to aging or to stress or may never be explained at all. This type of unidentified TBI is a common phenomenon, one that needs attention from medical, educational and military systems—the last because TBI is "the signature injury"[1] of the wars in Iraq and Afghanistan.

The prevalence of unidentified TBI is difficult to determine both in civilian and in military populations because something that is not identified, by definition, is not counted. The best civilian estimates are based on extrapolations from the number of *known* injuries, which the Centers for Disease Control and Prevention place at 5.3 million (2 percent of the U.S. population).[2] They acknowledge that these numbers underestimate the true prevalence of TBI, since only individuals treated in hospitals, those seen in ERs and those who die are counted. Not included are those who receive care outside of hospitals (e.g., in medical offices) or who do not receive medical attention at all (e.g., people injured in assaults, domestic violence, falls and the like). Research suggests that for every person hospitalized with a brain injury, three to five others are injured but do not receive any care.[3, 4] So, the question is: Among people who have sustained a brain injury, do we have any idea how many continue to experience symptoms commonly found after mild TBI but fail to causally link the symptoms to the injury? We have data that begin to answer this question. For example, in a population-based survey† in New Haven, Connecticut, Jonathan Silver at New York University and colleagues at Columbia University found that 8.5 percent of the 5,034 people surveyed reported a brain injury with continuing challenges.[5]

An unpublished study at the Mount Sinai School of Medicine in New York City found a similar level of unidentified TBI: about 7 percent of a sample of people identifying themselves as non-disabled

(***Consequences*** *Continued on page 7)*

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(Consequences Continued from page 6)
met criteria for TBI and also reported numerous symptoms associated with known TBI. If we consider such data in the context of the current U.S. population, they suggest that unidentified TBI may affect as many as 20 million to 25 million Americans. Clearly, more studies are needed to refine these estimates and get a better handle on the extent of the problem among civilians.

The number of unidentified TBIs in the military is also difficult to determine. We have learned in the past few years, thanks to media coverage, to expect large numbers of soldiers to have a known TBI. In reality, the prevalence of "probable" TBI is estimated at 19.5 percent, which translates to possibly 320,000 of those returning from Iraq and Afghanistan.[6] However, these numbers are probably underestimates because post-deployment screening has yet to be fully implemented, and many soldiers do not acknowledge their mental health challenges.

Widespread Consequences

The large number of estimated injuries in both civilian and military venues should raise concern, as the consequences of TBI, whether known or unidentified, can be life changing. TBI is strongly associated with multiple, often overwhelming, challenges that can undermine a person's efforts to live a productive life, leading to "social failure." For example, among prisoners, estimates of the prevalence of TBI range from 42 percent to 87 percent;[7–9] and for most, the brain injury preceded the start of criminal activity. TBI is also common in inpatient psychiatric and substance abuse populations, and, similarly, the injury often precedes onset of psychiatric symptoms[10, 11] or substance abuse. Most of these brain injuries had gone unidentified prior to the respective studies. TBI is associated with high levels of co-occurring depression, anxiety and post-traumatic stress disorder, or PTSD.[6, 12] (While some symptoms of TBI and PTSD are similar, such as fatigue and difficulty sleeping, other symptoms are unique to each disorder—heightened startle response and night sweats are unique to PTSD, for example.) Although the overlap between the estimated 320,000 returning soldiers with known TBI and the 300,000 returning with depression and/or PTSD is relatively small (7 percent), this figure includes only those with identified TBI. In Silver's study, New Haven residents reporting TBI attempted suicide four times more often than those with no brain injury, they were more likely to be receiving public assistance or disability benefits, and they experienced poorer overall emotional and physical health.[5]

Researchers are trying to determine what causes the extensive and often severe emotional and behavioral consequences of TBI, but they face many challenges in that quest. Linkages between injury site(s) and specific post-trauma symptoms have not been well established, and the lesions that occur following TBI are likely to be diffuse rather than localized. For so-called mild (and often unidentified) TBI, the neuroimaging tools currently in use are not sensitive enough to detect the locus of damage. Although diffusion tensor imaging (DTI) is showing promise as a more sensitive tool, additional research is needed to evaluate its reliability, validity and ultimate utility. Furthermore, although research has identified links between specific injury sites and changes in cognitive functioning, certain sites are not firmly linked to specific emotional and behavioral consequences.

Children with TBI are at increased risk for social failure as they mature into adulthood. TBI in children is associated with poor academic performance,[13] as well as problem behaviors.[14] It has been estimated that 130,000 U.S. children need special education classes because of TBI but that in fact only 11 percent of children with TBI are currently enrolled.[15] These estimates mean that 89 percent of such children remain fully "hidden" to their schools or are misidentified as having other types of emotional or learning disorders.

Thus TBI places a heavy burden on the injured child and adult, as well as on the family. Additionally, in *The Incidence and Economic Burden of Injuries in the United States*, researchers Eric Finkelstein, Phaedra Corso and Ted Miller estimate the costs to society at $60 billion annually.[16] Because this estimate does not include the costs associated with unidentified TBI, the real figure is higher.

Responding to Traumatic Brain Injury

The key to reducing the personal and societal burdens is to address the needs of people with TBI appropriately. This goal cannot be achieved, however, if people with unidentified injuries remain hidden to themselves and to those who may be helpful in addressing their challenges. As with most health problems, *early* identification can be lifesaving. Imagine a life, like John's, in which nothing made sense to him or to his family no matter where they turned. Without an explanation, problems are likely to get worse, as a sufferer becomes bewildered and experiences the emotional burden of becoming a stranger to himself and others. Further, parents and teachers often don't link problems in school to an earlier injury and begin to misapply labels that don't help and are likely to do harm.

So, how can "hidden" TBI be pulled into the light and recognized for what it is? First, parents and the medical and educational professionals who address children's needs must become more aware of the potential results of a blow to the head, which any child may experience. Similarly, in the military, officers, medical personnel and loved ones at home must be aware of the necessity to track, for many months, soldiers who have been in combat or have experienced concussive explosions or military accidents, to determine if cognitive, physical, emotional and/or behavioral problems emerge. Such tracking is especially important when soldiers return home and try to pick up the fabric of their former lives, leaving the structure of military life behind them. And last but not least, whenever a concussion or similar injury to the brain is observed or suspected, doctors, family members and friends should take it seriously. In children, surveillance needs to persist over many *years*, as some problems do not emerge immediately. Unlike adults, children may "grow into" the injury—as they age, their injured brains become unequal to the more-sophisticated learning challenges of later childhood, adolescence and adulthood.

In addition, we must develop a good way to screen for brain injury. Community agencies, health care service providers and other organizations should screen populations that are known to be at risk, such as schoolchildren, abused women, athletes, people receiving social support services and members of the military. Similarly, within medical contexts, people who have experienced a non-brain physical trauma, such as a fall from a ladder, also should undergo screening as a precaution.
Such screening would both explain the circumstances that underlie problems and facilitate appropriate diagnosis, possible treatments and accommodations. The *Brain Injury Screening Questionnaire* (BISQ), which was developed at Mount Sinai School of Medicine, incorporates elements of symptom checklists developed by Donald Lehmkuhl[17] (at The Institute for Rehabilitation and Research) and by the Medical College of Virginia,[18] and is based on the structure of a brief screening tool developed by Meryl Picard, David Scarisbrick and Robert Paluck in 1991.[19] It has been used to conduct brain injury screening in a variety of populations and is the only instrument validated by the Centers for Disease Control and Prevention to screen for a history of TBI.

The BISQ first determines whether minimal criteria for brain injury, as established by the American Congress of Rehabilitation Medicine, are met. These criteria include a blow to the head, a loss of consciousness or a period of being dazed and confused.[20] The questionnaire is particularly effective because to help jog the memory, particularly of long-ago events, it lists situations in which a brain injury may have happened. If a possible brain injury is so documented, the questionnaire then reviews symptoms that may be present and how frequently they occur. The BISQ can be administered via self-report or can be completed by a proxy. It is now being adapted for administration online, with immediate turnaround of results. The BISQ takes 5 to 20 minutes to complete, depending on whether or not the person has a history of blows to the head. It can easily be administered by social service agencies, in schools, in medical

(Consequences Continued on page 8)

(*Consequences* Continued from page 7)
contexts and among at-risk populations.

A point to be emphasized is that the BISQ cannot determine that a TBI is the known source of an individual's problems. BISQ data are used only to generate a statement that a weak, moderate or strong possibility of a brain injury exists. This feedback is based on research showing that 25 of the symptoms in the BISQ checklist are sensitive and specific to TBI—especially cognitive symptoms.[21] People showing more of these symptoms are more likely to have experienced a TBI.

If a person screens positive, three avenues of response present themselves: testing, treatment and accommodations. Neuropsychological testing can more precisely document the nature of deficits that may have been caused by a TBI, and advances in brain imaging could one day be useful as well.

If testing indicates that a TBI has or is likely to have occurred, the next step is to seek treatment or implement accommodations. While available standard treatment typically focuses on cognitive rehabilitation, studies currently under way at Mount Sinai (and elsewhere) focus on treating behavioral and emotional consequences of TBI. For example, we are currently evaluating the effectiveness of a version of cognitive therapy, adapted to accommodate the cognitive challenges of people with TBI, on alleviating post-TBI depression and/or anxiety, and we are examining the efficacy of treatments for executive dysfunction. Accommodating people with TBI is important outside treatment programs, in people's daily lives. Although TBI cannot be cured, families and educators can address its consequences in a variety of ways. Schools should obtain professional input and technical assistance to learn how to accommodate students with TBI in the classroom. Taking steps that permit a student with TBI to learn and to prosper usually helps the other students in the class as well; good teaching for the one is good teaching for all. Individuals who are not in school should seek help from a professional who has experience in dealing with TBI. Such expertise is not available in all areas of the country, but the resources that *are* available can be found through national and state brain injury associations (including the Brain Injury Association of Oregon).

A colleague tells the story of having sat through many meetings where professionals were talking about people with traumatic brain injury and the challenges they face. One day she realized that the cognitive problems she had experienced since childhood may have resulted from the two blows to the head she had experienced as a child as a result of falls; in one incident she remembered she was lying on the ground in her backyard as a young child, having just fallen from her perch on the top of a swing set, landing on the top of her head and feeling dazed for a while. She had never linked the learning and memory problems she was troubled by over the years to these long-ago episodes. There is no way of knowing without doubt that her continuing problems are the result of the two childhood accidents, but she now conceptualizes her problems in this way, which allows her to explain her challenges and see more clearly the need to compensate for problem areas. For my colleague, for John, for returning soldiers and for the millions of civilians suffering from traumatic brain injury, we must improve our response to this underestimated problem.

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* The preparation of this manuscript was supported in part by Grants H133A07033 and H133B040033 from the National Institute on Disability and Rehabilitation Research, United States Department of Education, Grant 1R49CE00171-01 from the Centers for Disease Control and Prevention and the generosity of the John Blair Haldeman Fund. The author wishes to acknowledge the constructive criticism of Margaret Brown, Ph.D., in the development of this manuscript.

† A survey conducted by Silver et al. within the National Institute of Mental Health Epidemiologic Catchment Area in New Haven, CT.

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By Wayne A. Gordon, Ph.D.: Jack Nash Professor of Rehabilitation Medicine and Associate Director of the Department of Rehabilitation Medicine at Mount Sinai School of Medicine in New York City. Gordon has received a number of awards for his outstanding work in the field of traumatic brain injury.

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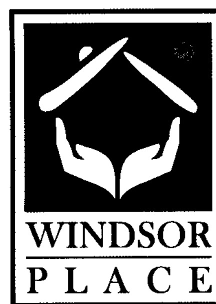

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Neurosciences Institute Discovers Drug Extends Stroke Treatment Time to 24 Hours, Repairs Brain Tissue

Could Be Life-Changing for Stroke, Traumatic Brain Injury, Alzheimer's Patients

Scientists at the Blanchette Rockefeller Neurosciences Institute (BRNI) have discovered that Bryostatin, and a related class of drugs discovered at BRNI, administered 24 hours after stroke can rescue and repair brain tissue. These findings are markedly advanced compared to current stroke treatments that must be administered within three hours and are unable to repair damaged brain tissue.

In an article published in the September 3 issue of the Proceedings of the National Academy of Sciences (PNAS), BRNI Scientific Director and Toyota Chair Daniel Alkon, M.D. and Professor Miao-Kun Sun, PhD describe how this Alzheimer's candidate drug repairs the brain and improves memory.

"Today's stroke patient has precious minutes to receive care without suffering irreversible damage or death. One of the greatest challenges in modern medical practice is finding an effective treatment that extends that treatment time and repairs damage," said BRNI Scientific Director Daniel Alkon, M.D. "Bryostatin could be an answer."

Bryostatin could be life changing for millions of Americans who suffer neurological conditions -- from Alzheimer's disease to stroke. Each year in the United States, there are more than 780,000 strokes. It is the third leading cause of death in the country and the most common cause of long-term disability in developed countries. Nearly three-quarters of all strokes occur in people over the age of 65 and the risk of having a stroke more than doubles each decade after the age of 55.

"We're facing an aging Babyboomer population, an influx of 55-plus Americans, and treatment that is less time-restrictive and able to repair the brain if a stroke destroys tissue is urgently needed," said Alkon.

How Bryostatin Works:

Stroke symptoms typically develop rapidly -- within seconds to minutes -- and as oxygen becomes depleted in the brain tissue, cells die. This means that hundreds of thousands of neurons -- each linked to thousands of connections -- die. In animal testing, Bryostatin completely rescues these dying neurons, stimulates the growth of new connections and restores memory capacity. Additionally, the drug can be administered up to 24 hours following a stroke, increasing the number of patients it could potentially help.

This drug, suggests Alkon, offers potential to prevent and/or reverse brain degeneration not just in stroke victims, but also Alzheimer's disease and traumatic brain injury.

Previous studies have also shown Bryostatin's ability to accelerate the generation of new connections in the brain when paired with learning exercises. According to Alkon, this could eventually lead to new treatment therapies for children with compromised memory activity. BRNI is in discussion with the Food and Drug Administration (FDA) to begin clinical trials of the drug.

SOURCE Blanchette Rockefeller Neurosciences Institute—http://www.marketwatch.com/news/story/neurosciences-institute-discovers-drug-extends/story.aspx?guid=%7B54C58153-74BF-40DF-9FD9-5143EF8A9EDC%7D&dist=hppr

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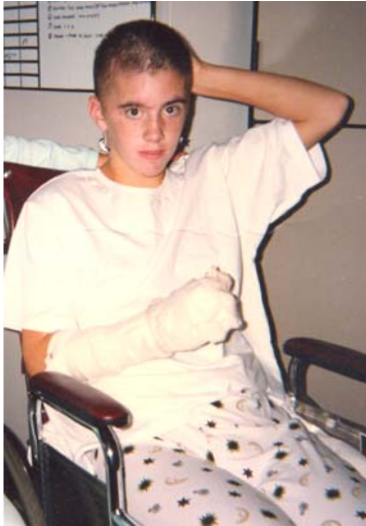
Memories Lost— The Kate Moore Robinson Story

My life memories begin in the hospital at the age of sixteen. My hospital bed faced a get-well poster signed by high school friends I did not remember. My new friends were the Therapists and Doctors that I saw every day. I wish I remembered play-dates with childhood friends, winning track races, going to parties, and the first two years of high school. But I don't. My past only exists in stories I've been told, pictures, and memory boxes, (thank goodness for those!).



On a sunny September day in 1991, my Dad came to Sister's, Oregon to fly my best friend and me home to Portland in his private plane after a birthday celebration. The plane did not gain enough altitude and we crashed shortly after take-off. I was the only survivor and apparently, I was rescued just in time. I was air - lifted to St. Charles Hospital where I spent three weeks in a coma in intensive care. There, I had brain surgery to relieve swelling. After intensive care, I spent several months as an inpatient at Emanuel Hospital slowly regaining skills I had lost.

Most of my stay in the hospital is a blur. I experienced the common cognitive, physical, and behavioral consequences of a TBI. I went through stages such as confusion, inappropriate child-like behavior, anger, and poor impulse control. I laugh at some of the stories I've been told about things I said and did early on in my recovery. I swore to my brother, and bit off pieces of my arm cast and spit them at visitors. Some of the things I said are not appropriate to print!

Returning to high school was the hardest part of my recovery. Academics were challenging and because of increased fatigue and my reduced ability to process information, remembering what I learned was difficult. There were tutors and extended time on tests to help with academics, but there was nothing as concrete to help former friends try to understand what I had been through. As a result, high school was lonely and frustrating. I had to develop new friendships.

Despite a horrific accident and a TBI, this is not a sob story. I learned early on that because my injuries were "invisible" I had to advocate for myself when I needed help with something or wanted others to understand me better. Many of my college professors did not understand what my needs as a brain injury survivor were, so I got in the habit of meeting with them during the first week of school to explain my learning differences.

The overwhelming lack of understanding about brain injuries led me to get my Master's degree in Rehabilitation Counseling several years ago.

(In September of 2007 Kate married John Robinson and has now started her own business.)

I am excited to say I recently started a private counseling and consulting practice in Portland. I work with survivors of all ages to help them reach their goals, big or small. I also offer family counseling. Some of the services I provide include:

- Counseling for families to help them better understand and communicate with the survivor.
- Help clients work through depression, anger, anxiety, fatigue and social isolation.
- Help clients learn memory techniques and organizational skills that work best for those clients.
- Help clients connect to community resources and other professionals.
- Help clients find and maintain employment.

To find out more about my counseling and consulting services or to schedule an appointment, please contact Kate Robinson Monday-Saturday at # 503-318-5878 . My office is conveniently located at 715 SW Morrison, on the Max line.

Kate and John Robinson
September, 2007

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Living with Brain Injury: Indentifying the Problems— Finding Solutions

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You are invited to participate in the 7th Annual Pacific Northwest Brain Injury Conference *Living with Brain Injury: Indentifying the Problems—Finding Solutions* to be held March 6-7 2009 in Portland Oregon at the Sheraton Portland Airport Hotel. This conference will provide the latest medical research, clinical applications, techniques and education to survivors, family members, and medical and legal professionals across numerous fields and disciplines working with people with brain injury. The tracks will look at medical clinical issues, blast injuries, behavioral challenges, and much more. Presenters will be from Oregon, Washington, Idaho, Nevada, California, Alaska, Hawaii, New Mexico, Wyoming, New Jersey and Washington DC. Speakers will be from State Agencies in the Pacific Western States, the Oregon Reintegration Team, the Veterans Administration, Brain Injury Associations from 9 states, and survivors, family members, medical, professional and legal experts from throughout the country.

KEYNOTE SPEAKER, FRIDAY, MARCH 6, 2009: HARVEY JACOBS.-BEHAVIORAL ISSUES

KEYNOTE SPEAKERS, SATURDAY, MAR 7, 2009-MORNING: CYNTHIA LEFEVER AND RORY DUNN-LIFE AFTER IRAQ

AFTERNOON: SPORTS CONCUSSION AND RETIRED PRO PLAYERS—SPORTS CONCUSSION AND HOW IT AFFECTED THEIR LIVES

HIGHLIGHTS: TRACK 1: MEDICAL CLINICAL AND RESEARCH

- Co-Occurring Disorders: Identification and treatment—Issues in Psychopharmacology–Ron Heintz, MD
- Pain Management Following a Brain Injury
- Cortical mechanisms underlying sensorimotor integration
- Anxiety, Fatigue and Depression after Mild TBI
- Effectiveness of Cognitive Rehabilitation
- Neuro-Imaging and Functional Outcomes
- The Overlooked Value of Neuro-Optometric Intervention
- Treatment for Balance Disorders
- Adult Human Neural Stem Cell Therapy for TBI
- Treating People With Brain Injury-for Rehab nurses and what they need to know
- Risk Factors For Suicide Ideation After TBI
- Anger Management: Dealing with Behavioral Problems
- Residential Design for Persons with ABI
- A Multi-Modal Approach to School Re-entry for the Brain Injured Student and Under-identification of Students

Track 2: Legal and Veterans

- Medical Legal Issues for the Brain Injury Professional - Best Practices, Differential Diagnosis, and Legal Issues Related to Individuals with Brain Injury survivors: Understanding your client's brain injury.
- Blast Injury and TBI: Unique Aspects of Injury Pathology, Assessment and Management—The US Experience
- Current Issues in Blast Injury: From Modeling Brain Dynamics to Developing Models of Care
- PTSD/ TBI—Identification, Assessment and Treatment in Returning Veterans

Track 3: Consumer

- Working together-What is happening in other states and how we are working together to make a difference
- Enhancing Quality of Life Through Employment -Vocational Rehabilitation: Specific Needs and Interventions
- Using Electronic Aids to Daily Living After ABI
- PDAS and Smartphones Used to Support Memory and Organization for Persons with Cognitive Challenges
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Please register before February 28, 2009 to assure admittance and facilitate check-in.

(Note: A separate registration form is needed for each person attending. Please make extra copies of the form as needed for other attendees. Members of BIAWA, BIAOR and The Brain Injury Alliance receive member rates)

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Agenda:

7 am—8 am: Breakfast
8 am - Noon: Keynote and Break- Outs
Noon - 1 pm: Lunch and Networking
1 pm - 5 pm: Break-Outs
* Breakfast and Lunch are provided

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Molalla OR 97038
1-800-544-5243
Fax: 503-961-8730
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This conference is designed for family members, survivors, doctors, nurses, medical and mental health professionals, attorneys, military, state employees, educators, vocational and rehabilitation counselors, and service providers.

(Sports Concussion Continued from page 1)

them on other helmets and sell them as NEW. Max's father, Ralph, has heard this from high school coaches and from the New York times reporter Alan Schwartz..

All of the equipment in the world will not prevent head injuries as long as kids do not play the game correctly. The training for football coaches needs to be upgraded. Swimming and football coaches are required to take the one same workshop. In the case of Max Conradt – a senior in Eugene HS who sustained a permanent brain injury a week after being sustaining a concussion during a game, his father said that while reviewing game footage with Max's coach as Max lay in a coma, Don Kordosky pointed out how Max's poor technique could have been at fault. He was dumbfounded. Just who is responsible for teaching technique?? I was driving through Beaverton in late October and saw a high school team practicing head butting. This is not a legal play, but this is what they were being trained to do.

Each student and football coach should take a course in the sport they will be playing to learn techniques and about safety issues. There are many DVDs and self paced programs out there. Further, a test needs to be devised that would weed out the art teachers who get drafted to coach a violent game like football and have no knowledge of correct techniques. (Ideally a workshop should be offered but we know that budgets are tight and we need to get something passed)

While it is helpful to have the coach be knowledgeable about concussions, he/she is not the person who should be watching for impaired players. They are busy coaching. Ideally every school should have a certified athletic trainer (3/4 of Oregon schools do not).

With sports related injuries becoming more and more common, serious precautions need to be used when trying to make the decision whether a player is healthy enough to return to their sport. One way to determine the health of the player is by performing an Immediate Post-Concussion Assessment and Cognitive Testing system, also known as ImPACT. This assessment, given immediately after a concussion, tests the athlete's memory, reaction, and processing speed. The results of this assessment can be compared to results from future assessments that can be given as the athlete becomes healthier. ImPAct takes the guesswork out of the process. Ralph Conradt said that Max's coaches' idea of screening Max as to whether Max was well enough to return to play after he returned to play was to ask him "How are you feeling?"

A concussion occurs when the brain, which is made of soft tissue, is moved so aggressively that it slams into the inside of the skull. When this occurs, the brain often gets damaged, bruised, or receives injuries to the blood vessels and nerves. Some of the symptoms associated with concussions are memory loss, unconsciousness immediately after the injury, lightheadedness, nausea, headaches, and blurred vision. After a concussion occurs the brain needs to begin to heal, this is when it is vital for your child to see a doctor to find out how long they should wait before returning to daily activities, especially athletics. The personal injury that this boy from New Jersey suffered could have been prevented if the doctor hadn't cleared him to play after only a few weeks of rest. The well being of this boy was in the hands of the doctor, and somehow the doctor allowed that to slip away. The responsibility for the boy who died, not only falls on the doctor who cleared him, but also on the coaching staff who should have had the medical knowledge to think "Hey maybe allowing him to play in a football game isn't the best idea right now," especially when the sport relies on so much player to player contact. When coaching a team, the team's safety should be the coach's principal goal.

Teach athletes and parents that it's not smart to play with a concussion. Sometimes players and parents wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let athletes persuade you that they're "just fine" after they have sustained any bump or blow to the head. Ask if players have ever had a concussion.

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USING PULSED ENERGY THERAPY for BRAIN INJURY and CONCUSSION

By Ted Russell Neff

Concussions and traumatic brain injuries (TBI) have been one of life's more vexing injuries. Every year in the US there are an estimated 1.5 – 3 million brain injuries, resulting in 50,000 deaths, with 80,000 leading to lifelong disabilities. The actual number of brain injuries is hard to determine since concussions are one of the most under-reported injuries, especially in sports. And if you think TBI is primarily the result of sports, like football, think again; falls are the number one cause of TBI, followed by motor vehicle accidents, sports/recreation injuries, and assaults.

And to date there are no direct treatments for traumatic brain injury.

Sports medicine care may hold the key to finally developing a treatment protocol for concussions and TBI; a treatment that can directly help the brain recover from the injury and one that can reduce long-term damage so common with TBI.

I recently attended a local high school football game. In the second half of the game a player was injured and lying on the field. It took the sports trainer ten minutes to get the athlete to his feet and it took two people to walk him to the sideline. Forty minutes later this same athlete was still unstable as he walked gingerly into the locker room. His coach informed me that this was the player's second concussion in two weeks. (I was surprised that the sideline doctor had not sent this concussed athlete to the hospital for scans and a neurological evaluation.)

The concussed athlete's parents brought their son to our office at 11:30 that same night. When he arrived he still had a headache, was a bit groggy and seemed a bit "out of it." I immediately started him on a 90-minute protocol using pulsed energy therapy, eventually applying the pulsed energy on the sides of the neck below the ears. (The working theory being that the neck often absorbs the kinetic energy from the blow to the head. In a protection response, the neck muscles squeeze tight restricting the flow of blood in and out of the brain. This leads to swelling which can lead to cerebral damage.) An hour and a half later all of his concussive symptoms were resolved. Subsequent follow up calls to this athlete indicated the recovery from the concussion went faster than might normally be expected.

For concussions, the resolving of symptoms lasts for most but *does not mean the brain injury is fully healed*. It indicates instead that the body is now in a healing mode and no longer in a trauma cascade from the brain injury. Pulsed energy seems to give the brain much needed energy, open up the flow of cranial fluids for cerebral repair, and activate and enhance the body's own healing ability.

Energy as therapy goes back to the Romans, where they used electric eels to treat mental disorders - the first shock therapy. In America during the late 1860s, with the advent of electricity, the innovation of electrotherapy devices quickly expanded, and by 1900 there were over 10,000 physicians using energy therapy on a daily basis. Politics intervened in the form of the Flexner Report and energy therapy fell out of favor and has largely stayed that way.

Pulsed energy therapy, also called pulsed electro magnetic field (PEMF) therapy works by creating the energy the body needs to function and repair properly. The body's own genetic codes do the healing; PEMF maximizes the available energy, so the body can proceed at the best possible rate as determined by a person's own DNA.

PEMF saturates the cells of the body with the appropriate resonate energies on which the cells' electro-chemical systems depend. The high-resonate potential provided by the pulsed electro magnetic field therapy brings all of the cells to an equal level, basically natures way of resetting them to their normal state. This provides the potential for healing to occur at an accelerated pace.

Pulsed energy therapy operates on a simple principle; it oscillates the cell's subatomic structure to increase its energy. The transfer of energy is accomplished through induction. This charges the total molecular structure of the cell, increasing its energy-field size, and this helps the body heal itself faster from injury, illness, and disease.

Clinical results to date indicate that pulsed energy therapy works with both brain injury and stroke. The sooner that pulsed energy therapy can be applied following the trauma the less damage will occur. If weeks, months or even years have passed since the initial injury that means more pulsed energy therapy sessions will be needed to get a healing response.

In the largest PEMF study to date, NASA conducted a 4-year collaborative study on the efficacy of electromagnetic fields. This study used human donors to define the most effective electromagnetic fields for enhancing growth and repair in mammalian tissues. The NASA study concluded that pulsed energy fields displayed the best efficacy for the repair and regeneration of human tissues. http://ston.jsc.nasa.gov/collections/TRS/_techrep/TP-2003-212054.pdf

With over 30 years of current use and more than 5000 PEMF research studies, most of the world has discovered and embraced pulsed energy therapy as a safe, effective, and low cost healthcare tool. The United State is one of the only industrialized countries that has yet to integrate this promising modality into our healthcare system.

What is needed now are more specific studies to verify what we have found in our clinical experience, with pulsed energy therapy, in regard to brain injury, concussion and stroke. We are hopeful that someday soon people will have an actual treatment for brain injuries that is something more than just rest.

Ted Russell Neff is the director of Edmonds Wellness and Revolution Sports Medicine in the Seattle area where he specializes in using pulsed energy therapy for both injury and illness. He can be reached at EdmondsWellness1@aol.com or (425) 778-5215.

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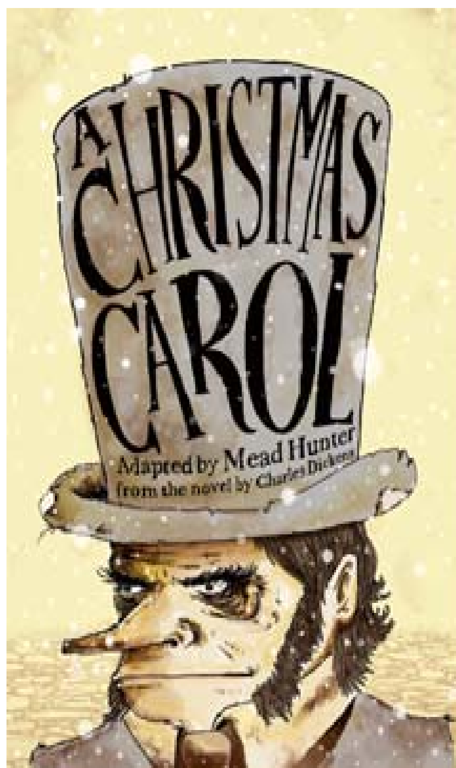

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Oral Auction: 1:00 pm

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Sign up early—tickets limited to the first 80

For further information please contact:
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Brain Injury Rest Defined

In our modern medical world the most common treatment for traumatic brain injury is rest. So while doctors dazzle us with organ transplants and re-attached severed limbs it may be more accurate to say that concussions and brain injuries are managed not treated.

For many, the recommendation to rest has been vague and abstract. Rest may mean a lot of different things to different people. Rest for brain injury is the avoidance of any physical and mental exercise/exertion until the symptoms are gone. Mental exertion causes the same symptoms as physical exercise.

Activities to avoid while recovering from a brain injury include not going to work or school, no reading, no video games, no walking the dog, no movies at the local theater, no test taking or mental tasks, no computer use, no text-messaging, no soaking in hot tubs, no socializing and no events or activities with sensory stimulation.

A little television is okay but start with 15-20 minute blocks. Books on tape may be okay as well as listening to soft music; if any symptoms return stop immediately. These specific rest guidelines should be used for 3-4 day following a brain injury, or until symptoms resolve. This form of rest therapy can assist the body to heal faster from TBI.

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Advocacy : What Are The Issues ...

BIAOR will be sponsoring six pieces of legislation in the 2009 session. We will need your help to get these passed. Our six pieces of legislation will be:

1 – A bill asking for an optional $5 on every moving traffic violation. This bill was passed in Washington State in 2007. The funds will go to DHS for brain injury support services.

2 – A bill requiring all medical insurance in the state of Oregon to cover cognitive rehabilitation. This bill was passed in Texas in 2007.

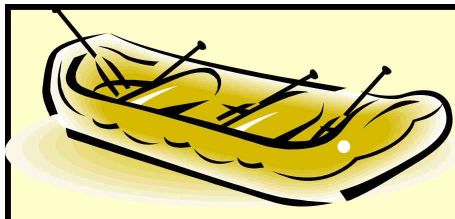
3 – A TBI/ABI Community based Waiver. Currently 23 states offer this waiver in some form. This waiver would allow persons with ABI/TBI between ages 21-65 who meet the nursing facility level of care to remain living at home and in the community (community based residential homes). Services offered under this waiver might include: personal care, case management, respite care, environmental modifications, specialized medical equipment and supplies, and community residential services.

4 – A TBI Registry. A registry is a method of systematic and ongoing data collection that is population-based (includes all cases of TBI in a defined population, e.g., a State), includes personal identifying and contact information for each case, and may be used for follow-up of TBI cases over time and/or linking TBI cases to services.

5 - One Stop Toll Free number and support services for TBI. The bill would cover Neuro-Resource facilitation that would promote TBI awareness and education, help link survivors and families with information and services, and promote coordination of services. Neuro-Resource services would provide ongoing support for individuals with brain injury in coping with the issues of living with a brain injury and in assisting such individuals in transitioning back to employment and living in the community. The resource facilitator is intended to provide a linkage to existing state services and increase the capacity of the state's providers of services to persons with brain injury by doing all of the following:

- Providing brain injury specific information, support, and resources;
- Enhancing the usage of support commonly available to an individual with brain injury from the community, family, and personal contacts and linking such individuals to appropriate services and community resources;
- Training service providers to provide appropriate brain injury services;
- Accessing, securing, and maximizing the private and public funding available to support an individual with a brain injury.

6 - A bill requiring all coaches at the elementary, middle and high school levels to have concussion identification training, all helmets used to have bar codes for tracking the number of repairs and type of repair, and helmets to be decommissioned after ten years of use. (See page 5 for online PBS program on concussions.)



1st Annual Brain Injury Camping and Rafting Trip Part 2: By Lorita Cushman

Back at camp, homemade cookies from Lynn Ludwick and Nancy Skeen along with fruit supplied by Kelly Latham were laid out for all to graze on. Rafting builds up an appetite. Free time along with Frisbee golf were scheduled next. Only Frankie had the energy for the Frisbee golf but gave it up since she didn't have any challengers. Dave arrived back at 4:30 in order to have dinner ready by 6. He started with whole chickens which over night he marinated in his own special recipe. He first BBQed them whole then cut, quartered and glazed by spraying wine (which burns off) to keep the chicken the right moisture. I heard a number say it was the best chicken they had ever had.

After dinner I had some bookkeeping to take care of. Due to generous donations I was able to fulfill our goal to reimburse those who had put money out for campsites. I was also able to reimburse up to $25 for gas. At least one group had almost not come as they didn't have gas money and in the end someone loaned them gas money as they had been planning this getaway for months. I had a sheet for all of the survivors to sign stating if they would like to be reimbursed or not. While some were extremely grateful for the reimbursements others opted to not be reimbursed and instead have the money go towards seed money for next year.

Sitting around the campfire Lisa played the auto harp and sang with Tom accompanying her on the harmonica. Another game of Apples to Apples with more players ended up with Jenny as the winner. This night the smore fixings were brought out.

About 9 months ago Gloria Way had said she would be willing to help with the cooking. Since I had just found out plans had fallen through for a Sunday breakfast cook, I informed Gloria the night before she was the cook for breakfast. When I got back from my shower I realized cooking breakfast for Gloria meant her husband Ed cooked while she stood beside him helping. Ed enjoyed it; he loved the huge gas grill owned by Chuck McGilvray which used to grace the Lions club back around the 1920s. Ed loved it so much he has volunteered to cook on it next year. After breakfast we tore down camp and headed about 14 miles down stream to the wild and scenic part of the river where our "1 mile hike" was to take place. Due to unforeseen incidents I

arrived at the trail head a bit behind the rest of the group who started off down the trail when they saw us coming. Starting out on the trail it was a lot rockier in places and steeper in others than I remembered. Ok, rewind here to a meeting months ago. I told Russ Rudometkin, Mary Ann and Romona Jones (the other committee members) that I remembered the hike as being 1 mile, flat, easy and shaded. I thought it was ½ mile in and a ½ out though possibly 1 in and 1 out. When I used to hike for or when I took groups hiking I would do the 7 mile hike on the opposite side of the river: sharp drop offs, totally in the sun with steep ups and downs. Therefore, I remembered this side as the really easy hike I use to take my grade school son and a few of his friends on. At the meeting Russ said he would go check the hike out ahead of time as he was in charge of leading the hike (Mick didn't think I should do it due to my balance issues). Russ even set aside a particular time and day weeks ahead to check it out. On Friday when I arrived at camp I asked Russ about the hike. He stated he hadn't checked it out though would do so before the hike. As with so many of us with brain injuries we have great intentions of doing things which just never happen.

Since Russ had not checked out the hike ahead of time all we had to go on was my memory. This can be a dangerous thing to count on with a brain injured individual. As we were going along I mentioned to someone how it seemed like we should be getting there soon if it was only ½ mile in and out, unless it was 1 in and out. I was informed at this point there was a sign at the trail head which said it was 2 miles to Rainy Falls. Ok in my defense this was soooo much easier than the other side. I just didn't remember how far, though it was short enough to take grade school boys. The difficulty factor wasn't difficult before my balance issues. Everyone else had seen it was 2 miles before starting out so they could make

informed decisions though everyone decided to go ahead. It was a beautiful hike. Once at Rainy Falls we sat and watched Rafters hoping someone would dare the falls themselves. We saw a couple go on the far side (the easiest shoot), a lot go down the middle shoot (sometimes losing oars, or unintentionally ending up backwards). No one braved the falls themselves this time. I have yet to see someone make it over the falls without tipping. The rafters are let out up stream to walk past the falls while the guides take the raft through this area. After watching for an hour we headed back only to have a raft further up stream tell us they were going to risk the falls and to walk back down to watch. Let me tell you it was tempting. Why does the hike back seem shorter even though there is more up hill? Why is it trying to take group pictures we never were able to get all of us to be in them?

We arrived back at the trail head with a sense of triumph. I heard a few comments about the easy "1 mile hike". The sign at the trail head said mild to moderate. Though as a few of us were talking if we had known the distance and/or the actual difficultly we never would have attempted the hike. Our families are concerned for us and a lot of times we do not get to attempt things. There had been much discussion beforehand about talking our loved ones into allowing us to attempt the "1 mile hike". There is strength in numbers and some relented as they saw others were going: Me with my balance issues, Mary Ann who also has some balance issues, Rose with a still healing fractured leg, Mechelle with her ankle splint, Lisa with asthma and Russ who was bruised from his swim through the rapids. Wow, I am impressed we not only took on this challenge, we conquered it. Only God knows what we are truly capable of. I thank Him for this glimpse.

Thank you to our families, friends and community members who believed in us and gave us this chance. Had it not been for each and everyone of you who donated in one way or another whether it was making food to send, coming up and cooking or cash donations this would never have been possible. You allowed us time for normal family recreation, a chance to test ourselves and prove we are capable. I can not even begin to say how much your generosity has touched me and the others who had the opportunity to attend. Thank you.

Watch for details on the 2009 Camping and Rafting trip.

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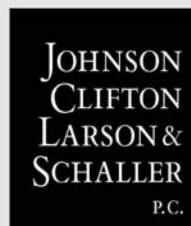

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Returning Veterans Resource Project NW is a nonprofit organization comprised of politically unaffiliated and independent health care practitioners who offer free and confidential services to veterans of past and current Iraq and Afghanistan campaigns and their families . Our volunteers include mental health professionals, acupuncturists and other allied health care providers. We believe it is our collective responsibility to offer education, support, and healing for the short and long-term repercussions of military combat on veterans and their families.

For more information contact:
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The Oregon TBI Team

The Oregon TBI Team is a multidisciplinary group of professionals and parents trained in pediatric brain injury. They provide support, in-service and consultation to educators of students with brain injury. TBI Team members are available to work with school teams and families to assist in locating resources and information about specific concerns such as: consultation and presentations on topics such as re-entry to school following a brain injury, support in schools, special education process, problem solving for academic and social difficulties and the creation of transition plans. For more information please go to the website at www.tr.wou.edu/tbi/TEAM ,email tbiteam@wou.edu, or phone 541-346-

Affordable Naturopathic Clinic in Southeast Portland

An affordable, natural medicine clinic is held the second Saturday of each month. Dr. Cristina Cooke, a naturopathic physician, will offer a sliding-scale.

Naturopaths see people with a range of health concerns including allergies, diabetes, fatigue, high blood-pressure, and issues from past physical or emotional injuries.

The clinic is located at: The Southeast Community Church of the Nazarene 5535 SE Rhone, Portland.

For more information of to make an appointment, please call:
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http://brainist.com/

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Sam's Brainy Adventure

Join Sam on his adventure into his own brain.

http://faculty.washington.edu/chudler/flash/comic.html

"Brain Injury Partners: Navigating the School System," an interactive, multi-media intervention, is now available on-line free of charge. The easy-to-use website is designed to give parents of school-aged children with a brain injury the skills they need to become successful advocates. <http://free.braininjurypartners.com/>.

The Brain Injury Association of Oregon can deliver a range of trainings for your organization. These include:

- Brain Injury 101
- Blast Injuries: The "Signature Injury" of the war
- Methamphetamine and Brain Injury
- ADA Awareness—including cognitive interactive simulation
- Judicial and Police: Working with People with Brain Injury
- Traumatic Brain Injury: A Guide for Educators
- Native People and Brain Injury
- How Brain Injury Affects Families
- Brain Injury for Medical and Legal Professionals-What you need to know
- Caregiver Training
- Dealing with Behavioral Issues
- Returning to Work After Brain Injury

For more information contact Sherry Stock, Executive Director, Brain Injury Association of Oregon at sherry@biaoregon.org 503-740-3155 or 800-544-5243

Facts About TBI in the USA

⇒ An estimated 1.5 million head injuries occur every year in the U.S.*
⇒ An estimated unreported 1.6 million to 3.8 million sports-related TBIs occur each year.*
⇒ At least 5.3 million Americans, 2% of the U.S. population, currently live with disabilities resulting from TBI.*
⇒ Moderate & severe head injury (respectively) are associated with a 2.3 and 4.5 times increased risk of Alzheimer's disease.*
⇒ Traumatic Brain Injury (TBI) is the leading cause of death and disability in children and adults from ages 1 to 44.*
⇒ Brain injuries are frequently caused by motor vehicle crashes, sports injuries, or even simple falls on the playground, at work or in the home.*
⇒ Every year, approximately 52,000 deaths occur from traumatic brain injury.*
⇒ Males are about twice as likely as females to experience a TBI.*
⇒ The leading causes of TBI are falls, motor vehicle crashes, struck by or against events, and assaults, respectively.*
⇒ TBI hospitalization rates have increased from 79 per 100,000 in 2002 to 87.9 per 100,000 in 2003.**
⇒ Blasts are a leading cause of TBI among active duty military personnel in war zones.*
⇒ The Rand Report states that at least 20% of Iraq veterans, or 320,000 service members, have some level of TBI.
⇒ 30% of soldiers admitted to Walter Reed Army Medical Center have suffered traumatic brain injuries.***

*Langlois, J. ScD, MPH; Rutland-Brown, W. MPH; Wald, M. MLS, MPH; The Epidemiology and Impact of Traumatic Brain Injury: A Brief Overview; Journal of Head Trauma Rehabilitation, Vol. 21, No. 5, pp. 375378 2006
**MMWR Morb Mortal Wkly Rep. 2007; 56:167-170
***Emery, Erin; Hidden wounds plague GIs, Denver Post; April 16,2007.

ARE YOU A MEMBER?

The Brain Injury Association of Oregon relies on your membership dues and donations to operate our special projects and to assist families and survivors. Many of you who receive this newsletter are not yet members of BIAOR. If you have not yet joined, we urge you to do so. It is important that people with brain injuries, their families and the professionals in the field all work together to develop and keep updated on appropriate services. Professionals: become a member of our Resource Referral Service. Dues notices have been sent. Please remember that we cannot do this without your help. Your membership is vitally important when we are talking to our legislators. For further information, please call 1-800-544-5243 or email biaor@biaoregon.org.

Brain Injury Association of Oregon

☐ New Member ☐ Renewing Member

Name: ____________________

Street Address: ____________________

City/State/Zip: ____________________

Phone: ____________________

Email: ____________________

Type of Membership

☐ Survivor Courtesy $ 0 (Donations from those able to do so are appreciated)
☐ Basic $35 ☐ Family $50 ☐ Students $25 ☐ Non Profit $75
☐ Professional $100 ☐ Sustaining $200 ☐ Corporation $300
☐ Lifetime $5000

Sponsorship

☐ Bronze $300 ☐ Silver $500
☐ Gold $1,000 ☐ Platinum $2,000

Additional Donation/Memorial: $__________

In memory of: ____________________

Member is:

☐ Individual with brain injury ☐ Family Member
☐ Professional. Field: ____________________
☐ Other: ____________________

Type of Payment

☐ Check payable to BIAOR for $ ____________________

☐ Charge my VISA/MC/Discover Card $ ______________

Card number: ________ ________ ________ ________

Expiration date: __________ _____

Print Name on Card: ____________________

Signature Approval: ____________________

Date: ____________________

Please mail to:

BIAOR Membership
PO Box 549
Molalla, OR 97038
800-544-5243 Fax: 503– 961-8730
www.biaoregon.org • biaor@biaoregon.org

Oregon Brain Injury Support Groups

Bend
CENTRAL OREGON SUPPORT GROUP
2nd Saturday 10:30am to 12:00 noon
St. Charles Medical Center
2500 NE Neff Rd, Bend 97701
Rehab Conference Room, Lower Level
Joyce & Dave Accornero, 541 382 9451
Accornero@bendbroadband.com

Brookings
BRAIN INJURY GROUP (BIG)
To be announced
1-877-469-8844, 541-469-8887

Cottage Grove
BIG II (Brain Injury Group II)
Thursdays 11 a.m. to 12:30 p.m.
Jefferson Park Recreation Room
325 S. Fifth St, Cottage Grove
For directions and information,
Anna, 541-767-0845.

Corvallis
STROKE & BRAIN INJURY SUPPORT GROUP
1st Tuesday 1:30 to 3:00 pm
Church of the Good Samaritan Lng
333 NW 35th Street, Corvallis, OR 97330
Call for Specifics: Mary Quibrera, (541) 768-5157
aeasterl@samhealth.org

Coos Bay
Traumatic Brain Injury (TBI) Support Group
2nd Saturday August 9th 3:00pm – 5:00pm
Kaffe 101, 171 South Broadway
Coos Bay, Oregon 97420
tbicbsupport@gmail.com

Eugene (2)
COMMUNITY REHABILITATION SERVICE OF OREGON
3rd Tuesday 7:00 to 8:30 pm
Central Presbyterian Church
15th & Patterson, Eugene, OR. 97401
Call for Information
Jan Johnson, (541) 342-1980
comrehabjan@aol.com

BIG (BRAIN INJURY GROUP)
Tuesdays 11:00am-1pm
Hilyard Community Center
2580 Hilyard Avenue, Eugene, OR. 97401
Curtis Brown, (541) 998-3951
BCCBrown@aol.com

Hillsboro
HOMEWARD BOUND SUPPORT GROUP
1st Monday 7-8 starting in August
Tuality Community Hospital
335 South East 8th Street
Hillsboro, OR 97123
Carol Altman, (503)640-0818

Klamath Falls
BRAIN INJURY SUPPORT GROUP
2nd and 4th Tuesday 1:00pm to 2:30pm
Lower Level
Klamath County Courthouse
316 Main St
Klamath Falls, OR 97601
Cheryl Broyles, 541-273-0334
biota@charter.net

Lebanon
BRAIN INJURY SUPPORT GROUP OF LEBANON
1st Thursday 6:30 pm
Lebanon Community Hospital
525 North Santiam Hwy, Lebanon, OR 97355
Conf Rm #6
Lisa Stoffey 541-752-0816
lstoffey@aol.com

Medford (2)
TURNING POINT
3rd Tuesday 4:00pm-5:00pm
11 W. Jackson St, Medford, 97501
Pam Ogden, (541) 776-3427
Pamela.Ogden@sogoodwill.org

SOUTHERN OREGON BRAINSTORMERS SUPPORT AND SOCIAL CLUB
1st Tuesday of every month, 3:30 – 5:30 PM
Providence Medical Center
Birthplace Conf Rm (Main Entrance, turn left),
1111 Crater Lake Avenue, Medford
Lorita Cushman-541-772-6528
LORITAMICKCUSH@aol.com

Molalla
BRAIN INJURY SUPPORT GROUP OF MOLALLA
4th Monday 6:30-7:30 pm
Son'light Vital Foods, Inc.
123 Robbins St., Molalla, OR 97038
Raeleah Brensen, 503.829.9456
Skeeter@molalla.net

Newport
BRAIN INJURY SUPPORT GROUP OF NEWPORT
2nd Saturday 2-4 pm
4909 S Coast Hwy Suite 340
South Beach, Oregon 97366
(541) 867-4335 or progop541@yahoo.com
www.progressive-options.org

Oregon City
1st & 3rd Friday 1-3 pm (Starts again in Sept)
Clackamas Community College McLoughlin Hall
Rm #M226 (2nd floor)
Sonja Bolon, MA 503-816-1053
Brain4you2@gmail.com

Pendleton
Inactive at this time.
For more information contact:
Joyce McFarland-Orr (541) 278-1194
jmcfarland@Oregontrail.net

Portland (12)
BRAINSTORMERS I
2nd Saturday 10:00 - 11:30am
Women's self-help group
Wilcox Building Conference Room A
2211 NW Marshall St., Portland 97210
Next to Good Samaritan Hospital
Northwest Portland
Jane Starbird, Ph.D., (503) 493-1221
drstarbird@aol.com

BIRC Alumni Support Group
Last Tuesday of every odd month
1815 SW Marlow, Ste 110, Portland, 97225
Contact Doug Peterson for additional information
503-292-0765 or doug@progrehab.com

BRAINSTORMERS II
3rd Saturday 10:00am-12:00noon
Survivor self-help group
Emanuel Hospital, M.O.B.-West
2801 N Gantenbein, Portland, 97227
Northeast Portland
Steve Wright (503) 413-7707
biaor@biaoregon.org

CROSSROADS (Brain Injury Discussion Group)
2nd and 4th Friday, 1-3 pm
Independent Living Resources
2410 SE 11th, Portland, OR 97214
Christopher Eason, 503-232-7411
christopher@ilr.org

FAMILY SUPPORT GROUP
3rd Saturday 1:00 pm-2:00 pm
Self-help and support group
Currently combined with *PARENTS OF CHILDREN WITH BRAIN INJURY*
Emanuel Hospital, Rm 1035
2801 N Gantenbein, Portland, 97227
Joyce Kerley (503) 413-7707
joycek1145@aol.com

FARADAY CLUB
Must be pre-registered -
1st Saturday 1:00-2:30pm
Peer self-help group for professionals
with brain injury
Emanuel Hospital, Rm. 1035
2801 N Gantenbein, Portland, 97227
Arvid Lonseth, (503) 680-2251 (pager)
alonseth@pacifier.com

HELP
(Help Each Other Live Positively)
4th Saturday - 1:00-3:00 pm
TBI Survivor self-help group **(Odd months)**
TBI Family & Spouse **(Even Months)**
Cognitive Enhancement Center
15705 S.E. Powell Blvd. Portland Or.
Brad Loftis, (503) 760-0425
bcmuse2002@yahoo.com
Please contact at least two days in advance

PARENTS OF CHILDREN WITH BRAIN INJURY
This group will meet once a month, and is a self-help support group. Currently combined with *FAMILY SUPPORT GROUP*

TBI SOCIAL CLUB
Location varies, call for times & locations
Meets twice a month - days and times vary
call for information
Sandra Ward, (503) 735-4857
slwsundance@qwest.net

Greater Persons Toastmasters Club (for People with Brain Injury)
2nd & 4th Wednesday 6:00-7:00 pm
Open to all including family members
2154 NE Broadway #110, Portland OR 97232
Caleb Burns, (503) 913-4517 Call in advance

Greater Persons Toastmasters Club (for People with Brain Injury) Eastside
Last Saturday of the month 10 am—11 am
Open to all including family members
Faith Community Church Street:
12414 *East* Burnside St *Portland*, 97233-1044
Caleb Burns, (503) 913-4517

Roseburg
UMPQUA VALLEY DISABILITIES NETWORK
2nd Monday 12 noon - 1pm
419 NE Winchester, Roseburg, OR 97470
Tim Rogers, (541) 672-6336 x202
timrogers@udvn.org

Salem (3)
SALEM BRAIN INJURY SUPPORT GROUP
4th Thursday 6pm-8pm
Salem Rehabilitation Center
2561 Center Street, Salem OR 97301
Traci Wilson, (503) 561-1974
TRACI.WILSON@salemhospital.org

SALEM STROKE SURVIVORS & CAREGIVERS SUPPORT GROUP
2nd Friday 1 pm –3pm
Salem Rehabilitation Center
2561 Center Street, Salem OR 97301
Scott Werdebaugh 503-838-6868
Ruby McEliroy 503-390-3372

SALEM SOCIAL CLUB
Temporarily inactive
Windsor Place
3005 Windsor Ave. NE
Salem, OR 97301
Sharon Slaughter , (503) 581-0393
sharonslaughter@qwest.net

Vancouver Washington
VANCOUVER TBI SUPPORT
2nd and 4th Thursdays 2-3 pm
disAbility Resources of SW WA
2700 NE Andresen, Suite D5
Contact: Charlie Gourde
charlie@darsw.com
10-4 Monday – Friday
360-694-6790 ext. 103

Idaho and Surrounding TBI Support Groups
Quad Cities
2nd Saturday
Tri State Memorial Hosp.
1221 Highland Ave.,
Clarkston, WA 99403
Deby Smith 509-758-9661
biaqcdeby@earthlink.net

Spokane
2nd Wednesday
St. Luke's Rehab Institute
711 S. Cowley, Room 200
Spokane, WA 99403
Gloria Malmoe justformejustice@msn.com,
Ashley Richard vjwcamis@earthlink.net
509-340-0786

Treasure Valley BI Support Group
4th Thursday 7-9 pm
Idaho Elks Rehab. Hosp. 4th Floor, Sawtooth Rms.
600 North Robbins Road Boise, ID 83702
Kathy Smith, 208-367-8962
kathsmit@sarmc.org

Southeastern Idaho TBI support group
2nd Wednesday 12:30 p.m.
LIFE, Inc., 640 Pershing Ste. A
Pocatello, ID 83201
Tracy Martin 208-232-2747
tracyfm@velocitus.net

Twin Falls
3rd Tuesday of each month 6:30-8 p.m.
St. Lukes Idaho Elks Rehab.
560 Shoup Avenue West, Twin Falls
Keran Juker KeranJ@mvrmc.org

Fall 2008 Sudoku

The object is to insert the numbers in the boxes to satisfy only one condition: each row, column and 3x3 box must contain the digits 1 through 9 exactly once. (Answer will be in next issue)

4		1				6		
	3	8		6	7	5		
	7		8		1		2	
6	9		1				3	
			3	9	8			
	8				4		5	2
	4		9		2		8	
		7	4	8		1	9	
		9				2		3

The seriousness of a brain injury can't be overstated. Its negative neurobehavioral effects can present long after the brain injury occurs and be lifelong.

Mounting empirical evidence suggests that the impacts of severe cognitive changes are major contributors to the broader problems of crime, homelessness, substance abuse, unemployment and divorce. Recognition of head trauma and its proper assessment and treatment, could prevent hundreds of thousands of people from unnecessary marginalization or worse. Our current knowledge and understanding of the societal impacts of brain injury are very preliminary but point to a problem that has enormous costs.

'As a neurosurgeon who has treated brain-injured patients over many decades, I have seen community-based cognitive therapy work wonders on many brain-injured people. Community-based treatment can prevent or reverse social and economic disaster. Just like high blood -pressure treatment or cancer screening, these prevention programs avoid large, predictable expenditures of suffering and dollars.

The return on investment is shockingly obvious." (Gerard S. Rodziewicz, M.D., FACS, *Syracuse, N.Y. 2/7/08)*

Summer 2008 Sudoku Answers

8	7	3	4	2	5	9	6	1
4	9	5	6	1	3	2	7	8
1	2	6	8	9	7	5	4	3
6	4	2	3	7	9	1	8	5
9	5	1	2	4	8	7	3	6
7	3	8	1	5	6	4	9	2
5	6	4	7	8	1	3	2	9
2	8	9	5	3	4	6	1	7
3	1	7	9	6	2	8	5	4

The Brain Injury Association of Oregon
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Portland, OR 97210-2924

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Living with Brain Injury: Identifying the Problems - Finding Solutions

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Sheraton Portland Airport Hotel

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Phone: 503-684-8831
Fax: 503-670-4861
Cellular: 503-804-6287
Email: BRobb2000@aol.com

How To Contact Us

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Molalla, OR 97038
(503) 740-3155
Toll free: (800) 544-5243
Email: biaor@biaoregon.org
Website: www.biaoregon .org

Oregon Brain Injury Resource Network (OBIRN)
Toll free: (800) 544-5243
Email: tbi@wou.edu
Website: www.tr.wou.edu/tbi

BIAOR Open
biaoropen-subscribe@yahoogroups.com
BIAOR Advocacy Network
BIAORAdvocacy-subscribe@yahoogroups.com

Vehicle Donations

Through a partnership with VDAC (Vehicle Donations to Any Charity), The Brain Injury Association of Oregon, BIAOR, is now a part of a vehicle donation system. BIAOR can accept vehicles from anywhere in the country. VDAC will handle the towing, issue a charitable receipt to you, auction the vehicle, handle the transfer of title, etc. Donations can be accepted online, or call 1-877-999-8322. The online web site is http://www.v-dac.com/org/?id=930900797

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