the HEADLINER

Summer 2006
Vol. VIII Issue 3

The Newsletter of the Brain Injury Association of Oregon

What's Inside?

4th Annual Pacific Northwest Conference on Brain Injury 2006

You are invited to participate in the 4th Annual Pacific Northwest Brain Injury Conference to be held October 6– 7, 2006 in Portland Oregon at the Holiday Inn Portland Airport. This conference will provide the latest research, techniques and education to professionals across numerous fields and disciplines working with people with brain injury. This preliminary program provides information about the conference is for your review on pages 7-10 as well as registration information.

The 4th Annual Pacific Northwest Brain Injury Conference has added a Law track this year presented by attorneys Ian Mattock, Hawaii, and Richard Adler, Washington, and Robert Fraser, PhD, and Jay Uomoto, PhD, from Washington. The Medical track will feature our Friday Keynote Speaker, Neuropsychologist, Rehabilitation of Brain Functions: Memory and Learning Issues After TBI from Towson University. On Friday the Medical track will focus on Dual and Triple Diagnosis. Saturday the Medical track will look at issues surrounding veterans returning from the war, vision and other sensory problems after TBI, and alternative health options. Saturday's Keynote Speaker will be Lisa Keller, developer of the Brain Injury Recovery Kit. The Consumer track will feature a two hour Advocacy training.

Friday night will end with a reception hosted by Day-Timer featuring Northwest wines, cheeses and fruits. This will also present a time for networking or just catching up with professionals from over 14 states. Exhibitors will present information on housing, accessibility and mobility, rehab services and resources available in the brain injury field.

Early registration is encouraged. Those who register before September 1 will receive a $50 discount.

We hope you will join us for this very special conference and enjoy an invigorating educational experience in beautiful Portland Oregon.

Molalla Bike Rodeo A Huge Success

The Brain Injury Association of Oregon and the Molalla Fire and Police Departments hosted a bike rodeo on May 19 & 20, 2006. Over 200 children and their parents attended. Each child and many of their parents received a free helmet from BIAOR. Emily Hochhalter of Think First Oregon, Catherine Kerrigan of Molalla Police and BIAOR executive director, Sherry Stock, and board members, Dave Kracke, Bob Malone, and Sharon Maynard fitted each person with a helmet and provided bike safety information and education. Each bike was checked for safety and repaired when necessary by the Molalla VFW. Molalla Police Officer Aaron Christopherson ran participants through the bike course set up by Molalla PD Sgt. Jim Barnhart . Mike Penunuri from Molalla fire allowed the course to be set up inside the bays of the fire station.

This event was made possible by the generous

(Bike Rodeo Continued on page 14)

Emily Hochhalter, Think First of Oregon
Courtesy Molalla Pioneer

Brain Injury Association of Oregon
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Executive Director: Sherry Stock

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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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Advertising in Headliner

Rate Schedule	Issue	Annual/ 4 Issues
A: Business Card	$ 75	$ 225
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Policy

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

When looking for a professional, look for someone who knows and understands brain injuries. The following are supporting professional members of BIAOR.

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The brain: mind-boggling. But whatever mysteries that lie within its folds, there's no better stimulation for the brain of a driver than an empty road, a full tank of fuel and energizing music over the sound system.

- Car Advertisement

The Brain Injury Association of Oregon has been fortunate to have a jewelry designer create a pin using our three heads logo. This beautiful pin is a pure sterling silver lapel stick pin for both men and women. It is available through the office for $15. It will soon be available online on the BIAOR website. The artist is creating additional pieces in 14 K gold and gold with diamonds. He will also be creating bracelets, necklaces and earrings in the same design. If you would like more information about the pin or to order your pin now, call the BIAOR office (503-413-7707 or 800-544-5243) or email (biaor@biaoregon.org).

The human brain starts working the moment you are born and never stops until you stand up to speak in public.
George Jessel

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

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

CONSERVATORSHIPS FOR BRAIN INJURED INDIVIDUALS

In our last issue, I discussed the establishment and operation of a guardianship for a person with a serious brain injury. In this month's column, I will discuss conservatorships, which in some ways are similar to the guardianship provisions.

A conservatorship is appropriate when a court finds by "clear and convincing evidence" that the injured person is "financially incapable" and has money or property that requires management or protection. Conservators are governed by the provisions of Oregon Revised Statutes chapter 125.400 to 125.540 (with references to other statutes as well).

The words "management" and "protection" are at the core of the conservatorship proceedings. On the one hand, the court desires to be sure that the injured person has a management support mechanism so that the protected person's assets are properly allocated to meet the needs of that person and, on the other hand, the court is saying that those same funds need protection from potentially unscrupulous individuals.

Both elements of protection that a conservatorship provides to an injured person are necessary. The "management" of one's financial assets is complicated in the best of circumstances and literally overwhelming to many brain-injured individuals. A conservator takes this burden of asset management from the brain-injured individual and typically provides asset management services that result in financial stability to the greatest extent possible.

The "protection" element of the conservatorship is equally important. In my years as an attorney specializing in brain injury cases, I rarely get as angry as I do when I hear about a brain-injured individual who is taken advantage of by con artists or thieves.

There is another important reason to establish a conservatorship with regard to a brain injured individual. Often an individual who suffers from a traumatic brain injury will not appreciate his or her actions. Sometimes these actions include literally giving their money away. I have heard stories of TBI sufferers handing out $100 bills to complete strangers. I have heard many stories of TBI sufferers purchasing large items for friends and family members, making huge expenditures for unnecessary items, or doing things such as buying drinks for an entire bar for no apparent reason. While I typically commend this type of generosity from healthy and wealthy individuals, when I hear about a brain injured person essentially giving away the limited funds that were meant to last that person's lifetime, it becomes very distressing to me.

While some expenditures require prior court approval (such as selling the protected person's house), the conservator does not need court approval for every financial transaction they make on behalf of the protected person. The conservator will, however, need to justify those expenditures in an annual accounting that is required to be filed and reviewed by the court. As a result, a significant responsibility of the conservator is to keep track of all money spent on behalf of the brain injured individual. This can be a daunting task for a conservator who is already under the stresses of normal life, and so it is not recommended that a person undertake the role of a conservator if he or she is not up to the task of this significant financial responsibility.

In addition to the annual accountings required by the court, the conservator must also submit an initial inventory of the protected person's property to the court within ninety days of the date of initial appointment. This initial inventory must include all the property of the estate of the protected person "that has come into the possession or knowledge of the conservator." (ORS 125.470). This initial inventory provides the starting point against which the conservator's actions will be measured. It provides the court with the totality of the protected person's assets and advises the court as to the nature of those assets.

I have decided not to relate the any more of the specific requirements that go into the establishment and operation of a conservatorship in this short column. Suffice it to say that the court requires a finding of disability on the part of the protected person and a finding of capability and honesty, together with an understanding of the fiduciary responsibility, on the part of the conservator.

The conservator essentially steps into the shoes of the injured individual and has control over most, if not all, financial decisions of that person's life. As a result, the conservator is responsible for the support, education, care or benefit of the protected person. It is a serious responsibility and ultimately a very beneficial responsibility

(Lawyer's Desk Continued on page 5)

(Lawyer's Desk Continued from page 4)
with regard to the well-being of the brain injured individual.

As I stated in my column on guardianships, if any readers of this column have questions regarding the establishment of a conservatorship I would urge them to contact me or another qualified attorney to discuss those questions. For the sake of the injured individual, if anyone notices behavior that is financially irresponsible, it is well advised to consider a conservatorship in order to protect that injured individual's limited funds.

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.

(This column is meant for general informational purposes only. It is not meant to impart any specific legal advice, and anyone who has a specific legal question regarding a person afflicted with a TBI should consult with an attorney skilled in that area of law.)

Stop Treating the Brain Injured

Harvey E. Jacobs, Ph.D.[1]

There is no doubt that brain injury is a devastating and life-changing event for too many people each year. It is an equally significant event for families, friends and other's involved in the individual's circle of life. Rapid access to emergency care, astute diagnosis, and timely treatment can make the difference between hope or despair, and future or frustration.

Research has documented that well-integrated treatment teams can decrease life long impairments and disability, making it possible to reduce the consequences of brain injury. Unfortunately, these services end too quickly for far too many people who are only beginning to achieve their promise when funding, programming and other critical elements to successful recovery cease.

It is equally devastating when services are improperly delivered, or when the person gets lost in their brain injury. As noted by the Portland neuropsychologist Muriel Lezak nearly 30 years ago, severe brain injury begins as a medical challenge, but ultimately becomes a social catastrophe.

Today, more people than ever survive the initial consequences of brain injury due to tremendous technological advances in emergency care and treatment. At this point a person's life or death depends on the precision and integrity of advanced medical technology and coordinated systems of clinical care. Intervention focuses on the specific challenges to a person's survival. Just as important is the social contract within our society to take care of one another in such circumstances of extreme need without exploitation for at this point a person is truly a victim with little or no involvement in the process.

Victims become patients as early medical intervention services transition to rehabilitation services. We long ago realized that approaches so important during the early stages to prevent people from dying are not adequate or appropriate for this equally important part of the recovery process; hence, the need for this different approach.

In rehabilitation we continue treating the damaged parts of people and this diagnostic approach can be useful when

2006 BIAOR Calendar of Events

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

September	BIAA Annual Brain Injury Conference Sept 8-10, Baltimore MD
	Salem Walk for Thought, September 30 Bush Park in Salem
October	Legislative forum for State Candidates Oct 3, 2-4 pm Milwaukie Senior Center 5440 SE Kellogg Creek Dr. Milwaukie, OR 97222, (503) 653-8100
	Annual Conference Oct 6-7, 2006 *Living with Brain Injury: Creating a Future*
December	7th Annual Holiday Fundraiser—Dec 7
	Support Group Holiday Parties

(Brain Injury Continued from page 5)
we are first trying to help a person regain such basic abilities as walking, talking, and self-feeding.

But rehabilitation has its own limitations and other approaches are needed to help individuals regain their perspective and identity. Location is a significant issue. Most rehabilitation services take place in designated medical or treatment facilities. Although helpful at the beginning when intensive treatment is needed, these locations can later become a hindrance as the challenges change from basic restoration to the use of compensatory strategies in one's home and community. Fortunately, some rehabilitation programs now reach out to community settings, but their grasp can be limited.

Too often treatment approaches continue to view the individual for their deficits instead of their abilities. This identity, unfortunately, becomes attached to the person and those who are with them. It is an insidious process, but over time one cannot help but feel devalued and viewed for what they cannot do instead of for their hopes, dreams and abilities. This in turn leads to increased dependency, depression and despair, which promotes isolation, behavioral disruption and further failure.

This may all sound like semantics, but it isn't. Working with the whole individual and not just treating a person's damaged components has a real effect on outcomes. People who have the ability to place their history of brain injury within the perspective of their overall lives have greater chances for personal development and success. They learn quickly that although a brain injury is part of their lives, it does not have to define their life. They can still be husbands, wives, brothers, sisters, workers, students, like sports, enjoy music, and be involved in all other areas that have always been important to them.

While many people still may need help and services, the difference is that these supports become incorporated into the cadence of their daily lives, rather than a separate component. In addition, the work and effort produce real payoffs that each person can see as they gain greater control and direction in their lives. It's no longer about incremental gains in therapy, but real life opportunities that develop and contribute to personal success and quality of life. Both cognitive and behavioral treatment approaches are most effective when they are used to help people address personally identified challenges in real world situations as compared to isolated treatment settings.

When we stop treating the brain injured we enter into partnerships with people to help them expand their horizons and celebrate their success. We replace the concepts of the "brain injured patient" and "life after brain injury" with the understanding that a brain injury is only one part of a person's life, but should never define the total person or how we relate to one another. Tying the past with the future is critical for a successful perspective of the full person.

For example, years ago I received a referral about a "52 year old female with a diagnosis of status post surgical resection for a brain tumor with major frontal lobe involvement who was easily agitated and socially inflexible." After a few dry clinical sessions, we met for lunch with several other "patients" one day, ostensibly to evaluate her social skill deficits so that she could learn to be "appropriate." A picture of an airplane hung on the restaurant and she began to talk about her earlier work as a Pan Am flight attendant. For the first time her eyes sparkled and her voice radiated as she talked about her international travels. People paid little attention until she mentioned a London to New York flight in early February 1964 that contained four unknown musicians on their way for an appearance on the Ed Sullivan show. Nobody at the table ever disregarded her again because of her brain injury. On that specific flight, she had brought the Beatles to America.

My friend rarely had problems relating to others again. It was not because of the Beatles, but because she and others acknowledged her life of which brain injury was only one part. From this initial base other wonderful facets also appeared. She could still be as cantankerous and unyielding as anybody, but this was only part of her and there was so much more that she had to give and receive from others. And she no longer introduced herself as "My name is Sally and I'm brain injured." From then on, simply "Sally" was sufficient.

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1. Originally published in Learning Services: Relearning Times. Harvey Jacobs is trained as a psychologist and serves people seeking opportunity who have been challenged by disability. He can be contacted at: 9221 Forest Hill Avenue; Richmond, VA 23235; 0609;jacobs@comcast.net

Sponsored by The Brain Injury Associate of Oregon

Living with Brain Injury: Creating a Future

The 4th Annual Pacific Northwest Brain Injury Conference 2006

Holiday Inn Airport Hotel
Portland, Oregon
October 6 & 7, 2006

Featuring:

Keynote Speaker Friday- Frederick Parente, PhD - **Neuropsychologist**
Rehabilitation of Brain Functions and Cognition: Memory and Learning Issues After TBI
Keynote Speaker Saturday—Lisa Keller - TBI survivor
Developer of the Brain Injury Recover Kit®

Highlights

Medical Track:	**Dr. Dilantha B. Ellegala, Director of Neurotrauma, OHSU, OR** **Jay Uomoto, PhD, WA; RD Mitchell, PhD** **Dr. Ron Heintz, State of Oregon, & Dr. Danielle Erb, BIRC, OR**
Legal Track:	**Ian Mattoch, Esq., HI; Richard H. Adler, Esq., WA** **Robert Fraser, PhD, UW; Tim Nay, Esq., OR**
Consumer Track:	**McKay Moore Sohlberg, PhD & Laurie Ehlhardt, PhD, UO** **Geoffrey Lauer, BIAA** **Tootie Smith—Former Oregon Congresswoman**
Native People:	**Two Day Indigenous Peoples Planning and Training Gathering** **Alta Bruce, ND, and Beverly Francisco-James, NM**
Poster Sessions:	**TBI projects**

4th Annual Pacific Northwest Brain Injury Conference

The Brain Injury Association of Oregon (BIAOR) invites you to participate in the 4th Annual Pacific Northwest Brain Injury Conference: "*Living with Brain Injury: Creating a Future*". The two day conference will be held on Friday and Saturday, October 6-7, 2006, at The Holiday Inn Airport Hotel, Portland, OR. 8439 NE Columbia Blvd. Portland, Oregon 97220 (800-465-4389)

Preliminary Conference Program

Friday, October 6 (*Professional Focus*)	Saturday, October 7 (*Professional & Consumer Focus*)
7:00 a.m. - 7:45 a.m. Registration and Check-in - Continental Breakfast	7:00 a.m. - 7:45 a.m. Registration and Check-in - Continental Breakfast
8:00 a.m. - 9:15 a.m. Welcome to BIA Conference 2006 Opening with Traditional Tribal Ceremony-Ramona Ahto, WA, Bell Ceremony Keynote Speaker - Frederick Parente, PhD - Neuropsychologist, Rehabilitation of Brain Functions: Memory and Learning Issues After TBI	7:30 a.m. - 8:00 a.m. Meeting of the Members 8:00 a.m. – 9:15 a.m. Welcome to BIA Conference 2006 Opening with Traditional Tribal Ceremony-Ramona Ahto, WA Keynote Speaker: Lisa Keller, Developer of the Brain Injury Recovery Kit
9:30 a.m. - 10:30 a.m. Track 1: Round Table: Managing Chaos: Dual and Triple Diagnosis-recommendations and solutions—Dr. Danielle Erb, Andrew Ellis, PhD, Jay Uomoto, PhD, WA; Moderator Dr. Tom Boyd Track 2: What Every Attorney Should Know About Brain Injury: Successfully Preparing A Legal Claim In TBI- Ian Mattoch, Esq. Track 3: *Can you hear me now?* The BIA's of OR, CA, WA-What We Are Doing To Help Our Community, State BIA Executive Directors Track 4: 3rd Annual Native Peoples Brain Injury Workshop–Alta Bruce-ND	9:30 a.m. - 10:30 a.m. Track 1: Panel- Impact Of The War In Iraq On The Number Of Cases Of Traumatic Brain Injury-Rep Brian Boquist, Jay Uomoto, PhD, Tara Stablein and Dr. Danielle Erb, Alec and Shana Giess Track 2: Bringing Family into Rehabilitation - BIRK - Sandra Knutson, Martin Russo and Lisa Keller Track 3: Securing the Future: Special Needs Trusts-Tim Nay, MA, MSW, JD Track 4: 3rd Annual Native Peoples Brain Injury Workshop–Alta Bruce-ND
10:45 a.m. - 12:00 p.m. Track 1: Managing Chaos: Dual And Triple Diagnosis-Mental Illness, Brain Injury And Other Issues-Recommendations And Solutions: Dr. Ron Heintz, OR Track 2: What Every Attorney Should Know About Brain Injury: Successfully Preparing A Legal Claim In TBI- Ian Mattoch, Esq. Track 3: Taking It On The Road: Multi State TBI Project Updates And Overviews-Russ Spearman, ID, Sue McDonough WA, Jane Laciste and Kathy Clark, CA; Ann Glang OR Track 4: *Can we stop the wild fire?* Methamphetamine In The Native American Populations And Throughout The West.– Alta Bruce	10:45 a.m. - 12:00 p.m. Track 1: Building Email Community - Dr. Mckay Sohlberg, UO and Dr. Laurie Ehlhardt, TRI Track 2: Families and Survivors in the Driver's Seat: The Importance of Collaboration Between Families and Service Providers; Karen McLaughlin, OU Track 3: Workshop- Interventions for Cognitive Impairment - TimiSue Abbott -creating memory books-scrapbooks - a family activity Track 4: The Silent Epidemic In The Home—Domestic Violence and the Native American and General Population - Alta Bruce
12 noon - 1:30 p.m. Lunch	12 noon - 1:30 p.m. Lunch
1:30 p.m. - 2:30 p.m. Track 1: Managing Chaos– The Medications Out There, What Is Working, What Is Not For Patients With Mental Illness And Brain Injury—Dr. Ron Heintz, OR Track 2: What Every Attorney Should Know About Brain Injury: Uses And Abuses Of Neuropsychological Evaluations-Jay Uomoto, PhD Track 3: What's Next After The Hospital: Short and Long-Term Care Following TBI - Delta Foundation, Doug Rusch, CNS, Matt Clough, CLI	1:30 p.m. - 2:30 p.m. Track 1: Treating Vestibular/Balance/Sensory Symptoms after TBI: Sensory Update, overview and simulation stations: Vision: Dr. Bruce Wojciechowski, OD, OR; auditory-Dr Litman, WA; olfactory: Janet Mott, PhD, WA Track 2: Advocacy Workshop-Geoff Lauer, Rep, Tootie Smith, Track 3: *I was to be there when?* Using Assisted Technology-a PDA– John Parker; Kristi Svendsen, Brain Train, cognitive retraining software
2:45 p.m. - 3:45 p.m. Track 1: Behavioral Issues And Community Re-Entry: Chris Persel, CNS Track 2: What Every Attorney Should Know About Brain Injury: Critical Issues In Long Range Planning And Earnings Loss - Robert Fraser, PhD Track 3: Educating Students with TBI: Strategies and Transitions: Ann Glang, PhD, Teaching Research Institute	2:45 p.m. - 3:45 p.m Track 1: Pulling Together: Community Collaboration And Outreach To Professionals and Local Community Members—Don Hood, TRI Track 2: Advocacy Workshop-Geoff Lauer, Rep, Tootie Smith Track 3: Rise To Next Level - Beyond Recovery (Personal Experience): Survivors On The Move. Sharing Their Stories: Parents of Brain Injury Survivors, Tom Ogan, MS, Leone Nully
4:00 p.m. - 5:00 p.m. Track 1: What Does The Future Hold In Brain Injury Research? Dilantha B. Ellegala, M.D., Assistant Professor, Director of Neurotrauma, OHSU Track 2: What Every Attorney Should Know About Brain Injury: The Winning Focus For Your TBI Case—Including Use Of Before And After Witnesses—Richard H. Adler, Attorney and Law; Chairman of BIAWA's Executive Board Track 3: Educating Students with TBI: Strategies and Transitions: continued 6 PM Reception Hosted by Day -Timer	4:00 p.m. - 5:00 p.m. Track 1: Isn't There Some Other Way? Alternative & Complementary Health Care Treatments: RD Mitchell, PhD, clinical psychologist, The Greenhouse Health & Wellness Center Track 2: Managing And Pulling It All Together, The Challenges Of Support Group Facilitators: Curtis Brown and Janet Novinger, WA Track 3: The Challenges Facing Road Safety: Driving After A Brain Injury - Teresa Valois, WA, OTR/L, CDRS, ATP and Jeff Lango, OR

Registration Form
4th Annual Pacific Northwest Brain Injury Conference 2006
Living with Brain Injury: Creating a Future *In Portland OR, Holiday Inn Airport Hotel*

Please register before September 1, 2006 to receive discount, 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.)

First Name			Last Name		
Badge Name			Affiliation/Company		
Address		City		State	Zip
Phone		Fax		Email	
Special Needs					

Please check all that apply:

__ I am interested in volunteering at the conference. Please call me.

__ I am requesting continuing education credits (CLE's, CEU's and CME's) for the conference.

__ I would like to make a donation to cover costs of survivors unable to pay (see below).

__ Call me about sponsorship/exhibitor opportunities.

Conference Registration Fees: Registration fees include: continental breakfast and lunch on Friday and Saturday; all conference related materials; continuing medical/educational units; and access to all conference sessions, exhibits, posters and roundtables.

	BIAOR Member [1]	*Non-Member*	Accompanying Person [2]	Amount
___ 2 Day 10/6-7/06 Conference Advance-	$250	$300	$130	
___ After September 1	$300	$350	$155	$
___ Friday Only 10/6 Advance-	$175	$225	$80	
___ After September 1	$225	$275	$105	$
___ Saturday Only 10/7 Courtesy[3] Advance	$25	$35		
___ Courtesy[3] After September 1	$25	$35		$
___ Saturday Only 10/7 Survivor/Family Advance-	$50	$100		
___ Survivor/Family After September 1	$100	$125		$
___ Saturday Only 10/7 Professional Advance-	$175	$225		
___ Professional After September 1	$225	$275		$
___ Scholarship Contribution (donation to assist in covering the cost of survivors with limited funds)				$

1) A limited number of conference scholarships are available to survivor members of BIAOR to cover the costs of conference registration.

2) Accompanying Person: Registration fee includes continental breakfast, lunch and exhibition only. Fee does not include admission to conference sessions.

3) Courtesy rate is for brain injury survivors with limited means.

I want to become a BIAOR member NOW to receive the discounted registration fee: ☐ Basic-$35 ☐ Student-$25

☐ Non-Profit-$75 ☐ Family-up to 3 people-$50 ☐ Survivor Courtesy[3]-donation ☐ Professional-$100 ☐ Sustaining-$250

☐ Corporation-$300 ☐ Sponsorship Bronze-$250 ☐ Sponsorship Silver-$500 ☐ Sponsorship Gold-$1000 ☐ Sponsorship Platinum-$2000

Sponsorships (2 day) and Exhibitors:

☐ Diamond $5,000 ☐ Silver $1,000 ☐ Gold $1,500 ☐ Platinum $3,000 (2 day) $2,000 (1 day) ☐ Copper $750

☐ Vendor/Exhibitor $500 (2 day) /$350 (1 day)

Customized Sponsorship:

☐ Continental Breakfast ☐ Luncheon-Friday ☐ Luncheon-Saturday ☐ Breaks Friday ☐ Breaks Saturday

☐ Keynote Speaker: Friday ☐ Keynote Speaker: Saturday ☐ Other:_____

Registration and Membership **Total** $

(Please add totals from Registration Fee, Membership Fee and Scholarship Contribution for final total costs)

Conference 2006 Registration Continued

Payment

Payment in full must accompany your registration. Payment may be made by check or money order, VISA , Discover, MasterCard, or AMEX.
Enclosed please find my check/ money order payable to BIAOR in the amount of $ _____.
Please charge to my credit card ($35 minimum):

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express *Total Charged to Credit Card* $ _____
Card Number: _____ Expiration Date _____
Print name as it appears on card: _____Signature of Cardholder: _____
Credit Card Payments may also be made online at http://www.biaoregon.org/2006Conference.htm

Confirmation and Cancellation Policies

Confirmation letters will be e-mailed within five business days of receipt of registration. If your confirmation is not received within 2 weeks, please contact us via e-mail at biaor@biaorgon.org or by telephone at +1-800-544-5243 or 503-413-7707, M-F, 9-5.

Cancellations must be received in writing by September 21, 2006 to qualify for a refund. A $25.00 administrative fee will be deducted. Substitutions are always welcomed and no-shows will be billed.

Registration, Payment, and Refund Policy

Please submit payment with completed registration form.
Fees are payable by check, credit card, or state government purchase orders which obligate payment. All payments must be received before September 1, 2006, to be eligible for discount. All cancellations are subject to a $25 processing fee. No refunds will be issued for cancellations received after September 21; however, registrations are transferable.

Mail registration forms and payments to:
2006 Conference
Brain Injury Association of Oregon
2145 NW Overton • Portland OR 97210-2924
Or Fax to: (503) 413-6849

Questions? Please contact BIAOR
2145 NW Overton Street • Portland OR 97210
800-544-5243 • 503-413-7707 • Fax: 503-413-6849
biaor@biaoregon.org • www.biaoregon.org

Accommodation Information

Please make reservations directly with The Holiday Inn Airport Hotel, 8439 NE Columbia Blvd. Portland, Oregon 97220

Reservations: (503) 256-5000 or (800) 465-4389
Reservation Deadline: September 15, 2006

A block of rooms has been reserved for the conference participants at a special rate of $84 for both singles and doubles. Reference the "Brain Injury Conference" for rooms. Rooms are limited, please make your reservations early.

Continuing Education Credit available.

ASHA, CRCC, CDMS, CLE, CEU's will be available

Approved Continuing Education Provider
American Speech-Language-Hearing Association

The Oregon Speech-Language Hearing Association is approved by the Continuing Education Board of the American Speech-Language-Hearing Association (ASHA) to provide continuing education activities in speech-language pathology and audiology. This program is offered for 1.1 CEUs, intermediate level, professional area for both days only. ASHA CE Provider approval does not imply endorsement of course content, specific products, or clinical procedures.

Highlights

- Improving Traumatic Brain Injury Outcomes Through Research
- Impact Of The War In Iraq On The Number Of Cases Of Traumatic Brain Injury
- 3rd Annual Native Peoples Brain Injury Workshop - TBI Issues in the Native Population
- What every Attorney Should Know-Winning TBI Cases.
- What You Know Can Make The Difference—Advocacy Workshop
- How families can help-using BIRK.
- Best Clinical Practices In Rehab Using Email - ***CogLink***
- What are States doing to help those with Brain Injuries?
- What are State Brain Injury Associations doing?
- Poster Presentations
- Neuropsychiatry Of Traumatic Brain Injury
- Interventions For Cognitive Impairment - Compensating For Impairments In Memory And Executive Functions: How Can We Maximize The Effectiveness Of External Aids And Adaptive Devices?
- The Use of Complementary & Alternative Medicine In TBI
- Driving After Brain Injury
- Memories Relived: Creating Memory Books-A Family Activity
- Domestic Violence and Brain Injury
- Meth Use and Brain Injury

We Have Work To Do To Assist Returning Iraq War Vets

From a purely military standpoint, the war in Iraq may be remembered for the widespread and lethal use of the improvised explosive device, the roadside bomb that detonates beneath the vehicles of U.S. troops or innocent Iraqis.

From its use has come what some medical specialists are calling the "signature injury" of the Iraq war: traumatic brain damage, often with disfiguring scars, sometimes not, often readily apparent, sometimes sneaking up on a victim days or weeks after the blast.

Today, we have an important opportunity to display our caring nature in response to the needs of veterans returning from Iraq and Afghanistan. In October, the Brain Injury Association of Oregon will have the 4th Annual Pacific Northwest Conference having sessions focusing on "Returning Veterans from Iraq and Afghanistan" in Portland, OR. The goal of the conference and these sessions in particular is to educate community health-care providers on the unique and urgent needs of returning veterans.

Why do the department of Defense and Veterans Affairs attach such importance in mobilizing communities for the return of these veterans? In short, health-care experts at Defense and the VA understand there were serious shortcomings in our response to veterans from previous conflicts, most notably regarding the Vietnam War.

In addition, recent studies indicate that, as a result of the nature of the Iraqi war, issues facing these veterans are significantly different from many of our previous wars (see box). While each factor can be considered common in other theaters of war, defense experts contend that the cumulative impact of these issues creates unique stressors on many of the soldiers returning from this conflict.

According to the Walter Reed Army Medical Center, approximately 2/3 of our troops wounded in Iraq are coming home with traumatic brain injuries. Additional demographic data from Iraq indicate more than 18,000 soldiers have been seriously wounded, meaning more than 12,000 have suffered traumatic brain injury and more than 10,000 have been wounded by explosive devices resulting in some 400 amputees.

According to Defense Department statistics, the chance of a U.S. soldier being wounded in Iraq is 3.1 percent, which is greater than the rate for the Vietnam, Korean, World War I and Revolutionary War.

Why should this matter to Oregonians? There are thousands of Oregon National Guard and military veterans who have served in Iraq or Afghanistan. Data indicates rates of substance abuse, emotional disorders, domestic violence and suicide are higher among these veterans than other veterans.

The VA recognizes that many returning veterans with social or psychological issues don't seek care upon their return. Reasons include the perception that a soldier is weak if he or she can't handle his or her own problems, potential loss of career opportunities and the threat of stigma.

Regardless of our personal view of the Iraq conflict, throughout the state our communities have an opportunity to reach out to veterans who need our help. What can we do as a community to improve the issues faced by our returning veterans?

We can welcome veterans back to our community with both formal ceremonies and individually. While veterans groups and families are on the forefront of this effort, how many regular citizens make a point to thank a service member for their dedication and sacrifice?

We should recognize that family members of these veterans also need our support and assistance. Often, children of veterans are being raised without one of the parents present, and family members of veterans are faced with unending anxiety and personal adjustments during deployment. BIAOR is increasing support groups and encouraging family members and veterans to join these groups. BIAOR has a veterans package that includes a Brain Injury Recovery Kit and personal support for veterans with a brain injury and their families. This Kit is sold on our website (www.biaoregon.org/store.asp).or it can be purchased by phone (503.413-7707 or 1-800-544-5243) for $600.

Health-care providers should prioritize returning veterans and their families for access to assessment and treatment services. Our policymakers and human-service funders can continue to support the expansion of resources to serve the needs of this population.

In addition to all their other problems, injured veterans are finding that there are not enough resources to meet their economic needs. Faced with the inability to work in the jobs they had before, making the income they made, many of these families are struggling to keep their homes. You can consider assisting individual service members through donations to BIAOR. Let's each consider how we can be part of the solution.

IRAQ STRESSORS *Factors that increase risk to Iraqi veterans:*

- Many service members are experiencing repeated tours of duty unlike in previous war assignments.
- A much higher percentage of "citizen soldiers" -- National Guard and Reserve -- are serving in this conflict who are older and with families when compared to career soldiers.
- Greater stress results from the nature of "urban guerilla warfare" rather than more traditional "frontline" warfare.
- This enemy uses non-traditional weapons and tactics such as ambushes that are difficult to anticipate or predict.
- "Insurgents" are an ill-defined enemy with our troops experiencing difficulty in determining friendly versus hostile individuals.
- There are significant cultural, religious, ethnic differences between U.S. forces and Iraqi citizens.
- More women are deployed and active in combat.
- It is difficult to measure "victories" or to be able to define when this mission is truly accomplished.

Behavioral Symptoms List for TBI

California's Center for Neuro Skills and Making Headway's senior case manager, Cheryl Loudon, provide the following list of behavioral symptoms commonly seen in people coping with behavioral changes brought on by traumatic brain injury. Symptoms and severity vary.

Short-term, long-term memory loss

- Fatigue/Headaches
- Anxiety/Increased fear level
- Slowed mental processing

  Loudon: "It takes them more time to understand and awhile to catch meanings. They may not understand a turn of phrase or get a joke."

Trouble concentrating

Loudon: "They may find it hard to read more than a page at a time, or to spend more than 15 minutes at a task."

Spatial disorientation

Loudon: "They may hold their heads differently when they walk, have trouble judging distances or seeing curbs."

Impulsivity

Loudon: "They may do before they think. This also impedes their ability to handle school, work or finances."

Distractibility

Loudon: "Noises, movements or crowds may affect a brain-injured person more."

Problems finding words

Loudon: "They lose their internal dictionary. They know what the word means and can describe it, but they lose the vocabulary."

Sensory changes

Loudon: "They may become more sensitive to light, lose their taste or smell, hear differently."

Changes in emotional affectation

Loudon: "They may become more depressed, isolated, easily frustrated. They may not be interested in the same things they used to be or they may cry at a movie they would never have cried at before. These are signs loved ones seem to see first."

Decreased personal insight/ egocentricity

Loudon: "They have difficulty seeing how their behavior and actions affect others. They may hurt others with their words and not realize it."

Organizational problems

Loudon: "They lose their executive function, the ability to organize and sequence a plan. You can't tell some people with a brain injury to grab a shirt, pick up a pen and meet at the corner in 30 minutes. They might show up with no pen, forget why you are meeting or forget the meeting altogether. They can also lose the ability to track, to do things like math and finance. They often can't multi-task, or they might start six projects and never finish one."

CNS will be presenting at the 4th Pacific Northwest Conference on Brain Injury, October 6-7, 2006

I like nonsense; it wakes up the brain cells. - Dr. Seuss

HELP!

Today 6,000 Americans will sustain a Brain Injury

Support Our Cell Phone & Ink Jet Cartridge Recycling Fundraiser

Oregonians Helping Oregonians

Proceeds to Benefit

The Brain Injury Association of Oregon

Call us for pickup or drop off at our office

CONTACT: Sherry Stock, 503-413-7707 1-800-544-5243
2145 NW Overton St.,Portland OR 97210 biaor@biaoregon.org

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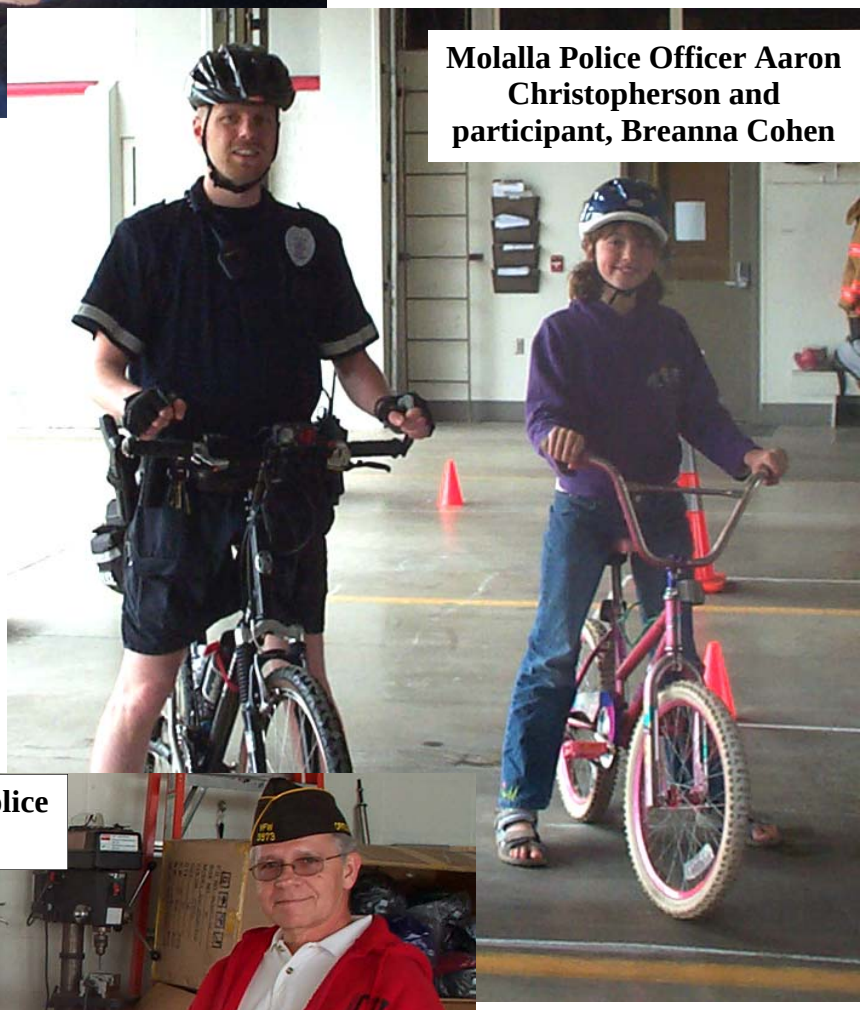
Molalla Bike Rodeo

Catherine Kerrigan, Molalla Police Department, volunteered both Saturday and Sunday, helping to make the Bike Rodeo a huge success.

(Continued from page 1)

donations from Ashrey Development; EC Company; Willamette Falls Hospital; Wells Fargo Bank; West Coast Bank; J & S Center for Wellness; Ohana Adult Foster Care Home; Bentley Feed Co. ; Big Meadow Realty; Dawn Huston Accounting; Ludemans, Inc; Rae Leah & Robert Brinson; Windemere Heritage



Molalla Police Officer Aaron Christopherson and participant, Breanna Cohen

Molalla VFW performed the bike inspections. Ron Jagodnik (left) and George Carroll

Catherine Kerrigan and Tyler Foust, Molalla Police Department, and Steve Morris, Molalla VFW

Real Estate; Molalla VFW; Lara McLaughlin; Family, Community, Education; Sonlight Vital Foods, Inc; Healthbytes; Adonai's Tae Kwon Do**;** Greenstone Montessori; Molalla Pioneer; Allied Cash Advance; and Perfect Look Salon #103.

2006 Brain Injury Awareness
Walk For Thought

Date: September 30.2006

Time: 10 AM

Bush Park in Salem, Oregon
Corner of High Street and Lefelle Street SE

For More Information
Contact Traci Wilson: 503-561-1974

Together We Can Prevent Traumatic Brain Injury

- Wear seat belts
- Use baby seats
- Wear Protective Helmets
- Help Stop Child Abuse

Join Us as we walk to Prevent Brain Injury & and Support Persons with Brain Injury

- **Registration starts at 10 am**
- **Walk begins at 11 am**
- **Entertainment and refreshments**
- **Walk is a fundraiser for the Salem Brain Injury Support Group**
- **Pledge sheets available prior to the Walk**

Come, have fun and show your support for persons with brain injury and their families

Legislative Forum for State Candidates
All Welcome

- Tuesday, October 3, 2-4 pm
- Milwaukie Senior Center
  5440 SE Kellogg Creek Dr.
  Milwaukie

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, 2145 NW Overton St, Portland OR 97210"

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

Nonconventional Treatments of Dementia/ Mild Cognitive Impairment

By James Lake, MD, Psychiatric Times
URL: http://www.psychiatrictimes.com/article/showArticle.jhtml?articleId=189500877, June 2006, Vol. IIII, No. 7

If current population trends continue and treatments that arrest or reverse Alzheimer disease (AD) are not found, the number of patients with AD in the United States is projected to increase to more than 13 million by the year 2050.[1] Numbers of persons afflicted with severe cognitive impairment caused by traumatic brain injury and stroke also continue to increase. Developing effective and cost-effective treatment approaches for AD and the other dementias is clearly an urgent priority.

In addition to conventional pharmacologic treatments of dementia and milder forms of cognitive impairment, promising research findings are being reported for many nonconventional treatments. "Nonconventional" treatments are those biologic, somatic, mind-body, and energy-information approaches not currently accepted in Western biomedical psychiatry. This column provides a brief overview of the evidence for selected nonconventional approaches used to treat dementia and mild cognitive impairment in the United States and other Western countries. A review of more substantiated approaches in this issue will be followed in the next installment by highlights of approaches for which there is limited evidence at present.

DIETARY MODIFICATION

Epidemiologic studies, case control studies, and prospective trials suggest that persons who consume a high-fat, high-calorie diet are at significantly greater risk for AD than are persons who have moderate fat intake and restrict total calories. A meta-analysis of findings from 18 community-wide studies concluded that the risk of AD increased linearly at a rate of 0.3% with every 100-calorie increase in daily intake.[2] However, a systematic review of 6 case control studies and 3 cohort studies that examined dietary preferences in dementia concluded that there is no compelling evidence for causal relationships between specific dietary factors and the risk of becoming demented.[3] Consistent relationships between dietary protein, vitamins, and minerals and the risk of dementia were not identified.

Evidence from epidemiologic studies suggests that regular intake of foods rich in omega-3 fatty acids may be inversely related to cognitive impairment or the rate of overall cognitive decline in nondemented elderly persons. However, findings to date are inconclusive. A large epidemiologic study concluded that consuming fish 2 to 3 times weekly significantly reduces the risk of cognitive decline in elderly populations.[4] Cognitive impairment scores were analyzed for 2 groups of elderly men (aged 69 to 89) with different dietary preferences. High fish consumption was inversely correlated with cognitive impairment. Findings from a prospective cohort study suggest that persons who consume fish at least weekly have a 60% lower risk of AD than do persons who seldom eat fish.[5] However, another study failed to show a correlation between fish consumption and the risk of AD.[6]

Moderate but not heavy consumption of wine (2 to 4 glasses per day) is also associated with a reduced risk of AD.[7] In a large 2-year follow-up study, moderate alcohol consumption was found to be associated with a significant reduction in risk for both AD and vascular dementia.[8]

MEDICINAL HERBS AND SUPPLEMENTS

Ginkgo Biloba

Standardized preparations of *Ginkgo biloba* are widely used in Europe to treat dementia and other neurodegenerative diseases. More recently, use of *G biloba* has become widespread in North America. Systematic reviews and early meta-analyses of double-blind controlled studies show that standardized preparations of *G biloba* in dosages between 120 and 600 mg/d taken for several weeks to 1 year result in consistent modest improvements. These improvements involve memory, general cognitive functioning, and activities of daily living in mild to moderate cases of both AD and multi-infarct dementia and are equivalent to improvements seen with donepezil (Aricept), a conventional cholinesterase inhibitor.[3,9-13]

However, a more recent meta-analysis revealed inconsistent findings of 3 trials based on more rigorous research protocols and commented on research design problems in both recent and early trials, including the absence of standardized ginkgo preparations and the use of different dementia rating scales across studies.[14] Although most controlled studies fail to support the claim that ginkgo significantly improves memory in

The brain is a monstrous, beautiful mess. Its billions of nerve cells - called neurons - lie in a tangled web that displays cognitive powers far exceeding any of the silicon machines we have built to mimic it.

William F. Allman (from *Apprentices of Wonder. Inside the Neural Network Revolution,* 1989)

severely demented patients, the findings of one double-blind study suggest that the rate of overall cognitive decline is moderately slowed in this population.[15] A systematic review of 40 controlled and observational studies suggests that ginkgo improves cognitive symptoms associated with cerebral vascular insufficiency, including impaired concentration and memory loss.[16]

To date, there is uneven evidence for beneficial effects of *G biloba* in dementia. However, a review of research findings suggests that *G biloba* extract should be regarded as a provisional approach for the prevention or treatment of mild cognitive impairment. A meta-analysis of 11 clinical trials of *G biloba* extract in elderly persons who reported cognitive difficulties but did not meet full diagnostic criteria for dementia confirmed consistent cognitive-enhancing effects.[17] However, more recent large studies on ginkgo in mild cognitive impairment have yielded negative findings.[18] Long-term use of *G biloba* extract in nonimpaired elderly persons may improve the efficiency and speed of information processing and delay onset of mild cognitive impairment.[19,20] However, a recent, large controlled trial failed to confirm a consistent preventive effect.[21]

Because of its strong anti–platelet aggregation factor profile, *G biloba* extract increases the risk of bleeding and should not be used by patients taking aspirin, warfarin, heparin, or other medications that interfere with platelet activity and increase bleeding time. *G biloba* preparations should be discontinued at least 2 weeks before surgery.

Huperzine-A

This alkaloid derivative of the herb Huperzia serrata is an important ingredient of many compound herbal formulas used in Chinese medicine to treat mild cognitive impairment that occurs with normal aging. Huperzine-A reversibly inhibits acetylcholinesterase and may also slow production of nitric oxide in the brain, possibly reducing agerelated neurotoxicity.[22] Controlled trials show consistent beneficial effects in both age-related memory loss and AD at dosages between 200 and 400 g/d.[23,24] Infrequent adverse effects include transient dizziness, nausea, and diarrhea.

Phosphatidylserine

This compound is one of the most important phospholipids in the brain and is an essential component of nerve cell membranes. The mechanism of action is believed to be enhanced fluidity of nerve cell membranes, indirectly resulting in increased brain levels of many important neurotransmitters.[25] Brainderived phosphatidylserine is probably more effective than the soy-derived product,[26] possibly because of its higher content of docosahexaenoic acid, an omega-3 fatty acid, but recent concerns have been raised over the risk of slow viruses in infected bovine tissue. The findings of large, double-blind, placebocontrolled studies confirm improved global functioning and memory in AD and age-related cognitive decline at typical dosages of 300 mg/d.[27-31]

CDP-choline

Cytidinediphosphocholine (CDP-choline) increases mitochondrial energy production and is used in many parts of the world to treat cognitive impairments that result from neurodegenerative diseases. CDP-choline, 500 to 1000 mg/d, improves overall energy metabolism in the brain, increases brain levels of dopamine and norepinephrine,[32] and enhances short-term memory in patients with AD.[33] Two Cochrane systematic reviews concluded that CDP-choline has consistent positive effects on the rate of recovery in post-stroke patients and in elderly persons who are cognitively impaired because of cerebrovascular disease.[34,35] There is preliminary but promising evidence of a beneficial effect following traumatic brain injury.[36] The findings of one small study suggest a possible effect of CDP-choline, 1000 mg/d, in the early stages of AD.[37]

Idebenone

This is a substance that is related to ubiquinone (coenzyme Q10), and like that compound, it also increases intracellular energy production in mitochondria. Animal and human studies have shown that idebenone, 360 mg/d, may be more effective than tacrine (Cognex)[38] and possibly other conventional treatments of cognitive impairtment in mild to moderate cases of AD.[39] However, in a large multicenter, doubleblind, placebo-controlled randomized trial, patients with probable early AD who received varying dosages of idebenone up to 300 mg tid did not experience slowing in the rate of cognitive decline compared with a control group.[40]

SOMATIC AND MIND-BODY APPROACHES

Physical exercise

Exercise increases levels of brainderived neurotrophic factors, probably enhancing neural plasticity and new synapse formation.[41] Regular exercise is associated with increases in the relative size of the frontotemporal and parietal lobes, which are important centers for learning, memory, and executive functioning.[42] Long-term regular physical activity is associated with a reduced risk of all categories of dementia in elderly men and women.

More than 2000 physically nonimpaired men aged 71 to 93 years were monitored with routine neurologic assessments at 2-year intervals starting in 1991.[43] At the end of the study period, men who walked less than a quarter of a mile daily had an almost 2-fold greater probability of having any category of dementia compared with men who walked at least 2 miles each day. Factors other than the level of physical activity were accounted for, including the possibility that limited activity could be a result of early but undiagnosed dementia.

Findings of the Nurses' Health Study, based on biannual mailed surveys over 10 years, showed that elderly women

(Alternative Continued on page 21)

We can help accident victims survive

Imagine yourself trapped in a car on Interstate 5 after a head-on collision. You are unconscious and have lost a significant amount of blood. You may have a severe brain injury. When paramedics arrive, they start intravenous fluids, critical to keeping you alive on the way to the hospital. The intravenous fluids currently used have been unchanged since their development in the 1960s.

University of Washington physicians based at Harborview Medical Center believe that a new intravenous fluid has the potential to improve your chances of survival. The fluid is a concentrated salt solution with or without a sugar component called Hypertonic Saline/ Dextran (HSD). It will soon be tested in Seattle and nine other communities in the U.S. and Canada as part of a research study sponsored by the Resuscitation Outcomes Consortium, with funding from the National Institutes of Health.

Hypertonic fluids are expected to help accident victims survive by resulting in more rapid improvement of blood pressure, improved blood flow to the injured brain and decreased likelihood of high pressure in the brain. They may also decrease the risk of infection and lung injury by altering the immune response.

HSD is already approved for use in 14 European countries, including the United Kingdom, France, Germany, Sweden, Norway and Denmark. It has been tested previously in eight clinical trials in the U.S. and shown to improve survival. Potential side effects include allergic reaction to dextran, seizures due to very high salt levels in the blood and rapid increase in blood pressure leading to more bleeding. None of those side effects has been seen in the previous clinical trials.

Would you want paramedics to give you HSD for life-threatening injuries following an accident? When asked this question in a recent telephone survey, more than 78 percent of Seattle area respondents said they would welcome the treatment.

The Food and Drug Administration and the UW Human Subjects Review Committee have given researchers permission to do this study and enroll patients without their consent because HSD must be administered shortly after injury when patients may be unconscious and family members not immediately available. Once it is possible to do so, all participants or family members will be asked to give their informed consent to continue in the study.

During the three-year study period, HSD fluid will be carried by paramedics in Seattle and King County and by Airlift Northwest. It will be given to approximately 400 patients ages 15 and over with severe blood loss due to either blunt trauma (e.g., injuries caused by motor vehicle crashes) or penetrating trauma (e.g., bullet or stab wounds). It will also be given to patients with evidence of severe traumatic brain injury.

In 1970, Seattle became a model for emergency care in the field with the creation of Medic One at Harborview. We're confident the new study will contribute to our continued leadership role in setting the best medical standards worldwide for pre-hospital emergency care.

Dr. Eileen Bulger is an attending physician at Harborview Medical Center and a UW associate professor of surgery. For more information, go to the study's Web site at www.roctrauma.org or call 1-800-607-1879.

Imagine What Your Gift Can Do.

The most important achievements often start where they are least expected. That's why BIAOR is the perfect place to give. It allows your money to go where it's needed most, when it's needed most, for information about brain injury, resources and services, awareness and prevention education, advocacy, support groups, and conferences and meetings throughout the state for professionals, survivors and family members. Your gift makes a difference at BIAOR.

Please mail to:
BIAOR
2145 NW Overton
Portland, OR 97205
503-413-7707
800-544-5243 Fax: 503-413-6849

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COME JOIN BIAOR AT OUR ANNUAL HOLIDAY BRUNCH, AUCTION AND PLAY

Join us for the seventh annual fund raiser

Brain Injury Association of Oregon

Portland Center Stage

Sunday, December 3, 2006

Please Purchase tickets by November 30, 2006.

Entertainment: 11:30 am

Pianist - Michael Allen Harrison

Portland Holiday Ornament signing by Betty Woods-Gimarelli (2006 Ornament)

Brunch and Silent Auction: 12 noon

In the Rotunda of the

Portland Center for the Performing Arts

In the Portland Amory in the Pearl

Portland Center Stage - 2:00 pm

I Am My Own Wife
by Doug Wright
Directed by Victor Pappas; Performed by Wade McCollum

Winner of the 2004 Pulitzer Prize for Drama, *I Am My Own Wife* spins the spellbinding tale of Charlotte von Mahlsdorf, a German transvestite who manages to survive the horrors and upheavals of mid-20th century Europe through a combination of cunning intelligence, primal instinct and amazingly good fortune. Her matter-of-fact retelling of this remarkable, yet at times questionable, tale is the key to the fascination she inspires in both the author and the audience. Although it is non-fiction, the story is spun like an action-adventure drama, with a cross-dressing furniture buff as the hero. The *New Yorker* described *I Am My Own Wife* as "Brilliant!" The *Wall Street Journal* proclaimed that "This play deserves every prize there is." And *Newsday* called it "A rich, riveting and thrilling mystery."

For further information please contact:
Sherry Stock at biaor@biaoregon.org

Brain Injury Association of Oregon
2145 NW Overton St.
Portland OR 97210
503-413-7707
800-544-5243
Tax ID # 93-0900-797

Sign up early—tickets limited to first 150

Here's my reservation!

Seventh annual fund raiser!

Brain Injury Association of Oregon

Portland Center Stage • Sunday, December 3, 2006

Name: _____

Address: _____

City: _____ **State:** ____ **Zip:** _____

E-Mail Address: _____

Please Reserve the following:

_____ **Table Sponsor • $1,000.00**

Sponsorship includes 10 tickets at the same table, name or company name listed in program, name or company name listed on BIAOR website with link, name or company name listed in newsletter, and signage on table the day of the event. ($500 tax deductible - Tax ID # 93-0900-797)

• I NEED _____ PLAY TICKETS (one ticket per paid attendee).

_____ **Please seat me at a no-host table • $100.00 per person**

If you have several friends that you would like to sit with, we encourage you to submit one check or multiple checks in one envelope. Tables accommodate 10 people. ($50.00 tax deductible)

• I NEED _____ PLAY TICKETS (one ticket per paid attendee).

I am unable to attend. Please accept my donation for: $ _____

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☐ **Charge my:** ☐ **Visa** ☐ **MasterCard** ☐ **American Express**

Account # _____ **Exp. Date:** _____

Signature _____

Please print guests' names clearly below:

_____ _____

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Return Registration to:

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2145 NW Overton St. · Portland OR 97210
503-413-7707 • biaor@biaoregon.org

(Alternative Continued from page 16)

aged 70 to 81 years who engaged in regular vigorous physical activity were significantly less likely to have dementia than were women with more sedentary lifestyles.[8] Although regular exercise is an important preventive strategy, it is probably not an effective intervention once dementia has begun. A randomized controlled trial showed that regular daily exercise in moderately demented individuals receiving in-home care reduces depressed mood but does not improve cognitive functioning.[44]

Dr. Lake is in private practice in Monterey, California and is an adjunct clinical instructor in the department of psychiatry and behavioral sciences at Stanford University. He co-chairs the American Psychiatric Association Caucus on Complementary, Alternative, and Integrative Medicine (www.APACAM.org), and is co-author of Chinese Medical Psychiatry (Blue Poppy Press, 2001) and is author of the soon-to-be-published Textbook of Integrative Medical Health Care (Thieme).

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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
Amy King, 541-382-5882
amyk@cohospise.org

Brookings
BRAIN INJURY GROUP (BIG)
1st Monday 7:00—8:30 pm
Brookings Evergreen Federal Bank
850 Chetco Ace, Brookings OR 97415
Dynelle Lentz, 541-412-8531

Cottage Grove
BIG II (Brain Injury Group II)
every Thursday 11 a.m. to 12:30 p.m.
the Jefferson Park Recreation Room
325 S. Fifth St, Cottage Grove
For directions and information,
Anna, 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
Amy Nistico, (541) 768-5157
aeasterl@samhealth.org

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 (3)
HELP
(Help Each Other Live Positively)
4th Saturday - 1:00-3:00 pm
TBI Survivor self-help group

(Odd months)
TBI Family & Spousal (Even Months)
Cognitive Enhancement Center
982 Naomi Court, Hillsboro, OR 97124
Brad Loftis, (503) 547-8788
bcmuse2002@yahoo.com

HOMEWARD BOUND SUPPORT GROUP
Call for further information - Starting in Sept
Carol Altman, (503)640-0818

Klamath Falls
SPOKES UNLIMITED TBI GROUP
4th Friday 3:00pm to 4:30pm
415 Main Street
Klamath Falls, OR 97601
Dawn Lytle, (541) 883-7547
dlytle@spokesunlimited.org

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
TURNING POINT
3rd Tuesday 4:00pm-5:00pm
Call for More Information
Pam Ogden, (541) 776-3427
PAM@sogoodwill.org

Newport
BRAIN INJURY SUPPORT GROUP OF NEWPORT
2nd Saturday 2-4 pm
657 SW Coast Hwy
Newport, OR 97365
(541) 574-0384
www.progressive-options.org

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

Portland (9)
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, 97211
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
Southeast Portland
Roxie Choroser, 503-232-7411 Roxie@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
Northeast Portland
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
Northeast Portland
Arvid Lonseth, (503) 680-2251 (pager)
alonseth@pacifier.com

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

HANDLING STRESS AND ANGER
This group will meet once a month to learn methods of stress reduction and to explore ways of lessening impulsive anger. For more information contact: Joyce Kerley
(503) 413-7707
joycek1145@aol.com

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*
Emanuel Hospital, Rm 1035
2801 N Gantenbein, Portland, 97227
Northeast Portland
Joyce Kerley (503) 413-7707
joycek1145@aol.com

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 (2)
SALEM BRAIN INJURY SUPPORT GROUP
4th Thursday 5pm-7pm
Salem Rehabilitation Center
2561 Center Street, Salem OR 97301
Carol Mathews-Ayers, (503) 561-1974
smpays@salemhospital.org

SALEM SOCIAL CLUB
6:30pm - 8:30pm
2nd Wednesday of
March, June, September and December
Windsor Place
3005 Windsor Ave. NE, Salem, OR 97301
Sharon Slaughter , (503) 588-7594
sharonslaughter@qwest.net

Vancouver Washington
VANCOUVER TBI SUPPORT
1st Thursday, 6-8pm
Disability Resources of SW Washington
5501 NE 109th Court Suite N
Orchards, WA
Cindy Falter (360) 694-6790
Kaycie Tolleson, (360) 750-6773

Aristotle taught that the brain exists merely to cool the blood and is not involved in the process of thinking. This is true only of certain persons.

— **Will Cuppy**

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. 2005 dues notices will be mailed this month. 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 503-413-7707 or 1-800-544-5243 or email biaor@biaoregon.org.

Brain Injury Association of Oregon

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☐ Survivor Courtesy $ 0 (Donations from those able to do so are appreciated)

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How To Contact Us

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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

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