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Towards a biblical mind

Dementia and the response of churches

Caring for church members, supporting the caregivers, and building partnerships

By Robin Thomson

Summary
This paper highlights medical, social and spiritual challenges which our society, and church, faces in light of the growing number of people living with dementia. After considering the need to complement medical care with person-centred holistic care, through relationships characterised by love, the paper surveys some key features of a biblical framework to undergird our care for those living with dementia. While a national conversation about the provision of adult social care has begun through the work of the Casey Commission and others, this paper is primarily concerned with the contribution that local churches can make: caring for church members, supporting caregivers and building partnerships in the community.

Understanding dementia

Dementia is an umbrella term for a collection of symptoms, usually associated with neurodegenerative diseases and involving a general and permanent decline in cognitive abilities, that affect a person's memory, ability to think, emotions, behaviour, and sometimes motor control.

Dementia is caused by a wide variety of underlying disorders, but the most prominent form is Alzheimer's,[1] accounting for 70 per cent of people living with dementia.[2] These underlying disorders affect brain function, and the resulting symptoms are experienced with varying degrees of severity. Some 982,000 people in the UK are estimated to be living with the disease (a figure projected to rise to 1.4 million by 2040).[3] These include an increasing number who experience 'young-onset dementia' below the age of 65 (estimates vary but perhaps up to 7 per cent of the total).[4]

The impact of dementia is 'like a stone dropping into a pool' affecting the person living with dementia, those caring for them (usually family members or close friends), other family members and a wider circle of friends.

Medical care

Medical care begins with diagnosis and, here, two mistaken reactions must be avoided. Such are the current limits of medical science that, even with an early and accurate diagnosis, we should not expect a cure. At the same time, the opposite response, one of fear that this is the end for the person living with dementia (and for those caring for them), is unduly pessimistic. There are many possibilities and opportunities still open to them.

If medical care for the body is important, so is holistic care for the person.

Despite recent drug discoveries, a cure for dementia still seems a long way off and the search remains a long and tortuous journey.[5]

1 Further examples include vascular, frontotemporal, Lewy Body, and Parkinson's-related dementia, among several others.
2 The phrase 'living with dementia' is preferred over 'dementia sufferers' or similar terms, as the language we use both reflects our understanding and can affect a person's well-being. For helpful notes on language, see <https://socialcare.wales/resources-guidance/improving-care-and-support/people-with-dementia/using-positive-language-about-dementia>.
3 <https://www.alzheimers.org.uk/blog/how-many-people-have-dementia-uk> [accessed 5 June 2026].
4 Ibid. See 'Who is affected by dementia?' and linked material [accessed 5 June 2026].
5 Joseph Jebelli, *In Pursuit of Memory* (London: John Murray, 2017) – a brilliant survey.

There is no consensus on the root causes and how to deal with them. Some drugs can help to slow down the effects, for some people, which helps them to maintain their quality of life for longer. Some recent drugs have shown promising results in removing the clumps of proteins that cause the breakdown of connections in the brain. However, these drugs are still in the early stages of development and come with strong side-effects for many, and questions remain about their effectiveness.[6] Nonetheless, medical help is important for dealing with physical effects and related illnesses, though it offers little help with the challenges of daily living.

Treatment and care through relationships

If medical care for the body is important, so is holistic care for the person: in social, emotional and spiritual dimensions. In this sphere, the quality of the relationships sustained with the person with dementia is central. Here – to anticipate the argument of the paper – churches have a distinctive opportunity, as they can offer relationships with continuity. Professionals come and go, and organisations are not always accessible. Church members, however, may be able to offer time in a way that few others can: to listen, to share, to be with people with whom they already have relationships. More important still, churches are communities of spiritual power which can share faith, hope, forgiveness and prayer. At the same time, churches face overlapping challenges. There are many calls on church members' time. And it is easy to neglect those living with dementia: they seem less important; there is still a stigma attached to this topic; we may not know how we should respond and, if so, we can end up doing nothing.

Dementia leads in only one direction. But we have hope beyond the end of this life.

A basic challenge we face with dementia is that the person seems to be changing. When my wife became ill, our children and I found ourselves asking, 'Is this the same person? What has happened to her?' The change had been quite gradual before, but now it was marked. Shoko no longer seemed to be the same person. Around this time a friend lent us a book: *I'm Still Here* by John Zeisel.[7] Reading it was a revelation:

> Zeisel's basic point was that the person with Alzheimer's is *still a person with whom we can relate*, though it is a different relationship. It's the same person, but it's not the same person. We need to understand this change: we can't go back to the old relationship. *But we can build a new relationship*.[8]

His viewpoint reflects fundamental changes in the way we have viewed dementia over the last forty years. In the 1990s Dr Tom Kitwood, a psychologist, found that the prevailing medical approach to dementia resulted in a 'malignant psychology'. It emphasised only the medical aspects of the patient's condition, with no concern for their personal situation. He found that dementia doesn't progress in a linear fashion, and varies from person to person. One of the most important factors is the quality of care and relationships. It is in relationship that a person's sense of self remains.[9] Kitwood re-emphasised the concept of person-centred care. The NHS has summarised such an approach: 'Being person-centred is about focusing care on the needs of individual. Ensuring that people's preferences, needs and values guide clinical decisions and providing care that is respectful of and responsive to them.'[10] Person-centred care has now become the 'gold standard' across all kinds of care and support, at least in theory, if not always in practice.

What does a person living with dementia need? It is essentially love at the centre, said Kitwood, expressed in five ways, like a flower's petals. They need: *comfort* or warmth, *attachment*, *being included* and *occupied*, having an *identity*. These various elements interact. Engaging in positive activities provides mental and physical stimulation, which can unlock more profound benefits: helping to maintain and strengthen relationship abilities[11] and a person's self-identity. It is especially valuable to build on their interests and experience of life, things in which they were experts and where, perhaps even now, we can learn from them. In recent years people living with young-onset dementia have experienced a different dynamic. They have been able to articulate their experiences through speaking at conferences and writing.[12] The focus has shifted to see those living with dementia as actors with their own worth, not just passive recipients of care.

A theme attracting growing support has been the importance of entering the world of the person living with dementia, rather than insisting that they return to 'our reality'. We need to develop a new relationship and learn to validate their experience. Entering into their world is challenging but rewarding. Stephen Miller comments: 'When it comes to communication you must remember that *a person with dementia cannot change the way they are*… It follows therefore that *you are the one who has to change*' (original italics).[13]

Remembering the biblical framework

This person-centred perspective rests, naturally, within a larger framework of convictions which flow from a biblical worldview.

6 <https://www.theguardian.com/society/2026/apr/16/effect-gamechanger-alzheimers-drugs-trivial-review-concludes>.
7 John Zeisel, *I'm Still Here* (London: Piatkus, 2011).
8 Robin Thomson, *Living with Alzheimer's – a Love Story* (Instant Apostle, 2020), p.80.
9 Tom Kitwood, *Dementia Reconsidered: The Person Comes First* (Buckingham: Open University Press, 1997) p.8.
10 See <https://www.hee.nhs.uk/our-work/person-centred-care> for this quotation and for a brief outline of the principles of person-centred care.
11 Lee-Fay Low, *Live and Laugh with Dementia* (Chatswood, NSW: Exisle Publishing, 2014).
12 For example, Christine Bryden, Wendy Mitchell and Jennifer Bute whose books are listed in the 'Further Resources' (see page 6).
13 Stephen Miller, *Communicating Across Dementia* (London: Robinson, 2015), p.13.

We have a loving and all-powerful Heavenly Father

This conviction gives us the basis for treating those living with dementia with faith that God is still in control of their illness, whatever happens. This attitude is 'a biblically grounded decision to trust God's sovereignty even when life feels unfair or painful. It is choosing to believe that God is still good, still present and still working, especially when nothing around you makes sense.'[14] This is a very secure framework for our lives. Dementia can shake that framework but we hold on to it in faith.

When we suffer, God is with us

As we think of the huge challenge of suffering, we are tempted to ask 'Why?' but it may be more important to ask 'Who?'. God tells his people: 'When you pass through the waters, I will be with you' (Isaiah 43:2; cf. Psalm 23:4).

We have hope, because a person's relationship with God continues, beyond this life

When my wife was changing before our eyes, my vicar reminded me, 'She is not as she was. And not as she will be.' Dementia leads in only one direction. But we have hope beyond the end of this life. We are promised a new life in our resurrection bodies. Jesus declared: 'I am the resurrection and the life. Whoever believes in me, though he die, yet shall he live' (John 11:25).[15] Paul reminds us that our bodies – which our culture both worships and denigrates – will not last forever but will be gloriously renewed (2 Corinthians 5:1–10).

The church is designed to be a loving community

Jesus insisted that love should be the hallmark of his followers: 'A new commandment I give to you, that you love one another: just as I have loved you, you also are to love one another' (John 13:34; cf. Acts 2:44, 4:34). In the new community of the church, care for the 'least' of Jesus' brothers and sisters is to be highly valued (Matthew 25:40). The apostle Paul insists that since the church is the body of Christ, 'If one member suffers, all suffer together; if one member is honoured, all rejoice together' (1 Corinthians 12:26). We are called to bear one another's burdens (Galatians 6:2). Our practical care for all those affected by dementia is an acid test of our belief in the church as a loving community.

Like us, those living with dementia are persons loved by God

This is so crucial for our attitude to those living with dementia, and so contrary to our prevailing culture, where people are primarily valued for their ability. What happens when a person loses their cognitive ability? Some, like the philosopher Mary Warnock, argue: 'The real person has gone already and all that's left is just the body.'[16] This utilitarian view of the person lies behind much of the drive

for assisted dying. However, the Christian understanding of the human person, while valuing our mental faculties, does not ultimately ground our personhood, or our humanity, in them. We are not just minds, and faith is not only cognitive, but an expression of the whole person, including emotions and relationships.[17] There are many examples of people with dementia responding remarkably to prayer and worship.[18]

This is where we think of the soul:[19] 'The LORD God … breathed into his nostrils the breath of life; and man became a living soul' (Genesis 2:7 (KJV)) or, in many translations, a 'living being'. Human beings do not 'have' a soul, or 'have' a body, but rather 'a human being "is" body and soul.'[20] The soul animates the body, until we die physically. The soul does not get dementia,[21] though it may become unable to articulate itself though our minds.

We are also not just individuals; we live in relationship with others. We help to maintain each other's identity. I was deeply moved by a letter from Phil Parker, our amazing Community Dementia Nurse. He wrote, 'You should be proud to have preserved Shoko's personhood, sense of identity and all that was important to her, even in the face of an illness that was trying to strip her of these things.'[22]

But what happens if people stop relating to us? Does the person cease to exist? One might think so from seeing those who are totally neglected and apparently unable to think or respond in any way. In promoting person-centred care, Kitwood drew on Martin Buber's work highlighting the 'I–Thou' relationship.[23] However, Kitwood did not acknowledge the transcendent dimension in Buber: 'Thou' is supremely God. Without that dimension, when a person's memory fails and when human relationships end, there is no apparent basis for continuing to believe in the person.[24] John Swinton draws attention to a distinctive way our identity is anchored in and by God. We are held

14 Ted Pagel Jr, *The Shift that Changes Everything: Managing Your Attitude When Life Doesn't Go Your Way* (Harp & Sword Media, 2026). Cf. Matt. 6:8–9, 25, 31–33; Rom 8:28, 32, 38–39.
15 Cf. John 14:1–2; Rev. 21:1–4.
16 Quoted in John Swinton, *Dementia: Living in the Memories of God* (SCM Press, 2nd edn., 2017), p.121.
17 Wendy Gleadle & Frances Attwood, *Dementia, God and the Church: Journeying with Hope* (Bible Reading Fellowship, forthcoming July 2026), p.15 and also pp.44–49, 50–60. The author has been provided with a pre-publication copy.
18 See, e.g., Louise Morse, *Worshipping with Dementia* (Oxford: Monarch Books, 2010).
19 It is beyond the scope of this paper to explore the wide range of meanings that the word 'soul' has in both the Old and New Testaments and in modern usage but a primary meaning, as in Gen. 2:7, is 'possessing life'.
20 Dietrich Bonhoeffer, *Creation and Fall: A Theological Exposition of Genesis 1–3* (ed. J. W. De Gruchy, trd. D. S. Bax) (Minneapolis: Fortress, 2004), p.77.
21 John Killick, *Dementia Positive* (Edinburgh: Luath Press, 2014), p.87.
22 Thomson, *Living with Alzheimer's*, p.171.
23 Martin Buber, *I and Thou* (Edinburgh: T&T Clark, 1938), quoted in Swinton, op. cit. p.141. See also Kitwood, *Dementia Reconsidered,* pp.10–12.
24 Swinton, *Dementia*, pp.144–5, 148–9.

in God's memory: 'To be remembered is to exist and to be sustained by God ... Our identity is safe in the memory of God.'[25] God does not forget us, even when we ourselves may have forgotten everything, including God. He knows us truly, to the very end of time. Our whole life, every detail, every moment, is laid out before God (Psalm 139:1–4, 14). God knew us in the womb when we could not speak and had no knowable personality. We are still persons, whom he knows intimately and cares for, even if we lose our speech or other abilities. He holds us in his infinite knowledge all through our lives. We have assurance that our names are written in his book of life, however disease may ravage our sense of his presence.

If we are 'in Christ' we also have his Spirit living in us, giving life to our spirit (Romans 8:9–11). When we pray, even at the best of times, we 'do not know what to pray for as we ought'. But always, 'the Spirit helps us in our weakness … the Spirit himself intercedes for us with groanings too deep for words' (Romans 8:26, 27). How much more true for the one whose mental grasp may be slipping and who has weakened in other ways.

At a human level, the marriage vows remind us to value the integrity of the inner person – even as the person changes. The real self is still there; it takes love to find it. I sometimes visited Vera, whose dementia meant she was in bed or in a chair all day, unable to talk and seemingly unable to communicate. Her husband Paul continually looked for ways to relate and to stimulate her. One day I found her listening to gospel songs, with simple words and appealing tunes. She was alert and communicated, without words, her pleasure at seeing me. Paul's loving care was sustaining her real self, even when others could not see it.

God knew us in the womb when we could not speak and had no knowable personality.

Adult social care for those living with dementia

A national conversation on the provision of adult social care is under way, and not before time: 'For too long successive governments have ignored the challenges facing adult social care.'[26] Recent years have seen a Government White Paper,[27] an Archbishops' Commission Report,[28] and the launch of the Casey Commission into adult social care.[29] Longstanding concerns exist over inconsistency of delivery across different regions and lack of co-ordination of health and social care services; current challenges are all exacerbated by demographic trends, growing fiscal pressures, and unresolved questions about the respective responsibilities of individuals, families and the state.

This wide-ranging discussion, relevant to the care of many living with dementia, lies beyond the remit of this paper but there is a value in recognising the need for new models of care in light of commonplace shortcomings of current arrangements. Frequently, social care:

- is not joined up – with medical care, between the many agencies for social care, with informal carers and the community. There is a vital role to help 'bridge' these gaps;
- focuses on a narrow range of tangible deliverables (e.g., how can we increase the beds in care homes?) rather than on people (how can we help people to live their lives to the full?); and
- pays insufficient attention to the crucial role of caregivers.

High quality social care needs a person-centred approach, delivered by multi-disciplinary teams, to support both those living with dementia and their caregivers. Here are some examples of first steps in these directions. First, an early intervention scheme in the community has been praised by Social Care Future: 'We can see green shoots of the root and branch change needed in initiatives like "Live More" in Greater Manchester where people and families living with dementia are being reached earlier and offered support to stay active and connected to the people, places and things that matter to them.'[30]

Secondly, there is evidence that 'person-centred' care in care homes can improve outcomes. Person-centred care may be seen as the 'gold standard' but research has found that many care home residents have as little as two minutes of social interaction each day.[31] The Well-being and Health for People Living with Dementia (WHELD) programme combines person-centred care, management of agitation, and non-drug approaches. A clinical trial in 69 care homes in London and Buckinghamshire showed that, at no extra cost overall, such approaches improved quality of life and reduced agitation, neuropsychiatric conditions (e.g. depression), hospital admissions and GP visits.[32]

Thirdly, a more radical approach has been pioneered in the Netherlands where 'dementia villages' revolutionise the physical infrastructure of care and its underlying philosophy. Dementia villages are rooted in the belief that people living with dementia deserve more than supervision – they deserve the chance to live well and access normal life experiences. A dementia village is a specially designed care facility built to look, feel and function like a small neighbourhood (with individual houses, shops, cafés, gardens, etc), allowing people with dementia to live in an environment that resembles the world they remember.[33]

25 Ibid., p.221.
26 People at the Heart of Care: adult social care reform' (2021), Government White Paper, Foreword (<https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper>).
27 Ibid.
28 'Care and Support Reimagined: A National Care Covenant for England' (January 2023) (<https://www.churchofengland.org/about/archbishops-commissions/reimagining-care-commission>).
29 For the Casey Commission, see <https://caseycommission.co.uk>.
30 From <https://socialcarefuture.org.uk/noticeboard/our-first-thoughts-on-dame-louise-caseys-first-thoughts-about-adult-social-care-reform/>.
31 https://oxfordhealth.nhs.uk/news/dementia-care-improved-by-just-one-hour-of-social-interaction-each-week/.
32 <https://www.theguardian.com/society/2022/dec/30/dementia-village-in-warwick-is-a-pioneer-in-person-centred-care>.
33 <https://operabeds.com/blogs/news/dutch-dementia-village>.

The churches' opportunity

The practical focus of this paper is on the opportunities for local churches[34] arising from the growing numbers of people, among them many churchgoers, living with and caring for those with dementia. Churches have an opportunity to be at the forefront of expressing the value and worth of those living with dementia, not only for their members, but more widely. But it seems that churches 'do not currently have a strategic plan' for ministry to families in this condition, whether inside or outside the church: the conclusion of Frances Attwood's recent research. She explores sensitively whether such a ministry is the job of the church, and argues that proclamation and practice together can powerfully reflect Christ to families living with dementia. Outreach to them 'can be, for some, the beginning of a journey to become part of the church community, and from there to seek answers to deeper spiritual questions. I heard a professional carer say: "I don't go to church, but if I did, I would go to this one!" Seeing love in action can open opportunities to share more about the God we serve.'[35]

Caring effectively for our own members living with dementia

We need, in the first place, to make sure that we are really 'seeing' those affected by dementia. Not everybody wishes to be identified in this way. The disease may come in stages, initially not noticeable at all – it doesn't fit into neat categories. Acknowledging it openly is difficult for some. There are no rules; as in any relationship, the people involved need respect and sensitivity. Some may be reluctant to ask for help or even to acknowledge their situation.

Meanwhile, others wishing to help may feel ill-equipped to relate, afraid of making mistakes. But if the church is designed to be a loving community, we can be more open and intentional. We could be proactive in offering to chat with a person living with dementia, which could encourage them and also be a help to their caregivers. Some churches have set up groups to provide this encouragement; others may have more informal ways to find out about needs and offer support. When people know that others recognise their situation and really want to know how to help, it is genuinely encouraging. A page on the church's website can raise awareness, suggest responses and give contacts.

The most basic qualification is simply love. We have received God's unfailing love, and we reflect that love to the ones that we are caring for.[36] We need to make sure that we are serving our own members effectively, that we are truly a 'dementia-friendly' church.[37]

Supporting the caregivers

It is important to pay attention to treating persons living with dementia with full respect but, in doing so, there is a danger of forgetting the vital role of caregivers. Many people living with dementia are cared for by informal family carers: their role deserves more attention. Some 700,000 families in the UK provide an estimated £11.6 bn worth of unpaid care.[38] Their role cannot be replaced by social care, not simply because of the financial implications, but because the bonds of love and links of family and community are irreplaceable. Their role has been described in these terms: 'Carers are the keepers of dignity and personhood for people living with dementia.'[39]

Caregivers for the most part gladly support those living with dementia but find the relentless responsibility draining and sometimes overwhelming. In a recent global survey, 54 per cent of carers indicated they feel stressed 'often' or 'all the time' in trying to cope with their caring responsibilities. Only 8 per cent said 'rarely' or 'never'.[40]

Supporting caregivers is therefore essential for a more effective overall response to dementia.[41] While every caregiver will have unique needs and each situation is different, a vital need for caregivers is to build a support team: 'providing care for someone with dementia is not a one-person job.'[42] A support team can take many forms, but there are two major components: informal support (family and friends) and professional support (medical and social). A church's most valuable practical contribution might be to help caregivers to build an effective support team.

Supporting caregivers is essential for a more effective overall response to dementia.

The starting point is understanding the caregivers' situation, asking them how they are doing and what help they might welcome. Then we can work with them to realise, if necessary, their need of support (not always easy for them to accept), and to identify those who can be a support team for them, both professional and informal. This is not difficult to do, but it does take time and effort. Members of a church house group could sit with them to make sure that friends and family are giving the needed support. It may need more structured efforts, perhaps by the church's pastoral team, to help them make contact with organisations and services that could benefit them. In the end it is certainly worthwhile.

Churches will be greatly helped in caring for those affected by dementia by connecting and collaborating with other churches. For a small congregation this is essential. Even larger congregations may find it hard to make room for this focus, with other priorities competing

34 Beyond the role of local churches, there is scope for Christians to serve – for example, as advocates in the public square for a vulnerable and neglected group – and social entrepreneurs to pioneer and multiply the provision of better care homes.

35 Gleadle & Attwood, *Dementia, God and the Church*, pp.105, 111. See also pp.109–110.

36 See 'Further Resources' (see page 6) for helpful resources on how to be a 'dementia-friendly church' (notably books by Wendy Gleadle & Frances Attwood, Joanna Collicutt and John Swinton, and on Lichfield Diocese's website).

37 Trevor Adams, *Developing Dementia-friendly Churches* (Grove Books, 2018).

38 <https://dementiacarers.org.uk/news/too-many-dementia-carers-are-reaching-crisis/>.

39 Zelda Freitas, *Navigating the carer journey as a daughter and social worker*, World Alzheimer Report 2022, p.266: see <https://www.alzint.org/resource/world-alzheimer-report-2022/>.

40 World Alzheimer Report 2022, p.72.

41 Embracing Age offers a short course for churches on caring for carers: see <https://www.embracingage.org.uk/supporting-carers-course.html>.

42 Simon Atkins, *First Steps to Living with Dementia* (Oxford: Lion Hudson, 2013), p.103.

for attention. There is great value in intergenerational involvement. We can help each other with this.

Churches can build partnerships with others in their community

In some places, local authorities may seek to bring together NHS trusts and local organisations (including churches and charities) to work together in care for those living with dementia. The London Borough of Merton, for example, has a Dementia Hub provided by the Alzheimer's Society. Its highly effective Community Dementia Nurse team is provided in collaboration with the NHS.[43] The Council emphasises 'co-production'[44] where 'an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered.'[45] Such an approach goes hand in glove with developing person-centred approaches. So they welcome the involvement of churches and other voluntary organisations.

By joining the network that the Council has set up, churches can be in touch with others, such as local support groups, 'Dementia Friends' training programmes, and doctors' surgeries, who may be glad to refer people to churches for support. This gives churches an opportunity both to receive support for their members and to minister to others. Organising a monthly lunch for older people in the church may be beyond the capacity of a single congregation. But by joining with other churches and local voluntary organisations it could be done, welcoming non-church members as well. Churches can also work with local care homes. Some homes already welcome a monthly worship service for their residents, including those living with dementia. Many more would certainly do so. Again, working with other churches can help this to happen. Merton may be a leader in this area. But it is certainly the right direction and gives a great opportunity for the churches. Our ministry is unique, as no secular organisation can provide such comprehensive support, based on our longstanding relationships and our ability to bring a spiritual dimension, which many are seeking.

Sometimes church leaders and church members have taken the initiative. For example, Caraway is a Christian charity that brings churches together with the health and social sectors in an effective network across Southampton.[46] It began from the work of the Rev Dr Erica Roberts who was appointed a City Chaplain for older people in 2014. That gave her links with council services and she was joined by others with active health links. In their network they have a team of 'Anna Chaplains'[47] and volunteers, and also work closely with 'Admiral Nurses'[48]. One of their distinctive tasks is bridging the gap between individuals, social services and the churches. It can be bewildering to find support and the churches have a key role to help bridge the gap. Caraway is one of the biggest such networks. But there is a lot that we can learn and could emulate, even if on a smaller scale.

Conclusion

We have a great opportunity to fulfil our gifts of community, relationships and spiritual power. There are many ways to support our members, and more widely, particularly in developing support teams. As part of that we will naturally look for ways to link with other churches and with others in the community. We remember Jesus' words that care for the 'least' of his brothers and sisters is care for him (Matthew 25:40).

Further resources

There are several resources and organisations that can help churches, church leaders, and church members, reflect more deeply, theologically and practically, on dementia and the challenges and opportunities involved in supporting people living with dementia and their carers. **See: www.cambridgepapers.org/dementia-resources/**

Robin Thomson was born in India and spent over twenty years teaching the Bible and training leaders there, with his wife Shoko. After she was diagnosed with Alzheimer's he cared for her and has since been active in raising awareness and equipping church members and others to support caregivers. He is the author of several books on Asian culture and religion.

43 <https://clch.nhs.uk/services/dementia>.
44 'Co-production: what it is and how to do it' (<https://www.scie.org.uk/co-production/what-how/>).
45 <https://www.merton.gov.uk/social-care/adult-social-care/co-production>.
46 <https://www.caraway.uk.com/>.
47 <https://www.annachaplaincy.org.uk/>.
48 <https://www.dementiauk.org/information-and-support/how-we-can-support-you/what-is-an-admiral-nurse/>.

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