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Global Perspective

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

ADI's 8th International Conference Fulfills Goals —and Adds Color and Excitement too!

"ADI's 8th International Conference in Brussels was superb," the caller said. "The program, the sights and sounds, people will not fully appreciate the experience until after they have returned home." In the weeks that followed, callers to the ADI office echoed the sentiment.

Indeed, from that moment at European Community Headquarters when Belgium's Princess Paola and ADI's President, Princess Yasmin Aga Khan Jeffries, entered the Assembly Room, through to the closing ceremonies in historic Antwerp, it was a colorful kaleidoscope of sights, sounds and events.

From their airport hotels, participants went by bus to Brussels, Leuven and Antwerp for segments of the Conference.

On Friday morning, September 25, 1992, at the EC Headquarters in Brussels, the Opening Session featured a discussion titled *The European Perspective* (on Alzheimer's Disease). In the afternoon, conferees rode out into the countryside to Ferme de Foriest, UCB Pharma's meeting center, for the *Sharing Programme* where ADI Members provided exhibits, and updated fellow members on their organizational progress and program plans.

On Saturday morning, September 26, participants traveled to historic Katholieke Universiteit (Est. 1425) in Leuven, for Parallel Workshops. They walked the lovely tree-shaded campus pathways to sessions on *Basic Research & Genetics; Neuropsychological Assessment; Psychomotor Rehabilitation; Guidelines for Care; Respite Care & Terminal Care*. Late morning

workshops included *Future Strategies & Guidelines for Drug Trials; Health Economics for Home Care; Younger Alzheimer Patients; Residential Care Programs & Services for Caregivers*. In the afternoon, the academic session, *Strengthening the Caregiving Family*, was held in the University's great Sporthal.

Workshops held early on Sunday September 27, focused on *Services for Patients & Caregivers; Dementia & Family Practice; Architecture & Environment; Information Network; and, Organizing a National Alzheimer Organization*. Opportunities to visit Belgian eldercare facilities were also offered.

Then followed a visit to the great Government House in Antwerp for the Reporteurs' Conference Summary and Closing Ceremonies. Afterward, Members visited the magnificent towering gothic style Cathedral of Our Lady (1352-1521) in Antwerp, where a moving ecumenical service was held just for ADI Members and Conference participants, a fitting end to the three-day event.

More on ADI's 8th International Meet-



(l to R) Princess Yasmin Aga Khan Jeffries, Princess Paola of Belgium, Professor Dr. Franz Baro, entering European Community Headquarters.

ing & Conference on these pages and the next issue of *Global Perspective*.

For a copy of the 8th Conference *Book of Abstracts*, write: Belgian Alzheimer Liga; Professor Dr. Franz Baro; Krijkelberg 1; B-3360 Bierbeek; Belgium.

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About Growth...Challenges... and 1993

Four national Alzheimer societies were added to ADI's membership in September. Today, the International Federation has 27 members—national Alzheimer societies located around the world in:

Argentina	Australia	Belgium
Brazil	Canada	Chile
Denmark	Finland	France
Germany	India	Ireland
Israel	Italy	Japan
Mexico	Netherlands	N. Zealand
Puerto Rico	Scotland	South Africa
Spain	Sweden	Switzerland
United Kingdom	United States	Venezuela

ADI's purposes are directed toward advancing the well-being of persons with Alzheimer's disease, their families and caregivers worldwide. ADI therefore holds an annual international conference to promote the exchange of scientific information and understanding about Alzheimer's disease; it publishes the *Global Perspective*, facilitates networking and exchange of information among members; and currently maintains communications with individuals in nineteen other countries to encourage possible future candidates for membership. In September 1992, ADI entered into an official Working Relationship with the World Health Organization (WHO).



Brian Moss

The development of national societies in new countries is vital to providing needed information and support to afflicted families. However, depressed economic circumstances and cultural differences will impact on the pace at which some national associations are able to form and develop to meet the criteria for ADI membership. Members have expressed interest in supporting nascent Alzheimer societies, and

we have further reason to be optimistic about formation of new societies in light of ADI's new relationship with WHO.

WHO understands the critical need for raising public awareness, promoting training and education, and providing services and support to Alzheimer families, particularly in third world countries. Finding ways to collaborate on these issues will be explored in ADI's relationship with WHO.

In 1993, ADI and WHO will be collaborating: 1) to produce a brochure on caring for a person with dementia, and 2) in providing training for doctors from third world countries.

As we enter 1993, we can share some satisfaction in knowing that concerted effort on behalf of persons with Alzheimer's and their families is now extending well beyond the borders of our own member countries. At the same time, we recognize that there is still much more to be done.

We are fortunate to have our strong and growing ADI membership. We know the work ahead will require added resources of energy, skills, talent—and money. It will be a challenge, but, if I may borrow a phrase from several Alzheimer societies ... *We Can Do it Together*.

Best Wishes for a happy and healthy New Year.

—Brian Moss, Chairman

Mark Your Calendar

ADI's 9th International Conference
September 20-23, 1993
Toronto, Ontario, Canada

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ADI Council Appoints Deputy Secretary General

Rachel Billington, ADI's part time Deputy Secretary for three years, was appointed by the ADI Council to serve as Deputy Secretary General on a full time basis, effective October 1, 1992.

Originally from Cleveland, Ohio, and a founding member and former President of the Greater Cleveland Chapter of the Alzheimer's Association (USA), she was invited to Chicago to serve as Director of the national office of the Association, in 1982. After establishing basic systems for the Association, her major contributions have been in program planning and development, Chapter Development and Patient & Family Services. She was instrumental in the initiation and develop-

ment of the Association's National Respite Care Demonstration Program.

Prior to joining the Alzheimer's Association, Mrs. Billington worked for nearly twenty years in the health care field in hospital administration and fundraising, patient advocacy and public relations.

Because her father died with a related disorder, she has a keen interest in current research efforts, and believes that wherever Alzheimer's strikes, the devastation, pain, and caregiver needs are the same the world over. "So, sharing information and linking families and caring professionals with existing Alzheimer societies or helping develop new national societies becomes most important," she says.

Australia's National Action Plan for Dementia Care

At the 8th International Conference in Brussels, Franceska Jordan, President of Alzheimer's Association (Australia), spoke about the Australian Government's recently released National Action Plan for Dementia Care, called *Putting the Pieces Together*. The Alzheimer's Association in Australia has played a key role in the development of this Plan, and will have a close working relationship with the Government in its implementation.

The Plan is the culmination of a successful 21-month campaign conducted by the Association, using its national network of State/Territory Associations and their extensive network of local support groups to lobby key politicians. We began in January 1991, with the publication of a paper calling for a National Task Force on Dementia. This four-page document was divided into four sections: The Need for a National Task Force on Dementia; The Objectives of a National Task Force; Its Structures and Strategies; and its Suggested Terms of Reference.

As well as using our local members to lobby politicians at the local level, an important strategy was to gain the support of key allied organisations, such as the Australian Council on the Ageing, the Australian Association of Gerontology, the Royal Australian and New Zealand College of Psychiatrists, and many oth-

ers. Their letters of support were sent to relevant Federal Politicians and were an effective reinforcement to our campaign.

This campaign fed into a major Review of Aged Care Reform Strategy which the Federal Government conducted from 1991-1992. The first report of this Review was produced in August 1991 and contained a recommendation that the Government produce a National Action Plan for Dementia Care for Australia. Our Association was frequently consulted in the development of the Plan, which was launched by the Federal Minister for Aged, Family and Health Services at the same time as he launched the opening of our National Alzheimer's Week on September 7, 1992.

Although we did not achieve exactly the response we wanted – i.e., the establishment of a National Task Force – our Association is pleased with the Federal Government's reaction, particularly bearing in mind the severe recession we are currently experiencing in Australia.

The Plan allocates an additional A \$31 million (US \$21 million) over five years. The Association heralds the Plan as a welcome first step towards a comprehensive system of care for people with dementia and their carers. It is also worth noting that the Federal Government has already allocated an additional A\$89 million (US

\$59.7 million) in 1992 to a "carers' package," which will also benefit carers of people with dementia, primarily by providing new or expanded respite programs. The main features of the Plan are:

- Improved diagnosis and assessment through local Aged Care Assessment Teams;
- Increased counselling services for family carers;
- Community care and residential care demonstration projects to promote best practice in dementia care;
- Development of a national training program for family carers;
- New training initiatives for community care and residential care workers;
- Four new research fellowships;
- Funding support for the National Secretariat of the Alzheimer's Association (Australia), and the conduct of National Alzheimer's Awareness Weeks.

Franceska Jordan has been asked to prepare a paper for ADI's 9th International Conference in Toronto, Canada (September 1993) which will include an explanation in more detail of the tactics used by the Alzheimer's Association (Australia) in its campaign. Further details on the Plan will be included in this paper.

—Pat Jones, Executive Director
Alzheimer's Association (Australia)

Declaration of Rights for Younger People with Dementia and their Carers

This declaration (distributed at the workshop on Younger Persons with Alzheimer's) was originally prepared for and on behalf of people with dementia under pensionable age in the Mersey Regional Health Authority (U.K.).

1. Full informed medical assessment. General Practitioners should have the relevant skills to recognize the symptoms of dementia in all age groups and be aware of the need to refer on to appropriate consultants.

2. Recognition of the need for specialist services. Identification of consultants with special responsibilities for this group of people who will make a diagnosis where possible and from whom carers are entitled to ongoing medical supervision.

3. After diagnosis, carers should have access to the following services organized on at least a sub-regional basis:

Specialist day care services organized in a flexible way so that carers can continue to work. The aim should be for appropriate stimulation with an emphasis on constructive occupational therapy for those who are able to benefit from it and, for those who cannot, diversional activities. Within the service should be properly funded resource centres providing comprehensive and accurate information and counselling, and support for carers with a drop-in facility.

Appropriate residential care when required—not elderly persons' homes or acute psychiatric establishments.

Implementation of care programmes and case management so that services are assessed at the time of need, enabling a progressive build-up of care as the person's health deteriorates.

4. Access to welfare benefits: Easy access to welfare benefits currently available plus some new benefits:

- A specialist carers' benefit.
- A benefit equivalent to mobility allowance, payable to people with dementia irrespective of age.
- Universal acceptance of Alzheimer's disease as a 'terminal' illness irrespective of age.
- Money to provide care for the person in the community on the scale now available to pay for residential care.

5. Retrospective reinstatement of rights and benefits for people who have had to terminate their employment either voluntarily or through dismissal and who have later been diagnosed as having dementia and who have consequently been discriminated against. Employers should be directed to recognize dementia as a reason for early retirement so that pension rights and other benefits are not affected.

6. Appropriate training and information to be made available at all levels for public and professionals alike, including GPs.

Spotlight on Two 8th Conference Presentations

Reducing the Agitated Behavior of AD Patients Through a Low Intensity Exercise Program

••**A Workshop on Psychomotor Rehabilitation:** Research has documented the prevalence of agitated behavior and the resulting care difficulties among nursing home patients, especially those with Alzheimer's disease (AD) patients. One study found that 93% of nursing home residents manifested one or more agitated behavior at least once a week, while another study reported that among 127 patients with probable AD, agitation was present in 10% of mild, 27% of moderate, and 38% of severe dementia cases. Causes and remedies for agitated behavior are not well known and usually vary from one study to another and among many other factors including inactivity and boredom.

Since the sources of these findings were anecdotal, and unverifiable, a quasi experimental study was designed with two

purposes: (1) to evaluate an exercise/movement program's impact on agitated behavior of patients with AD; and (2) to describe a program of physical activity suitable for an institutionalized population with AD. Twenty-two AD patients participated in a 40-minute exercise/movement study for 28 days. The program was divided into a 10-minute warm-up phase, a 20-minute exercise/movement phase, and a 10-minute cool down period.

Results indicated that most participants claimed they felt better, lost weight, slept better at night, and had fewer digestion problems. The results further showed that the exercise/movement program reduced the agitation behavior of AD patients by almost one-half. The study establishes that an exercise/movement program is both feasible and desirable for AD patients, and



such a program will successfully reduce some adverse behavior.

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Helping Hand Plus: Reaching Out to Long Term Care

••**A Workshop on Residential Care Programs.** Background: The Helping Hand founded in 1984, is a dementia-specific social model/volunteer model day center and in-home program for persons with Alzheimer's Disease and related disorders. The philosophy of care is based on accepting each person with Alzheimer's as an adult with feelings and a valued human being regardless of disability. This philosophy also recognizes the need for therapeutic programming and individualized care consistent with a person's life story. Families that have experienced improvement in the quality of life of their family member in the Helping Hand Program, have been distressed to find this quality of care missing once their loved one has been placed in a long term care facility.

Identified problem: Often, activities and therapeutic programming, appropriate for memory-disabled persons, simply do not exist in long term care facilities. If activities are provided on a limited basis, for a mixed population, there is not an adequate staff/resident ratio to provide in-

dividualized care and, thus, persons with Alzheimer's are often excluded. This problem becomes even more acute in the facilities on the weekends.

Project Description: Helping Hand is composed of three different projects all relating to improving the quality of care of memory-disabled persons in long term care facilities: 1) The Helping Hand day center model has been replicated in a long term facility where no organized dementia-specific activities had been available. The program operates three times a week, one of which is always Saturday. The volunteer director, a former Helping Hand family caregiver, assisted by other volunteers, conducts the structured program; 2) Eligibility criteria were revised to allow residents of long term care facilities to attend Helping Hand Center. This provides a 'window to the world' by providing an outing for nursing home residents to maintain social contacts and participate in dementia-specific activities; and 3) The Helping Hand in-home program now sends volunteers

into long term care facilities to provide companionship and therapeutic activities to persons with Alzheimer's. The volunteers serve as an "extra family member" or "substitute family member" for long distance caregivers.

Result: Replication of the day center model is a successful and ongoing project. The long term care facility was reluctant at first to accept the disruption to its schedule. Now, they say that the program has helped to change the quality of care provided by the facility in general. The other two projects, extensions of the Helping Hand day center and in-home program, have related in a special way to eight different nursing homes. These efforts have made a difference in dementia-specific care in long term care facilities. It is hoped this is only the beginning.

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Another Perspective on Caring

The following article was printed in the Chicago Sun-Times newspaper, on June 18, 1992, and is reprinted with permission from Jeffrey Zaslou.

The first stage of motherhood may be the most magical. A newborn doesn't know who you are, but needs your love—and love pours out of you naturally. A baby is dependent on you, but incapable of saying thanks. It doesn't matter. No thanks are necessary.

Eileen Carrier recalls her earliest days as a mother. At age 81, she is reliving that first stage of motherhood. But this time around, what was once magic is now tragic.

Her 60-year-old daughter, Donna Webb, has Alzheimer's disease. Donna can't talk, control her bowels or recognize her loved ones. Who knows what she's even thinking? And so Eileen has many flashbacks to the days Donna was a baby.

"When she's being diapered, I think, 'Oh my, how many times did I do this for you in the past?'" Eileen says. "When I push her in her wheelchair, I think of all the times I pushed her in a baby buggy. She was a good baby.

Eileen remembers Donna as a placid child, a good-natured teen and a fun-loving adult. Eileen always assumed that when she got old, her daughter would be there to look after her. She never imagined she'd be an octogenarian caring for Donna.

There are about 4 million Americans with Alzheimer's, a disease that steals your ability to think. Donna is one of the younger victims, and Eileen is one of the oldest caregivers.

Eileen, a widow living in Elgin (Illinois), says she has no choice but to accept her fate. "Feeling sorry for yourself, that's bad news. Then you lose control. I'm doing what comes naturally. I spend my days with Donna and try to help her.

Donna first showed signs of Alzheimer's in 1980, at age 50. She'd say, "What's the matter with me? I can't think." She got forgetful. She'd write checks and forget to fill in the name. Eventually, she had to quit her secretarial job and stop pursuing her passion—raising show cats.

In 1983, Eileen decided to move to Illinois from her home in Florida to help care for Donna. "I got my own apartment,

and I'd go to her house every morning at 6," Eileen says. "I'd stay all day until Donna's husband came home from work. Then he'd take over until morning.

Donna was incontinent and spent much of her day pacing. If Eileen wasn't watching, she'd head out the door.

When Donna's husband died in 1988, more of the burden fell on Eileen. A year later, Donna had to be moved into a nursing home, where she now sits, all day, with her fists clenched and her arms across her chest.

Donna's four children try to help, but two live out of town and the others have kids and jobs. "They do as much as possible," says Eileen. "But, basically, it's me."

Eileen spends much of her life at the nursing home—feeding Donna, making sure her diaper rash is under control, just keeping her company. It has been three years since Donna recognized her.

Eileen attends Alzheimer's Association meetings. The other people she meets there are around Donna's age. They're caring for their ill parents, who are Eileen's contemporaries. Though Eileen recog-

nizes the irony of her situation, she tries not to let it consume her.

At age 81, Eileen is understandably apprehensive about the future. She has heart problems and wears a pacemaker. "I often think to myself, 'I hope the good Lord takes Donna before me,'" Eileen says. "Donna isn't living. She's just a body. And I know her kids will do what they can, but they don't have the time to do what I'm doing."

When Donna was healthy, she used to say that if ever her mom got sick, she'd welcome her into her home and take care of her. Eileen remembers that promise, and in a way, it's comforting.

"Yes, it's heartbreaking as things turned out," Eileen says. "Donna looks right through me, and it kills me. But you have to figure there's a reason for everything."

When I tell Eileen that her efforts and her attitude are inspirational, she quickly dismisses my comment. "I'm not a hero. No way," she says. "I'm just a mother."

First reprint of this article appeared in the newsletter of the Chicago Chapter, Alzheimer's Association, (USA).

Opening Session at European Community Headquarters



(Clockwise from left) Dr. J. Sampaio-Faria, Regional Director for WHO; L. Onkelinx, Belgian Minister of Health; Michael H. Coote, Chair, Alzheimer Europe & Alzheimer Society of Ireland; Professor Dr. Franz Baro, 8th International Conference Organizer & Medical Advisor of the Belgium Alzheimer Liga; Brian Moss, ADI Chairman, R. Chanterie, Member, European Parliament; and photographer.

Focus on Quality Care . . .

Assuring quality care for persons with Alzheimer's disease is a matter of deep concern for Alzheimer societies around the world. Highlighted on these pages are summaries of two presentations at the workshop on guidelines for quality care held during ADI's 8th International Conference

1 *Myra Schiff, PhD, Director of the Guidelines for Care Project for the Alzheimer Society of Canada summarizes her workshop presentation as follows:*

It is estimated that 300,000 Canadians currently have Alzheimer's disease, and this number is expected to increase to 700,000 by the year 2020. Over half a million are expected to be severely incapacitated, requiring a high degree of care.

Despite the number of Canadians with Alzheimer's, and the profound effect the disease has on the individuals, their caregivers and on the Canadian health and social service system, there has been no mechanism for promoting a coherent and consistent direction about care for Canadians with Alzheimer's disease.

The Alzheimer Society of Canada has responded by developing guidelines for care of people with Alzheimer's disease and their caregivers, with the assistance of a three year grant from the Seniors Independence Program, Health and Welfare Canada. The Project is the responsibility of the Guidelines for Care Committee, which reports to the national Board of the Alzheimer Society. Committee members come from across Canada, and include older adults, family caregivers, and members of several relevant professions, including nursing, social work, physical and occupational therapy, and a chaplain.

Canadians with Alzheimer's disease—and their caregivers—live in a wide variety of situations. Many live at home with a family caregiver, while others live in long term care settings such as a nursing home. Many of those living in the community receive personal care, nursing care and homemaking services from community agencies, and some also attend day programs.

The quality of resources and the ease with which they can be accessed varies a

great deal across the country. Large urban areas are likely to have a greater number and variety of services than are small towns or rural areas. The variety is increased further by the fact that each of the ten provinces is responsible for health and social services for its residents.

“The challenge was to develop guidelines for individuals with Alzheimer's disease and their caregivers regardless of the circumstances under which they were living.”

The challenge was to develop guidelines for individuals with Alzheimer's disease and their caregivers regardless of the circumstances under which they were living. The guidelines needed to be relevant to people living in long term care settings as well as those living in the community. They needed to be appropriate for Prince Edward Island—the smallest province with about 130,000 residents—as well as for Ontario, whose 10,000,000 residents represent just over 1/3 of the Canadian population.

The project began with a Needs Assessment to identify any existing standards or guidelines and topics to include in the guidelines. Visits were made to long-term care settings (such as nursing homes) and

to agencies (such as day programs) providing care for people with Alzheimer's disease living in the community. A report summarizing those visits identified a number of areas in which guidelines would contribute to quality of care for people with Alzheimer's and their caregivers.

Beginning with a first draft, several revisions of the Guidelines were developed by Committee members in the Spring of 1991. A later draft was circulated in the Spring of 1992 to over 70 interested individuals (including family caregivers, staff and administrators from long term care settings and community agencies, family physicians, and representatives from provincial and local Alzheimer societies). Comments from the review were incorporated into the final document, printed and distributed in the Fall of 1992.

The Guidelines deal with the areas of training, education and support for caregivers, assessment, care planning, programs and activities, human resources, environmental design, transportation, decision-making, prevention of and response to abuse, and the use of restraints. They emphasize principles and goals, rather than rules and directions, within each of these areas.

The Guidelines recognize that all older adults are entitled to high quality care, and address those aspects of care which are in addition to the needs of other older adults. They deal with those aspects of Alzheimer's disease which have unique implications for the proper approach to care.

For example, the guidelines focus on the unique aspects of involving people with Alzheimer's disease in the decision-making process, because their mental status raises some problems about competence that do not exist for those who are cognitively intact. They assume that people with Alzheimer's disease will re-

—Continued on Page 10

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Jo Ellen Wicht, MSW, ACSW, is Director of the Alzheimer's Care Center, and Social Services, at Foxwood Springs Living Center, Kansas City, MO. She is a member of the Patient Care & Family Services Committee of the national Alzheimer's Association (USA), and summarizes her presentation as follows:

GUIDELINES FOR DIGNITY: GOALS OF SPECIALIZED ALZHEIMER/DEMENTIA CARE IN RESIDENTIAL SETTINGS

The Alzheimer's Association in the United States has been involved and interested in special dementia care units for many years. In 1987, the Association funded the first major research study of special dementia care units. The five state, three year study, provided considerable insight in describing the complexity of this developing field. In 1989, the booklet, *Selecting a Nursing Home with a Dedicated Dementia Unit*, by Mace and Gwyther was published by the Association as a guide for families.

The text of this booklet is being updated and will be available in early 1993. A patient and family services bibliography and other materials have been made available as responses to the growing number of requests, and now the Benjamin B. Green-Field National Alzheimer Library and Resource Center is open to better serve the public with information.

A number of chapters have also been involved in co-sponsoring conferences and developing booklets and information on special care units.

Need for *Guidelines for Dignity* became more and more evident as both the Association's national office and chapter offices fielded growing numbers of calls from families and providers with questions about special dementia care units.

In July 1992, the *Guidelines for Dignity* were released. The intent of this document is to define the dynamic process we call "specialized Alzheimer/Dementia care" for those with primary degenerative dementia or Alzheimer disease. With this beginning it is our hope to:

- encourage research,

- build a coalition of interested and involved groups and individuals,
- continue discussion of what components and characteristics should be considered in an effort to provide the best care, and
- build practical methods and strategies for implementation throughout the system

The Association seeks to encourage, support and research innovative models and programs so that "specialized Alzheimer/Dementia care" will continue to evolve and improve in the future.

This document proposes and describes eight goals for action which were created to serve as a guide and benefit providers, Alzheimer/Dementia unit residents and families. The goals follow the chronological process for placement and care as experienced by families.

GOAL 1: PHILOSOPHY

A specialized Alzheimer/Dementia care program has a written statement of its overall philosophy and mission which reflects the needs of residents afflicted with dementia.

GOAL 2: PRE-ADMISSION

There is an effective process, for placement in the program, by which diagnosis is verified, the needs of the person with dementia are assessed, involvement of family is recognized (to the desired extent of the individual family) and appropriateness of the facility is confirmed.

GOAL 3. ADMISSION

The person with dementia is admitted to the program in a convenient and supportive manner, and the family is able to complete the admission requirements in a timely fashion.

GOAL 4. CARE PLANNING AND IMPLEMENTATION

The plan of care and its implementation is resident oriented, flexible and inclusive of family; and it is intended to promote individual dignity, optimum health and well being and to maximize function of the person with dementia.

Care provision is the responsibility of the interdisciplinary team, committed to

creating a living environment that enhances quality of life for residents and families.

GOAL 5: CHANGE IN CONDITION

As the disease moves to late stages, the plan of care evolves and is responsive to changes in the individual's condition. A specialized program demonstrates commitment to assist families over the full course of the disease.

GOAL 6. STAFFING PATTERNS AND TRAINING

All staff, including administrators and non-direct care staff (e.g. housekeeping, dietary, maintenance, volunteers), who work with residents and families in the specialized Alzheimer/Dementia program receive the support of an ongoing training program.

GOAL 7: PHYSICAL ENVIRONMENT

The physical environment and design features support the functioning of cognitively impaired adult residents, accommodate behaviors and maximize functional abilities, promote safety and encourage independence of residents.

GOAL 8: SUCCESS INDICATORS

The program is involved in efforts to evaluate the benefits of their specialized Alzheimer/Dementia care.

This document is offered as a beginning point—preliminary goals and guidelines for action that providers of specialized Alzheimer/Dementia care can use as a guide. These guidelines are in no way meant to be the final word, the definitive answer to a very complex and developing field. The guidelines are an invitation to join the partnership of those interested in providing and improving specialized Alzheimer/dementia care in residential settings.

For a copy of *Guidelines for Dignity: Goals of Specialized Alzheimer/Dementia Care in Residential Settings*, write or call: Alzheimer's Association (USA); 919 N. Michigan Avenue; Chicago, Illinois 60611. Tel: +(312) 335-8700. Fax: +(312) 335-1110. \$5.00 USD, Plus Postage & handling.

What (In the World) We're Doing...

From Japan, Dr. Yoshio Miyake reports: "On 4 October, our Association held the 8th National Study Meeting in Gifu city. About 450 persons, including family caregivers, doctors, nurses, care workers of homes for the elderly and so on participated in the Meeting.

"At the Meeting, one interesting report was, "The Multi-functional Small Home for the Elderly." A few years ago, the private home for physically as well as mentally handicapped elderly was established in the central area of Izumo city. It has several functions, including day care, short term stay, middle term stay and long term stay. It has 15 beds. Mr. Tsukitani Kazuo, a director of the home, says that the home is able to be used, whenever the elderly and their families want. These services are not covered by the public social programs, therefore users must pay. However, Izumo city has just begun to provide financial support for day care services for the demented elderly.

"Presenile Dementia Committee of the Ministry of Health and Welfare
In September of this year, the Ministry of Health and Welfare (in Japan) began to study how medical and social services for the presenile dementia patients and their families should be provided. Mr. Tabei

Yasuo, a member of the National Board of our Association has joined the committee on presenile dementia. The Committee will submit a report to the Minister in March 1993."

Alzheimer's Association (USA) early in 1993, will launch its nationwide Safe Return Program. It is an identification and relocation program for persons with Alzheimer's disease who wander and may become lost.

A national toll free telephone number will be a part of the program. The number, widely publicized, will help the chapter network, emergency response personnel, and the general public in identifying and finding missing persons, and reuniting lost individuals with their caregivers. Extensive community outreach in the form of education, program promotion, and emergency response training are also major components of the program.

In Canada, it is reported that earlier clinical diagnosis means people must cope with the knowledge they have the disease while still capable of understanding what may lie ahead. "They often become quite upset to discover there are groups for their family but not for them," says a Society member.

In Fall 1992, The Alzheimer Society of

Nova Scotia responded to the expressed need of persons with Alzheimer's by designing a program to meet the needs of both caregivers and persons with Alzheimer's. Both groups meet at the same location and spend the first half hour together, discussing long range planning and working out mutual problems. They then split into different support groups. After the meetings, everyone gets together for coffee. A pilot program, it is based on a 14-week pilot program in the United States that is run with seven families by the Metro Denver Chapter of Alzheimer's Association (USA).

In Eau Claire, Wisconsin, USA, an innovative strategy for Alzheimer's Disease Awareness Month was devised by the Indianhead Chapter. They persuaded a local restaurant chain to use an especially designed Alzheimer placemat for the month. With a find-the-word puzzle and multiple choice questions, the attractive placemat helped provide information and identified the Chapter as the primary community source for Alzheimer information and support.

Does your Society have a news item or helpful hint to share with fellow members in ADI? Please send information to Rachel Billington by March 1 for inclusion in the next Global Perspective.

Special Note to ADI Members

A stated purpose of ADI is to "inform and educate.....collect and disseminate scientific and educational information about Alzheimer's disease and related disorders." ADI's annual International Conference supports this goal.

Members can further contribute toward this goal all year long, at little financial cost, by sending your newsletter to fellow ADI Members, and to the ADI office and library in Chicago.

The official language of ADI is English. While many members are non-English speaking, this need not create a problem. Please consider following the example of several members who send their newsletters with synopses of key articles translated into English. We encourage Members to exchange newsletters, educational literature, etc.

Thanks and Kudos for Volunteers

So much of the work of Alzheimer societies is dependent on volunteers. They are one of the most important (but sometimes taken for-granted) resources we have.

Volunteers answer Helplines, help provide respite and other programs for persons with Alzheimer's and their caregivers. They facilitate support groups, help with public relations and prepare newsletters for mailing. They raise funds and govern their Alzheimer societies.

We are always grateful for their willingness to give of their time, talents and energies. Some volunteers claim there is a therapeutic aspect to actively joining in the fight against Alzheimer's.

Certainly, they don't do it for thanks or for celebrity. Even so, some appreciation is due volunteers. Let's face it, we all enjoy an occasional pat on the back and

a thoughtful "thank you."

Have you thanked your volunteers in a unique way? We'd like to hear about it. Please share information with other members through *Global Perspective*.

From other nonprofit organizations, we hear that they express thanks with Volunteer Recognition Teas or evening dinner programs. Others do it with little gifts, pins, plaques, etc. Still others send a photograph and story about volunteers' activities to their local newspapers. This gives publicity to the Alzheimer society, tends to help recruit new volunteers, and expresses appreciation in an interesting way.

Please send your volunteer recognition ideas and suggestions to Rachel Billington; ADI; 919 N. Michigan Avenue; Chicago, IL 60611-1676 USA, for inclusion in future *Global Perspectives*. Photos Welcome.



Publications from Around the World

Dilemma of Dementia, by Julia Millen. Lansdowne Press; 59 View Road; Glenfield, Auckland, New Zealand. Author, a writer and broadcaster in New Zealand describes how she cared for an aging parent who was losing her ability to reason, to remember, to think and care for herself. It is an intimate story told with lively good humor—a story of sacrifice, frustration, and the battle between despair and hope.

A Planning and Design Guide for Community Based Day Care Centres, by **Adrian Cave**. Available from: Alzheimer's Disease Society; 158-160 Balham High Road; London SW12 9BN; United Kingdom. Tel: + (4481) 675-6557. Fax: + (4481) 675-8040. £7.95 plus postage & handling.

You and Caring, by Penny Mares. Produced for individual carers and carers' groups. Each section contains activities and action plans to be tried out. Available from King's Fund Centre; 126 Albert Street; London NW1 7NF; United Kingdom. Cost £4.50 plus postage and handling.

Dementia, by Justin Keen, Research Fellow Health Economics Research Group, Brunel University, United Kingdom. Reviews the current status and future prospects for research and service provision for people with dementia. Publisher: the Office of Health Economics; 12 Whitehall; London SW1A 2DY; U.K. Cost: £3.00 plus postage and handling.

An Annotated Bibliography on Adult Day Care Programs and Dementia Care. Designed to serve as a reference guide to day center staff, caregivers and experts in the field of aging. The two sections: Adult Day Programs and Dementia Care are indexed by subject matter, and the book includes an author and title index. Some of the Subjects include: cost effectiveness, environmental design, financing, program development, program staffing and transportation. Alzheimer's Association (USA); 919 N. Michigan Ave.; Suite 1000; Chicago, Illinois 60611. Tel: + (312) 335-8700. Fax: + (312) 335-1110. Cost: \$7.95 USD, plus postage & handling.

Guidelines for Dignity: Goals of Specialized Alzheimer/Dementia Care in Residential Settings. Alzheimer's Association (USA); 919 N. Michigan Avenue; Chicago, Illinois 60601. \$5.00 USD, plus postage & handling. Tel: + (312) 335-8700.

Music, Movement, Mind and Body, Bridget Watson and Victoria Peters. Published by ADARDS (Wellington) Inc., in New Zealand, this well-illustrated book offers a program of physical exercise for persons with dementia. Comes with a musical audio tape. Author discusses the therapeutic nature of music and exercise. Book and tape may be obtained from ADARDS (WGTN) Inc.; P. O. Box 16-049; Wellington, NZ. Phone: (644) 389-3433.

Taking Care: Alzheimer/Dementia Care Experiences and Advice. Alzheimer's Association (USA); 919 N. Michigan Avenue, Suite 1000; Chicago, Illinois 60601. Cost: \$13.00 USD, plus postage & handling. Tel: (312) 335-8700.

Alzheimer Demenz. M.Allard, J.-L. Signoret, D. Stalleicken. In diesem Buch wird der derzeitige Wissensstand über die Alzheimer-Krankheit praxisnah dargestellt. Dabei werden die häufig irritierenden Begriffe präsenile Demenz, senile Demenz vom Alzheimer-Typ, Multi-infarakt-Demenz, in einen Zusammenhang gestellt. Die Pathomorphologie und Klinik der Demenz werden ausführlich beschreiben, ebenso die verschiedenen theoretischen Modelle, die gegenwärtig die Diskussionen über die Ätiopathogenese dieses Krankheitsbildes bestimmen. Hinweise zu diagnostischen Verfahren, Testmethoden und Therapieansätzen ergänzen das Buch. Springer-Verlag, Berlin Heidelberg. Tel (USA office): + (201) 348-4033.

Putting the Pieces Together. (See P.3) Copies available, postage/handling must be pre-paid: UK/Europe, Airmail: \$A25.00; Economy Air: \$A21.00; Sea Mail: \$A16.00. USA/Canada, Air Mail: \$A25.00; Economy Air: \$A20.00; Sea Mail: \$A16.00. Asia, Air Mail: \$A22.00; Economy Air: \$A18.00; Sea Mail, \$A15.00. Write: Alzheimer's Association (Australia); P. O. Box 51; North Ryde; N.S.W. 2113; Australia.

Contemporary Environments for People with Dementia. Uriel Cohen and Kristen Day offer detailed descriptions of twenty facilities—including day and respite care centers, group homes, long-term care facilities, and continuum of care campuses—and critiques of the major therapeutic components of each site. Architectural line drawings and halftones, along with opinions from care providers, design professionals, and national experts, help the reader compare and contrast the case studies. Johns Hopkins University Press; 701 West 40th Street, Suite 275; Baltimore, Maryland 21211.

Alzheimer, Le Long Crépuscule: Un Guide de Ressources Pour Toute la Famille. Donna Cohen, PhD, Carl Eisdorfer, PhD, MD. Signes Précurseurs, diagnostics, réorganisation de la vie familiale, stress et fatigue psychologique, soins à domicile et hospitalisation, sexualité, problèmes juridiques et financiers, tout y est analysé clairement et à l'aide d'exemples concrets. Un Message d'espoir pour tous ceux qui sont confrontés à cette terrible maladie. Distributeurs Exclusifs: Pour le Canada: Agence de Distribution Populaire, Tel: (+514) 521-4434. Pour la France et l'Afrique: Inter Forum, Tel: +(331) 43-37-11-80. Pour la Belgique, le Portugal et les pays de l'Est: S. A. Vander, Tel: +(322) 762-9804. Pour la Suisse: Transat S.A.

Dementia: Memory Loss and Confusion - A Guide for Caregivers. Available in English, Greek and Italian. Cost: \$A 6.00 plus postage. Available from Alzheimer's Association (South Australia) Inc. P. O. Box 202; Eastwood, South Australia 5063

Alzheimer Disease: A Handbook for Care. A basic handbook for family members which gives an overview of the disease and strategies to help them look after themselves. Available in French & English. Alzheimer Society of Canada; 1320 Yonge Street, Ste. 201; Toronto, Ontario M4T 1X2 Canada. Fax: (416) 925-1649.

Long Distance Caregiving. This booklet poses some questions which may help family members who care for their relative with Alzheimer disease from a distance. Alzheimer Society of Canada; 1320 Yonge Street, Suite 201; Toronto, Ontario M4T 1X2 Canada. Tel: (416) 925-3552. Fax: (416) 925-1649.

Tales of a Male Caregiver

"Damn, I'm Good"

"When I went to one of my first support group meetings, I was talking with a woman who also was a caregiver. She said something that has helped me ever since. She said, 'First of all, realize that this is impossible (caregiving). You can't do it; you don't have the time or the talent.

"Once you realize it's impossible, that NO ONE could do it, then just do the best you can! And you don't have to compare yourself to anyone but yourself. You don't have to compare yourself to what you should do or what someone else thinks you should do.' I've remembered that ever since. I'm still a lousy cook, but compared to a couple of years ago—damn, I'm good!"

From "Male Caregivers' Guidebook," published by the Des Moines Chapter, Alzheimer's Association, 1200 Pleasant Street, Iowa Methodist Medical Center, Des Moines, Iowa USA 50309.

Welcome New Members—From Page 12

year and next are:

- To establish contact with a much larger proportion of afflicted families.
- To increase the number of relevant professionals in the Association.
- To increase the number of afflicted families which are members of the Association.
- To increase the participation of members and volunteers in national and local projects.
- To establish 20 new support groups in all regions of Israel.
- To support the existing groups and to intensify their activity.
- To establish a national data base dealing with all aspects of interest to afflicted families, such as: instructional literature, general Alzheimer literature, relevant information from abroad on available social, voluntary and private services.
- To improve public relations with the media in order to draw public attention to the ever-increasing number of patients and afflicted families, and to induce the fami-

lies to speak about their problems and ventilate the feelings of guilt and secrecy.

The Association will intensify the existing Helpline by increasing the number of days and hours the Helpline functions.

The Association will continue to publish its quarterly newsletter and work to improve it for the benefit of afflicted families.

• ***The Support Society of People Suffering of Alzheimer-Type Diseases in Romania*** was the fifth applicant. With regret, the application was deferred. However, the ADI Council gave the applicants strong encouragement to continue to build its constituency and program, and to re-apply in 1993. Some ADI members offered to serve as mentors to the representatives who attended the Conference under WHO and Belgian government sponsorship.

1993—TORONTO, ONTARIO, CANADA

ADI Council Meets September 18-19.

ADI's International Conference:
September 20-23, 1993.

Guidelines, Myra Schiff—From page 6

ceive the same quality care that is provided to elderly people who do not suffer from cognitive impairment, and so provide no guidelines on ethical treatment, respect for the individual, observance of confidentiality, and matters relating to providing or withholding care. These are assumed to be basic regardless of mental status.

The Guidelines also recognize that both paid and unpaid caregivers of people with Alzheimer's require special consideration, particularly with respect to their need for special education and training, along with supports to deal with the psychosocial and practical aspects of caregiving.

The Guidelines were developed to respond to the diversity of circumstances in which people with Alzheimer's disease live. By emphasizing principles and goals, rather than rules and directions, they allow caregivers to be creative and innovative in developing solutions that are most appropriate for the particular circumstances of the care receivers and the environment in which they live. Readers can use their experience and judgement to determine how best to achieve the goals described in

each of the care topics.

For example, one of the criteria on care planning states that: "A basic (care planning) team should consist of a family member and the paid caregiver with primary responsibility for providing direct care, plus other care providers as appropriate." By referring to "other care providers, as appropriate," the Guidelines acknowledge that an occupational therapist, for instance, may not be available to develop those aspects of the care plan relating to Activities of Daily Living.

The Alzheimer Society of Canada has identified several ways the guidelines can be used to improve the care of people with Alzheimer's disease. By guiding and directing paid and unpaid caregivers about how to provide quality care, they will help ensure that individuals with Alzheimer's disease receive the special type of care which reflects the unique nature of the disease.

The guidelines will also help family caregivers understand those features which define quality care. This will assist them in identifying these qualities in long term care

facilities, community programs, and home services provided by community agencies.

The Guidelines can also be used to encourage government bodies to review legislation and regulations relating to the care of people with Alzheimer's disease, and serve as the basis for guidelines that must be developed by the ministries responsible for health and social services in each province.

Although the guidelines were developed for use in Canada, the Alzheimer Society of Canada hopes they will be useful for other countries working to define quality care for people with Alzheimer's disease. Our efforts to produce guidelines which can be used in the diverse circumstances in which Canadians with Alzheimer's disease may be living has resulted in a document whose usefulness may extend beyond the borders of Canada.

For further information about the Guidelines, or to order copies, contact Myra Schiff, Ph.D.; Director, Guidelines for Care Project; Alzheimer Society of Canada; 1320 Yonge St., Suite 201; Toronto, Ontario M4T 1X2; Canada.

Calendar of International Events

APRIL 16-18, 1993

Geriatric Psychiatry: Treatment in the '90s, an International Psychogeriatric Association Workshop, Toronto, Ontario, Canada. Presentations will be on: New Horizons in Geriatric Psychopharmacology; Biologic Treatment for the Alzheimer Patient: New Developments; The Physician-Pharmaceutical Industry Partnership; The Use of ECT in Geriatric Depression; and Integrated Psychotherapy for the Elderly. Two dialogues are scheduled, one on cognitive enhancers, and the other on the behavioral complications of dementia. Send abstracts to: Dr. Robin Eastwood; 250 College Street; Toronto, Ontario M5T 1R8; Canada

JULY 4-9, 1993

15th International Congress of Gerontology, Science for Healthy Aging, in Budapest, Hungary. Topics to include: Biology; clinical medicine, geriatrics, behavioral and social sciences; practice, planning and policy; multidisciplinary approaches to selected issues. Contact: Gerontology World Congress Secretariat, Budapest Convention Centre; Budapest; P. O. Box 233; H-1444 Hungary. FAX: (361) 185-2127. For Scientific Information: Tel: (361) 113-5411.

JULY 25-28, 1993

Alzheimer's Care Strategies: Partners in Quality Care. Second National Alzheimer's Disease Conference, Chicago, Illinois. Includes Pre-conference full & half-day intensive workshops on practical applications of care strategies for managing the Alzheimer patient; networking opportunities for sharing ideas and management techniques; over 40 innovative educational sessions by national experts on Care Management; Education & Training Trends; Legal & Ethical Dilemmas; Research & Practice Issues; Special Care Environments & Programs. Registration \$240. USD before May 1; After May 1, \$275 USD; at Conference, \$300. USD. Contact: Educational Services; Alzheimer's Association; 919 N. Michigan Ave., Suite 1000; Chicago, Illinois 60611. TEL: (312) 335-5790.

SEPTEMBER 5-10, 1993

6th Congress of International Psychogeriatric Association (IPA), Berlin, Germany. Topics: Neurobiology, neuropsychology, neuroendocrinology; Clinical topics: Services for elderly; Interface between psychogeriatrics, neurology, and other disciplines; rehabilitation in psychogeriatrics, multidisciplinary aspects of diagnostics & treatment strategies. Contact: Congress Secretariat, Gerocon GmbH, Schwalgengasse 38-40, 5000 Cologne 1, Germany. TEL: 49-221-219047. FAX: +(49-221) 23-1131.

SEPTEMBER 20-23, 1993

ADI's 9th International Conference: Global Challenge, Local Action. Alzheimer Society of Canada, Toronto, Ontario, Canada. Promises a diverse program that will appeal to both lay and professional delegates. Challenges in the areas of research, including bio-medical, treatment and care, and organizational issues of interest to developing Alzheimer societies worldwide, will be discussed with a view towards the actions required to facilitate change. Conference will be held at the Royal York Hotel. For more information, contact: ADI's 9th International Conference Secretariat; c/o Alzheimer Society of Canada; 1320 Yonge Street, Suite 201; Toronto, Ontario; Canada M4T 1X2. Tel: (416) 925-3552. Fax: (416) 925-1649.

SEPTEMBER 30-OCTOBER 1, 1993

Behavioral Symptoms in Dementia: Theories and Therapies, Cleveland, Ohio. A two-day conference designed to address the phenomenology of these symptoms, the conceptual frameworks of their biology and psychology, and the biological and behavioral interventions that enhance management. Conference format: Plenary session, break-out sessions, site visits to Cleveland day care programs, special care units, and Fairhill Institute for the Elderly, an integrated campus of services for older persons. Contact Peter J. Whitehouse, M.D., PhD., Alzheimer Center, University Hospitals, 2074 Abington Rd, Cleveland, OH 44106. TEL: (216) 844-7360.

OCTOBER 28-29, 1993

Perspectives in Geriatric Medicine, Ten Years of Certified Clinical Geriatric Medicine in the Netherlands. A combination of plenary sessions, micro-symposia: sleeping disorders, nutrition, geriatric infections, mobility disorders, geriatric nursing, iatrogenic disorders, psychogeriatric disorders, disturbances in fecal and urinary continence, over/under hydration and management of healthcare for the elderly. Contact: Congress Secretariat "Perspectives in Geriatric Medicine" c/o RAI Organisatie Bureau Amsterdam bv; Europlein 12; 1078 GZ Amsterdam. The Netherlands.

MARCH 20-25, 1994

Dementia in Parkinson's Disease International Symposium, Tel Aviv, Israel. Looking at this related disorder, the symposium will focus on the latest advances in cognitive changes in Parkinson's disease and extrapyramidal features in dementias, with particular emphasis on diffuse Lewy body disease, risk factors for dementia in Parkinsonism, and medical management. Plenary lectures by some of the world's leading medical specialists will be augmented by the latest in research results. Contact: Professor Amos D. Korczyn, Chairman, Organizing Committee; PO Box 50006; Tel Aviv 61500; Israel.

SEPTEMBER 1994

10th International Conference and Annual Meeting of Alzheimer's Disease International, Edinburgh, Scotland. Contact: Ewan Davidson, Executive Director, Alzheimer's Scotland; 33 Castle Street; Edinburgh EH2 3DN Scotland. Tel: 44-031-226-3762. FAX: 44-31-225-8748.

SEPTEMBER 1995

11th International Conference and Annual Meeting of Alzheimer's Disease International, Buenos Aires, Argentina. Contact: Dr. Carlos Mangone; Servicio de Neurologia; Hospital; Santojanni; Pilar 950,

Welcome to New ADI Members

FULL MEMBERSHIP APPROVED IN 1992:

ADI received five applications for membership in 1992. The ADI Council granted Full Membership to:

Association of Family Caring for the Demented Elderly (AFCDE) which has 28 chapters throughout Japan. It is a strong organization, founded in the mid-eighties, with a membership of over 5,000 persons (fifty percent being family members). The main activities of the Association are directed toward:

1. Social Education on Dementia
2. Distribution of information materials on dementia
3. Telephone advice for family caregivers
4. Publication of monthly newsletter
5. Survey on conditions and medico-social services on dementia
6. Annual national meeting on dementia
7. Support of activities of chapters
8. Contact with the Ministry of Health and Welfare
9. Professional committee on policy on dementia
10. Exchange of information with Alzheimer's societies of foreign countries

FUTURE PLANS OF AFCDE CALL FOR:

1. Increasing recognition of AFCDE among well-known professionals as well as family caregivers
2. Increasing the number of chapters and members
3. Improving financial status

President of AFCDE is Mr. Kunio Takami, a family member, and Vice President and Medical Advisor is Yoshio Miyake, MD.

PROVISIONAL MEMBERSHIPS APPROVED IN 1992:

The ADI Council approved three candidates for Provisional Membership (to be reviewed in 1993):

ABRA Associação Brasileira de Alzheimer (ABRA) in Brazil, has 1,000 members, 50% are family members. It has a total of 18 branches and 22 support groups located in seven states and 11 cities.

Dr. Norton Sayeg, President of ABRA, presented the society's mission and goals as giving directions and promoting the welfare of family and caregivers of individuals having Alzheimer's disease, by:

- Setting up regional units throughout the country.
- Setting up sub-regional units in the major cities of the main states (Sao Paulo, Rio de Janeiro, Minas Gerais, Paraná, Rio Grande do Sul).
- Encouraging the creation of a network of family support groups, through the adoption of an adequate strategy.
- Disseminating knowledge on Alzheimer's disease and its characteristics, through the press, other media.
- Supporting the continuing presence of ABRA members at meetings and congresses, to present papers and propagate our association.
- Creating an ABRA journal.
- Obtaining funds with private and official entities, and the community in general.
- Sponsoring at least one regional event per year.
- Sponsoring at least one national event per year, the first of which is to be held on October 30, 1992.
- Sponsoring regional courses for caregivers, at least twice a year. The first: October 30, 1992.
- Organizing at least two day-care centers in Sao Paulo, one in Rio de Janeiro, one in Paraná and one in Rio Grande do Sul, within a time frame of four years. These day care centers are to be managed by patient family members, with resources coming from official and private sources.
- Lobbying politicians at federal, state and municipal levels, for special legislation on Alzheimer's disease and to promote research funding and support for specific diagnostic and treatment services.
- Cooperating with similar institutions from other South American countries, aiming at a continuous experience exchange, and at the political reinforcement of our institution.
- Setting up a representation of ABRA, with at least one member, at every university or school offering courses related to our area of interest.
- Working with directors of all major hospital out-patient clinics to help create dedicated Alzheimer's facilities and services, equipped with the necessary diagnostic resources.

Alzheimer's & Related Disorders Society of India (ARDSI). The Society's five chapters are located in Bombay, Delhi,

Bangalore, Madras and Cochin. They have 480 members, 55% are family members. ARDSI held its First National Seminar on Dementia on November 16, 1991. Co-sponsors were the World Health Organization/Ministry of Health and Family Welfare, Govt. of India; Department of Science and Technology, Govt. of India; HelpAge India; State Committee on Science, Technology and Environment, Govt. of Kerala; and the Rotary Club of Cochin mid town.

Dr. K. Jacob Roy is the founder of ARDSI and now serves as its Secretary General. Dr. S. Raj Kumar is President.

Families of Victims of Alzheimer's Disease Association (FVADA), in Israel, has nine Support Groups: Jerusalem, Tel Aviv, Peta Tikva, Ramat Gan, Bat Yam, Haifa, Kiryat Motzkin, Hadera, Emek Yezreel. Eighty percent of the Association's membership are family members.

The statistically estimated number of persons with Alzheimer's in Israel is 30,000.

About 80% of the Board members are from afflicted families, and all are volunteers. They are in the process of organizing a prestigious medical and scientific advisory committee, having already received the consent of a significant number of such personalities. The Association has public recognition which increases with the frequency of meetings on the subject.

Primary aims of the Association for this

—Continued on Page 10