Editor’s Note
Linda Lam

Welcome to the Spring 2000 issue of the Newsletter of the HKPGA. In this issue, you will find a very inspiring article from Professor Tom Arie, the Founder of Old Age Psychiatry. He has kindly given us an overview of the directions of psychogeriatric services development at the dawn of the new Millennium. Besides, we are delighted to have Ms. Maria Tsang to share with us her views about Dementia Care Mapping in her report on the 'Seminar on Dementia Care Revisit'. For those who are interested in conducting research projects related to psychogeriatrics, Mr. Li Sing Yuen’s announcement of the HKPGA Research Awards submission criteria will certainly attract your attention. Please enjoy these special articles in addition to the regular informative contributions from our members.

WHAT’S COMING NEXT IN SERVICES?

Based on a plenary address at the 9th Congress of the International Psychogeriatric Association, Vancouver, August 1999.

What’s coming next in services?

Futurology is generally a mug’s game. Who predicted the revolution in the price of oil in 1970? - But it permanently transformed the world economy just three years later. Who predicted AIDS in 1980? - But it became a world epidemic well before the end of that decade. And who expected to see the Berlin wall coming down just a few years before its bricks became collectors’ pieces? Who predicted Viagra five years ago?

I shall play safe. My theme is the growing salience of trends, which have already begun. I draw examples from my own field of old age psychiatry, but the care of old people is like care of any other group - only more so, and all these matters are relevant to the care of people of all ages. I make no pretence to novel insight: most of my topics are already much discussed. But it may be helpful to bring them together here.

The themes, which I identify, may appear very disparate; in fact, they are largely inter-related. Some I do mention more than list, as they either speak for themselves or are too complex to consider here in detail. My list follows no very logical sequence, and I shall try to avoid what is already well-accepted - such as the continuing transposition to ‘the community’ of much work which was previously hospital based, or the certain emergence of new drugs (though I have a few words to say about the changing objectives of drug use).

Tensions between growing consumerism, and retraction of public provision

‘Consumerism’ is gathering pace, and part of it is scrutiny of all forms of professional practice. The reliability of professionals is no longer taken for granted, and old attitudes of paternalism by professionals are now inappropriate. With growing expectations, successive generations of better educated ‘service users’ are turning from merely grateful acceptance of services, to a much more critical appraisal of them. People draw also on the hugely increased availability of information, of which I speak below.

Alongside these changes is a shift in political ideology against the ‘welfarism’ that has largely formed part in many countries, of a public consensus. Pressures of demography, technology, expectations and cost, and particularly changing political ideologies, have brought about a retraction of public provision almost everywhere.

In a field such as psychogeriatrics, which is ‘service intensive’ and is used by the old, who everywhere are one of the largest groups of the poor and thus least able to buy alternative services, these developments are particularly telling. But in our field there is in addition the fact that long stay care, or long term intensive support at home, is so often at issue, and private payment for this is usually beyond the means even of the relatively well-off. Clinicians stand at the focal point at which tension is sharpest between consumer expectations and retraction of public provision.

Rationing, with socially divisive consequences

In publicly provided health services ‘rationing’ can be found almost everywhere, in covert or explicit form. We are likely to see much more explicit rationing, and with it erosion of ‘comprehensive’ publicly provided care in countries where previously that was widely available. This has perhaps been most sharply visible in the new
Eastern Europe. Even in rich 'Western' countries, much that is effective is no longer available to those who cannot buy it for themselves, or is rationed by waiting lists.

This applies alike to expensive treatments and to high quality personal care for severe chronic illnesses, and to long-stay care: even the well-off will often find that paying the whole cost of good quality long-term care for heavy dependency is beyond their means, or is incompatible with their own natural expectations of conserving something to leave to their family, or with expectations of their heirs of inheriting.

We seem to be nowhere near seeing an effective insurance system for long-term stay, the cost of this being potentially enormous - much higher than that of insuring against the need for major high-tech procedures. It may thus be that the well-off and the poor will together come to make common cause in favour of greater and better public provision of, or support for, such services; this may yet become one of the major political issues in 'rich' countries, because it touches the 'young', who have old relatives, as much as the old themselves.

**Increased managerialism, with demedicalisation and deprofessionalisation**

These trends are growing everywhere. Partly they derive from a reaction against past medical paternalism and even arrogance, but probably the chief driving force is a more egalitarian view of the professions, and the fact that doctors are seen as expensive, and certainly are well paid in most countries.

Without doubt much of what doctors have traditionally done can be as well done by less highly paid and less expensively trained staff - indeed sometimes better done, for that which for doctors may be seen as relatively unexciting routine work, can give greater job satisfaction to some other workers, and work is generally better done when those who do it enjoy what they are doing. Thus, the scope of what is nowadays being done, and well done, by nurses and other health staff has grown hugely in recent years, and will probably grow even faster in the future.

**More and better training for staff**

This is a challenge especially in the long-stay field, where much or even most care is given by non-professionals. Vocational training for non-professionals is only just beginning, and it calls for a different approach from that which is appropriate to the education of professionals. The lay paid supporters of the disabled are now known as 'carers', a new word in this sense (the Oxford dictionary of '20th Century Words' gives this as a coinage first seen in this sense in the 1970s). They provide indispensable paid care, and are already seeking and requiring training in huge numbers; they will no doubt come to aspire to near-professional status. 'Dementia carers' are already a defined subgroup, and many journals and meetings are devoted to 'dementia care'.

Equally, training for professional staff in the care of the aged and the demented, and particularly 'continuing professional development', is already rightly in great demand, though the extent to which it consumes time and resources at the expense of care is not always recognised. The demand will grow as 'revalidation' becomes established.

**Rapid advance in neuroscience, especially in molecular biology and genetics**

This is so huge a field that little can usefully be said here. Of 'gene therapy' the potential is still uncertain, but one instance from my field of the new importance of genetics, is the fact that giving genetic advice to individuals and families is already a routine item in the working week of the practical psychogeriatrician, and the demand for this - novel for those of us who began work in an earlier era - is likely to become a major activity, as new knowledge and new tests become available. The implications of the ability to predict, and the ethical and legal issues that flow from it, are already raising difficult questions.

**The 'Information Explosion'**

This touches almost every aspect of our work, but perhaps least noted is its effect on our now much more sophisticated patients, who can be very searching in their questioning. This will become a major aspect of the dialogue with patients. 'Complementary' therapies are sure to feature more and more in this dialogue. Potential patients will ask doctors for good evidence their own past performance (much harder to measure in some branches of medicine than in others) and of 'validated' continued performance. The time is not far away when most consultations will be preceded, and followed, by a visit to the Internet - perhaps by both parties to the consultation.

Measurement of 'outcomes' of services and treatments are the subject of a torrent of writing and debate; we shall hear even more of it. Suffice it here to say that 'outcomes' in our field (as compared with some other fields, such as, say, surgery) can be hard to measure and easy to fake.

**Growing ethical debate and legal debate and legislation**

In my field, the law of 'capacity' is widely under review, and traditional statutory arrangements for the care of incapacitated people are stretched beyond their former scope by demography, and beyond their relevance to modern times by changing expectations. Topics such as advance directives and thorny questions of 'physician-assisted death' are under debate. Ethical questions include 'rationing', mentioned above, and in my context especially 'ageist' rationing (as I write 'Age Concern' has published a report on evidence of ageist discrimination in our health service). One can safely predict a continued increase in the number of attempts to provide 'evidence-based' (another phrase of which even more will be heard, in diverse and often not clearly defined senses) disbursement of scarce resources.
Improved technologies for imaging and other investigative and therapeutic techniques

For my generation, which grew up with ‘air studies’ of the brain (and for who 'fibre-optic' technology was then unheard of) the huge increase and routinisation of such advances seems miraculous, and the future possibilities appear limitless. This week's British Medical Journal (November 13th 1999) is devoted to New Technologies; there (as one fingers one's way between overprinted text and shrieking advertisements - another sign of a change of style) one can marvel as one reads of non-invasive 'virtual colonoscopy' replacing fibre-optic endoscopy, which itself in my time has replaced cruder techniques; or of 'stem-cell technology'. And each item carries a pointer to relevant websites.

Electronics - for restoring function, or for 'prosthetic' care

The scope for electronic 'tools for living' is practically unlimited and far transcends the applications that are already in use. It ranges from electronic implants designed to alleviate or eliminate neurological disability, to electronic environments which act as replacements for human care. Its ultimate scope is no doubt still unimaginable.

New drugs

The fascination of the future is both in the certainty of powerful new drugs and drug delivery technologies, and in the issues that they may raise, such as the potentially ambiguous nature of their relationship to 'illness'.

Viagra is currently a much publicised case in point; another is 'age related memory impairment'. Drawing the lines between treatments for 'disease', treatments for 'normal' changes, and treatments for 'aspiration' will become a drama in which patients, providers, citizens, insurers, governments and drug manufacturers will all be actors. Who will pay for drugs designed to make well people happier, or to perform better in examinations? - or to be more attractive (at any age), or to retard or arrest aspects of ageing? Already there is controversy on when impotence is to be recognised as a 'medical' matter, and when not. And when Viagra, or eventually an even more effective - and probably even more expensive - successor arrives, how many tablets should the state or insurers provide? (One Viagra a week is our government's current rule for those deemed to be 'medically entitled': they are the 'deserving impotent', like the 'deserving poor' of former times).

It is worth remembering that use of drugs for 'non-medical' purposes in no way takes them out of the medical domain, indeed it inevitably extends the latter, for the ingestion of novel chemical substances has medical implications, whatever its purpose.

Conclusion

The only conclusions must be that there is no conclusion to change - and that change will become even more rapid, and that it will surprise. But the 'jobbing peripatetic hands-on practitioner' is unlikely ever to be out of work.

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Council News

A conjoint seminar on 'Early Detection and Management of Dementia' was held on 29 January 2000 at Sheraton Hotel, Tsim Sha Tsui. Over 200 participants attended the seminar. Dr. W. T. Law, Ms. Zion Law and Dr. S. W. Li shared their views in assessment and management of dementia with the participants. Professor Helen Chiu, our President, and Dr. S. H. Ay-yeung, representative of the College of Family Physicians, joined the speakers in the discussion session at the end of the seminar.

In order to facilitate sharing of knowledge and experience in psychogeriatric research among our members, the HKPGA is going to hold a Mid-year Scientific Seminar regularly in addition to the Annual Scientific Meeting every November. The first Mid-year Scientific Seminar will be held on 9 June 2000 (Fri) at Seminar Room 1, M/F, HAJO. Buffet lunch will be served before the seminar. Please see the 'Events Calendar' on P. 8 for details.

The HKPGA receives an annual donation from Pfizer Corporation to establish the HKPGA Research Awards. It aims at encouraging and rewarding fine research projects in psychogeriatrics. Three awards will be given each year to the best-submitted projects. The postgraduate awards will be awarded to postgraduates of any disciplines excluding Fellows of the Hong Kong College of Psychiatrists. Only members of HKPGA will be eligible for the postgraduate prizes. Please refer to the 'HKPGA Research Awards' on P. 5 for details.

The HKPGA logo competition was completed successfully. The entry submitted by Mr. Ronald Kwong & Ms. Frances Chow was selected as the winner. The prize presentation ceremony will be held during the Mid-year Scientific Seminar.
It was the first time for the Hong Kong Sino British Fellowship Trust Scholars’ Foundation, the Psychogeriatric Nursing Group and the Hong Kong Psychogeriatric Association (HKPGA) to organise a conjoint seminar. The seminar was a great success with about 150 participants including representatives from the Elderly Commission, Hospital Authority Head Office, Social Welfare Department and staff from various hospitals and elderly services units. We were honoured to have Prof. Sir Harry S.Y. Fung to give us a welcoming speech, and to have Prof. Rosie T.T. Young & Dr. Li Siu-wah as our moderators.

Prof. Helen Chiu, President of HKPGA, kicked off the seminar by introducing ‘An Overview of Dementia Care in Hong Kong’. She briefed the audience on the background and the latest developments in policies and service provisions in dementia care locally. In her speech, she reiterated Prof. Edmond Chiu’s comment that the psychogeriatric service in Hong Kong was ten years lagging behind the international standard. Nonetheless, with our endeavour, Prof. Chiu believed that our services would be catching up.

The speech on ‘Dementia Care at Primary Health Setting’ delivered by Dr. Wong Hung-wai, Vice-President of the HK College of Family Physicians, helped us understand the important role of family physicians in the care of people with dementia. He illustrated their dual role in the prevention and early detection of the illness as well as the long-term management of the dementia sufferers at community level, both of which were well established in other countries. We were delighted that Hong Kong was heading towards the right direction. In collaboration with the family physicians and other primary health care workers, we are looking forward to establishing a better system to cater for the service needs at the primary care level.

Mr. David Lane, Director of Thomson Adsett, highlighted the significance of social model and holistic approach in dementia design and how the care environments could affect the total care outcome and cost-efficiency in his speech entitled ‘Practical Solutions for Dementia Design - Issues and Realities’. Mr. Lane emphasized that we had to bear in mind the knowledge of dementia and its effect on the lives of its sufferers and their carers when designing the care environment for demented people. In his view, even though Hong Kong is always short of land, ‘space’ should not be the most important factor to consider. A homelike, cozy atmosphere, capturing the warmth, humanity and comfort needed for a familiar and pleasant life was of utmost importance. It promoted a sense of wellness and encouraged independence and enjoyment among older people. He also pointed out that the principle of dementia design should be simple and ordinary.

Dementia Care Mapping (DCM) with emphasis on the psychosocial needs and well-being of people with dementia is a new concept developed in the UK. It aims at evaluating and promoting the quality of dementia care and has been gradually accepted by other countries including the USA and Australia. It was our pleasure to share our experience in DCM with the audience. We hoped to ring the changes and through these changes in the way we practiced, the well-being of the dementia sufferers could be maximised and their quality of life would be improved. DCM is an objective, systematic method with a strong theoretical basis in terms of personhood and to evaluate the care process and measure both the quality and quantity of the care from the clients’ perspectives. It works by recording the degree of well-being of the clients and the existence of personal dehumanization episodes (which are forms of interactions that demean or depersonalize people with dementia and undermine their personhood) and positive events which promote the well-being. The concept emphasizes that each client is a special and unique person and care delivery should be tailored to meet individual needs. We hope that this concept can be spread out and applied to our daily practice to effect a change of traditional dementia care to a practice with more sensitivity to human needs.

Representatives from hosting organizations: left to right, Mr S Y Kwan, Mr Y H Cheung, Mr Kelvin Tsang, Dr Marion Fang, Prof. Sir Harry Fang, Mr David Lane, Prof Helen Chiu, Ms Maria Tsang, Ms Cordelia Kwok, Dr S W Li, and Mr S Y Tse.
The Awards
The Hong Kong Psychogeriatric Association (HKPGA) Research Awards were established with an annual donation from the Pfizer Corporation to encourage and reward fine research projects in psychogeriatrics. There are three awards, which will be given annually to the best-submitted projects that have attained a good scientific standard as decided by the selection board. The HKPGA Pfizer Research Award, of value HK$10,000, will be awarded to the best-submitted postgraduate research project. The HKPGA Postgraduate Research Award, of value HK$5,000, will be awarded to the second best-submitted postgraduate research project. The HKPGA Undergraduate Research Award, of value HK$5,000, will be awarded to the best-submitted undergraduate research project. The submitted projects have to be either unpublished research reports or research reports that have been published within one year dating back from the closing date of submission. The postgraduate awards will be awarded to postgraduates of any discipline excluding fellows of the Hong Kong College of Psychiatry. Only members of the HKPGA will be eligible for the postgraduate prizes.

The prizes will be presented at the Annual Scientific Meeting of the HKPGA and winners will present their research reports in the same meeting.

The abstracts of the winning projects will be published in the HKPGA Newsletter.

Call for Submissions
Submissions of research reports are invited for the 2000 HKPGA Research Awards. Research reports should reach the Association not later than 31 August 2000.

Requirements
* Papers must be written in English with author-date citations of references in text. APA style (per Publication Manual of the American Psychological Association, 4th ed.) is preferred.
* References must include complete titles, all author names, and journal names spelled out in full. References to works written in another language must include both the original title and its English translation.
* Papers must be double-spaced on one side of A4-size white bond paper with margins on all four sides. When a paper has been written on a computer, a floppy disk containing a copy of the paper should be sent, if possible. Be sure the disk is labeled with the name of the word processing program used and the correct file name under which the paper is saved.
* An abstract of no more than 250 words must precede the text.
* The paper should have no more than 30 pages of text, plus literature citations, tables and figures. The latter should not exceed 12 pages.
* The title page should include the following information: title of paper, author(s) name(s), degrees, and affiliations; complete mailing address and telephone, fax and e-mail for the corresponding author, and at the top, the phrase "Submission for 2000 HKPGA Research Awards".
* A page stating only the title of the paper also must be included. This page, which is needed for the blind-review process, must immediately follow the complete title page.
* If art is included, only original black-and-white drawings or glossy prints may be submitted.
* Four copies of the paper must be submitted. Submissions should be forwarded to:
  Selection Board of HKPGA Research Awards
  Hong Kong Psychogeriatric Association
  Attn to Mr. Li Sing Yuen
  c/o Community Psychogeriatric Team
  Block C, Castle Peak Hospital
  15 Tsing Chung Koon Road
  Tuen Mun, N.T.
  Hong Kong

Recent Advances (selected articles with Medline abstracts)

"We, not them and us?" Views on the relationships and interactions between staff and relatives of older people permanently living in nursing homes.

Hertzberg A, Ekman SL
Department of Clinical Neuroscience, Occupational Therapy and Elderly Care Research, Karolinska Institute and Red Cross College of Nursing and Health, Stockholm, Sweden.

This study describes relatives' and staffs' experiences of each other in their relationships and interactions in connection with the care of old people with dementia living in nursing homes. The aim was to identify obstacles and promoters concerning these interactions. A qualitative method was used. Data were collected from 27 hours of observations of group discussions about relatives' and staffs' communication, interactions and experiences. Three different groups, with eight participants, relatives, staff and a group leader in each, met six times during a period of 3 months. Findings indicate that the experiences that relatives and staff have of each other are related to issues about influence, participation, trust and measures to avoid conflicts. These conclusions build on concrete descriptions about care, activities, competence, communication and visits given by research participants. Experiences of situations were sometimes contradictory between relatives and staff. This implies that the potential for cooperation between relatives and staff in care of the elderly is not fully utilized. Suggestions for enhancing the relationships between relatives and staff are: pre-planned informal, individual conversations between relatives and staff; development of ways to give regular two-way feedback about matters concerning the resident and
the relationship between staff and relatives; giving staff credit for measures taken to facilitate relatives' involvement in the nursing home care; measures to improve documentation about families' involvement; and working together with minor practical tasks.

Evolving standards in patient and caregiver support.
Ham RJ
Alzheimer Dis Assoc Disord 1999 Nov;13 Suppl 2:S27-35
State University of New York, Health Science Center at Syracuse, 13210, USA.
It has become increasingly clear that family members and others have enormous potential to contribute positively to the care of the patient suffering from Alzheimer disease (AD). Various methods such as respite services and day care as well as counseling and support groups have been shown to reduce caregiver stress and burnout. Moreover, there are many areas in which the informed, trained caregiver can contribute positively to, and even lead, the interdisciplinary ongoing care of AD patients. For example, the caregiver can help with memory aids, behavioral interventions, the maintenance of exercise and nutrition, healthcare proxies and housing arrangements, decisions about intensity of treatment, and the timely implementation of palliative care approaches. Caregivers skilled in such matters will increase the quality of life of the AD patient and reduce their dependency. Many support services and educational activities are known to help caregivers and their patients, yet their availability is variable, and it is unclear whose responsibility it is to organize and finance them.

Cholinesterase inhibitors: A new class of psychotropic compounds.
Cummings JL
Department of Neurology, UCLA School of Medicine, Los Angeles, CA 90095-1769, USA.
OBJECTIVE: This article reviews evidence indicating that acetylcholinesterase inhibitors have psychotropic properties. METHOD: The author reviewed the English-language literature pertinent to the response of neuropsychiatric symptoms in Alzheimer's disease and related conditions to cholinergic agents. RESULTS: The cholinergic system originates in the basal forebrain and projects diffusely to the cerebral cortex; the limbic and paralimbic regions receive the most abundant cholinergic projections. The basal forebrain nuclei are positioned at the interface of the limbic system and cerebral cortex, where they play a role in mediating emotional responses. The basal forebrain nuclei are atrophic in Alzheimer's disease, leading to a widespread cholinergic deficit. The cholinergic disturbance may contribute to neuropsychiatric manifestations of the disease. The treatment of patients with Alzheimer's disease with acetylcholinesterase inhibitors reduces neuropsychiatric symptoms, particularly apathy and visual hallucinations. In some studies, a variety of other neuropsychiatric symptoms have been reported to respond to treatment with acetylcholinesterase inhibitors. Response profiles vary among acetylcholinesterase inhibitors. CONCLUSIONS: Acetylcholinesterase inhibitors have psychotropic effects and may play an important role in controlling neuropsychiatric and behavioral disturbances in patients with Alzheimer's disease. These agents also may contribute to the management of other disorders with cholinergic system abnormalities and neuropsychiatric symptoms. The beneficial response is most likely mediated through limbic cholinergic structures.

Managing common behavioral problems in dementia. How to improve quality of life for patients and families.
Burke JR, Morgenlander JC
Postgrad Med 1999 Oct 15; 106(5): 131-4, 139-40
Division of Neurology, Duke University School of Medicine, Durham, NC 27710, USA.
Dementia is the most common reason for nursing home placement, and related behavioral symptoms are the primary factors precipitating the decision. Disruptive behaviors such as depression, sleep disturbance, agitation, aggression, and psychosis can tax family members' abilities to care for a loved one who has reached that stage of the illness. Working with families to institute effective management strategies may help delay institutionalization. In this article, Drs Burke and Morgenlander present a systematic approach to identifying and treating common problems in dementia.

Community care for patients with Alzheimer's disease and non-demented elderly people: use and satisfaction with services and unmet needs in family caregivers.
Unit for Epidemiology and Community Medicine, University of Padua, Italy.
OBJECTIVE: This study measures and compares use of and satisfaction with medical and social services in addition to subjectively perceived needs of family supporters of patients with probable or possible Alzheimer's disease (AD) and family supporters of non-demented elderly people. Differences in judgement of services within the subpopulation of families of AD patients are also assessed by gender and burden level. METHODS: The main family supporters of 60 community-dwelling elderly (aged over 65) with Alzheimer's disease and of 60 age- and sex-matched controls were tested with a detailed questionnaire on use and satisfaction with services, any unmet needs and kinds of intervention perceived to be helpful. RESULTS: Supporters of elderly people with AD were significantly more involved in providing care than supporters of non-demented people. Judgement on the health, social relations and financial status of their families was significantly worse in AD supporters than in supporters of non-demented elderly people. Although the former made more use of available health and social services than the control population, they did appear to make little use of such services, not only because of lack of information but also for logistic reasons or because they would prefer a service with more specifically trained operators or more tailored intervention. AD family supporters would like to receive more information and support from their general practitioner, which confirms the importance of this figure in management of this pathology. They were less satisfied with the care provided than the control population, particularly those with a moderate-high burden. Irrespective of burden level, they also expressed a need for financial and psychological support and adequate intervention schemes, especially within the home. These should be provided by specially trained personnel and be tailored to specifically manage the individual patient's problems, especially in relation to behavioural disorders. This would help alleviate caregiver burden and allow patients to continue to be managed at home.
Interdisciplinary geriatric primary care evaluation and management: two-year outcomes.
Burns R, Nichols LO, Martindale-Adams J, Graney MJ
Department of Preventive Medicine, University of Tennessee, Memphis, USA.

BACKGROUND: The long-term efficacy of interdisciplinary outpatient primary care Geriatric Evaluation and Management (GEM) has not been proven. This article focuses on results obtained during the 2 years of the study. METHODS: In this 2-year randomized clinical trial, at the Veterans Affairs Medical Center, Memphis, TN, 128 veterans, age 65 years and older, were randomized to outpatient GEM or usual care (UC). Two-year follow-up analyses are based on the 98 surviving individuals. Study outcome measurements included health status, function, and quality of life including affect, cognition, and mortality. RESULTS: At 2 years, there were positive intervention effects for eight of 10 outcome measures, five of which had attained significance at 1 year. GEM subjects, compared with UC subjects, had significantly greater improvement in health perception (P = .001), smaller increases in numbers of clinic visits (P = .019) and instrumental activities of daily living (IADL) impairments (P = .006), improved social activity (P < .001), greater improvement in Center for Epidemiologic Studies-Depression (CES-D) scores (P = .003), general well-being (P = .001), life satisfaction (P < .001), and Mini-Mental State Exam (MMSE) scores (P = .025). There were no significant treatment effects in activities of daily living (ADL) scores (P = .386), number of hospitalizations (P = .377), or mortality (P = .155). CONCLUSIONS: These findings suggest that a primary care approach that combines an initial interdisciplinary comprehensive assessment with long-term, interdisciplinary outpatient management may improve outcomes for targeted older adults significantly. Findings suggest further that outcomes may continue to improve over time and that the GEM care model provides an effective way to manage health care of older adults.

The nature and management of mania in old age.
Shulman KI, Herrmann N
Department of Psychiatry, University of Toronto, Ontario, Canada.

Mania in old age represents a syndrome involving affective vulnerability in association with neurologic lesions that affect specific areas of the brain. Most patients suffering from mania in late life have converted to bipolarity later in life after many years and often repeated episodes of depression or else have developed mania in association with specific neurologic insults, particularly cerebrovascular disease. The outcome is generally worse in mania than in depression with higher prevalence of cognitive dysfunction, persistent symptoms, and greater mortality. The management of elderly bipolar patients with mood stabilizers reflects the experience with a mixed age population primarily involving the use of lithium carbonate and valproate in appropriately adjusted dosages and serum levels, with valproate having an edge on better tolerability. The use of neuroleptics is often unavoidable in initial stabilization, and electroconvulsive therapy can be life-saving in severely overactive or refractory patients.

Management of poststroke depression in older people.
Rigler SK
Department of Medicine, Division of General and Geriatric Medicine, Center on Aging, University of Kansas School of Medicine, Kansas City 66160-7376, USA.

Depression is a common and under-recognized cause of suffering after stroke. Poststroke depression (PSD) is associated with poorer stroke recovery and increased mortality. Much published research focuses on controversies about demographic and lesion-related associations with PSD and the extent to which it is different from primary depressive illness without stroke. Methodological and population differences across studies account for at least part of the inconsistent research findings about PSD. Rates of treatment for PSD appear to be extremely low. Surprisingly little evidence is available about the effectiveness of various treatments for PSD, and randomized controlled clinical trials are needed. This article summarizes epidemiologic data about PSD, highlights stroke-related and demographic features that increase risk, and reviews the literature on treatment.

Multifaceted shared care intervention for late life depression in residential care: randomised controlled trial.
Llewellyn-Jones RH, Bialke KA, Smithers H, Cohen J, Snowdon J, Tennant CC
BMJ 1999 Sep 11; 319(7211): 676-82
Department of Psychological Medicine, University of Sydney, New South Wales 2006, Australia.

OBJECTIVE: To evaluate the effectiveness of a population based, multifaceted shared care intervention for late life depression in residential care. DESIGN: Randomised controlled trial, with control and intervention groups studied one after the other and blind follow up after 9.5 months. SETTING: Population of residential facility in Sydney living in self care units and hostels. PARTICIPANTS: 220 depressed residents aged >65 without severe cognitive impairment. INTERVENTION: The shared care intervention included: (a) multidisciplinary consultation and collaboration, (b) training of general practitioners and carers in detection and management of depression, and (c) depression related health education and activity programmes for residents. The control group received routine care. MAIN OUTCOME MEASURE: Geriatric depression scale. RESULTS: Intention to treat analysis was used. There was significantly more movement to "less depressed" levels of depression at follow up in the intervention than control group (Mantel-Haenszel stratification test, P = 0.0125). Multiple linear regression analysis found a significant intervention effect after controlling for possible confounders, with the intervention group showing an average improvement of 1.87 points on the geriatric depression scale compared with the control group (95% confidence interval 0.76 to 2.97, P = 0.0011). CONCLUSIONS: The outcome of depression among elderly people in residential care can be improved by multidisciplinary collaboration, by enhancing the clinical skills of general practitioners and care staff, and by providing depression related health education and activity programmes for residents.
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<td>Jun 9</td>
<td>Hong Kong</td>
<td>Hong Kong Psychogeriatric Association 1st Mid-year Scientific Seminar</td>
<td>Venue: Seminar Room 1, M/F, HAHO, Argyle Street, Kowloon.</td>
<td>Tel: 2635 5449 – 2635 5452, Fax: 2637 3987, Contact: Ms. Grace Chung, Sponsored by Benafour Ipsen International</td>
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<td>'A randomized double-blind trial of risperidone &amp; haloperidol in the treatment of BPSD in Chinese dementia patients' by Dr Wai-chi Chan, Senior Medical Officer, Castle Peak Hospital</td>
<td>Time: 12:45 p.m. - 4:15 p.m. Buffet lunch is served before the seminar.</td>
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<td>'A study of the validity &amp; reliability of the Chinese version of Dementia Rating Scale' by Ms. Irene Chan, Occupational Therapist, Kowloon Hospital</td>
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<td>'Reminiscence therapy in old age psychiatry' by Mr. Vincent Pang &amp; Mr. Lui Siu Fung, Registered Nurses (Psy.), Pamela Youde Nethersole Eastern Hospital</td>
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<td>Nov 9-12</td>
<td>London</td>
<td>The Royal College of Psychiatrists Annual Meeting</td>
<td>The Conference Office, The Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG</td>
<td>Tel: 44 207 235 2351, Fax: 44 207 259 6507, e-mail: <a href="mailto:mkerby@rcpsych.ac.uk">mkerby@rcpsych.ac.uk</a></td>
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<td>Jul 3-7</td>
<td>Edinburgh</td>
<td>Themes for this year's meeting include disorders of the mind &amp; brain, rights &amp; practice, services and patients, the law, and research &amp; new directions</td>
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<tr>
<td>Jul 9-18</td>
<td>Washington DC</td>
<td>World Alzheimer Congress 2000: With Change in Mind</td>
<td>Tel: 1 312 335 5813, Fax: 1 312 335 1110, e-mail: <a href="mailto:alzheimer2000@alz.org">alzheimer2000@alz.org</a>, website: <a href="http://www.alzheimer2000.org">www.alzheimer2000.org</a></td>
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<td>USA</td>
<td>Hosted by Alzheimer's Association (U.S.A.), Alzheimer's Disease International &amp; Alzheimer Society of Canada. Main themes include pivotal research, bridging research &amp; care, and creative care.</td>
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<td>Jul 23-28</td>
<td>Stockholm</td>
<td>The 27th International Congress of Psychology</td>
<td>Stockholm Convention Bureau Box 6911, SE-102, 39 Stockholm, Sweden</td>
<td>Tel: 46 8 736 1500, Fax: 46 8 734 8441, Contact: Mona Moback, e-mail: <a href="mailto:stocon@stocon.se">stocon@stocon.se</a></td>
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<td>Sweden</td>
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<td>Sep 6-8</td>
<td>Buenos Aires</td>
<td>A Joint Meeting of the International Psychogeriatric Association (IPA) &amp; Argentine Society of Geronto-NeuroPsychiatry - Mental Health and the Elderly: Transcultural Perspectives</td>
<td>IPA Secretariat, 550 Frontage Road, Suite 2820, Northfield, Illinois 60093 USA</td>
<td>Tel: 1 847 784 1701, Fax: 1 847 784 1705, e-mail: <a href="mailto:ipa@ipa-online.org">ipa@ipa-online.org</a></td>
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<td>Argentina</td>
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