



# The Long Goodbye

## Press Kit

**The Long Goodbye** a 55 minute documentary by Luminous Films Pty Ltd and Kaye Harrison.  
Produced in association with Screen Australia, Screen NSW and ABC TV.

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# **THE LONG GOODBYE**

## **Synopses**

### **1 Line**

Thousands of Baby Boomers are living in fear of what may lie ahead. On the eve of a dementia epidemic, three families reveal how love and humour can balance despair for those living THE LONG GOODBYE

### **1 Paragraph**

Our brain makes us who we are, it gives us our memories, our ability to think, to understand the world around us and it gives us our sense of self. All this is slowly stripped away for a person living with dementia. THE LONG GOODBYE follows the journeys of three families living with dementia as they struggle to maintain the identity and dignity of those they love. Filmed over a 3 year period, the documentary celebrates the capacity of the human spirit to search for meaning and hope when the end is known and inescapable.

### **20-25 Word Precis**

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## 1 Page Synopsis

Our brain makes us who we are, it gives us our memories, our ability to think, to understand the world around us and it gives us our sense of self. All this is slowly stripped away for a person living with dementia. THE LONG GOODBYE follows the journeys of three families living with dementia as they struggle to maintain the identity and dignity of those they love. Filmed over a 3 year period, the documentary celebrates the capacity of the human spirit to search for meaning and hope when the end is known and inescapable.

The three families are at different stages of the condition and they each offer a different perspective. **Michael**, a criminal barrister with four teenage children was diagnosed with early onset Alzheimer's disease at the age of 49. Three years on and still in the early stages of his condition, Michael retains insight and articulately shares his thoughts and feelings from within the disease. Although adamant he will fight on with a positive attitude and a sense of humour, Michael struggles with the loss of his professional identity and the shifting relationship dynamics within the family home. As his condition deteriorates, Michael and his family bravely strive to maintain as normal a family life as possible and to live each day as it comes.

The second strand is from the perspective of **Myrle**, an elderly carer committed to looking after her husband of 60 years until his dying day. Well into the mid stages of his Vascular dementia, Ken requires constant care and supervision. A fiercely independent woman, Myrle knocks back all offers of help, she sees it as her duty and is determined to carry out the caring responsibility alone. Although Myrle maintains control over all aspects of Kens care she is unable to control the decline of her beloved. As Ken's condition deteriorates, Myrle is faced with the fact that she is losing the love of her life. The burden of care continues to build and Myrle's health is significantly threatened. Forced to relinquish control over Ken's care Myrle must find a new way to stay with her man.

The final strand is from the perspective of **Tom**, a 72 year old carer who is desperately struggling to look after his wife Brenda who is in the latter stages of her Alzheimer's disease. No longer able to care for Brenda at home, Tom very reluctantly opts for dementia specific residential care. Racked with guilt and loneliness, Tom struggles to cope with his new life separated from his wife. As Brenda's memory and speech continue to diminish and she slowly withdraws from the world they shared, Tom refuses to let her go. He finds a new way to remain connected with his soul mate, the woman who loves him yet no longer remembers his name.

Every week 1000 more Australians are diagnosed with dementia and the numbers continue to escalate in line with our ageing population. There are currently 245 000 Australians living with dementia and it's estimated that there will be over 1.13 million by 2050. Raised in the unparalleled optimism and prosperity of the '50s and '60s, the baby boomers are accustomed to controlling their own destiny. As the dementia epidemic looms it is unknown whether science will save them this time.

For our three families the end is known and inescapable and yet they refuse to despair. Their insight, humour and wisdom will provide comfort and hope to thousands of Australians facing a similar fate. A very intimate and ultimately uplifting documentary, THE LONG GOODBYE celebrates the best the human spirit has to offer.

**Kaye Harrison**

## Story Outline

A condition typically associated with the elderly, **Michael d'Arbon** is very young to be diagnosed with Alzheimer's disease at the age of 49. Blessed with a quick wit and a resilient temperament, Michael isn't about to give in to the disease. He strives to create something positive out of his dire predicament by speaking at forums and seminars with his wife Jane. Michael uses his gift for public speaking to challenge the stigma surrounding dementia by increasing public awareness and empathy about the condition.

Before he was forced to retire, Michael enjoyed an active and intellectually challenging career as a senior criminal barrister. Three years on, Michael struggles to adjust to the much slower pace of his day to day life and the fact that his world has got smaller and a lot less interesting. He tries to fight off depression by staying as busy as possible, however the activities are mundane and compared with his professional achievements, rather meaningless and demeaning. Michael derives so much of his sense of self from his professional achievements and status. With all that gone now, Michael's self esteem begins to crumble.

Michael is the father of four children aged 17 to 25, all of whom live at home. It is a very active household characterized by noisy yet playful banter between Michael and the kids. As Michael continues to deteriorate the power dynamics between him and his 20 year old son Chris also shift. Once the head of the house and the supreme wordsmith in the family, Michael no longer "wins" the arguments and no longer reigns supreme. A man who made a successful career out of arguing the merits of a case based upon what was right and what was wrong now feels he can no longer make that claim, not even in the family home. Michael begins to lose his self confidence, he no longer trusts his own judgment and he feels others are too quick to point out his errors. He slips into a very lonely and sad place.

Jane and the kids must learn how to manage Michael's worsening mood disorders and his distorted perception of events. With the help of Michael's anti-depressant medication and a more understanding approach by all, the d'Arbon family strives for a more harmonious household. Although Jane and the kids make allowances for Michael whenever necessary, they refuse to treat him as a "special case". They continue their teasing and playful banter unabated. To change their interactions would only remind Michael he has the condition and allow it to dominate their lives. They all feel unprepared for Michael's inexorable decline but don't see the point in focusing on the future, a future they have no control over. They prefer instead to focus on the present and cherish what they have with Michael right now. They will adjust to the changes in Michael's condition as they occur, trust in one another and just take each day as it comes.

**Myrle Hauser** has been married to her childhood sweetheart Ken for 60 years. A fairly traditional relationship, Ken worked as a Police Officer for 40 years while Myrle stayed home to raise three children and run the household. Post retirement Ken suffered a number of life threatening illnesses, one of which required a very radical type of medical treatment. Although it did save his life, the treatment ultimately caused the onset of Vascular dementia. Ken had always been considered the head of the house and made most of the big decisions for the family. However, once he took ill, the power dynamics between Myrle and Ken began to shift.

Four years following his dementia diagnosis, Ken is totally dependent upon Myrle for all his needs. She has embraced the role of decision maker and sole carer with a passion. Strongly committed to her wedding vows, Myrle is dedicated to looking after her man until his dying day. She takes pride in fulfilling her duty and feels that she shouldn't accept help from anyone, be it from the government nor family.

In order to feel she can cope with the growing burden of care, Myrle exerts control over every aspect of Ken's life. Ken's sense of authority in the family and the status he enjoyed in his previous career is inadvertently diminished by Myrle. She is intent on winning the battle against the dementia despite the hurt her bossiness might cause Ken and despite the risk she is taking with her own emotional and physical wellbeing. As Ken's condition deteriorates and the burden of care increases, Myrle's health is severely threatened. She is unable to look after Ken nor herself and is forced to face the fact that she can't manage alone. Myrle is shaken out of her denial about Ken's condition, she realizes that she can't beat the dementia and she is losing the love of her life. She also accepts that she needs to approach Ken's ongoing care very differently if they are to stay together in the future. After 62 years of caring for her man on her own, Myrle bravely takes the first steps towards accepting help.

**Tom** is a very masculine ex-Submariner who tenderly cares for his diminutive wife Brenda. She was diagnosed with Alzheimer's disease 6 years ago, her condition is now quite advanced and she requires around the clock care. Tom grieves for the woman he once knew whilst struggling to keep her at home with him as long as he possibly can. Tom and his family realize he is barely coping however the decision to put Brenda in fulltime care remains on the horizon for quite some time. Tom is racked with guilt, he feels he is abandoning Brenda if he puts her in fulltime care and it's only his inability to go on that pushes him into making the decision.

Tom and Brenda take some time to settle into their new lives apart. Although Brenda doesn't really comprehend where she is and what is happening, she does notice Tom's absences. He is the only living person she remembers so she clings to him for security. Tom feels home is empty without his wife of 53 years and in the dead of the night regrets his decision to place Brenda in care. For the first time in his life Tom struggles to control his emotions and finds himself crying at the drop of a hat. He tries not to judge himself too harshly and just let the grief happen.

Brenda's condition has taken away her memories of the life she shared with her husband as well as her ability to understand Tom and communicate with him. Despite the huge chasm that has developed between them their love for each other remains strong. Brenda may no longer remember Tom's name and she may no longer be able to express her feelings, however she knows what Tom means to her. By simply lying together in each others arms, Tom and Brenda are able to comfort each other with the sense of touch. Their intimacy bridges the enormous chasm caused by the disease and allows them to remain forever bonded.

**Kaye Harrison**

## Director's Notes

I have personal experience with dementia. My Nanna died with the condition when I was in my mid twenty's. In her more advanced stages she no longer recognized her children let alone her grandchildren. I visited her less and less in the nursing home as it was a painful experience. I believed there was no point as she was already "lost" and didn't know me anyway. Perhaps making **The Long Goodbye** was a subconscious effort to understand what was going on for my Nanna in those latter years?

When I began researching the topic, I came across Christine Bryden's (Boden) book "*Who Will I Be When I Die?*" I had only ever associated dementia with the elderly. My misconception was blown away when I discovered Christine was a high achieving 46 year old when diagnosed with Alzheimer's disease. Her book took me right inside the disease and I was particularly intrigued by her exploration of identity; *if our memories make us who we are then who do we become when we lose our memories?*

I wanted to challenge the stereotype commonly associated with the condition so I set out to find an early onset participant. They also needed to be in the early stages as I wanted to capture that intriguing insight from within the disease. When I met **Michael**, I knew he was the perfect participant for my documentary. He was articulate, funny and completely free of self pity. The fact that he had four children still living at home and was a retired criminal barrister just made his story all the more tragic. He had already lost so much and had so much more to lose in the future.

I developed quite a close relationship with Michael. Even though he wouldn't be able to recall anything we have discussed and shared in the making of this film, he has trusted me enough to share his story. He is the only character in the film with dementia who remembers me and I think that's why our relationship has a different feel about it. Witnessing his deterioration and the impact on his family has been difficult and at times very painful. The second visit to the doctors where it was obvious he had deteriorated significantly was quite traumatic for us all. It is very rare to see Michael upset and he was totally devastated during that visit. The only positive that came out of it was that half an hour later he had forgotten about it all. Poor Jane was left with the lingering sadness.

One thing I have learnt from making this film is that it is possible to protect those with dementia by not reminding them when they have forgotten something. It's surprising how often you tend to raise a subject by saying "do you remember....?" Of course this is the last thing you want to do as no, they probably won't remember and you have just inadvertently reminded them of their deficit. It is also pointless to constantly correct someone who has dementia as once again this rubs it in their face. What is right and what is wrong gradually becomes a lower priority. I think it shows true love and compassion on the part of a carer, family or friend to subvert ones own ego, to let their loved one be right, to let them save face and to gently steer them away from painful insights.

Filming with the **Myrle & Ken** was an absolute delight. Ken is such a cheeky and lovable character and the banter between them continues whether the camera is running or not. Over the three years of filming I developed a very close relationship with Myrle. I think she really enjoyed the visits and found it cathartic. It was an opportunity for her to get some things off her chest without having to burden her family. It would have been easy for me to judge Myrle's devotion and refusal of help as that of a martyr. However Myrle was raised at a different time when there was a greater emphasis on values and duty in a relationship. I learnt to accept that it would be very difficult for an 80 year old woman who is very strong and independent to suddenly change her behaviour, despite its obvious flaws. Myrle's illness was the trigger. It was heart breaking to see her so beaten by the illness and so anxious about Ken's welfare. For the first time in her life she seriously contemplated that she might pass away first. Although it took a fright to change her attitude, I do feel great admiration for Myrle. Very humbly she was able to let go of the reins a little bit and accept some help. I

think it was only her love for Ken that gave her the strength to take those first brave steps. I can only hope that when I am her age I have the capacity to show such love and devotion to my man!

Filming with **Tom & Brenda** was an intensely emotional journey. I was so moved by the tender care that Tom showed his wife and how devastated he was by their eventual separation. I had to carefully judge when I really needed to film certain moments in order to faithfully document the journey but at the same time be very careful to not over do it and become intrusive. It was a constant balancing act which required a lot of mixed emotions on my part. My natural inclination is to let people be and respect their privacy when they are experiencing such pain, however to withdraw at this point would have seriously undermined our shared objectives for the film. I wouldn't have documented their journey honestly and to the best of my ability.

The decision to put a loved one in fulltime residential care could be the toughest decision that a person ever has to make in their life. Tom's story powerfully conveys the guilt and anguish leading up to that decision. I am hopeful that those watching who are quick to judge others who make that same decision will feel greater empathy for carers. I am also hopeful that those who have or are about to make that decision and are experiencing similar guilt will feel some sort of validation and support.

I stopped visiting my Nanna in the nursing home as I believed she was already "lost" and didn't know me anyway. Through the making of this film, I now think that my view was fairly selfish and misguided. I have seen how people living with dementia can be reached, that a connection can be made even if they don't know who you are. Family and friends experience the pain of being forgotten and the tragedy of seeing their loved one become a shadow of their former self. However, I hope people will find some comfort when they witness the ongoing connection between Tom and Brenda. Despite the advanced nature of her dementia she was not "totally lost". Love can be given to those living with dementia and in most cases they will be comforted by this. I wish I had have known this when my Nanna was deteriorating with the condition.

**Kaye Harrison**

## Stories or incidents from the making of the film

I really enjoyed my days filming with **Michael**, we had a great deal of fun although it was not without its challenges. Due to his failing short term memory I had to film many hours of repetitive responses and it was virtually impossible to keep him on subject. Initially I was reluctant to cut him off whilst he recounted his favourite legal story for the umpteenth time, however we eventually developed an understanding and he was happy for me to interrupt and direct him back on track.

The other challenge was Michael's pragmatic and tough exterior. Always quick to dismiss his concerns with a joke or pure logic, it was a challenge to document his true thoughts and feelings about the condition. It was hard for me to know if his pragmatism was a personality characteristic typical of the old Michael, part of his persona as a criminal barrister or if it was a symptom of his condition. (It is typical for those living with dementia to lose empathy for others, to lose insight into their own feelings as well as the ability to project into the future.) I was concerned that I wouldn't do justice to his story and that it might be superficial. I think Michael's lack of self pity and courageous approach to the disease made his revelations (when he did share them,) that much stronger.

Such a deeply personal film raised many personal challenges for me as a director. For example when Michael began to share his thoughts and feelings about tensions within the family, I was surprised and moved and a little conflicted. Whilst I knew his frustration and loneliness as a result of the family conflict was central to his story I did feel a sense of responsibility to fairly represent his family. My top priority was to document Michael's perspective from within the disease but I also wanted the audience to understand that (due to his condition,) Michael's recollection of events may have been skewed and his emotional response may have been inappropriate at the time of the conflict. It was a delicate balance but I feel we managed to convey all of that in the finished film.

The most significant challenge I had when filming with **Myrle** and **Ken** was that Ken never remembered me nor the documentary from one week or even one day till the next. Every time I went to film him over the 3 years I needed to renegotiate access. We went through the same questions each time and every time he told me he was suspicious of cameras as he had been a Policeman for 40 years and distrusted the media. After about half an hour of discussion he would be satisfied with my intent and would be happy to be involved. Sometimes mid filming he would look up in confusion and need to be reminded who I was and why I was there. I wanted to be sure that he was ok with his participation each time I filmed despite the fact that he has no memory of being involved in the documentary. He was always comforted by Myrle who said it was a good thing and she would make sure nothing dishonest or disrespectful would be included.

**Brenda** was the one character in the film that was unable to tell her own story as she had deteriorated so much from her condition. I felt it was important that the audience truly care about who Brenda was in order to care about what **Tom** was experiencing. It was a bit of a challenge to create a picture of Brenda as I hadn't known her prior to her illness. I hope the family recognizes the Brenda in the documentary as the wife, mother and grandmother they had known and loved over the years.

Brenda passed away in the final days of our edit. It was a very traumatic time for Tom and his family and I was unsure of what I could do to support them and if it was my place to do so. At the funeral I was struck by the constant reference to the documentary and how important it had become for Tom in the latter years of Brenda's life. Nothing could ever take away Tom's grief or sadness however the documentary did have some kind of healing benefit for him. He had something tangible of his shared life with Brenda and he had done something meaningful in the effort to raise awareness about the insidious nature of dementia. It was good for me to know that the film had given him something positive when he had given so much.

The power of the film lies in its intimacy, the very honest and open sharing of deeply personal thoughts and feelings. It was always my hope to achieve such a level of intimacy, and this could only happen once I'd spent the time and effort to develop strong personal relationships with all the participants. I wanted each of them to freely share their journeys with me, feeling confident that I would handle the material sensitively and would maintain their dignity or the dignity of their loved one at all times. The generous access did evolve as the trust and mutual respect strengthened. Although I was very pleased with the poignancy of the material and felt confident that the film would be very strong and engaging, I did feel an ever building weight of responsibility to the people involved. So much faith had been put in me and the nature of the material was so personal, I was very anxious not to misrepresent them in any way. I felt it was my absolute duty to make the film the best possible film it could be for them, to lovingly honour their love and their loss.

**Kaye Harrison**

## **About the Film-makers**

### **Kaye Harrison – Director/DOP**

Kaye Harrison is a documentary filmmaker who approaches all stages of production with the very highest level of personal integrity. Kaye began her career as a DOP and has worked both in Australia and overseas on high profile projects including THE REAL WORLD - NEW YORK 2001 and THE OSBOURNES 2002. Kaye has also worked across a number of other factual genres including The 7:30 Report, Dateline, Insight and Stateline. More recently Kaye has begun directing and shooting her own documentaries. She is drawn to topics which have a profound physical, social and emotion impact on the lives of individuals but are largely unexplored as they are plagued by fear and ignorance. In 2005 Kaye directed and filmed CROSSING THE LINE which was broadcast on ABC-TV and won a number of awards. THE LONG GOODBYE is her second documentary and will broadcast on ABC-TV in 2010. Whilst developing her own documentaries, Kaye continues to work as a director/DOP (2<sup>nd</sup> unit) on the landmark series LIFE@1 2006, LIFE@3 2008 and LIFE@5 2010.

### **Gina Twyble - Producer**

Gina Twyble has had an extensive career in the production of documentaries and drama. Throughout the 1990s Gina worked at Film Australia overseeing the production of more than 40 documentaries made by some of Australia's finest directors and producers. Since then, she has formed her own production company, Luminous Films, and continues to work in feature film, TV drama and documentary. Her work has been screened at festivals around the world, and has been nominated for awards, including the Dendy EAC Award (winner 1999), IF Award Best Documentary (nominee 2007), Best Narration & Merit Awards at International Wildlife Film Festival, USA (2009), Best Feature Documentary at Reel Earth Festival, NZ (nominee 2009) As a documentary producer, her credits include *Steel City, Our Drowned Town, Flour, Sugar, Tea, Chasing Birds, Feral Peril and The Long Goodbye*.

## Background Notes

(sourced from Alzheimer's Australia website)

**Key Facts about Dementia** (Alzheimer's Australia in reference to the Access Economics Report: *'Keeping Dementia Front of Mind: Incidence and Prevalence 2009 – 2050'* released September 2009)

- Dementia is fatal and there is no cure - it is not a normal part of ageing
- There are an estimated 245 000 people with dementia in Australia
- Without a significant medical breakthrough that is expected to increase to 591 000 by 2030
- And again to 1.13 million people by 2050
- \*Every week there are more than 1 300 new cases of dementia in Australia
- That will grow to more than 3 600 by 2030
- And to 7 400 by 2050
- The baby boomer bulge in the Australian population means that the coming decade will see an acceleration of the impacts of ageing on dementia prevalence.
- The first baby boomers turn 65 in 2010 and there will be 75 000 baby boomers with dementia by 2020
- Dementia is the fourth most common cause of death after heart disease, stroke and lung cancer
- Dementia has an impact on every part of the health care system
- Australia faces a shortage of more than 150 000 paid and unpaid carers within a generation. The direct cost of dementia is already estimated at \$5.4 billion per annum
- The cost of replacing all family carers with paid carers is estimated at \$5.5 billion per annum
- By the 2060s, spending on dementia will outstrip that of any other health condition, reaching \$83 billion (in 2006-07 dollars) and representing around 11% of all health and aged care expenditure
- Dementia is already the biggest single cause of disability in older Australians (aged 65 years or older)

### What is dementia?

Dementia is the term used to describe the symptoms of a large group of illnesses, which cause a progressive decline in a person's mental functioning. It is a broad term, which describes a loss of memory, intellect, rationality, social skills and normal emotional reactions.

### Who gets dementia?

Dementia can happen to anybody, but it is much more common over the age of 65. People in their 50's, 40's and even in their 30's can also have dementia. The incidence rate rises with age. For people 85 years and over, 1 in 4 have dementia

**Alzheimer's disease** is the most common form of dementia accounting for between 50% and 70% of all dementia cases. It is a physical disease which attacks the brain resulting in impaired memory, thinking and behaviour. As brain cells die, the substance of the brain shrinks. Abnormal material builds up as "tangles" in the centre of the brain cells and "plaques" outside the brain cells, disrupting messages within the brain, damaging connections between brain cells. This leads to the eventual death of the brain cells and prevents the recall of information. Memory of recent events is the first to be affected, but as the disease progresses, long term memory is also lost. The disease also affects many of the brain's other functions and consequently, many other aspects of behaviour are disturbed.

**Vascular dementia** is the second most common cause of dementia. It is the broad term for dementia associated with problems of circulation of blood to the brain. In Vascular dementia, very small blood vessels are blocked, resulting in the death of small areas of brain tissue on the cerebral cortex.

## **Causes of Alzheimer's disease**

Scientists are rapidly learning more about the chemical changes which damage brain cells in Alzheimer's disease but it is not known why one individual gets Alzheimer's disease late in life and another does not. A variety of suspected causes are being investigated including factors in the environment, biochemical disturbances and immune processes. The cause may vary from person to person and may be due to one factor or a number of factors.

## **Preventing dementia**

Although there is no proven way to prevent dementia, research indicates that a healthy lifestyle and engaging in physical, mental, and social activity may help to reduce the risk of developing dementia. The Access Economics Report: Keeping Dementia Front of Mind, includes projections showing that reducing the number of Australians who are physically inactive by 20% would result in 6% fewer cases of dementia in 2050. Numbers would be reduced a further 6% by simply maintaining current trends in improvements in management of high blood pressure.

## **Treatment of Alzheimer's Disease**

At present there is no cure for Alzheimer's disease. However, one group of drugs called cholinergic drugs appears to be providing some improvement in cognitive functioning for some people with mild to moderate Alzheimer's disease. Drugs can also be prescribed for secondary symptoms such as restlessness or depression or to help the person with dementia sleep better. Available medications can reduce symptoms and improve quality of life in some people, but they do not stop the progress of the disease.

## **Current research into the treatment of dementia**

Researchers are continually searching for new treatments for Alzheimer's disease and other dementias. The potential treatments discussed below are in the early stages of research and are not currently available. However, they are all part of the research effort to find more effective treatments for Alzheimer's disease and ultimately a cure.

*Alzheimer's Vaccine and Immunotherapy* - Researchers have been attempting to develop a vaccine for Alzheimer's disease for several years. The strategy behind the immunotherapy approach is to use the body's own immune system to destroy amyloid-beta plaques.

*Gene therapy*- Gene therapy has been promoted as a promising technique for many different conditions. A very small trial of gene therapy for Alzheimer's disease has shown beneficial effects - slowing the progression of the disease by about 50%. Although, the study is very preliminary, it indicates that gene therapy may provide beneficial treatment for Alzheimer's disease in the future.

*Non Steroidal Anti-inflammatory Drugs (NSAIDs)* - Several studies have shown that non steroidal anti-inflammatory drugs (NSAIDs), which include drugs like aspirin, may be protective against Alzheimer's disease. In a 1997 study, people taking NSAIDs were shown to have half the relative risk of developing Alzheimer's disease of those not taking the drugs. However, other studies have reported no benefit. Additionally, some NSAIDs can have serious side effects. Other trials using NSAIDs for the prevention or treatment of Alzheimer's disease continue, using NSAIDs with a lower risk of side effects. Results are still pending on whether safer NSAIDs will be an effective preventive strategy for Alzheimer's.

*Targeting amyloid-beta production* - Several treatment strategies for Alzheimer's disease rely on targeting amyloid-beta. One such strategy focuses on trying to understand the role of enzymes which are active in the production of amyloid-beta protein. Researchers are trying to develop drugs that inhibit these enzymes in order to stop the production of plaque forming amyloid-beta. However, as both beta and gamma secretase have many other roles in the body, it has proven difficult to selectively inhibit their effects on APP and amyloid-beta.

*Cholesterol lowering medications* - Several studies have indicated that the use of cholesterol lowering drugs, such as statins, is linked to a lower risk of developing Alzheimer's disease. This may indicate an important role of cholesterol in the pathology of Alzheimer's disease. More research is needed to fully examine the effects of cholesterol lowering medications on the development and progression of Alzheimer's disease.

There are many therapies in different stages of development currently being tested in clinical trials around the world. These include new medications, such as Alzhemed (aims to prevent plaque formation by binding amyloid and reduces inflammation at existing plaques), Flurizan (aims to reduce the level of circulating amyloid-beta protein), and Metal Protein Attenuating Complexes (MPACs, aims to reduce the binding of metals to amyloid-beta), as well as other therapeutic interventions such as vitamin trials (including Vitamin E and Selenium) and herbal formulas (including Huperzine A, a natural Chinese herb with anti-cholinesterase effects).

### **Peak body contact**

Alzheimer's Australia is the national peak body for people living with dementia, their families and carers and provides leadership in policy and services.

Alzheimer's Australia  
PO Box 4019  
Hawker ACT 2614  
+61 (2) 6254 4233

The appropriate number to put at the very end of the program would be:

**The National Dementia Helpline  
1800 100 500**

The National Dementia Helpline provides the following:

- Understanding & support for people with dementia, their family & carers
- Practical information & advice
- Up to date written material about dementia
- Information about other services
- Details of the full range of services provided by Alzheimer's Australia