Editor’s Note

Welcome to the third issue of the HKPGA Newsletter. In this issue, Prof. Alistair Burns from Manchester has kindly consented for publication of his dinner speech at our AGM. In addition, we also have Prof. Yip from Taipei discussing about the dementia services in Taiwan. You will certainly enjoy these special articles in addition to the regular informative contributions from our members.

CLINICAL MANAGEMENT OF ALZHEIMER’S DISEASE
PRACTICALITIES AND ETHICAL CONSIDERATIONS

Professor Alistair Burns
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University of Manchester, United Kingdom

This report will be divided into three parts: first, a discussion on the management of early Alzheimer’s disease where anticholinergic drugs have proven benefit; second, management in the later stages of the disease where many patients will be in nursing and residential (care and assistance) homes; and third, ethical issues such as advance directives and assisted death. An overarching theme will be to discuss the role that carers have in supporting patients suffering from dementia.

It is important to emphasise that the diagnosis of dementia is a two-stage process. First, dementia needs to be established and the differential diagnosis at this level is between delirium, depression (so-called pseudo dementia), drugs (the adage is that ‘any drug can cause any psychiatric symptom’) and normal ageing where loss of memory occurs but this is regarded as part of normal ageing. (This concept is enshrined in the description of mild cognitive impairment.)

Defining the aetiology of the dementia is the next stage. The three commonest causes in practice are Alzheimer’s disease, vascular dementia (whose pathologies account for the majority of patients), and dementia of Lewy body type.

Treatment with anticholinesterase drugs

A number of different methods are available to act on the anticholinergic system, with the ultimate aim of increasing the level of acetylcholine in the neuronal synapse. Landmark studies in the 1970s demonstrated that markers of acetylcholine activity were significantly decreased in the brains of patients dying from Alzheimer’s disease. The basal nucleus of Meynert has cholinergic projections to the frontal, parietal, temporal and occipital cortices. Acetylcholine is made following the combination of choline and acetil co-enzyme A, is released into the synapse and then is broken down by the enzyme acetylcholinesterase. Precursors can be given in the form of lecithin, but these generally are not effective in the treatment of Alzheimer’s disease. However, lecithin can be combined with anticholinesterase such as tacrine, and this may provide an additive effect. Director receptor agonists, such as M1 agonists, have been developed, but so far none have been licensed.

It is the inhibitors of the enzyme acetylcholinesterase which hold the biggest promise for the treatment of Alzheimer’s disease. Tacrine was the first agent to be developed, but significant liver toxicity accompanied its administration. Two drugs are currently generally licensed in many countries for the treatment of Alzheimer’s disease: donepezil hydrochloride (Aricept®, Eisai/Pfizer) and rivastigmine (Exelon®, Novartis). In a study involving 818 patients, Burns et al (1999) demonstrated the benefit of 5 and 10mg of donepezil compared to placebo on measures of cognitive function (the ADAS Cog), global functioning (the CIBIC +, Clinicians’ Interview Based Impression of Change) and Activities of Daily Living (using the Index of Deterioration of Daily living in Dementia, IADD). Improvements were noted at six weeks, and after twelve weeks the placebo group had returned to approximately the same level as they would have been had the natural history of the illness taken its course. Table 1 summarises the percentage of people who improve on Aricept and Exelon in some of the published studies.

Prof. Burns gave his speech at the first Annual Scientific Meeting of HKPGA
Treatment with the anticholinesterases is the most promising treatment and is likely to remain so for the foreseeable future.

Care in nursing and residential homes
Two studies with which the author has been involved have demonstrated the positive benefits of interventions in nursing and residential homes (care and assistance homes) for older people. The first study (Proctor et al 1999) demonstrated in a randomised controlled trial, the positive benefits of an outreach team providing advice in homes for residents in whom challenging behaviours had been identified. Sixty residents received an intervention package consisting of a series of weekly seminars, and individual advice was provided for residents with problem behaviours such as screaming or repeated and unnecessary requests to go to the toilet. Improvements in staff morale were found along with benefits in terms of the mental state of the residents. An economic analysis showed that the intervention was cost effective because it decreased the requests for visits for specialist staff made by the home.

The second intervention (Furniss et al submitted for publication) examined the effect of a pharmacist providing advice about medication for older people in nursing and residential homes. 330 residents were assessed over a 4-month period. 261 individual recommendations of medication change were made. Residents were on average taking 5 days, the maximum number being 17. In the form of a randomised controlled trial, it showed that a review of medication charts was accompanied by a reduction in the number of prescribed drugs for residents. Table 2 shows the changes that were made. There was a marginal deterioration in the behaviour and mental state of the residents in those who were in the intervention group, but this was offset by the perceived benefits.

These two studies demonstrate that significant improvements in the care of older people can be made by relatively simple and straightforward interventions. The idea that nothing can be done for residents in long-term care is clearly wrong.

Carers of people suffering from dementia
A number of studies have demonstrated that caring for someone with dementia is very stressful. Brodaty and Gresham (1989), and Mittleman (1992), have shown the positive benefits of providing support for carers (whether in an individual or group setting) in terms of decreased psychological distress but also delayed nursing home admission. A study in Manchester has replicated these positive findings in forty-two carers of patients with dementia (Mariott et al submitted for publication). In a randomised controlled design, fourteen carers were allocated to one of three groups. The first group received treatment as usual, a second group had an interview using the Camberwell Family Interview (this is an assessment used in general adult psychology to assess Expressed Emotion, and has been used in a number of studies looking at the relationship between carers of young patients with schizophrenia), and the third group received the Camberwell Family Interview and an intervention package of fourteen sessions (consisting of structured information given to the carers, including detailed information about Alzheimer’s disease and its manifestations, practical suggestions as to how to cope with difficult situations, and goal setting whereby individual symptoms and problems were discussed). Over a period of nine months the intervention showed positive benefits, as measured by the General Health Questionnaire given to carers – a measure of general psychological morbidity and a robust indicator of strain.

Ethical considerations
In the UK, this is a topic of current importance and interest. There is much discussion around the concept of advance directives, or living wills. There has been debate for a number of years and recent legislation and case law in the UK has served to highlight some of the points at issue.

Advance directives
In practice, these are essentially advance refusals of treatment – if a patient wishes to have continued treatment, the multidisciplinary team will always agree to that and there is no need for debate or discussion. Advance directives are essentially a way of extending autonomy to individuals by allowing them to make decisions about their future care at a time when they are competent to do so. In practice, they are taken up relatively infrequently, and a recent study showed that less than 10% of older people in the USA actually enacted a living will. There are a number of criteria for a living will to be considered valid: it must be made by a mentally competent adult; the consequences of refusal of treatment must be appreciated; the refusal of treatment must apply to the circumstances to which it refers (e.g. a person saying they wished treatment to be withdrawn in very specific circumstances would not allow that advance directive to be followed through in any other circumstances); it must not have been made with the influence of anyone else; it needs to be ensured that the advance directive had not subsequently been cancelled; and the person themselves has to have become incompetent.

Two case law examples in the UK have recently underscored the importance of advance directives. A schizophrenic patient in a secure mental hospital developed a gangrenous leg. He refused to have the leg amputated and the court decreed that the individual was able to make that decision, and pronounced that the operation could not go ahead. Furthermore, it forbade the doctors to ever amputate the leg in the future because of the advance directive that the patient had stated. Second, the case of Tony Bland, a young man who was in a persistent vegetative state following a tragic accident at a football ground called Hillsborough in Sheffield, England. The hospital and Mr Bland’s family agreed that his treatment should be stopped. The court went to the House of Lords, and although Mr Bland had not specifically stated any advance directive, the court said in their judgement that, essentially, if he had then the doctors would not have acted unlawfully by carrying out his wishes but, and probably more importantly, they would have acted unlawfully had they not carried out his wishes.

The Law Commission in the UK and the UK Government (through the Lord Chancellor’s Department) have produced a number of
consultation documents on the subject. Consultation papers in 1993 and 1995 discussed issues of incapacity and its relationship to given consent in patients. In 1997, a document entitled “Who decides?” was published and 4,000 responses were received from a variety of individuals and organisations within the UK. In October 1999, a document was released as a result of these various discussions called ‘Making decisions’. The key elements of this were:

- A new definition of incapacity is to be created with the statutory presumption that capacity exists unless otherwise deemed.
- The concept of ‘best interests’ is to be further discussed and refined – this has often been a catch-all concept and has been very hard to accurately define.
- A ‘general authority’ is to be given to individuals who will be able to act on behalf of a mentally incompetent adult. The powers of that individual would be restricted to relatively simple and straightforward administrative tasks concerning their finances, and there are specific exclusions, i.e. the individual would not be able to deal with savings in a bank account, would not enable them to arrange for a marriage or a sexual relationship for the individual, would not be able to arrange a divorce for that person, could not interfere with the parenting responsibilities of the individual, and could not vote on their behalf.
- There is to be developed a continuing power of attorney – currently in the UK an enduring power of attorney allows an individual to deal with financial and other matters of an incompetent person. The power of attorney must be enacted when the person is competent, and continues to be valid when the individual becomes incompetent (in contrast to the original power of attorney which ceased once incompetence was present). More importantly, the continuing power of attorney will enable decisions about a person’s healthcare to be determined.
- There is to be a new Court of Protection – up until now the Court of Protection confined itself to financial matters. The Court of Protection’s jurisdiction will be increased and it will have statutory powers to decide and test for incapacity, and also will allow decisions about the person’s future healthcare to be decided.
- It was decided that the concept of advance directives in living wills should not be legislated for, as it was felt the current law was entirely adequate. Two specific concerns about living wills were addressed. There is a perception that the living will has no legal status. However, the case law described above confirmed that they do in fact have legal status if appropriately enacted. Second, there is a common perception and fear that advance directives are on a slippery slope to assisted death or euthanasia. The UK Government explicitly states that this is not the case and that euthanasia is in no way supported by the Government. It remains the case that if a doctor does anything to hasten the death of a patient, he or she would be liable to a charge of manslaughter or murder, and the law would take its course in the usual way.

Assisted death or euthanasia

Strictly translated, eu means good and thanatos means death, i.e. a good death. Opinions vary greatly on the subject in relation to those who support and those who are against the practice. Arguments for including the issue of choice and autonomy, and there is an economic/utilitarian view. Against the view is the group who believe in the sanctity of life at all costs. It is clearly something about which there is absolute right or wrong, and it is, by and large, a matter of personal choice.

Further sources of information include:

- One of the early documents was the Law Commission Consultation Paper No. 129 available from HMSO (Her Majesty’s Stationery Office) entitled “Mentally Incapacitated Adults in Decision Making: Medical Treatment and Research?” 1993.
- More recently the consultation document “Who Decides?” was published in 1997 by the Lord Chancellor’s Department. Chapter 4 is about advanced statements. The Web page is http://www.open.gov.uk/lcd/mentincap.

Making Decisions is available on:
http://www.open.gov.uk/lcd/family/ndecisions


There is quite a lot of other literature in the same BMJ website and putting in “some advance directives” or “living wills” will find most of it.

Other interesting websites include:

The Voluntary Euthanasia Society: www.ves.org.uk
The US Living Will Registry: www.livingwillregistry.com
Choice in Dying: www.choices.org
The Living Will Centre: www.rights.org/deathnet/LWC.html
www.euthanasia.org/wwwhtml
www.donoharm.co.uk/alert

The British Geriatrics Society has advice on advance directives on http://www.bgs.org.uk/compendium

Summary

There has never been a more satisfying and challenging time to work with individuals suffering from dementia of any aetiology. In the early stages, anticholinesterase drugs hold great promise for improving symptoms. Care can be improved in residents of long-term nursing and residential homes by simple effective interventions. Interventions are very effective at reducing stress and strain on carers and can have very positive benefits in terms of delaying entry to nursing and residential homes. Finally, the issue of advance directives is very important in the care of people with dementia in the terminal stages, and recent legislation in the UK will put this on a very firm footing.

(continues in page 8)
Council News

In the First AGM on 1 November 1999 (Monday) at Miramar Ballroom, Penthouse, Miramar Hotel, 118 Nathan Road, Tsim Sha Tsui, Kowloon, all office bearers and council members were re-elected to their original posts except that Dr. CHAN Wai Chi became the Honorary Secretary and Dr. CHAN Wah Fat became a Council Member.

The Clinical and Organizational Psychiatry of Old Age - Hong Kong Arie Course was completed successfully on 14 November 1999. Over 200 participants including psychiatrists, geriatricians, nurses, clinical psychologists, occupational therapists, physiotherapists, and social workers attended the sessions in Shatin Hospital & Castle Peak Hospital.

Message from the Treasurer

Just a friendly reminder to members with one-year membership subscription in 98/99:

Your membership will be due on 31 Dec 1999. We would be most delighted if you can fill in the enclosed application form and return it to Dr. CHAN Wai Chi, Psychogeriatric Department, Castle Peak Hospital.

Members who have not obtained a copy of the audited 98/99 financial report of HKPGA are welcome to request one by writing to Mrs. Miranda Tung, Physiotherapy Department, Kwai Chung Hospital. (Fax line: 27447623)

Congress Report: Ninth Congress of the International Psychogeriatric Association

Ms. Cordelia Kwok & Dr. Chi Shing Yu
Psychogeriatric Department
Kwai Chung Hospital

The Ninth Congress of the International Psychogeriatric Association was held in Vancouver from August 15-20 1999. The theme was “Challenges for the New Millennium: Professional, Cultural and Regional Diversity”. It encouraged multidisciplinary collaboration: presentation on basic and applied sciences, diagnosis, acute, chronic and rehabilitative aspects of care. It also emphasized the organization of services, including policy, advocacy and economic aspects of providing care to the elderly in different societies and cultures.

The programmes covered different aspects of dementia, ranging from update courses, to in-depth examinations of the disease process such as an examination of a new perspective on disease process, biochemical aspect, in-depth look of the frontal lobe dementia, Lewy body dementia, various neurobiological factors in dementia and the patient centred approach to management issues in BPSD. Several satellite symposia presented the latest data on new drugs for Alzheimer’s disease, and nonpharmacological approaches in therapy. Other important topics included late life depression, suicide prevention and psychosis in the elderly.

In this congress, there was significant input from health professionals other than doctors. One of the winners of 1999 IPA/Bayer Research awards in psychogeriatric is L. Gerder who studied nursing intervention on agitation in elderly persons with dementia. In the presidential address, Prof. Reisberg emphasized not only the importance of the knowledge of science but also of applicable basic human factors such as a desire for dignity, accomplishment, social acceptance, and love, as well as a need for physical activity and movement. “With good quality of care, persons with dementia need not suffer”. They can enjoy life as ordinary people even in late stage of dementia.

In sum, the programmes were stimulating and updated in a world perspective. Besides, we enjoyed the unique opportunity to meet new and old friends, professionals, world renowned experts and researchers in psychogeriatrics from around the world. The valuable information and experience garnered from this congress will inspire us for the future endeavors.
The modern history of medical and social care of demented elderly in Taiwan can be divided into three stages of events dating back to the recovery of Taiwan from the Japanese regime in 1945. The rationale of these divisions was based on the progress of medical and social activities, development of health and social policymaking systems and implementation of major laws or policies. The first stage was roughly before the era of 1980. During this period, the demented patients were mainly taken care of by psychiatrists in teaching hospitals. Sporadic studies only included dementia as part of the mental disorders in the epidemiological studies. No formal social care was organized for mentally disabled elderly and their families during this period. The second stage was from 1981 through 1990 and the third stage of dementia care started in 1991 and continues to the end of this century. The present summary overviews the present status of dementia care in the third stage of the aforementioned scheme. Three different aspects are addressed to synthesize an overall image and to point out some of the present problems that exist. Finally, some suggestions are given for future reference.

(1) **Medico-social aspect; from research to application:** During the 1980's, clinical services and research activities for demented patients began to be implemented by clinicians; initially this included psychiatrists who were later joined by neurologists. Epidemiological studies were the major topics of research from the 1980's to the 1990's; this gave insight as to the incidence, prevalence and subtypes of dementia in Taiwan. These studies mainly focused on the medical aspect of dementia, especially the concerning patients themselves. Limited studies by paramedical and social researchers were also seen which included caregivers and related problems. Such activities were mainly confined to professionals from academic institutions, and dialogue between different disciplines was uncommon. In the 1990's, some features were implemented and deserve to be mentioned, i.e., (a) the special attention paid to the caregivers and the strategy of care; (b) research activities involving multidisciplinary cooperation; and (c) active participation and direct involvement in planning the strategy of care of patients with dementia by academic professionals. Despite communication between the academic system and the administrative system of the government, most of the planning for care of patients with dementia from the government, both nationally and regionally, is limited to short-term and non-continuous policies.

(2) **The beginning of long-term care by the health and social policymaking systems:** A long-term health care program is one of the major projects of medical and public health officials this decade. In 1994, the Department of Health organized a Long-Term Care Planning Committee to design, in collaboration with the Ministry of the Interior (Section of Social Welfare), mid- and long-term development plans for long-term health care (Department of Health 1997). The basic models of home-care, community-care and institution-care systems have started to operate in selected major cities or districts under both the healthcare and social welfare systems. The concept of dementia care as a unique part of the long-term care system is in the infancy stages and has been implemented only since 1997. A mixed-model of community day-care for dementia and physically disabled patients is being tested at limited sites in the metropolitan cities. Only two specialized care institutions for patients with dementia, which are funded by the government, are just in the preliminary phase. By the end of this century, four major problems are still identified (Wu 1995): (a) The most urgent and severe problem is the great shortage of long-term care manpower and facilities; therefore, most dependent elderly persons are cared for by their families without any formal support program. And unfortunately, the number of uncertified nursing homes with poor quality care has begun to increase rapidly. (b) Elderly persons with dementia are usually excluded from the formal long-term care system due to the divisions between the care of psychiatric patients and patients with neurological illnesses. (c) The health and social services for the elderly are organized through different bureaucratic systems in Taiwan, again formal care and services for dementia patients are not clearly specified in either systems. It is difficult to coordinate between these two systems. (d) Almost all the expenses of long-term care come from out-of-pocket payment. The National Health Insurance in Taiwan only covers the benefits of hospital services for patients who stay in the hospital for long periods, whereas, the benefits of long-term care services are excluded.

(3) **Involvement of non-governmental organizations:** One of the characteristics of the promotion of care for dementia patients this decade in Taiwan is the active involvement of non-governmental organizations. Some of the representative activities are worth
mentioning: (a) A multidisciplinary 2-day conference for dementia care was held in April 1995, organized by The Genesis Foundation. The meeting should be accredited as the landmark movement that brought together more than 10 non-governmental organizations to have dialogue with governmental administrative systems. Concrete actions were made possible after this communication. The first community-based dementia care home started to operate that same year. (b) The first group devoted to dementia service was formed in January 1997. Under the support of Catholic Sanipax Medico-social Educational Foundation, a specialized “Dementia Service Group” (DSG) started to operate. The aims of this service group were to serve and train caregivers and to educate the public. Regular activities to train caregivers, running support groups to reduce caregivers’ burdens and creating a resource center for information related to the care of dementia patients have been the major activities carried out since 1997. (c) Under the support of the Catholic Diocese in Taipei, the first non-governmental national organization, The Foundation of Alzheimer’s Disease and Related Dementia (FADRD) was established on the World Alzheimer’s Day 1998. The FADRD has a long-term plan to build community-based dementia center(s) in the major cities of Taiwan. The DSG of the Catholic Sanipax foundation and the FADRD are working together to promote the concept and practice of care for dementia patients in Taiwan which is similar to the works of Alzheimer’s Disease Associations in other countries. The characteristic in common with the aforementioned movements is that the religion-related organizations are doing active participation in medical and social services. Such phenomena were once a common feature for under-developed and developing countries.

Based on the previous review of the past and present status of care for dementia patients in Taiwan, we have some suggestions for administrative systems in the government (both on the national and regional levels) and academic professional institutions:

(1) The establishment of professional and long-term research units at the national level which may be helpful in figuring out the pathogenesis, the characteristics, the supply and demand, the appropriate strategy of care for dementia patients and related problems in Taiwan.

(2) The production and training of related professionals devoted to the care of dementia patients in medical and social institutions to meet the needs in the future.

(3) The establishment of long-term and formal network in the departments of medical and social affairs, either on the national or regional government level, for the establishment of clear policy objectives for the development of dementia care. An integration and coordination of health care and social welfare systems in this regard should be promoted.

(4) The strengthening of the model, the increase of the facilities and the enlargement of the capacity of dementia care in the three different levels, i.e., home, community and institutional basis.

(5) The financing of long-term care services to cover the expenses of the caregivers.

(6) The strengthening of the function of non-governmental organizations for promotion of care for dementia patients.

**Events Calendar**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Organizer/Contact Information</th>
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</table>
| Mar 12-15, 2000 | American Association for Geriatric Psychiatry 13th Annual Meeting "New Horizon for Geriatric Psychiatry: Images of Aging" | Tel: +1 301 654 7850  
Fax: +1 301 654 4137  
website: www.aagpgrp.a.org |
| March, 2000 | Journal of Dementia Care 2000 Conference  
Alzheimer Scotland-Action on Dementia in association with Dementia Services Development Centre | Teresa Jacobson  
Conference Organizer  
Journal of Dementia Care  
Hawker Publications Ltd  
Park House 13  
140 Battersea Park Road  
London SW11 4NB  
Tel: +44 171 720 2108 Fax: +44 171 498 3023  
website: www. stir .ac.uk/dsd/ejdconf.htm |
| April 4-7, 2000 | Non-Alzheimer Cognitive Impairment  
A joint meeting of the International Psychogeriatric Association and the Faculty of Old Age Psychiatry, the Royal College of Psychiatrists. | IPA Meeting Secretariat  
C/o Institute for the Health of the Elderly  
Wolfson Research Centre  
Newcastle General Hospital  
Westgate Road  
Newcastle Upon Tyne  
NE4 6BE, UK  
Tel: +44 191 256 3018 Fax: +44 191 219 5071  
E-mail: ipaconference@ ncl.ac.uk  
website: www.ncl.ac.uk/psychiatry/ipa_conference |
Primary care issues related to the treatment of depression in elderly patients. 
J Clin Psychiatry 1999;60 Suppl 20:45-51
Montano CB
University of Connecticut Medical School, Farmington, USA. 
Late-life depression is a serious public health problem and a concern for the primary care physician. Illnesses that often occur with aging may present in association with depression, which can interfere with patient compliance and recovery and worsen disease outcomes. Late-life depression is also associated with disproportionately high rates of completed suicide and high mortality rates independent of suicide. A shared therapeutic nihilism exists between many patients and physicians, who inappropriately accept major depression as normal and inevitable during advanced age and with related chronic disease states. Thus, the older depressed patient is too often not diagnosed and not treated. Furthermore, symptom overlap between depression, anxiety, and many chronic medical illnesses may confuse proper diagnosis. Therefore, screening for and diagnosing depression using an inclusive approach is highly recommended in the primary care setting and long-term care facility. Because of their improved safety, tolerability, and ease of dosing, newer generation antidepressants, such as the selective serotonin reuptake inhibitors, should be the first choice of treatment. Collaboration between primary and specialty providers is recommended, and referral to psychiatry is advised for patients with complex medical illnesses, comorbid psychiatric illness, suicidal ideation or intent, complicated medication regimens, and poor or no response to antidepressant therapy.

McKeith IG, Perry EK, Perry RH
Department of Old Age Psychiatry, Institute for the Health of the Elderly, Newcastle General Hospital, Newcastle upon Tyne, UK. 
BACKGROUND/OBJECTIVE: The second International Workshop of the Consortium on Dementia with Lewy Bodies (DBL) met to review developments since publication of consensus guidelines for the clinical and pathologic diagnosis of DBL in 1996. The specificity of a clinical diagnosis of probable DBL, made using consensus criteria, is generally high (>85%), but sensitivity of case detection is lower and more variable. Inter-rater reliability for the core clinical features-recurrent visual hallucinations and spontaneous motor features of parkinsonism-is acceptable, but reliable identification of fluctuating cognition remains problematic. Depression and REM sleep behavior disorder may be additional features supportive of a diagnosis of DBL that were not included in the original guideline. RESULTS: It is recommended that the clinical consensus criteria continue to be used in their current format with research efforts focused on increasing sensitivity of case detection. Antibody in immunocytochemistry is the method of choice for routine detection of Lewy bodies for diagnostic purposes in research and clinical practice. The use of alpha-synuclein antibodies to label Lewy bodies and Lewy neurites represents a major methodologic advance since the first DBL workshop. Alpha-Synuclein-based methods are likely to be most useful in research laboratories, particularly for clinicopathologic correlative studies. CONCLUSION: Clinical management of DBL patients usually centers on the treatment of nongenetic features. There is now a pressing need to establish appropriately designed randomized controlled trials in DBL. Collaboration between dementia and movement disorder specialists is essential for rapid progress in research and clinical management protocols.

OBJECTIVES: This article describes the development of an assessment of functional disability for use with proxy-respondents of community-dwelling persons who have Alzheimer’s disease as well as a study testing its reliability. METHOD: Panels composed of health care professionals and caregivers of persons with Alzheimer’s disease were used to develop the Disability Assessment for Dementia (DAD). Fifty-nine caregivers participated in the refinement of the content and the testing of reliability. RESULTS: The DAD includes 40 items: 17 related to basic self-care and 23 to instrumental activities of daily living. It demonstrated a high degree of internal consistency (Cronbach’s alpha = .96) and excellent interrater (N = 31, ICC = .95) and test-retest (N = 45, ICC = .96) reliability. In addition, it was found not to have gender bias. CONCLUSION: This instrument may help clinicians and caregivers of the population with Alzheimer’s disease make decisions regarding the choice of suitable interventions.

Koger SM, Chapin K, Brotons M
Willamette University. 
A recent qualitative review of literature in the area of music/ music therapy and dementia published since 1985 suggested that music/ music therapy is an effective intervention for maintaining and improving active involvement, social, emotional and cognitive skills, and for decreasing behavioral problems of individuals with dementia (Brotons, Koger, & Pickett-Cooper, 1997). The present analysis sought to update and quantify this relationship, and investigate the extent to which methodological variables influenced treatment effectiveness. Twenty-one empirical studies, with a total of 336 subjects suffering from symptoms of dementia, were included in the meta-analysis. Overall, the effect of music/musical therapy was found to be highly significant. A homogeneity analysis determined that the effect sizes were not consistent across studies; thus, a series of moderating variable analyses were conducted. We were unable to determine the source of variability between studies by analyzing type of therapeutic intervention (active or passive), music (live or taped), therapist’s training (trained music therapist vs. other professional), dependent variable (behavioral, cognitive, or social), or length of treatment. Although the published literature demonstrates that music/musical therapy is an effective method overall for treating symptoms of dementia, systematic variation of treatment protocols is necessary to identify the underlying mechanisms and delineate the most effective techniques.
TABLE 1 IMPROVEMENTS RESULTING FROM ANTICHOLINESTERASES

<table>
<thead>
<tr>
<th></th>
<th>Donepezil</th>
<th>Rivastigmine</th>
</tr>
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<tbody>
<tr>
<td>% improved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>placebo</td>
<td>5mg</td>
<td>10mg</td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>16%</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>18%</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td>37%</td>
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TABLE 2 REASONS FOR RECOMMENDATIONS SUGGESTED BY PHARMACIST

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<tr>
<th>Reason for Recommendation</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
<td>indication for medication no longer present</td>
<td>85</td>
</tr>
<tr>
<td>safer or more efficacious use of drug used</td>
<td>77</td>
</tr>
<tr>
<td>safer or more efficacious drug available</td>
<td>22</td>
</tr>
<tr>
<td>review of treatment - individual drugs</td>
<td>22</td>
</tr>
<tr>
<td>review of treatment - individual drugs</td>
<td>22</td>
</tr>
<tr>
<td>economy</td>
<td>17</td>
</tr>
<tr>
<td>indication present, no medication prescribed</td>
<td>14</td>
</tr>
<tr>
<td>review whole treatment</td>
<td>13</td>
</tr>
<tr>
<td>side-effect / adverse drug reaction</td>
<td>5</td>
</tr>
<tr>
<td>contra-indication</td>
<td>3</td>
</tr>
<tr>
<td>therapeutic duplication of drugs</td>
<td>2</td>
</tr>
<tr>
<td>drug interaction</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td><strong>261</strong></td>
</tr>
</tbody>
</table>

TABLE 3 ADVANCE DIRECTIVES – EXAMPLE FROM THE VOLUNTARY EUTHANASIA SOCIETY

To: “my family, my doctor and all other persons concerned”
“I declare that if at any time the following circumstances exist, namely ...
- suffer from one of these conditions (disseminated malignant disease, AIDS, advanced degenerative disease, dementia, severe and lasting brain damage) and
- unable to participate effectively in decisions and
- two independent doctors (one a consultant) say recovery unlikely “that I am not subjected to any medical intervention or treatment aimed at prolonging life”
“that any distressing symptoms (including any caused by lack of food or fluid) are to be fully controlled by appropriate analgesic or treatment even if that treatment may shorten my life”

Newsletter Committee Members:
Prof. Linda Lam (Chinese University of Hong Kong)
Dr. Chan Wai-fat (Pamela Youde Nethersole Eastern Hospital)
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