

### Editor's Note

Linda Lam

Welcome to the Winter issue of HKPGA Newsletter. In this issue, we are glad to have Prof Wilcock, a pioneer in the management of dementia, to share with the readers his precious experience in establishing and operating a memory disorders clinic in Bristol. Besides, Mr Timothy Ma gives us an in-depth insight into the need for older adults to live in safe environments and the innovative Personal Emergency Link service that he established. Dr Katheleen Plum and other nurse researchers from the

University of Rochester send us an abstract of their interesting study about catastrophic reaction in cognitively impaired nursing home residents. We are also delighted to receive the contribution from Ms Gemma Wong. She gives us an informative and interesting account of the recent IPA International Congress in Nice. Please enjoy these special articles and the regular contributions from our members. If you are interested in contributing to the Newsletter, you are welcome to pass your article to the Editor by email: [hkpga@hongkong.com](mailto:hkpga@hongkong.com). Looking forward to hearing from you.



### THE BRISTOL MEMORY DISORDERS CLINIC

Gordon K. Wilcock

Professor, Department of Care of the Elderly  
University of Bristol, Frenchay Day Hospital  
Bristol, UK

A number of approaches have been developed in the UK for assessing people who appear to have dementia. These include the specialised memory clinic, but also assessment of patients in their own homes, or in routine general clinics of other specialists, e.g. psychiatrists specialising in old age, neurologists and geriatricians.

We decided to establish a Memory Disorders Clinic in Bristol, based on the clinic I had established in Oxford before moving to Bristol, in preference to the other approaches because we felt that it was easier to have the range of different disciplines available in one place at specific times so that a multi-dimensional assessment could be made more effectively. It would be difficult, for example, for a patient being assessed in their own home to have a full psychiatric assessment, and medical assessment, laboratory blood tests taken, and neuropsychology as well.



Our other main reason for developing a memory clinic approach was the need to establish a research base that would enable us to evaluate new treatments, and also to explore the natural history of the different diseases that cause dementia. The specialised clinic environment, with the multidisciplinary meeting that we hold after each clinic, is also a valuable opportunity for teaching and we have regular visitors from elsewhere in the UK and abroad, as well as teaching local undergraduate, and post-graduate staff.

In my experience, the minimum required for a comprehensive assessment of a person who may have dementia consists of:

1. a doctor who can take the history, conduct a physical examination and arrange appropriate laboratory tests and brain scanning,
2. a neuropsychologist, or somebody trained under the supervision of a neuropsychologist, who can provide the results of assessment on a neuropsychological test battery, such as the one described in our manual "Diagnosis and Management of Dementia - A Manual for Memory Disorders Teams".

3. access to psychiatric expertise if the clinic is not being run in a department of old age psychiatry.

Some clinics, but not our own, have assessments undertaken by other disciplines within medicine, e.g. occupational therapy and speech and language therapy.

We see approximately four to six new patients each week and the initial assessment is split into two components. At the first visit the basic history, examination and laboratory tests are undertaken, together with the neuropsychological assessment. At the second visit the information is co-ordinated and any other assessments that seem necessary are arranged. At the end of each clinic all the patients who attended that session are discussed with the multidisciplinary team to ensure that there is a consensus about their diagnosis and management.

We follow people up for about two years so that we have a longitudinal assessment of their progress, and at subsequent visits we sometimes find we have to alter the diagnosis.

At a research level the clinic supports people with different dementias who are offered the opportunity of participating in clinical trials. Some of these are sponsored by industry and others are therapeutic approaches that we wish to explore ourselves. All the information about each patient is entered on a computerised database, with careful attention to maintaining confidentiality, and this is used as a basis for subsequently identifying suitable subjects for research projects, as well as providing a database of information that can itself be the subject of research. We currently have information on more than 2000 patients on our research database, with a wide variety of different underlying disorders. This has also proved a valuable resource for researchers from outside Bristol, and might, for example, be the basis for comparative studies between the UK and Hong Kong.

More recently we have had to establish an extra clinic session to allow us to assess people for the prescription of a cholinesterase inhibitor, i.e. Donepezil, Rivastigmine, or Galantamine. Instituting and monitoring treatment would be too big an added burden to the main clinic sessions where we wish to run our usual protocol.

Providing all these clinics is a significant financial drain upon my academic department as we have very little support from the Health Service. We are, however, hoping that the need to prescribe

cholinesterase inhibitors will persuade the authorities to make some funds available for us to establish these clinics on a more secure footing.

As much of the community support that patients and their families require is provided, in the UK, by the Psychiatry of Old Age Service rather than my own internal medicine and geriatric medicine service, we usually have at least one psychiatrist in the clinic with us. This enables appropriate patients and their families to be referred to the Psychiatry of Old Age services, and also the local Social Services Department and the voluntary organisations within Bristol.

Our clinics therefore concentrate on the early diagnosis of dementia, diagnosis of the potential underlying cause and follow-up assessment to ensure that the initial diagnosis is correct. In addition we provide therapeutic support, e.g. through the cholinesterase inhibitor clinic if the person has probable Alzheimer's Disease of mild to moderate severity, and also try and provide more practical day to day support through our colleagues in psychiatry, Social Services and the voluntary organisations. The research ethic is however, very important to us, and my research team works in the clinic as this provides a cohort of people who are usually very happy to participate in research projects.

The research contribution of the clinic goes beyond that of clinical research. Many of the patients who we assess agree to donate their brains after they have died, and also give a sample of blood so that we can build up our DNA Bank as well as our Brain Bank, and we now have samples from many hundreds of patients in the DNA Bank as well as over 600 brains in the Brain Bank. These samples then support the laboratory research teams that are part of my department, and more



Staff of Memory Clinic with Dr Patrick Chiu (third from right, middle row)

detail of the research under way in Bristol can be found on our website, using the appropriate links ([www.brace.org](http://www.brace.org)).

Much of the work that we undertake is of course, supported by grants from the Medical Research Council and Medical Research Charities within the UK. In addition we have a very active local charity that I established, along with other supporters, when I first came to Bristol. This is called BRACE and stands for Bristol Research into Alzheimer's and Care of the Elderly. It has provided the resources for the clinic

building in which our Memory Clinic team works, and also a contribution to new laboratories and the salaries of some of the staff who work in these laboratories, as well as supporting some of the research in the Memory Disorders Clinic setting.

The research workers and the volunteers who work for the charity get to know each other well and meet at least once a year so that the research team and their support is very much a "family affair". The BRACE website tells you about the charity, and has links to our research pages.

We receive many visitors each year, a significant number coming from abroad. Many of you will know that Patrick Chiu was a very valued member of our team whilst he

was with us, and we have had other visitors from China, North America and Canada, Scandinavia, and parts of Europe. We are always very keen to host honoured colleagues from abroad.

In summary, we have a Memory Disorders Clinic in Bristol that provides the service to patients and their families, but which also makes an important contribution to our research into the dementias, both at a clinical and laboratory level. The research team works very closely with the local community with whom we have a very good rapport.



## Catastrophic reactions among persons with dementia

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This study described the occurrence of catastrophic reactions among persons with dementia in nursing homes and determined precipitating events/circumstances and characteristics of those most likely to experience them. Catastrophic reactions were defined as severe agitation (i.e., Cohen-Mansfield) accompanied by severe/extreme negative emotions such as (1) sadness, (2) anxiety/fear and/or (3) hostility/anger. It differs from normal agitation because it also involves intense emotional distress. The study was observational including a case/control comparison design.

One hundred nursing home residents with dementia were observed on four units in two nursing homes across all three shifts for seven days. Those residents who had a reaction were "cases" and those that did not were considered "controls." Slightly more than half of residents observed (57%) experienced at least one reaction (i.e., ranging from 1 to 18 events in a 7 day period). Reactions were most likely to occur on the evening shift (42%) and day shift (40%), the least likely being the night shift (18%) and most often in the 60-minute period between 5:30 PM to 6:29 PM (11%). Reactions ranged in duration from 1 to

130 minutes. The extreme negative affect most often present was anger/hostility (91%), followed by sadness (28%) and less often by anxiety/fear (16%). Over half (53%) of the reactions occurred during a care activity.

Those most likely to have reactions were identified using case/control analyses. There were no differences by sex, age, type of dementia diagnosis, stroke history, or pain. However, those with middle range deficits in functional and cognitive ability were at significantly higher risk. Residents with Cognitive Performance Scale scores of 3, 4 (i.e., moderately or moderately severe cognitive impairment) were 5 times more likely to experience reactions than those with either less or more impairment. Findings suggest that these intermediate ranges of cognitive and functional impairment may be the period in the progression of dementia when reactions are most likely to occur.

*Presented at the First Congress of the European Union Geriatric Medicine Society in Paris, France (August 29 - September 1, 2001)*

The 3rd HKPGA Annual General Meeting & Annual Scientific Symposium was held on 9 November 2001 at HKAM Jockey Club Building, Wong Chuk Hang. Over 170 members and guests attended the meeting. Dignitaries in attendance included Dr Marion Fang,



More than 170 members and guests participated in the meeting

Mrs Eliza Leung and Mrs Kathy Ng. A new Council led by Prof Helen Chiu was elected at the Annual General Meeting (see below). We were honoured to have Prof Edmond Chiu from Australia and Prof Jen-ping Hwang from Taipei to be the speakers for our Annual Scientific Symposium this year. Their talks titled "Vascular diseases and psychogeriatrics - it is more important than you think!" and "How to manage senile dementia with behavioural problems?" respectively were both informative and interesting.

### Office Bearers and Council Members (2001-2003)

President	Prof Helen CHIU
Vice-President	Dr Wah-fat CHAN
Honorary Secretary	Dr Wai-chi CHAN
Honorary Treasurer	Ms Daphne LAW
Council Member (Clinical Psychology)	Mr Sing-yuen LI
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Council Member (Nursing)	Ms Frances CHOW
Council Member (Occupational Therapy)	Ms Grace LEE
Council Member (Physiotherapy)	Mrs Miranda TUNG
Council Member (Social Work/Services)	Mr Wing-on AU YEUNG
Council Member (Voluntary Sector/Other)	Mr Kar-mut LEE

We would like to thank Mr Stephen Leung who presented the HKPGA Research Awards to winners on behalf of the Association. This year, Dr Teresa Chan, a psychiatrist from Tai Po Hospital, and Dr Wai-kwong Tang, an Assistant Professor from Department of Psychiatry of Chinese University, were the winners of HKPGA Pfizer Research Awards. Their research projects were "Validity and applicability of the Chinese



Prof Edmond Chiu (left) and Prof JP Hwang shared with the audience their valuable experience

version of Community Screening Instrument for Dementia (CSI-D)" and "Psychiatric morbidity in first-ever stroke patients in Hong Kong: a pilot study in a rehabilitation unit" respectively. The HKPGA Undergraduate Research Award went to Mr Sunny Wing-kin Wong, a Medical Student from Chinese University, and his submission was a review article on "Sleep in dementia". Abstracts of their projects will be published in the April 2002 issue. We would also like to take this opportunity to express our heartfelt gratitude to the referees, including



Officiating guests of the kick-off ceremony: (left to right) Prof Helen Chiu, Ms Christine Fang, Mr William Yiu, Mrs Carrie Lam, and Ms Nora Yau



Prof Helen Chiu (left), Ms Anita Wong, and Prof Iris Chi at the Seminar of Elderly Suicide Prevention

Prof Tom Arie, Prof CN Chen, Dr PC Pan and Dr Freedom Leung, for their continuous support.

The Association is organizing its second overseas Study Visit. We plan to visit psychogeriatric and dementia facilities in Tokyo, Japan. The

tentative dates will be from 20 to 23 August 2002. Details about the visit will be posted to all members as soon as they are finalized.

The Association, in collaboration with the Social Welfare Department and the Hong Kong Council of Social Service, has put forth a "Joint Project on Prevention of Elderly Suicide"(珍愛生命—預防長者自殺計劃). The project is funded by the



The function room was packed with enthusiastic audience

Hong Kong Jockey Club Charities Trust and will last for three years. It comprises a 3-tier coordinated service, community education projects, and an Asia-Pacific Regional Conference on Elderly Suicide Prevention on 28-30 May 2003. The 3-tier service provides assistance to those in need, ranging from a hotline service 珍愛生命長者熱線 (Tel:23820881), volunteer visits, early detection by general practitioners, psycho-social intervention by professional counselors to the "Life Clinic" at Prince of Wales Hospital. On 7 December 2001 the three organizations held a seminar and the kick-off ceremony at YMCA, Tsim Sha Tsui. Prof Helen Chiu and Prof Iris Chiu delivered very informative speeches about elderly suicides in Hong Kong and overseas. 250 attendants participated in this ceremony officiated by Mr William Yiu, Mrs Carrie Lam, Ms Christine Fang, Ms Nora Yau, and Prof Helen Chiu.

Gemma K C Wong

Assistant Professor

School of Professional and Continuing Education

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This year, the IPA International Congress was held in Nice, France. With its relaxing atmosphere for learning and sharing, the Nice Meeting attracted more than two thousand participants from five Continents. The theme of the conference for 2001 was "Bridging the Gap between Brain and Mind".

Three Pre-Conference courses and workshops were organized, which included *Advances in Psychogeriatrics: Expert Update*, *Behavioural and Psychological Symptoms of Dementia (BPSD) Teaching Course: Train-the-trainer*, and *Essentials of Psychogeriatrics*. The training courses were open to all and offered excellent opportunities for us to meet participants from different disciplines.

One of the foci of the symposia was the management of behavioural and psychological symptoms of dementia. The oral sessions about drug trials highlighted the use of novel pharmacological agents to control the undesirable behaviours of dementia. Some sessions, however, threw attention onto the importance of understanding dementia itself. The speakers adopted the theory of dualism when discussing the two separate yet interrelated

collaboration between the UK, Australia and the US. The researchers conducted a randomized controlled trial to evaluate the effectiveness of family caregivers intervention programs and drug therapy for patients with Alzheimer's disease. As it was an ongoing project, only interim results were reported at the session. Australian data showed that a combination approach incorporating psychoeducation, counseling, day care, overnight respite and training was more effective than single intervention strategy. The US researchers observed that caregivers held a negative attitude towards respite care. There was a constructive discussion between the researchers and the audience after their presentation.

for reminiscence to intensive neurological training program. In the UK, similar networking centres were also established. They held regular



More than 2000 participants joined the IPA Congress in Nice

meetings to discuss about the service support and the policies for dementia care. Such networking would certainly bring in an effect on policy making in dementia services.

It was also a delightful experience to learn about the European initiatives in different aspects of dementia. The European Alzheimer Disease Consortium (EADC) was established to co-ordinate and to standardize the assessment tools across European countries. It was involved in the researches in cognitive assessment, database management, genetic therapy and neuroimaging. Other research themes included caregivers' burden,

education, nutrition and physical exercise for dementia clients. Its website is [www.alzheimer-europe.org/eadc](http://www.alzheimer-europe.org/eadc). Another innovative program deserved attention was the French Alzheimer's Disease Network developed in France. At present, there are 17 centres networking more than 500 elderly clients with dementia. It was a three-year project looking into the quality of life in dementia clients longitudinally and the effects of interventions. They planned to develop a variety of aids ranging from memory books

As a whole, it was an interesting conference covering a variety of topics. Alzheimer's disease was still the focus of the conference. We can assume that this phenomenon would continue in the next decade or so till a vaccine is developed to slow down the rapid brain cells death in the disease process. There would be more findings in relation to screening, neuroimaging, pharmacological and behavioural management, and community service support in the future meetings.

The conference has achieved its mission of bridging the gap between brain and mind.



Sumptuous welcome dinner at the beautiful Citadel in Villefranche

entities - mind and body. It has certainly brought in a different perspective to look at the disease. Besides, Kitwood's extensive work on understanding the persons with dementia and the development of personhood had an important impact on the development in care approach of dementia people in residential homes.

Another interesting session was the introduction of a program specially developed for dementia clients. It was a multi-national



Some of the delegates from Hong Kong

# Building a Full Network for the Safety of Elders in Hong Kong

## A 24-hourly Operating Personal Emergency Link Service



Timothy Kam Wah Ma  
Executive Director

Senior Citizen Home Safety Association

### Forewords

Aging process commences upon the first day of life. It is an unavoidable process that all human beings experience. When one grows old, he may need to count on family members and outsiders to meet his needs. If their healths deteriorate, elderly people even have to rely on support and provision of services from the community.

What format of service could be more effective in fulfilling the diversified needs of the elders? Can the concept of 'Caring in the Community' be strategic and relevant to the elders in Hong Kong? What would be the most effective and efficient means to serve our respectable elders?

Among the 18 UN Articles for Older Persons, the fifth one - Older Persons Can Live In Safe Environments and Obtain Family and Community Care - has obviously indicated the importance of fulfilling their needs for security by all means.

Hence, there should be some ways out to enable the elders to enjoy their remaining life with pride and safety. Importantly, they can enjoy their aging lives independently and satisfactorily.

### Elders in Hong Kong

As of Dec. 2000, there are more than 1.03 million older persons in Hong Kong. Among them, 130,000 live 24-hour singly by themselves. They may face any sudden crisis or accidents, or even sudden relapse of their chronic illnesses at home. Around 13.3 % of the elderly population is dependent on Comprehensive Social Security Assistance (CSSA). Besides, 72% of the elders are receiving Old Age Allowance. The above figures aim not to impress you that the elders in Hong Kong are poor, but reflect that not all the elders in Hong Kong enjoy their remaining lives with pride and abundance. They have to count on the community support.

On the other hand, there are more than 882, 700 people found with chronic illnesses. More than 70% among them are aged over 50. Most of them are female. Surely, most of them belong to the aging group. Although many elders participate in activities of social centers or other related social activities, there are thousands of vulnerable or singly living elders who do not take part in any social activities. They are homebound elders who have no access to news update, community services as well as social contact. For those who have more than one long-term illness, they even dare not step out of the front doors of their home lest that accidents or

illnesses may come over them suddenly.

Another poor scenario of older persons in Hong Kong is the high elderly suicide rate. More than one report of attempted elderly suicide can be found in the newspaper every three days. The major causes of their suicidal attempt were pain from chronic illnesses, depression, poverty as well as a lack of kinship support. While suicides are getting more common in Hong Kong in the recent economic downturn period, an increasing number of elders chose to end their precious lives by copying the simplest way of killing themselves - burning charcoal inside a closed room. Certainly, if they can be linked up with any handy and existing resources, concern and care, the situation should be better.

### Tragedy happened on the elders in 1996

In January 1996, a cold spell unexpectedly stayed long in Hong Kong for more than one month. More than 150 singly living elders were found dead unattended at homes. They died not owing to the cold weather, but due to the sudden relapse of their chronic illnesses or a lack of proper and immediate assistance after having domestic accidents.

After the tragedy, the Hong Kong community and media strongly queried why Hong Kong elders, living in such a prosperous city, were not provided with proper care. People believed that proactive and aggressive measures should be adopted to prevent the repetition of such tragedy.

### The 24-hour Operating Personal Emergency Link Service

It was identified that the crucial issue leading to the tragedy was that the elders were in lack of a 24-hour operating HELP service. Though safety alarms or strings have been installed at some of the singly living elders' homes, they were not user friendly. Their difficulty to use, fixed location and non-mobile function prevented the elders from asking for HELP when they encountered crisis or need at home. Hence, identifying an effective and affordable system for HELP that is backed up by a 24-hour operating Call Centre should be a must for the thousands of elders in Hong Kong.

Around three months after the tragedy, a group of solicitous people, including Legislative Counselor, front-line social workers, volunteers and heads of welfare agencies established a non-profit making social service agency, Senior Citizen Home Safety Association, on Aug. 31, 1996. It ministers to fulfill the urgent needs of the elders. A 24-hour operating Personal Emergency Link Service Centre (PE Link

Service) was also set up to render immediate assistance to the elders round the clock. By means of a remote trigger and an emergency alarm system installed at the user's home, one can call for HELP anytime by simply pressing the trigger. More importantly, the caller need not even to identify himself as all his particulars (including the health record) are kept at the data system of the call centre. Efficient follow-up service is also rendered accordingly.

### A Comprehensive Network of Operation

Aiming at serving one million elders, it is impossible for a single agency to render all the services to them. Hence, a comprehensive community network is built up to form the very key backup system for the PE Link service. During the course of service delivery, not only the formal resources, but also the informal resources of the elders are also deployed for the operation of the service. (For details, please refer to Figure 1)

### Service Contents

Run and manned by professional social workers, the PE Link Service not only aims at providing a safety measure to the users, but also makes the best use of relevant community resources as a network for the elders. The service carries multiple functions namely: preventive, remedial and developmental functions.

When the users are in need of immediate HELP, they can ask for transferal to Accident & Emergency Department of public hospitals simply by pressing the trigger button. After confirming the need, ambulance will be contacted whilst health history of user will be faxed to the AED. Significant others of the users will also be informed of the latest situation of the user.

Apart from passively waiting for the HELP requests from the users, operators of the Call Centre and the social workers of the agency will also contact the users regularly to check whether there are any active problems. During the cold season and the typhoon time, those who live at the risky area (flooding area) will also be reminded to be cautious about the change in weather. They are encouraged to make the best use of the service if needed.

On the other hand, family relations between members and users are enhanced as the PE Link Service brings the users and their families together. Relatives are encouraged to foster care and concern to the users.

In order to achieve the above goals, the following types of service are provided (Table 1):

**Table 1: Service Statistics as of September 30, 2001\***

Type of Service	Number
Service Users	25,149 People
Pressing PE Link for Help	369,640 Times
Pressing PE Link and Being Sent to A&E Department	19,165 Times
Pressing PE Link Due to Fire and Robbery	252 Times
Visit by Social Workers and Volunteers	8,653 Times
Telephone Assurance	314,348 Times
Calls Received by "Elder Ring"	12,036 Times
Short-term Counseling by Social Worker	3,207 Cases
Referring to Other Social Service Organizations	427 Cases
Giving Coats, Quilts and Other Materials	3,281 Times
Talks for Promotion and Education	927 Times
PE Link Center Visit	352 Groups
Charity Cases	1,610 People

*Since September 1996\**

And, to provide a viable back up to the service, the following support are also identified and involved for the implementation of the PE Link service:

**Hospital Authority** - Accident & Emergency Department of all public hospitals

(Health record of the service users are faxed to them for early preparation of the intake & admission of the service user)

**Telephone Company** - render supportive and quick maintenance service to our entire telephone system and the users phone lines as well

**Electricity Supply Companies** - Provide Planned Shut Down report on Power Supply and en-route service to the users who could not afford any termination of power supply.

**Ambulance Control Centre** - Assignment of ambulance in responding to the emergency needs of the service users

**Housing Department** - Assigning staff of Estate Management Office to provide timely support service to those who call for help

**Social Welfare Department** - Handling the EAS Special Allowance application of the eligible service users

**Media** - Helps in promoting the service to the general public by means of regular coverage

**The PE Link Volunteer Network of the Association** - more than 300 volunteers render regular telephone assurance service, home visits and even escorting service to those needy elderly

**General Public** - donating fund in supporting the free service for those who are non-eligible for the EAS special allowance

**Feedback of Service Users and the Counter-partner Agencies in Elderly Service**

Upon the commencement of the service, commendations from the counter-partner agencies and users were received from time to time. The most outstanding one is from an old woman aged 86 who sent her handwritten thank you letter for our efficient service to her husband. We also received the commendations from Hospital Authority, Social Welfare Department as well as referring agencies for our non-stop services, which contributed to the improvement in the quality of life of their members.

On the other hand, the high consumption of our service, including the number of calls received from the service users has reflected their confidence and acceptance of the service. We are now one of the three similar service providers in Hong Kong. Among the three, SCHSA obtained a 75% market-share of like kind service in Hong Kong due to the strong professional social work operation approach.

The following call record summary also indicated the well acceptance of the service users and their family members towards the effective PE Link Service (Table 2):

**Table 2: Summary of Call Record**

Nature of Emergency Calls	No. of calls	Percentage
Expressed facing with robbery & fire	316	0.08
Expressing having serious sickness & accidents at home, and need immediate assistance / service	19185	5.18
Unintentionally pressed the HELP button	72094	19.48
Tested the system without prior notice *	91301	24.67
Expressed in low emotion	74	0.02
Did not response after pressed the button	1358	0.37
All types of enquiries	23885	6.45
Electricity Shutdown	103174	28.00
Others	58263	15.74
Total	369,640	100

\* SCHSA encourages users to test the system frequently to help them to be familiar with the service

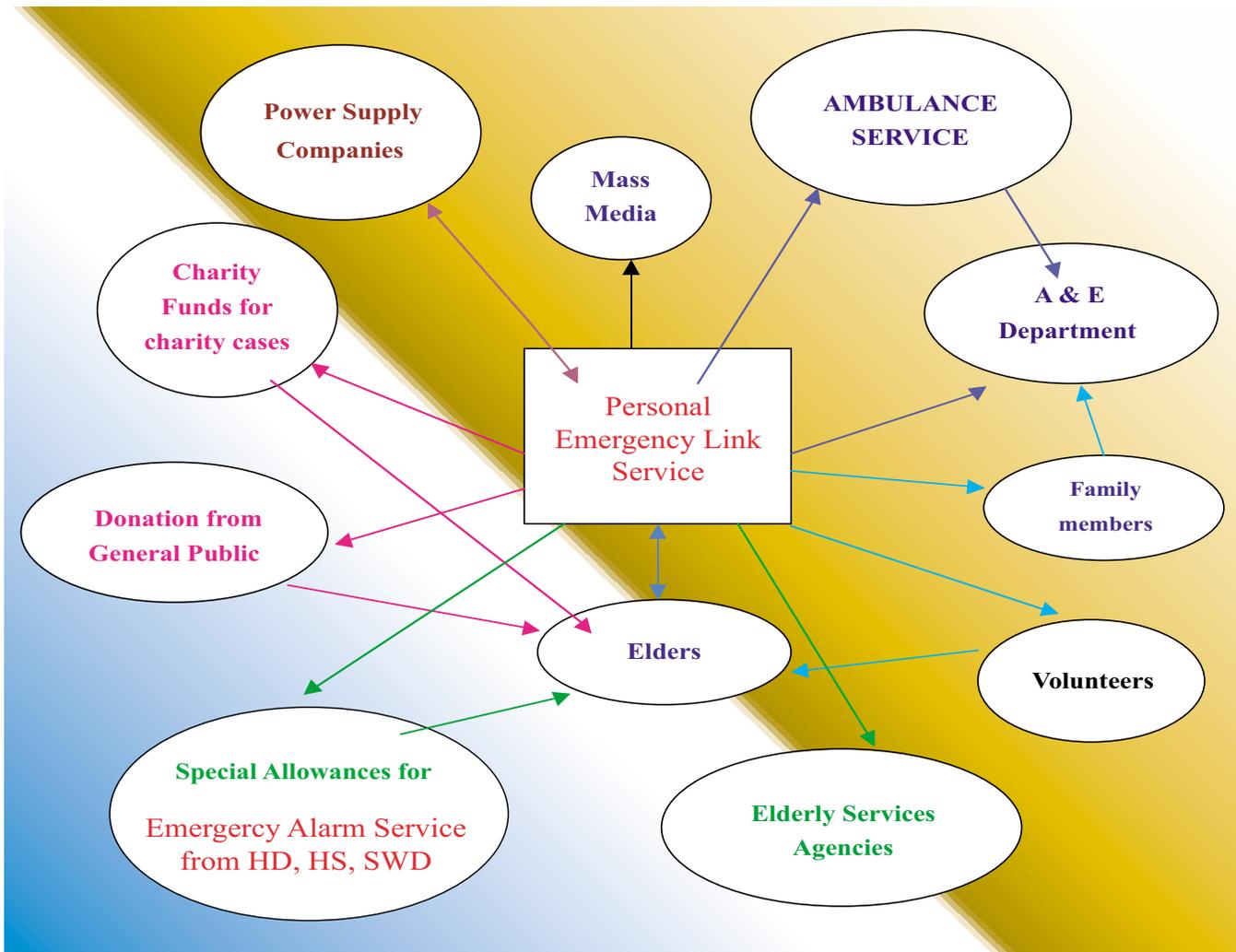
**Conclusion**

Being the only social welfare service agency rendering emergency support to elderly in Hong Kong, we commit not only to be reactive, but proactively rendering the most timely and prompt service to the elderly, and their family members as well.

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**Figure 1**

**Operation Network of the Personal Emergency Link Service, SCHSA**



**Events Calendar**

Wai-chi Chan

<p>20-23 August 2002 (tentative)</p> <p>Tokyo Japan</p>	<p><b>HKPGA 2nd Study Visit</b></p> <p>After the successful study visit to Taipei in June 2001, the Association is planning to visit psychogeriatric and dementia facilities in Tokyo next year. One of the highlights of the trip will be a visit to the Dementia Care Research and Training Tokyo Center, which was newly established in 2000. Participants may also take this opportunity to take part in the XII World Congress of Psychiatry that will be held in Yokohama from 24-29 August.</p>	<p>Information and application forms will be posted to members in due course. For more information contact: E-mail: <a href="mailto:hkpga@hongkong.com">hkpga@hongkong.com</a></p>
<p>23-26 October 2002</p> <p>Gold Coast Hotel Hong Kong</p>	<p><b>International Psychogeriatric Association Asia-Pacific Regional Meeting</b></p> <p><b>"Dementia, Depression &amp; Suicide in the Elderly: Clinical &amp; Cultural Aspects"</b></p> <p>This important regional meeting will look at the cultural influences on these afflictions and how practitioners can best treat these disorders.</p> <p>It is difficult to go through the program and not be charmed by its many distinguished speakers. To name a few: Tom Arie, Alistair Burns, Eric Caine, Jeffrey Cummings, Akira Homma, Joel Sadavoy, Zhang Ming Yuan &amp; of course, our President Helen Chiu. More local practitioners &amp; experts from the region will be there. It is an excellent opportunity to exchange ideas and to increase communications and networking among colleagues in Asia-Pacific Region.</p> <p>Welcome to join us in Hong Kong for this important summit.</p>	<p>For more information contact: IPA Secretariat 550 Frontage Rd., Ste 2820 Northfield, IL 60093 USA</p> <p>E-mail: <a href="mailto:ipa@ipa-online.org">ipa@ipa-online.org</a>          Web: <a href="http://www.ipa-online.org">http://www.ipa-online.org</a></p>



# Hong Kong Psychogeriatric Association Ltd.

香港老年精神科學會

## Membership

Hong Kong Psychogeriatric Association is at all time open for recruitment of members. Anyone interested in the mental care of the elderly is welcome to join and become a member.

### Membership application/renewal\* form:

Full Name: \_\_\_\_\_ ( \_\_\_\_\_ )  
(Title) (Surname) (Name) Chinese Name (if applicable)

Present Post: \_\_\_\_\_ Professional Group: \_\_\_\_\_

Office Address: \_\_\_\_\_

Tel. No.: \_\_\_\_\_ Fax No. : \_\_\_\_\_ E-mail: \_\_\_\_\_

Correspondence Address (if different) : \_\_\_\_\_

Tel. No.: \_\_\_\_\_ Fax No. : \_\_\_\_\_ E-mail: \_\_\_\_\_

Professional Qualifications(s): \_\_\_\_\_

I hereby apply for/renew the Membership of the Hong Kong Psychogeriatric Association Ltd.

I enclose a cheque\*\* of :

[  ] HK\$100 as annual subscription for ordinary membership (valid up to 31 Dec. 2002)

[  ] HK\$250 as a 3-year subscription for ordinary membership (valid up to 31 Dec.2004)

[  ] HK\$800 as a lifetime membership

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*please delete where appropriate.

\*\*All cheques should be payable to “**Hong Kong Psychogeriatric Association Limited.**”

Please return the completed form with payment to Ms. Daphne LAW (Hon. Treasurer) c/o Occupational Therapy Department, 2/F Shatin Hospital, 33 A Kung Kok Street, Shatin, N.T.

Tel: (852) 2636 7556 Fax: (852) 2647 7850 (Attention: Ms Daphne LAW, O.T. Department)

E-mail: [KPGA@HongKong.com](mailto:KPGA@HongKong.com)

#### Newsletter Committee Members:



Prof. Linda Lam (Chinese University of Hong Kong)  
Dr. Wah-fat Chan (Pamela Youde Nethersole Eastern Hospital)  
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