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ADI Global Perspective

A newsletter for Alzheimer's Disease International (The International Federation of Alzheimer's Disease & Related Disorders Societies, Inc.)

In Ireland, Alzheimer Families Need Not Stand Alone

An estimated 25,000+ men and women in the Republic of Ireland have Alzheimer's disease. Fortunately, they and their carers do not have to face this dread disease alone. They have the support of the Alzheimer's Society of Ireland (ASI).

CARERS TAKE CHARGE

Ten years ago in Dublin, a handful of family members formed a support group to share experiences—and their coping strategies as carers. The group expanded rapidly: members held press receptions and lobbied politicians and various state agencies to raise awareness about the disease. They demanded that Alzheimer's be recognized as a serious and special problem.

That was the beginning of the Alzheimer's Society of Ireland. Now, the Society is a strong national organization represented throughout Ireland's 26 counties.

Last year the Society celebrated its 10th anniversary. During its first decade, it saw Alzheimer's disease go from being a little understood problem—to one of science's highest research priorities. ASI played a major role in bringing about this change.

The story of the Society's expansion nationwide is inspiring. Early on, its leadership established a national develop-

ment plan which included setting up support groups, branches and regional offices throughout the country with at least one day care center in each of the eight Health Board Regions. The fulfillment of this plan has been made possible by a strong network of loyal members and volunteers. This will ensure that help is available for Carers and individuals countrywide.

However, you can't have growth without funds and the Society is in constant pursuit of sufficient funding to make sure its growth plan moves forward. It takes at least £50,000 to establish a Day Care Center. Statutory funding has been less than 10% of the total ASI budget, so the Society relies heavily on funds contributed by many generous individuals, firms, banks, other institutions and a variety of fundraising activities by members, groups, and individuals countrywide.

PROGRAMS

Contributing to its success, the Society surrounds itself with quality programs and dedicated individuals running them. Eight care Centers have been established, and one of them has eight beds for overnight stay four nights per week.

A joint development project *Caring for Carers* was established with the Irish branches of Soroptimist International. The



Michael Coote, ASI's Chairman, couldn't resist a dare for publicity and fundraising

results of a national research program into the needs of Carers was published entitled *Caring Without Limits*, Continued, Page 3

ADI's 10th International Conference

"A Decade of Change
Looking back...Looking Forward"

September 21-23, 1994
Edinburgh, Scotland

In This Issue. . .

European Tour of Alzheimer Care, Part II ... Page 4

Public Policy Page ... Page 6

Research Update ... Page 7

What in the World We're Doing ... Page 8

The Story of ARDSI ...Page 10

ADI 1994—FOCUS ON MEMBER SOCIETIES

Much of the important work of the Alzheimer's movement is done at the national, chapter and support group levels where families can obtain information, help and in some places, services. This issue of *Global Perspective*, focuses on ADI Members' roles and activities. The over-



Brian Moss

view offers exciting information and recognizes that the Alzheimer cause is addressed by more and more national societies around the world. We regret that space limitations allow us to cast

the spotlight on only a few, we hope to highlight other societies in the future.

As you may know, individually, Members of ADI are national societies that represent persons with Alzheimer's and their families within their countries. All ADI societies provide Helplines, support groups and chapters across their countries, they offer educational programs for affected families and the general public. These are all required under ADI Membership Criteria. Some members also provide counseling, day centers, home care, and other types of respite care programs. Collectively, the societies are Alzheimer's Disease International (ADI). As such, they are concerned about the desperate need for information, education and support that exists in non-member countries around the world—where there are no Alzheimer societies to help.

Members understand and feel deeply about this tragic lack, because only a few short years ago, they experienced the

same situation in their own countries. In fact, raising global awareness and providing support to families were major issues on the agenda when (with only six countries then) ADI was formed in 1984.

Today, ADI has twenty-eight Members, all national societies in as many countries. Additionally, ADI's Secretariat is in contact with Alzheimer societies that are in various stages of development in a number of other countries, including Luxemburg, Poland, Romania, Hungary, Ecuador, Korea, Costa Rica, and Uruguay.

Because Alzheimer's does not discriminate, we hear from families around the world. Rachel Billington, ADI's Secretary General, advises that letters, phone calls and faxes, come in daily, verifying that when Alzheimer's strikes, the shock, pain and burden experienced by families, is the same the world over. No matter the culture, geographic location or economic circumstances, families desperately need information, understanding support, and qualified, informed, medical help.

It is gratifying to make a referral with the confidence that in an ADI Member nation there is good information and help available, and persons in need will re-

ceive basic Alzheimer's information and the opportunity to participate in Alzheimer Support Groups at no charge.

Globally, ADI maintains an outreach program and on-going effort to stimulate and encourage development of new Alzheimer societies. In 1993, ADI received a two-year grant from the Helen Bader Foundation in support of Project Global Outreach. In its collaborative work with the World Health Organization, the grant helps ADI support training of physicians from under-developed countries to diagnose, treat and care for persons with AD.

This is responding to needs recognized by ADI's founders ten years ago. However, while we note progress made to date, it is only a beginning. With the commitment and support of its Members and friends, ADI will continue its outreach and support efforts to non-Member countries.

Along with compassionate goals, there is the potential for an interesting circular effect in all this...as the network of ADI members grows, it will have a strengthening effect on the Alzheimer's movement, worldwide, ultimately contributing to the credibility and strength of each individual Member society.

—Brian Moss

"Jonathan Swift Had Alzheimer's Disease," doctor says.

Jonathan Swift, author of *Gulliver's Travels* and Dean of St. Patrick's Cathedral, may have been one of the first recorded victims of Alzheimer's disease, according to an American doctor.

Writing in the influential British medical magazine, the *Lancet*, Dr. John Lewis, an anesthetist from North Carolina, who is a specialist in dementia conditions, says Swift is vividly describing the symptoms of his disease in his tale of the Immortals of Luggnagg in *Gulliver's Travels*. "Anyone acquainted with Alzheimer's will recognize a familiar ring in the words written over two centuries ago," he writes. In Swift's tale, the Immortals "have no remembrance of anything but what they learned and observed in their youth and middle age, and even that is very imperfect. In talking they forget the common appellation of things, and the names of persons, even those who are their nearest friends and relations.

"For the same reason they can never amuse themselves with reading, because their memory will not serve to carry them from the beginning of a sentence to the end...neither are they able to hold any conversation (farther than a few general words) with their neighbours."

Dr. Lewis writes: "Since it seems unlikely such a picture could have been drawn other than from reality, it is probable that Swift was describing in 1726, what we know now as Alzheimer's disease."

Although doctors agree that Swift suffered from a variety of neurological problems, including memory loss and speech difficulties, they previously believed these were symptoms of involuntional melancholia or cerebral arteriosclerosis. Swift, 78 when he died, began writing about his condition 10 years before his death. In 1738, he wrote: "I have entirely lost my memory." Two years later he stated: "I hardly understand one word I write."

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PRESIDENT
Yasmin Aga Khan, USA

CHAIRPERSON
Brian Moss, Australia

SECRETARY GENERAL
Rachel G. Billington

EDITORIAL ASSISTANT
Amy Shirar

ASSOCIATION ADDRESSES ALZHEIMER'S ON FIVE FRONTS

The Alzheimer's Association (USA) strategic plan to conquer Alzheimer's is best described under the acronym RECAP:

- R—Research
- E—Education
- C—Chapter Development
- A—Advocacy
- P—Patient & Family Services

RESEARCH. Through 1993, the Alzheimer's Association (USA) has committed \$32 Million in its support of research into the cause, treatment and cure of AD. Its 1994 Research Grant Program will include awarding: Investigator-initiated Research Grants; Faculty Scholar Awards; Pilot Research Grants; and the Zenith Awards. Decisions in awarding grants are made on a competitive, peer-review basis by the Association's MSAC.

EDUCATION. The Association holds a national Education Conference, in July.

In addition, it has developed a wealth of information and educational materials in the form of pamphlets, manuals, books, audio tapes and videos. A fine library is located at the national headquarters.

CHAPTER DEVELOPMENT. With 221 Chapters and over 2,500± support Groups, the Alzheimer's Association (USA) is in all 50 United States. Association Chapters are currently undergoing a self-assessment process utilizing the Association's Standards & Guidelines. Chapters participated in developing the Standards & Guidelines to help assure chapter strength, and provision of a high quality and consistent level of services to Alzheimer families.

ADVOCACY. An annual Public Policy Forum on Capitol Hill, Washington D. C., offers Chapter members an opportunity to learn techniques in advocacy, at the State and Federal levels. Members seek an improved level of services and care for

persons with AD. Opportunities to meet and talk with legislators also are included in the week-long Forum program.

PATIENT & FAMILY SERVICES. The Association has developed a number of programs, including: A National Respite Care Demonstration program with 74 respite programs across the country; the *Guidelines for Dignity and Taking Care*, developed for care providers and family members; Safe Return—the national Wanderers Registry; and, a national community services survey.

To help make all these elements viable, the Association conducts an aggressive fundraising program which includes the Rita Hayworth galas; the annual national Memory Walk and other special events; a direct mail campaign; and a major gifts program. The Association conducts an on-going awareness campaign including Alzheimer's Disease Awareness Month.

ASI...Families Need Not Stand Alone—Continued from Page 1

a video of the same name was commissioned for introducing the general problems of Alzheimer's disease and the Society's activities to help the Carers.

OTHER ACTIVITIES

To promote its cause, the Society produces AD literature, organizes events, including an Annual Public Lecture.

A quarterly newsletter, Carer's Handbook and Dementia Information Packet for the medical profession are among its widely disseminated publications.

The Society generates a number of creative fundraising activities, an annual Alzheimer's Awareness Week—with a range of national and regional events—was originated in '92.

ORGANIZATION

Individual subscribers are known as Friends of the Alzheimer's Society of Ireland and are members of a local branch convenient to their home or place of work. Membership is open to anyone. And, there is no fixed subscription but a minimum contribution of £5 is suggested. Currently, 1500+ Society members are rep-

resented by 70 Support Groups, 20 Branches and eight Regional Committees.

Branch members hold an annual meeting at which a committee is elected to run the activities of the branch and two of its members to the Regional Committee. The boundaries of the Regional Committees are coterminous with the boundaries of the eight Irish Health Board

Regions in which they are located.

The Regional Committee co-ordinates the activities of the branches in its area and at its annual meeting, two members are elected to the National Council.

The National Council meets quarterly to implement policy. Activities of the National Council, Regional Committees and Branches are in accordance with the aims and constitution of the Society and are inspired, encouraged and co-ordinated by the National administrative team consisting of Norman Stuart, chief executive, Winifred Bligh, national co-ordinator for respite care; Michael Neville, national development officer; Barbara Scully, public relations officer; secretaries Nurala Dunphy & Myrtle Sullivan and two honorary counselors Joe Rowe and Muriel Banks.

HOW ASI RECRUITS OTHERS TO HELP

The Society encourages people to become involved in its programs, and suggests that the best ways to help are to:

- Become a member of the Society
- Persuade friends, relatives, others to join
- Offer help with day care, support groups
- Organize/support fundraising activities

ASI AIMS

The Society intends to fulfill and maintain the following goals:

- Arouse maximum awareness of Alzheimer's disease;
- Supply information and help to affected families;
- Inform the medical profession and all ancillary services about the disease and the carers' problems;
- Provide carer assistance by establishing Support Groups and organizing respite and other caring facilities;
- Campaign for statutory Day Care, Short Term Respite, and Long Term Residential Care for persons with AD;
- Obtain practical and financial support for carers who are caring for an Alzheimer sufferer in their home;
- Support medical and statistical research into the cause, diagnosis, incidence and treatment of AD.

European Tour of Alzheimer's Care—Part II

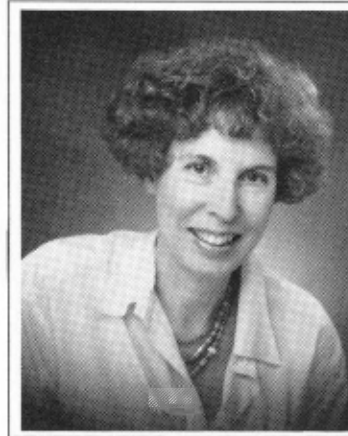
In the last issue of *Global Perspective*, Beverly Sanborn, a Clinical Social Worker in California, wrote of her 1993 tour of Alzheimer care facilities in Europe—focusing on long term care. As promised, following are her reflections on Day Care programs she visited.

Ten years ago, I participated in a California State Demonstration pilot project which tested the concept that adult day care, if properly staffed and funded, could provide a therapeutic program for people with moderate to severe levels of Alzheimer's disease. Working in eight sites, selected because each embraced a different model of care, our mission was to provide service for the people who were rejected by all other day care programs. We actively recruited the wanderers, the combative, the incontinent persons who had no place else to go and were at risk of institutionalization. Our eight programs were housed in senior centers, a converted house, a former warehouse, and an old classroom. They were sponsored or cosponsored by hospitals, day health programs, Alzheimer Association Chapters, adult education and community foundations.

We were essentially novices when we began work in this untested area, but we were highly experimental, willing to try new strategies and vigilant about our evaluation of the results. At the end of three years, both the State and the participants pronounced our project a rousing success. (Since then, 26 similar programs have been added to the mix.) Yet, what surprised all of us the most was not our mutual success, but the way that all the programs had come to resemble each other. It was this observation that sparked my curiosity about exemplary practices. Were there universal themes, essential elements, that high-quality programs must possess? Since my work had been confined to the U. S., I took advantage of a European trip in the summer of 1993 to follow my curiosity, and I visited four outstanding dementia day care programs.

It seemed particularly fitting to begin the quest in Europe, specifically England, where the adult day care movement originated. Day hospitals and psychiatric

day treatment had been in existence since 1942. Day care for the frail elderly came ten years later when Dr. Lionel Z.



Beverly Sanborn

Cosin set up the first Geriatric day care at Cowley Road Hospital, United Oxford Hospitals, England. This program completed the missing piece in his comprehensive array of supportive home health and home health services designed to allow elderly people to *age in place*. Nearly two decades later, Dr. Cosin brought the concept to the United States. The decade of the 1980s and 90s has seen the greatest proliferation of the concept worldwide as health care systems de-emphasize institutionalization in favor of aging in place. Adding dementia-capable programs has been a natural extension of this world-wide movement. Although many day care programs are free-standing single services, my interest was in the model established by Dr. Cosin in which day care is an integral part of a larger system of long term care. My search for exemplary programs led me to seek out day care that was not only excellent programmatically, but was innovative from a systems point of view.

In the United Kingdom I visited two examples of dementia-capable programs in which day care is the linchpin of a service system that aims to maintain the elderly in their own home: Acomb Gables in York, England and Rosebank, in Kilmarnock Ayrshire Scotland. In both programs, the *client* is the whole family.

Acomb Gables: York, England

Acomb Gables has an interesting history. It is actually a creative response to budget cuts. Confronted with shrinking

funds for the elderly mental health and dementia services, consulting psychiatrist Dr. Christine Kirk brought together the health and social service providers plus a larger representation of local residents and consumer groups. This task force explored the fiscal problems and options. Months of study, research and planning produced the CUE (or Community Unit for the Elderly) concept, of which Acomb Gables is the first example. The purpose of Acomb Gables, indeed all subsequent CUE's, is to maintain people in their own home as long as possible.

Acomb Gables is a center which is designed to be homelike, where participants do normal activities such as laundry and cooking. It reflects the local culture in architecture and in program, with committee members, not bureaucrats having the last word. Much to the dismay of the architect, the Acomb Gables planning committee insisted that the lovely interior courtyard have a clothesline planted in the middle of the patio "because our patients expect to see one."

Acomb Gables is meant to be and forever remain an important part of the York community. Besides caring for local older adults, the facility offers training, internship and community education programs. To further insure its integration into the community as a whole, the planning committee established the Acomb Gables Coffee Shop, run by volunteers, where local townspeople can enjoy the ambience, meet participants, and be enticed to volunteer.

The financial and programmatic success of Acomb Gables is due in part to the way the service is structured. The focal point is the adult day health center. Here, participants can enjoy an enriched social and cognitive program while receiving the medical monitoring and assessment which allow them to continue living at home safely. Providing the medical services at the center is more efficient and costs a fraction of a medical-team home visit. Meanwhile, families receive the benefit of support groups, medical education, instructions in self-care and respite services. Staff work in partnership

with families to prevent burnout and exhaustion. Respite beds and some long term beds are available, but home care supports are always encouraged. Acomb Gables is similar in many respects to the United State's On Lok day care programs which have very successfully used day care for both social and medical management purposes.

Rosebank: Kilmarnock, Ayrshire Scotland

Rosebank, Kilmarnock, Ayrshire Scotland (about one hour south of Glasgow), envisions itself as an extension of the larger Kilmarnock community. Every effort is made to be small, intimate and

resource to the community through its outreach and educational services. Unlike the CUE's, the volunteers are able to manage all levels of dementia. One gentleman who is in the severe stages of the disease, unable to speak and prone to combativeness, is gently guided in and out of groups according to his ability to handle stimulation. Volunteers are always respectful to him, even when he threatens them with his fists. Their calm manner defuses his agitation. When he settles down, they give him a kiss and hug. Later, when participants sing old Irish folk songs, this same gentleman joins the group and begins to hum a prolonged almost weeping melodic line.

"There were several themes..."

My visit to the four day care programs revealed a wide range of program structure and program purposes. There were several unifying themes, however, that contributed to the high quality of these programs.

1. All view the family as the client. Support, respite and education for family caregivers is a high priority.
2. Self-care and autonomy is fostered to the degree possible. Staff give prompts and cues to enhance functioning.
3. Programs are directed to stimulating remaining strengths and are adult-oriented, offering activities that are meaningful to residents (e.g. observing coffee time in Ger-

- many; singing Irish folk songs in Ireland)
4. Programs are integrated into larger community-not just the health and social service sector-but the whole community, particularly evident in the strength of volunteer involvement.
5. Staff are highly interactive with participants.
6. There is respect, indeed, almost a reverence, for the elderly participants who are viewed as being special people because they are valiant survivors of wars and social upheavals, and have lived a very long time.
7. Social climate is light and fun.

homelike, with activities that are adult-oriented, creative, appropriately challenging and *normal*. Mary Cullinane, Officer in Charge, proudly displays the participant's handcrafts, and photos of festivals and gala events that punctuate the typical week. Rosebank is dedicated to helping each participant maintain a sense of self. Staff take great delight in giving prompts sufficient to help lower functioning participants respond at surprisingly high levels.

Rosebank divides groups into functional levels for some activities, but whenever possible, all groups are integrated into the daily events. Staff display a remarkable skill in finessing the integration of participants functioning at different levels so that dignity and self-esteem are preserved.

Like Acomb Gables, Rosebank is a

The volunteers explained that he is very moved by the folk songs. "This is his favorite part of the day—Day Care is so important for him and for his wife," they tell me. "She would never make it without us."

At the end of the day, six participants remain to spend the night in the much-coveted respite beds. The night nurse who supervises the overnight program is the only paid position. Stillorgan's level of volunteer commitment and skill is outstanding and demonstrates how a program can succeed without grants in aid from the government.

Die Staatlichen Pflegeheime Hamburg, Germany

On the continent, Hamburg Germany's Die Staatlichen Pflegeheime is experimenting with using a day care model to solve the special care dementia needs in

a large skilled nursing facility. Rather than build a special facility or set up a dementia floor, the dementia residents are placed during the day in a large, beautifully decorated penthouse-style room. Residents enjoy an enriched program of therapeutic activities, with space to wander and pace if necessary, and beds for resting. All three meals are taken in this day care environment. Meanwhile, the cognitively normal residents are provided with the activity program (and privacy) that is commensurable with their interests and needs. Families and residents have been highly satisfied with the experiment, which is currently being evaluated for possible replication.

The Alzheimer programs in Hamburg are under the direction of two psychiatrists: Dr. Bruder and his colleague, Dr. Wojner. Amazingly they have taken large institutional facilities and transformed them into homelike, cozy, intimate environments. They and their staff are constantly experimenting with therapeutic programs and seeking new uses for existing resources. Designs for the facilities, for example, come from contests they hold with University design students.

The staff are exceptionally skilled and interactive with participants. Staff are trained in nursing programs run by Dr. Bruder and Wojner. The staff are obviously inspired by the immense dedication of these two physicians. Dr. Wojner gave me a tour of the day care and three other facilities. I saw him model a type of interaction which can be described as *loving care* for the dignity and uniqueness of each participant and resident. Dr. Wojner not only knew every resident by name (he oversees 4,700 residents in his total program), but he inquired about their family members or other seemingly small though significant details of their lives. Restraints of all types are virtually non-existent in this caring community.

Looking back on my journey, I am deeply impressed by the people of good will and imagination who are drawn to this work. Important issues such as location of program, funding for services, size of facility all appear to be far less important than two central factors: commitment to dignity and quality of staff. Probably the single theme which unifies all the exemplary programs I visited is the joining of staff, families and elderly people who, together, celebrate life.

PUBLIC POLICY PAGE

At its meeting in Toronto, September 1993, the Public Policy Committee received a paper written by Jim D'Arcangelis, Policy Analyst. The paper helped set the tone for future Committee activity. Following is his executive summary of the paper. Jim is an ADI volunteer. Many thanks, Jim!

The ADI Public Policy Committee has a significant role to play in providing information and advice to national Alzheimer's societies. ADI and its member nations share an interest in developing good information which can help change public policies for the benefit of persons with Alzheimer's and their families.

Success is the best educator. However, no systematic mechanism exists for collecting and transferring information about successful advocacy and public policies. The Public Policy Committee can assume this role and begin to identify, analyze, and report information which advocates can use to campaign for change.

The Public Policy Committee can provide information on topics of concern to national Alzheimer's societies: education and public awareness; improved caregiver standards; and patient and family services, which include improved respite, home, and nursing home care, as well as long-term health care insurance and finance. For national Alzheimer's

societies to succeed in these areas, they need comprehensive information on the following factors: the ways to conceptualize policy issues; the parameters of national health policies; the costs of Alzheimer's; various advocacy techniques; the structure of advocacy; and the political context of each nation. The Public Policy Committee can provide comparative in-

“Success is the best educator”

formation on these topics, which national Alzheimer's societies can use to craft campaigns for change.

The Public Policy Committee can produce information for the global policy making community and for nations interested in developing a national Alzheimer's society. The committee can release an

annual state of Alzheimer's policy around the world for the global policy making community. The report would feature an Index of Alzheimer's Indicators, which shows comparative government efforts to address Alzheimer's issues.

For members of ADI, the Public Policy Committee can produce:

- quarterly newsletters with information about advocacy and public policy in member nations.
- policy and advocacy briefs which describe successful campaigns to change government policies on respite, home, and nursing home care; long-term health care insurance and financing; and improved caregiver standards.
- a public policy manual which provides how-to information on advocacy techniques and methods, model legislation, etc.
- videos for motivating and educating Alzheimer's advocates as they lobby for change.
- a clipping service that collects and summarizes news about Alzheimer's public policy around the world.

SOME ADI MEMBERS' PUBLIC POLICY EFFORTS IN REVIEW

Alzheimer's societies can make a significant difference. Even in light of political differences from country to country, similarities in Alzheimer issues exist, and ADI Members' purposes are the same world-wide—to make life better for persons with AD and their families.

Alzheimer's Association (Australia) introduced Policy Papers on Education/Training and Residential Care, to work with governments and interested organizations to develop programs to better serve the needs of people with dementia and their carers. Now, service providers are using the statements to ensure that their services are compatible with the Association's guidelines.

The National Action Plan for Dementia *Putting the Pieces Together*, was the first step towards comprehensive care for persons with dementia in Australia. The plan was a result of a 21-month campaign. Local members lobbied key politicians, and allied organizations provided support by writing letters to relevant politicians. The Association produced a paper calling for a

National Task force on Dementia. These efforts led to a governmental review of Aged Care Reform Strategy. A National Action Plan for Dementia for Australia followed and an additional \$31 million allocated over five years.

Alzheimer Society of Canada will hold a breakfast meeting on Ottawa's Parliament Hill with Federal members. This will be an awareness and educational activity, with the support of Canadians who have personal experience with Alzheimer's disease telling their story to representatives in Ottawa.

Association of Families Caring for the Demented Elderly, Japan (AFCDE) identified problems in providing care to younger persons with AD and took action to solve them. AFCDE called for abolition of age discrimination for social services programs and financial support to families of young persons with dementia from the Ministry of Health and Welfare. As a result, the ministry established a special committee to study a policy for young persons with AD. A national board

member of AFCDE became a member of the committee. Now, social programs for younger persons with dementia and their caregivers are improving in Japan.

Alzheimer's Association (USA) will hold its 6th Annual Public Policy Forum: *Alzheimer Advocacy: Families in Action*, in Washington D.C., April 9-13, 1994.

The event will bring together people from the Association's chapters to advocate for long term care and federal funding for Alzheimer's research.

With a significant educational component, the four-day Forum helps participants learn how to address members of Congress on Alzheimer issues, and prepares them for effective advocacy when they return home. On the last day members will visit Capitol Hill to utilize what they have learned. On the Forum agenda are: an opportunity for children of Alzheimer families to share their personal stories with the Nation's leaders; a Congressional Hearing on Alzheimer's; a Congressional Reception; and, the first National Candlelight Vigil.

Interpreting News Headlines on Alzheimer Research

“U. S. Scientists Find a Test of Early-Stage Alzheimer’s...”

“Vitamin E Called a Boon for Alzheimer patients...”

“Heart Disease Gene, Alzheimer’s Linked...”

“Tea...aspirin...etc...”

These headlines appeared over the last year in newspapers around the world. Of course, not every research report covered in the media will be significant. True scientific breakthroughs occur infrequently. Families reading research articles or seeing television coverage of a “breakthrough” may be unable to judge the significance and may seek guidance. Here are some tips on how to handle newspaper headlines and television medical updates:

- Get as much information as possible. Ask, was a particular researcher or institution mentioned? Was the story about a new therapy, diagnostic procedure, or discovery of a possible cause for AD?
- If an article or report is about a new drug for AD, contact your physician or the national Alzheimer society in your country for the latest information available.
- Ask if the study was performed with animal or human subjects, or in cells grown in the laboratory. A change in nerve cells grown in the laboratory under controlled conditions (in vitro) does not mean that such a change would happen in a living animal (in vivo). In addition, the results of studies using laboratory animals can not be generalized to humans (e.g., if vitamin E shows a benefit in animal studies, that does not mean it will also benefit patients with Alzheimer’s disease). Studies using either cells or laboratory animals will require additional research before they will be of practical use in medical treatment or diagnosis.
- If the subjects were human, how many were studied? Have the findings been repeated at more than one site? Small numbers of participants in a single study suggest that any conclusions are preliminary

and will need to be confirmed in larger numbers of people and by independent groups of researchers. Good studies are those that can be repeated by other investigators and produce similar results.

- Remember that conservative claims by scientists reporting their own work are in general more plausible than are very enthusiastic statements.
- Evaluate the gains reported. Ask what they mean for Alzheimer patients. A test

that can definitely and consistently indicate that a person has AD can be a major step forward. One that can only rule out other causes may not be an improvement upon what is currently available.

- If you have any questions, or need more information, call your physician or your national Alzheimer society.

—From the U. S. Alzheimer’s Association’s 1993 Research Update Summary: *Predicting the Development of Alzheimer’s Disease*.

MORE ON THE APOE GENE & AD

The APOE gene is found on chromosome 19. This gene contains the instructions that enable the body to make a protein called apolipoprotein E (apoE). The most well-known function of apoE is to transport cholesterol into cells. ApoE has other functions throughout the body, some of which are just beginning to be discovered. ApoE is made in the liver, brain, spleen, kidneys, and other organs. In the brain, apoE is made by astrocytes, cells that perform important supportive roles for nerve cells, such as maintaining a structural framework and regulating the environment around the nerve cells.

Researchers know that the APOE gene has three slightly different variations: ε2, ε3, and ε4. Every human has two copies of the APOE gene. The proteins (ε2, ε3, and ε4) produced from these different variants also differ slightly in their chemical makeup. Though these differences may seem small, they cause major differences in the way these proteins function. For example, researchers studying heart disease have learned that the apoE4 protein is more effective than the other forms at moving cholesterol into cells. To protect itself from cholesterol overload, the cell limits the amount of cholesterol it lets inside using a receptor on its surface. Eventually, cholesterol in the bloodstream will build up, making a person with the E4 variant more susceptible to coronary heart disease.

DUKE TEAM’S RESEARCH

For years, Dr. Roses and his colleagues

have been studying families with multiple members who have AD. They focused primarily on families with the common “late onset” form of AD, which arises after age 65. In 1991, Dr. Roses’ team reported that some families with late-onset AD show evidence for the presence of a genetic factor on chromosome 19. Subsequently, several independent research teams around the world confirmed this finding in other families.

In late 1992 and early 1993, Dr. Roses’ team announced that the APOE-ε4 gene is more than three times as common in patients with late-onset familial AD than in people without the disease. A more important aspect of this work was revealed when the prevalence of the gene was examined in cases of apparently sporadic AD—cases with no family history.

“We found basically the same numbers for the sporadic cases as for the familial cases, which suggests that at least some of what has been divided into familial and sporadic Alzheimer’s disease is the same thing,” says Dr. Roses. “Our evidence points to the ε4 gene variant as the first concrete biological risk factor for late-onset Alzheimer’s disease”.

“Having this gene does not necessarily mean that a person will develop Alzheimer’s disease in his or her lifetime. Not having it doesn’t mean that they won’t.”

A genetic risk factor (susceptibility gene) is different from a disease gene: If a disease gene is inherited, the person will develop the disease (an example is Huntington’s disease). *Continued on Page 12*

What (in the World) We're Doing



FROM AUSTRALIA

Alzheimer's Association (Australia) now has total coverage in Australia with the opening of the Canberra branch (ACT) in September 1993.

The Association received funding from the Minister of Housing, Local Government and Community Services at launch of National Alzheimer's Week. \$185,000 was given, \$85,000 for National Secretariat operations and \$100,000 for community awareness activities. Alzheimer's week brought about numerous TV and radio interviews and articles in the print media. Societies around Australia reported a significant increase in calls from the public during the week and after.

The Association will hold its 4th National Conference—*A Family Crisis?: The positive and negative sides of caring*—on April 10-13, 1994, in Sydney. Sessions will focus on this theme including *Research and Discovery with a Human Face in Alzheimer's Disease*, in the *International Year of the Family*, the address of the keynote speaker, Dr. Wischik, Co-Director, University of Cambridge Brain Bank Laboratory. For family carers, the Association will provide ten scholarships to attend the conference. There will be free day care and free transportation for the carer and person with dementia.

Western Australia created a *drop-in* resource center with a library of books and videos providing carer information. Members, professional and family carers may borrow or view the material at the center and hold discussions with a counselor.

Also, carer support programs continue to grow with 19 groups in the metro area and 10 in county areas. A counseling service is available with a 24 hour Helpline (via pager) and state wide with a 008 number. Support is provided for people who have received a diagnosis and are in the early stages of dementia, for relatives who care in their homes, or are dealing with nursing home placement.

FROM THE U.K.

The Alzheimer's Disease Society received funds and praise when their offices were opened by the secretary of state for health. The sum of £10,000 was given for branch officer training days to help volunteers take an active role in the health and social services of the branch.

The Society will allocate £1.25 million to research over the next five years. Funds are allocated in the form of Research Fellowships. These are awarded annually, through a system of evaluation and review, to the brightest and best working in the field of dementia in the UK. The Society's research fund pays for fellows' salaries, capital costs and consumables. University administration and Society support costs are not charged to the fund. 100% of each donation to the Research Fund goes to research.

A recent recruitment campaign resulted in a significant number of new members. Membership is now over 18,000.

Around Westminster, Members delivered a 10,000 signature petition to London on behalf of caring costs.

The Society's recently published survey resulted in government inquiry into the district health authorities. The survey of 64 district health authorities showed that a significant proportion of these authorities did not have NHS beds available. Also, a majority (56%) provide fewer psychogeriatric care and respite care facilities than in 1990 - despite the rising number of people with dementia, and access to such services depends on where one lives, rather than on need.

FROM CANADA

Alzheimer Society of Canada, (ASC) received \$100,000 from Extendicare Health Services Inc. to support biomedical research into Alzheimer's disease. This gift will enable the society to increase its research efforts and move closer to finding a cause and a cure.

Over 400 ethnic newspapers and mag-

azines and 160 ethnic radio and television stations will receive information about AD from *Canadian Scene*, a multilingual news and information service. *Canadian Scene* contacted Alzheimer Society of Canada to determine what literature and services are offered throughout Canada in languages other than French and English. With assistance from the provincial associations and some local chapters, ASC discovered that Alzheimer information and services are available in 14 languages across Canada.

British Columbia will produce material in Vietnamese, Punjabi and Iranian.

In Ontario the ASC covers 22,000 square miles and a population of 117,339 with a residential door-to-door campaign. The first campaign raised \$10,500. Last year 375 volunteers raised 5 times that amount.

FROM IRELAND

Alzheimer's Society of Ireland, in an effort to raise funds and awareness for Alzheimer's disease and the Society, an intrepid group of 48—members of the Irish Soccer Squad—cycled throughout Ireland. Publicity and awareness were raised in all areas descended upon. The successful week-long activity was an example of effective cooperation between Alzheimer's Society of Ireland's branches.

FROM JAPAN

Association of Families Caring for the Demented Elderly, Japan (AFCDE) received nearly 400 participants at their 9th National Study Session held at the Chiba City Hall. The head of the social welfare bureau of the Ministry of Health and Welfare, presented a lecture entitled *The Future of Services for the Elderly*. Various cases of day care and day services were reported by volunteers, people from the social welfare council, public health centers, and hospitals.



FROM SCOTLAND

Alzheimer's Scotland (AS) focuses on carer education through its over 40 carers' support groups throughout Scotland. In addition to meeting emotional support objectives, the groups provide information through professional speakers.

The Society aims to provide a rolling program of education sessions for carers. Society projects have facilitated successful carers education courses including topics such as: What is Dementia?; Coping with Difficult Behavior; Managing Incontinence; and Services in the Com-

FROM ITALY

Federazione Alzheimer Italia—to promote public awareness and support, is offering a prize competition for a logo design among students. The aim of the competition is to obtain a logo that properly represents the social value of the involvement with Alzheimer's disease, and identifies the Federation and the local Alzheimer's Associations activities. The competition is open to students living in Italy and attending graphics courses at the High School or University level. The jury to make the final decision, is composed of internationally well-known professionals. 1st prize is 1,500,000 Itl Lire; 2nd is 1,000,000 Itl Lire; and 3rd is 500,000 Itl Lire.

munity. A Stress Management course for carers is in the making.

FROM NEW ZEALAND

ADARDS New Zealand Inc. now has a *Forget Me Not* song. Composed especially for ADARDS, the song was heard on radio during Awareness Week and is available on cassette.

Also available from ADARDS Groups, or the National Office, are Memory Loss Bracelets made of silver metal. The ADARDS New Zealand logo and *Memory Loss* is inscribed on the front. There is room on the back for a name and contact telephone number.

ADARDS New Zealand's Fourth National Conference titled: *Getting it Together* will be held at St. Cuthbert's College, Epsom, Auckland, on May 13-15, 1994.

FROM SOUTH AFRICA

Alzheimer's & Related Disorders Association (ARDA) held a successful fundraiser when it hosted a play on Alzheimer's disease. A well-known actress presented the play *My Sad Inheritance*. It was semi-autobiographical, the actress' father had AD for 15 years.

FROM INDIA

Alzheimer's and Related Disorders Society, India (ARSI) held its First

National Conference *Trends in the Management of Dementia* in Madras, on February 9, 1994. Madras is one of several locations around the world for the World Health Organization's multi-site Epidemiologic Study of Dementia.

FROM THE U. S. A.

Alzheimer's Association (USA) will hold its Third National Alzheimer's Disease Conference, in Chicago, on July 18-19, 1994. This educational conference provides a learning environment rich with offerings of practical strategies and techniques for managing effective Alzheimer care. This year, it will be held in cooperation with the National Institute on Aging's Collaborative Studies of Dementia Special Care.

The Association has available a national video public service announcement (PSA) for its Safe Return program

for use by Chapters. More than 3,000 people have registered with Safe Return—and 150 Association Chapters are participating in the program.

In 1993, the Alzheimer's Association's Memory Walk collectively raised over \$4 million. Of the Association's 221 chapters, 167 participated in the Walk and exceeded the national goal of \$3 million. The number of walkers recorded to date is 46,200—they're expecting to hit close to 50,000 nationwide.

Northern New Jersey Chapter mixes art and Alzheimer's disease to educate. The Chapter, in collaboration with a major corporation, sponsored an art exhibit about aging and AD called *Imaging aging: An Artist's perception of the Aging Process*. The exhibit featured compelling works by local artists and offered educational information on AD and the Chapter's services.

Members of the Canton Ohio Chapter created a clever tool for persons with Alzheimer's—the *Activity Apron*. The apron has pockets that contain various items of interest for mental and sensory stimulation of persons in the later stage of the disease. This helps stimulate activity that is purposeful and non-threatening, and is appropriate for the person's cognitive level as determined by the person's own responses.

FROM OTHER PLACES AROUND THE WORLD

ADI is in touch with people in 20+ countries where there is potential for developing Alzheimer groups. Some indicate that they hope soon to be ready to apply for ADI membership. In 1994, applications have already been received from Ecuador and Luxembourg.

The Story of ARDSI

India, with a population of 843.9 million has the second largest population in the world—out of which 60 million people are 60 years and above. Although we do not have the exact number of people affected by dementia, it is estimated that India has 3-4 million people (which is nearly 5-7 percent of those above 60 years) with some form of dementia. Yet awareness of this devastating disease is grossly lacking among the general public and professionals. This may be due to socio-cultural attitudes in India. Traditional Indian societies give respect and support to the senior citizens. However, the joint family system is breaking down at a tremendous speed; mainly due to urbanization and migration to other parts of the country and abroad for employment. This has put tremendous pressure on the family to look after demanding conditions like dementia. Yet, surprisingly no facilities are available in India to care for them.

Personal Insight

Despite the fact I am a medical doctor, my knowledge about dementia was limited, until it struck my father seven years ago. It took almost two years before we realized that something had seriously gone wrong with him. Later, we took him for a neuro consultation. A diagnosis of dementia didn't help him very much.

Other than prescribing some non-specific medications, there was nothing more, the attending physicians could offer to us. To my great surprise in a vast country like India, which has over 200 teaching hospitals and major medical centers, there is hardly any facility available to meet the special needs of a person with dementia. Worse still is the lack of knowledge and information of this major health problem affecting the elderly. Then, I started contacting various Alzheimer's organizations in the U.S., Canada, U.K., Ireland and Australia and received a wealth of information. Although we realize there is no cure, a lot can be done to make the lives of thousands of people with dementia and their carers more bearable.

Strong Initiative Leads to Start of Organization

Because of my background in working with handicapped children since 1986 as the executive director of Tropical Foundation of India; I decided to take the initiative and start programs to help victims of dementia in India. The first step, a national seminar was organized by the Tropical Health Foundation of India in November 1991 at Cochin. This seminar was supported by the World Health Organization, Ministry of Health & Family Welfare, Government of India, Department of Science & Technology, HelpAge, State Committee on Science, Technology & Environment, Government of Kerala, Rotary Club, and Psychiatrists Guild of Cochin and Trichur. This seminar drew 170 delegates from all over the country comprising caregivers and professionals. An unanimous resolution was adopted at the seminar to form a national organization for dementia and I was entrusted with the responsibility of organizing the same.

A Society Grows

A series of ad hoc committee meetings were held and finally in August, 1992 constitution of the proposed organization was approved by the committee. The new organization was named as Alzheimer's and Related Disorders Society of India. A governing board comprising 17 members was constituted. The following were elected as office bearers: Dr. S. Raj Kumar, Professor Psychiatry, Madras Medical College, as the president; Dr. Vinod Kumar, Professor of Medicine, A.I.I.M.S., Delhi, Vice President; Dr. K. Jacob Roy, Secretary General; Maj. A.V. Thomas, Joint Secretary General and Dr. K.C. George, Treasurer

The registered office is located at the Norman Vincent Peale Center for Community Mental Health and Dementia at Thevanal Valley which is nearly 24 kms from Cochin city. We have registered ARDSI under the Charitable Societies Act. In 1993, ARDSI was accepted as a full member of Alzheimer's Disease International (ADI).

Chapters are Formed

The society has a total membership of 490 with chapters in Bombay, Delhi, Madras, Bangalore, Cochin and Trichur. We publish a quarterly news bulletin named *Dementia News* which is free of charge to members. A caregivers manual has been developed by our staff. Brochures on various aspects of dementia management are being developed. Efforts are being made to get these translated to local languages. Also, various chapters are organizing workshops and seminars.

Other Developments Include

- Cooperation with the N.V.P Center which is involved in the epidemiological and intervention studies of dementia.
- Training and geriatric nurses
- Out patient services for those affected
- Information services

Plans for the Future

Aims and objectives of ARDSI may be summarized as:

- To provide support, succor, help and information to affected families
- To encourage chapter formation throughout India
- To secure both governmental and non governmental help for the affected
- To promote dementia research
- To encourage training of health personnel in geriatric care and dementia
- To educate the general public about dementia
- To offer training programs for caregivers, organize seminars & medical camps
- To provide legal help
- To collaborate with various national and international agencies in our pursuit for dementia care

In Summary

We have only touched a fringe of the problem. We have a long way to go before we can reach out to each and every needy dementia victim in India, but with the help of our friends, we will be able to achieve this goal.

Dr. K. Jacob Roy
Secretary General ARDSI



Publications from Around the World

Living in the Labyrinth: A Personal Journey Through the Maze of Alzheimer's. By Diana Friel McGowin, the book, tells the story of a woman experiencing early-onset Alzheimer's. The reader shares her fear, panic and pain as she is faced with the affects of the disease in her everyday life. The author, diagnosed with Alzheimer's in her fifties, recorded her experiences for this book. A new look at the disease. Delacorte Press, Bantam Doubleday Dell Publishing, Inc. Cost: \$22.95

A Personal Care Book. Provides caregivers with individualized information to enhance the quality of care of persons with Alzheimer's disease. A journal section provides physicians and other professionals with invaluable information. Alzheimer's Society of Canada; 1320 Yonge St., Suite 201, Toronto, Ontario, Canada M4T 1x2. Tel: +(1 416) 925-3552. Cost: \$2 each or \$250 for box of 160.

Dining Skills: Practical Interventions for the Caregivers of the Eating-disabled Adult. Includes sections on Alzheimer's disease, swallowing problems, preparations to increase calories, etc., c1992. Available from the American Dietetic Association. Tel: +(1 312) 899-0040 X4853.

Doing Things: A Guide to Programming Activities for Persons with Alzheimer's Disease and Related Disorders. Baltimore, MD., Johns Hopkins University Press, c1987.

Alzheimer's Disease and Heredity. An information sheet for families, available in English and French. Alzheimer's Society of Canada; 1320 Yonge St. Suite 201, Toronto, Ontario, Canada M4T 1x2. Tel: +(416) 925-3552. Cost: Free

The Support You Need: Information for Carers of Afro-Caribbean Elderly People. Booklet by Dr. L. Eribo, Alzheimer's Disease Society; Gordon House, 10 Greencoat Place, London SW1P 1PH. U.K. Tel: +(44 71)306-0606. Cost: free, enclose a large self-addressed envelope.

Carer's Dementia. By George Gent, this book shares the authors detailed, thoughtful, and honest description of his triumph of caring for his wife who had Alzheimer's. Deryck Ellis, 5 Tye Gardens, Pedmore, Stouridge, West Midlands DY9 0XU, U.K. Cost: \$2.25 including p&p.

Thirtysomething: Caring for the younger person with Dementia. Alzheimer's Disease Society; Gordon House; 10 Greencoat Place; London SW1P 1PH UK, Tel: +(44 71) 306-0606.

Community Care for People with Dementia: An Evaluation. Anne O'Brien, Lincoln Gerontology Center; La Trobe University; Locked Bag 1, Carlton South; Victoria 3053, Australia. Cost: \$18.

Coping when a Grandparent has Alzheimer's Disease. By Beth Wilkenson, book is written for teenagers who have a grandparent with AD. Explains the nature, behavioral effects and diagnosis of AD. Discusses grandchild's emotional feelings during the course of the disease; positives and negatives of having a grandparent with Alzheimer's sharing the home; moving grandparent into a nursing home; choosing the home and the kind of care provided in nursing homes. Lots of advice on what to say and do when visiting in the nursing home. Discusses coping with the death of the grandparent. Poignant accounts of thoughts and feelings of grandchildren who have experienced having a grandparent go through the course of the disease. Available from: Ilam Booksellers; P. O. Box 845, Christchurch, New Zealand. Price: \$48.95, NZD.

Living with Alzheimer's Disease: the complete self help guide for family and professional carers. By Dr. Gordon Wilcock, this a self-help manual designed to help carers faced with the "living bereavement" of dementia. With clear and concise information, backed by personal case histories. Penguin Books, 27 Wrights Lane, London W8 5TZ, U.K.

• • VIDEOS

Four-part training series for Social Workers from Duke University. Covers how to help families by identifying issues and potential strategies for daily care of the person with Alzheimer's disease. The series translates years of research into a practical, easy to use format, and puts how-to information in the hands of direct care workers. Available from: Terra Nova Films; 9848 S. Winchester Ave., Chicago, IL 60643. USA. Tel: +(312) 881-3368. Cost:\$69.95 each, series \$199.00.

Part 1—Assisting Families of Patients with Alzheimer's disease. 20 mins. Covers emotional reactions of patients and caregivers to hospitalization, and how family caregivers can locate help and information once the patient returns home.

Part 2—Family Support Groups: Help for the Families of Alzheimer's Patients. 18 mins. Illustrates the mutual help role of participants in a family support group.

Part 3—Alzheimer's Disease: Interviewing and Assessment Techniques for Social Workers. 30 mins. Demonstrates testing techniques and responses from three persons with AD in different degrees of impairment.

Part 4—Thicker than Water. 10 mins. Demonstrates techniques for working with families in a nursing home setting, focusing on distraught family members.

Alzheimer's Disease: Care at Home. A seven-part training package designed for front-line workers providing care at home for persons with Alzheimer's. Included are: Instructor's Guide, Participant's Workbook and seven videos. Topics: Aging; The Nature of Alzheimer's; Communication Strategies; Working with Families; The Home Environment; Activities of Daily Living; Challenging Behaviors. Available in English or French plus GST. Alzheimer's Society of Canada; 1320 Yonge St., Suite 201, Toronto, Ontario, Canada M4T 1x2. Tel: +(416) 925-3552. Cost: \$150

MORE ON APOE and AD —From page 7

If a susceptibility gene is inherited, the person's chance of developing the disease is greater than that of a person who does not have the gene, but it is by no means certain. The question now for APOE-ε4 is, How much does this gene increase a person's likelihood of developing Alzheimer's disease?

Because some Alzheimer patients do not have the APOE-ε4 gene, it is safe to say that this gene is not the only risk factor for AD. Dr. Roses suggests that Alzheimer's may be like heart disease, in which multiple intersecting factors can lead to the development of the disease.

In the year since Dr. Roses released his findings, numerous research groups around the world have reported similar results. Replication of these results by various researchers affirms that this finding is important and generalizable—it is not just a peculiar characteristic of a small group of Alzheimer patients, but appears to be consistent.

Dr. Roses' team quickly extended their early findings with three other important pieces of information:

ApoE Proteins Bind Differently to B-amyloid. In initial studies, his team found that apoE4 latches on faster and better than the other versions to B-amyloid—the protein present in senile plaques found in the brains of Alzheimer patients.

APOE Genotype Predicts Level of Amyloid Pathology. When the research team examined the brains of deceased Alzheimer patients, they found that patients with two copies of the ε4 gene had much more B-amyloid present than patients with two copies of the ε3 variant of the gene.

APOE Genotype Seems to be Related to Risk and Age of Onset. When Dr. Roses' team compared APOE genotype with the age of onset of AD, they found an intriguing pattern: In 42 families studied, people with AD and two copies of ε4 had an average age of disease onset of 68 years; patients with AD and one copy of ε4 showed an average age of onset of 76 years; and people with no copies of ε4 had an average age of onset of 84 years. It also appears that when people inherit a copy of the ε2 version of the gene, their risk of developing AD is decreased and age of onset is increased.

While it appears that people with the APOE-ε4 gene are at increased risk for

AD, it is currently impossible to say how much a person's risk of developing AD is increased by the presence of this gene. Researchers are beginning the long term epidemiological studies that must be done before this information will be known.

Why would someone want to know that they are at higher risk? Such knowledge, while not very useful now, will be important once controllable risk factors are identified, as is the case with heart disease. If a person has a genetic predisposition for heart disease, he will probably be more likely to exercise regularly, avoid smoking, and pay attention to diet. Scien-

tists hope that a greater understanding of the APOE gene and the apoE protein can help them identify controllable risk factors for AD.

Finding such a risk factor may be easier now, because researchers can focus their studies on people who have the APOE-ε4 gene. Why do some people with this gene develop AD while others do not? Could it be that they are exposed to something in the environment? These are the questions that researchers will now be able to ask. —From the U. S. Alzheimer's Association's 1993 Research Update Summary: *Predicting the Development of Alzheimer's Disease.*

Calendar of Events

MARCH 20-25, 1994

Dementia in Parkinson's Disease International Symposium, Israel. Latest on research into cognitive changes in Parkinson's disease and extrapyramidal features in dementias. Particular emphasis on diffuse Lewy body disease; risk factors for dementia in Parkinsonism; and medical management. Prof. Amos D. Korczyn, Chair, Organizing Committee; Tel Aviv, Israel. Tel: +(9723) 517-4571

MARCH 24-25, 1994

4th Annual Rotman Research Institute Conference, Toronto, Ontario. The Dementias: Diagnosis and implications for Management. Contact: Rotman Research Institute, Baycrest Centre, 3560 Bathhurst St. Toronto M6A 2E1. +(416) 789-5131.

APRIL 10-13, 1994

4th Alzheimer's Association (Australia) National Conference, "A Family Crisis? - The positive and negative sides of caring," Sydney, Australia. Contact: Conference Management Pty Ltd. at 532 Park Road, Park Orchards 3114. Tel: +(61 3) 879-9460

MAY 1-7, 1994

46th Annual Meeting, American Academy of Neurology, Washington DC, U.S.A. Contact: AAN, Minneapolis, MN. Tel: 612-623-8115

MAY 9 1994

One Day Scientific Conference Alzheimer's Update Dun Laoghaire, Dublin. Current Progress in Research and Treatment of Alzheimer's Disease. Contact: Barbara Scully, Alzheimer's Society of Ireland: Tel: +(353 1)288-1282.

MAY 13-15, 1994

4th ADARDS New Zealand National Conference, Auckland, NZ. Contact: Leigh Kelly, Alzheimer's Foundation (Auck) Inc; P.O. Box 24042, Royal Oak, Auckland, NZ

JULY 29–AUGUST 3, 1994

Fourth International Conference on Alzheimer's Disease, Related Disorders, Minneapolis, Minn. Topics: Diagnosis & Course, Epidemiology & Genetics; Neuropathology; Cytoskeletal Pathology; Amyloidogenesis; Model Systems; Therapeutic Strategies. Contact: J. Mortimer, M. Dyksen. Tel: +(1 612) 725-2051. Fax: +(1 612) 725-2084.

JULY 18-19, 1994

3rd Alzheimer's Association National Education Conference: Quality Alzheimer Care, Chicago, IL. State-of-the-art information on AD & related disorders for healthcare providers; practical strategies & techniques for managing effective Alzheimer's care. Contact: Alzheimer's Association; 919 N. Michigan Ave., Chicago, IL 60611. Tel: +(1 312) 335-5790.

SEPTEMBER 21-23, 1994

10th International Conference and Annual Meeting of Alzheimer's Disease International, Edinburgh, Scotland. Contact: CEP Consultants Ltd.; 26-28 Albany Street, Edinburgh, EH1 3QH. Tel: +(44 31) 557-2478.

SEPTEMBER 1995

11th International Conference & Annual Meeting of Alzheimer's Disease International, Buenos Aires, Argentina. Contact: Dr. Carlos Mangone; Servicio de Neurologia; Hospital Santojanni; Pilar 950; Capital Federal 1408; Buenos Aires, Argentina. Tel: +(54 1) 652-0751.

SEPTEMBER 1996

12th International Conference & Annual Meeting of Alzheimer's Disease International, Jerusalem, Israel. Contact: Shoshana Efrat, Alzheimer's Association of Israel; P. O. Box 8261; Ramat Gan, Israel, 52181. Tel: +(972 3) 535-2164.