

Editor's Note

Linda Lam

Welcome to the Spring issue of HKPGA Newsletter. It has long been recognized that good training is the foundation of effective service provision. In this issue, we invite Dr Brian Draper to introduce to us the renowned old age psychiatry training programmes in Australia and New Zealand. Besides, we are privileged to have Sir David Goldberg, one of the best-known names in psychiatry, updating us on the current opinions in social psychiatry development. Meanwhile, Dr Carmelo Aquilina, the coordinator of the Royal College of Psy-

chiatrists Faculty of the Psychiatry of Old Age website, guides us to this information-packed yet interesting web based resource center, which caters for the needs of both general public as well as the health care professionals. Last but not least, we are pleased to announce that we have obtained the permission from Dr David Folks, the Editor of *IPA Bulletin*, to reproduce its popular Recent Advances column. Hope you will enjoy this new addition. Please don't forget to contribute to your Newsletter. You are always welcome to pass your articles to the Editors at chanwc1@ha.org.hk. Looking forward to hearing from you.

Advanced training in Psychiatry of Old Age in Australia and New Zealand

Brian Draper MBBS MD FRANZCP

Chair, Committee for Advanced Training in Psychiatry of Old Age, RANZCP
Prince of Wales Hospital, Randwick, NSW Australia

Advanced training (or subspecialty training as it is known in some countries) in psychiatry of old age officially commenced in Australia and New Zealand in 1999, though of course unofficial training had been occurring for years. At this time the Section of Psychiatry of Old Age, an interest group within the Royal Australian and New Zealand College of Psychiatrists (RANZCP), became a Faculty (FPOA). Becoming a Faculty includes the responsibility of running a College accredited two-year training program that culminates in the Certificate in Psychiatry of Old Age. This is undertaken as the final part of the 5-year RANZCP training for College membership and recipients of the certificate are eligible for membership of FPOA. Unfortunately, for trainees or psychiatrists from other countries, it is not possible to complete the Certificate in Psychiatry of Old Age as a stand-alone qualification.

In the four years since the Faculty training commenced, the training program has grown enormously. There are now 50 trainees registered with the program and 14 training centres scattered across the two countries. So far there have been 20 graduates. Each year interest has been increasing amongst College trainees to join our program.

The Committee for Advanced Training in Psychiatry of Old Age (CATPOA) is charged with the responsibility of accrediting training programs through a combination of documentation of training opportunities and activities as well as regular site visits. It also monitors the progress of trainees through 6-monthly self-assessment and supervisors' reports. CATPOA in turn reports to the Fellowships Board that devises policy and monitors all training activities within the College.

Because our training program is spread across two countries with



Dr & Mrs Draper (first & second from left) visited friends in Hong Kong

many training centres having only one or two trainees at any one time, it has been necessary to develop strategies to overcome the distance and isolation. Our initial strategy involved the use of chat sessions on the Internet as a type of tutorial. It was an interesting experience with many bizarre cross conversations. We were just starting to get used to it when most hospitals and universities put firewalls up for Y2K and this effectively prevented most people from joining in. Subsequently we decided to run a monthly tutorial on a bulletin board on the College website. Due to technological limitations on the website, this has taken much longer to get going than we had hoped but will be commencing in 2003.

In the meantime, we decided to run annual advanced training weekends where trainees are brought together in a university centre for a day or two and have an opportunity to get to know each other. Tutorials, mini-lectures from local and international experts, workshops and trainee presentations allow the trainees to share their knowledge and experiences in an informal manner. We have been able to obtain sponsorship so that the trainees have limited expenses. These training weekends have been very well received by the trainees.

As advanced training in psychiatry of old age becomes more popular, we are finding that there is now increasing pressure for mental health services to develop positions for old age psychiatrists. Whereas for years there has been a 'demand' driven job market, this is now switching to a 'supply' driven market. There are still places searching for old age psychiatrists but not as many as a few years ago. But there are still many parts of Australia and New Zealand without old age psychiatrists or with insufficient numbers so there is still plenty of room for improvement.

Even in the brief span of four years, I feel that the RANZCP advanced training program in old age psychiatry has been a resounding success and promises to go on to bigger and better things.

Recent Research in Social Psychiatry

Sir David Goldberg
Professor Emeritus, Institute of Psychiatry
Kings College, London, UK

(Based on the keynote address given by Sir David Goldberg at the Mental Health Association Professor PM Yap Memorial Lecture in Hong Kong on 24 June 2003. Prepared by Dr Cathy Chow of Excerpta Medica.)

Sir David Goldberg discussed the advances in social psychiatry, as well as challenges that remain.

Population surveys and models, levels and filters

In the UK, the epidemiology of mental illness has been studied on five different population levels:

1. The general community
2. People presenting to general physicians
3. People perceived to have mental illness by doctors at presentation
4. People referred to specialist mental health services
5. People hospitalized due to mental illness.

The prevalence figures of mental illness in the UK (Manchester) for these five different levels were comparable with those obtained from similar epidemiological studies performed in the Netherlands and USA (Figure 1).

Figure 1. Mental illness prevalence on five population levels

5 Levels in 3 Centres Annual period prevalence /			
	Manchester	Groningen	Seattle
1: Community	250-315	250-303	221-281
2: All attenders	210-230	224	164
3: CPM	101	94	78
4: Referral	20.8	34	58
5: Beds	3.4	10	9

More recent epidemiological data on level 1 populations (general community) indicate that the prevalence of mental illness has remained relatively constant. The most prevalent mental illness in this population was depression.

For each of these population levels, Sir Goldberg described the use of “filters”, which are intended to aid and improve the detection and diagnosis of mental illness. Even so, it is still possible for cases to remain undetected. For example, patients with mild mental disorders tend to go undetected, as do patients who present with somatic symptoms.

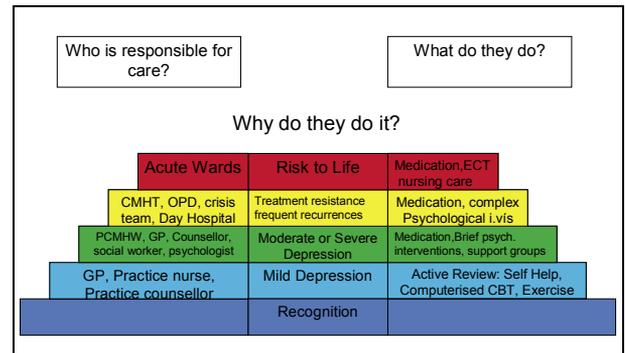
Stepped care and community care

In the UK, mental disorders are increasingly being managed using a stepped care approach. This strategy places the majority of early mental illness management on primary care providers, such as general physicians (GPs) (Figure 2).



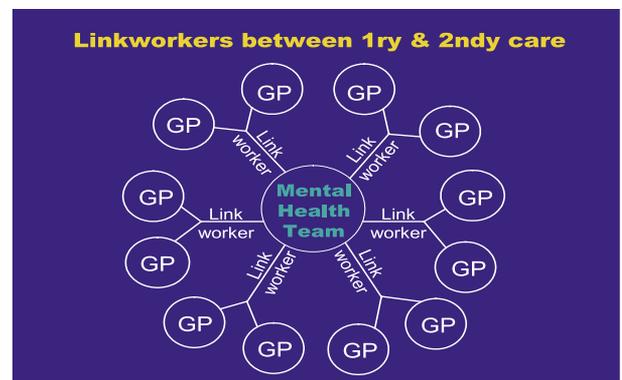
Sir Goldberg at Professor PM Yap Memorial Lecture

Figure 2. Stepped care



In the long term, in the UK at least, care of the mentally ill will continue to be shifted onto primary care/community care providers. Undoubtedly, GPs need to receive further training to be able to cope with this new and additional role. Studies have shown that multi-disciplinary mental health teams (comprising social workers, occupational therapists, psychologists, psychiatric nurses and psychiatrists) that liaise with GPs may be an optimal and effective way to manage mental illness (Figure 3).

Figure 3. Mental health management by mental health teams and GPs



If put into practice effectively (e.g., using a mutual support network of mental health teams and GPs, as described), the management of mental illness by community care can achieve similar if not better outcomes than traditional methods and may be more cost-effective.

Epidemiology of schizophrenia

The debate surrounding the epidemiology of schizophrenia continues to include the “drifter” and “breeder” hypotheses. Very generally, the first hypothesis suggests that schizophrenics have a tendency to drift towards and group in deprived, inner-city areas. At the same time, healthy people tend to drift out of these areas; thus, giving the appearance that schizophrenics are concentrated in poor, urban areas. The second hypothesis alludes to the idea that schizophrenia may be familial and related to environmental or genetic factors. Both hypotheses need to be investigated further.

(Editor’s note: We are grateful to Mental Health Association for permitting us to reproduce Sir Goldberg’s photo)

The 5th HKPGA Annual Scientific Symposium was held at Assembly Hall, the Salisbury YMCA of Hong Kong on 7 November 2003. We were privileged to have Prof John O'Brien from Institute for Ageing and Health, Newcastle, UK to be the keynote speaker, and Dr Pey-chyou Pan as the moderator. Prof O'Brien gave us an insightful presentation on "Dementia with Lewy Bodies". Members thoroughly enjoyed Prof O'Brien's talk, which stimulated fruitful discussion and exchange of ideas among participants.



Over 120 participants attended Annual Scientific Symposium

We held the 5th HKPGA Annual General Meeting at the same venue on 7 November. Members passed unanimously votes of thanks to our Honorary Legal Advisor Mr Paul Ng, and Honorary Auditor Mr William Po. A new Council led by Dr Wah-fat Chan was elected at the Annual General Meeting.



Council members joined Prof O'Brien (middle), Dr Pan (2nd from left), and award winners at the 5th Annual Scientific Symposium

and psychological symptoms in dementia in Alzheimer's disease in Chinese: an open label study". Mr Jimmy C W Leung won HKPGA Undergraduate Research Award by his submission on "Clock-face drawing and copying tests in recognition of early dementia". We would also like to take this opportunity to express our heartfelt gratitude to the referees, including Prof Tom Arie, Dr Pey-chyou Pan, Dr Freedom Leung, and Dr Chetywn Chan, for their generous support.

Over 100 delegates participated in the Symposium on "Elderly Suicide Prevention Programmes in Hong Kong" which was jointly organized by Department of Psychiatry, Chinese University of Hong Kong and Hong Kong Psychogeriatric Association on 8 January 2004. Dr Wah-fat Chan, President of HKPGA, chaired the symposium. He was joined by a number of local experts who introduced to the participants the Joint Project on Prevention of Elderly Suicide organized by the Hong Kong Council of Social Service, Hong Kong Psychogeriatric Association & Social Welfare Department, and the Elderly Suicide Prevention Program operated by Hospital Authority. Profs Eric Caine and Yeates Conwell joined the group as discussants. Their feedback and opinions on the programs in Hong Kong were both encouraging and inspirational.

Office Bearers and Council Members (2003-2005)

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Council Member (Voluntary Sector/Other)	Mrs Eliza LEUNG



Ms Anita Wong gave the audience an overview of the Joint Project on Prevention of Elderly Suicide

We would like to congratulate the winners of the 2003 HKPGA Research Awards. This year, HKPGA/Pfizer Research Award went to Dr Joshua M Y Tsoh whose research project was "Attempted suicide in Chinese elderly: a multi-group study". Dr Cheong-fai Chan won HKPGA Postgraduate Research Award by his project entitled "Efficacy of rivastigmine in the treatment of behavioural



Profs Eric Caine & Yeates Conwell as discussants

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 report. The submitted reports for postgraduate awards 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 submitted reports for the undergraduate award have to be research reports, projects or review articles relevant to the local setting. The postgraduate awards will be awarded to postgraduates of any discipline. 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. Abstracts of the winning projects will be published in the HKPGA Newsletter.

Referees

We are very privileged to have the following world-renowned experts as the referees of 2004 HKPGA Research Awards:

Prof Edmond Chiu (Australia), Prof Eric Caine (US), Prof David Thompson (HK), Dr Pey-chyou Pan (HK), and Dr Chetywn Chan (HK)

Call for Submissions

Submissions of research reports are invited for the 2004 HKPGA Research Awards. Research reports should reach the Association not later than 31 August 2004.

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 2004 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
c/o Community Psychogeriatric Team
Castle Peak Hospital
Tuen Mun, NT
HONG KONG

Membership Cards for HKPGA Life Members

Daphne Law



It gives us great pleasure to announce the introduction of HKPGA Membership Cards. It is a benefit for life members of the Association. Current and newly joined life members (on or before 30 June 2004) are entitled for Life Membership Cards bearing their names and membership numbers. In view of the practical difficulties, we can only issue cards with membership numbers for life members joined HKPGA after 30 June 2004. So act fast to get your own HKPGA membership cards! Besides, we would like to take this opportunity to thank Mr Schwinger Wong for his help in designing the Membership Card.



Introducing Faculty of the Psychiatry of Old Age Website

Carmelo Aquilina
Consultant in Old Age Psychiatry
Queen' Resource Centre, Croydon, UK

The Faculty for the Psychiatry of Old Age presence on the world wide web is within the bosom of the Royal College of Psychiatrist's website (<http://www.rcpsych.ac.uk/college/faculty/oafaculty/index.htm>). This article is a short guide to the features currently on site as well as those which we hope to expand to make this site worth visiting.



Dr Aquilina

The site is split up into three areas: one for College members, another for old age psychiatrists worldwide and another one for the public. All areas now have direct links as shown below to allow easy and quick access without having to click through the main College site.

The Faculty Pages

The Faculty pages can now be accessed directly through www.oldagefaculty.org. The aim is to allow all members to keep up to date with the activities of the Faculty and to allow easy communication with the Executive and regional representatives. There is therefore a section with their names and eventually e-mail contact details. There are summaries of recent business meeting lectures, minutes of faculty business meetings and news of future meetings. An archive of official policy documents from the Faculty is available to download e.g. care of younger people with dementia. Another highlight of the site is a guide to current United Kingdom guidance and legislation written by Professor Baldwin. We hope to add a discussion area in the near future to allow members to air their views on any topic of interest, vote on questions put to them and to register for an e-mail alert system to receive Faculty information quickly. Our newsletter *Old Age Psychiatrist* is available through this section as well as from the professional pages.

The Professional Pages

The professional pages are aimed at any professionals working with older people with mental health problems wherever they live. It is accessible directly through www.oldagepsychiatry.info. One of the main attractions of this section is the *Old Age Psychiatrist* section which is available through its own address www.eoap.com. It contains the complete archive of all issues since 1995 in PDF format. The more recent issues have a web-friendly HTML version where each article is longer, had full references, links to other websites, has suggestions for further

contacts and further reading and links with articles on a similar topic or more from the authors. Additional articles which did not appear in the printed issue are also available. Another highlight is the full text of the current College textbook of old age psychiatry 'Seminars in Old Age Psychiatry' by Professor Brice Pitt and Rob Butler. This will be an invaluable reference to students and professionals alike. There is a guide to websites of interest to old age psychiatrists and the chance to order old age psychiatry books published by the college. A section on books, films, theatre and even software of interest to old age psychiatrists rounds up these pages.

The Public Pages

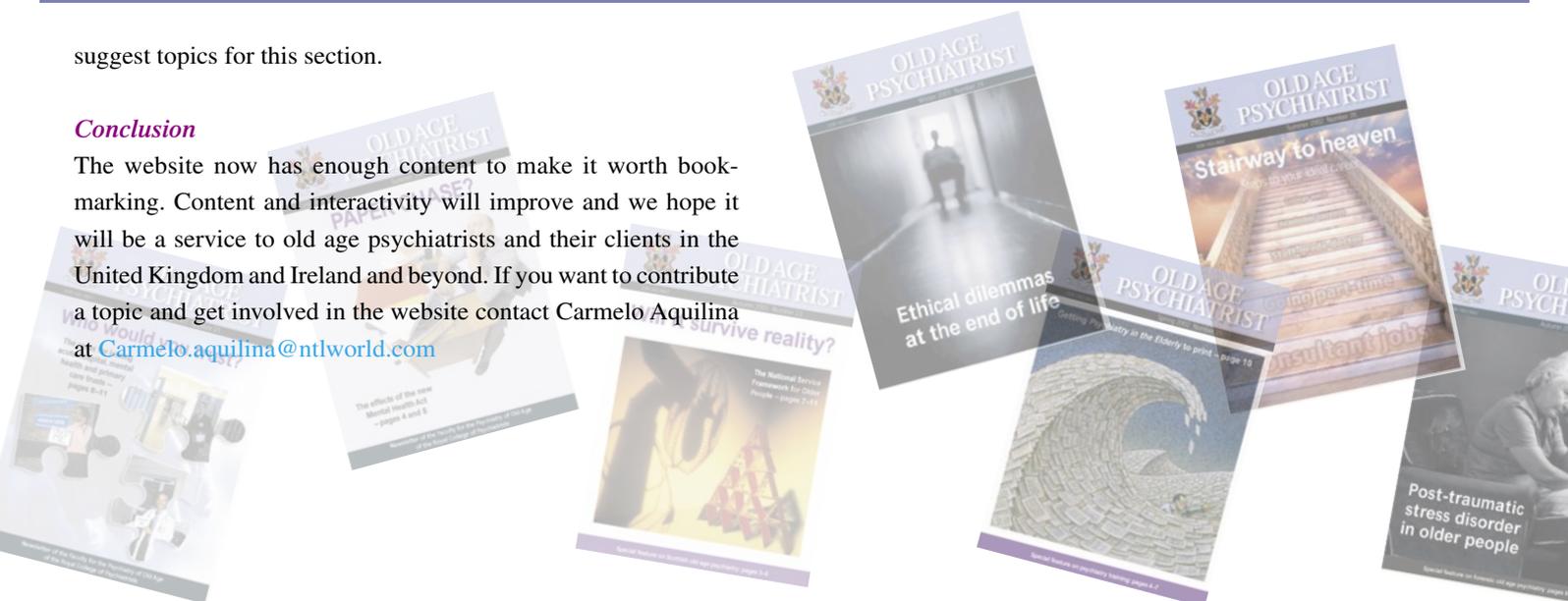
These can be accessed directly through www.mentalhealthinoldage.info and has some downloadable leaflets on dementia and depression. The main attraction however is the complete text of *Dementia at your fingertips*. This was first published in 1997 and immediately proved very popular with carers of patients with Alzheimer's disease and other dementias. The book aimed to answer those questions, which carers frequently ask, (or would ask, if allowed the opportunity) about all aspects of the condition and its management. The book is therefore relevant, comprehensive and accurate and is now its second edition. It was 'Highly Commended' in the 'Popular Medicine' category at the British Medical Association (BMA) Medical Book Awards, 2002. The Faculty has acquired exclusive rights to reproduce this book on the website and this can be found through www.rcpsych.ac.uk/college/faculty/dementia/index.htm.

It provides a comprehensive online resource to advice on the following topics (and many more): diagnosis of dementia, practical care, help with dealing with problem behaviour, support services available, legal and financial issues. These topics are covered in 13 chapters all of which are divided into several logically headed sections making the relevant questions easy to find. The answers themselves are clearly written and succinct yet thorough. There is a very extensive "Useful Addresses" appendix with web-links, and an eclectic "Further Reading" list. The whole area is very easy to navigate using pull down menus. There is the opportunity for anyone to ask the Alzheimer's disease society. Members might want to print out individual questions of interest to individual patients and relatives. The Faculty hopes to increase the quantity of similar content written for a general audience. Anyone with an interest or expertise in a particular topic is welcome to write on or

suggest topics for this section.

Conclusion

The website now has enough content to make it worth bookmarking. Content and interactivity will improve and we hope it will be a service to old age psychiatrists and their clients in the United Kingdom and Ireland and beyond. If you want to contribute a topic and get involved in the website contact Carmelo Aquilina at Carmelo.aquilina@ntlworld.com



Recent Advances

(Reproduced with permission from *IPA Bulletin* Volume 20, Number 4)

Professor John O'Brien
Dr Robert Barber
Professor Robert Baldwin

ALZHEIMER'S DISEASE AND DEMENTIA

Treatment of Vascular dementia with donepezil: new findings

New data from a 24-week RCT (Wilkinson et al *Neurology* 2003, 61:479-486 with commentary by Farlow p429) found patients with vascular dementia (VaD) treated with donepezil demonstrated significant improvements in cognition (ADAS-cog and MMSE) and global function (CIBIC-plus) compared with those on placebo. Altogether 616 patients were recruited and 423 randomised to active treatment (donepezil 5mg n=208; 10mg n=215). 76% of patients had probable VaD and 24% possible VaD using standardised criteria. The primary efficacy measures were similar to those used in treatment studies for Alzheimer's disease (AD). Overall, the placebo group did not show cognitive decline over 24 weeks. In contrast, patients on active treatment had on average an endpoint treatment difference from baseline of 2 points on ADAS-cog. Improvements on CIBIC-plus were 25% for placebo, 39% for 5mg and 32% for 10mg. Sub-analysis showed similar responses in patients with probable and possible VaD. The magnitude of treatment effects was smaller than those observed in AD, and the authors suggest that the lack of progression within the placebo group made it more difficult to demonstrate drug-placebo differences. The proportion of patients with adverse events and serious adverse events were similar among the three groups, but donepezil 10mg was associated with increased diarrhea, vomiting, nausea, abnormal dreams, leg cramps and rhinitis. In the accompanying commentary, Farlow suggests donepezil may have a narrower therapeutic window with a lower optimal dosage in VaD than for AD. These results, in conjunction with similar findings from an RCT using galantamine in VaD, add to a growing evidence base for supporting the use of

cholinesterase inhibitors in VaD.

Wine-related polyphenols and Alzheimer's disease: could they be beneficial?

Motivated by epidemiological evidence suggesting a protective effect of wine consumption on Alzheimer's disease (AD), researchers from Japan (Ono et al *J Neurochem* 2003, 87:172-181) conducted a series of laboratory experiments to determine whether wine-related polyphenols effected the formation and destabilization of beta-amyloid fibrils. They found all polyphenols tested inhibited the formation of the fibrils and destabilized preformed fibrils. Extrapolating from cell culture experiments to real life is of course a complex business, but these preliminary findings offer insights into how wine may protect against AD, and as the authors speculate, polyphenols may be key molecules for the development of therapeutic interventions in AD.

Do patients with probable or possible Alzheimer's disease have different clinical outcomes?

Probably not according to the findings from Villareal et al (*Neurology* 2003; 61:661-667). They followed up a large group of patients with either probable (n=432) or possible (n=208) AD for up to 11 years. Outcome was assessed using a range of cognitive measures supplemented by clinical endpoints such as nursing home placement and death. Overall, they found no difference in outcome between the two groups. Given that patients with possible AD are often excluded from studies, the authors suggest that future studies would be more representative if these patients were more readily included.

Nonsteroidal anti-inflammatory drugs and the risk of Parkinson disease

The potential role of NSAIDs in reducing the risk of various degenerative diseases, particularly Alzheimer's disease, has been widely studied, often with conflicting findings. Chen and colleagues (*Arch Neurol* 2003; 60:1059-64) were interested to determine whether findings from animal models showing NSAIDs reduce dopamine neuronal degeneration would be replicated in human studies and influence the natural history of Parkinson disease (PD). They followed up two large prospective cohorts (n>142,000 in total) and found regular use of non-aspirin NSAIDs was associated with a lower risk of PD than non-regular users (relative risk 0.55). The authors conclude that NSAIDs may delay or prevent the onset of PD, though whether treatment with non-aspirin NSAIDs will ever prove effective is unclear.

Sleep and insights into brain pathology

Could alterations in sleep behavior be the "Royal Road" to neuropathology? Well, possibly under certain circumstances. In a clinicopathological study spanning 12 years, Boeve et al from the Mayo Clinic, USA (*Neurology* 2003; 61:40-45) conducted autopsies on all subjects (n=15) who were diagnosed with REM sleep behavior disorder (RBD) plus a neurodegenerative disorder. Clinically, RBD is characterized by loss of muscle atonia during REM sleep with prominent motor activity and dreaming. Patients may literally act out their dreams. Based on previous case reports and their own experience, the central premise was that RBD would be associated with synucleinopathy. In summary, they found 12 patients had a neuropathological diagnosis of Lewy body disease (LBD) and 3 had multi-system atrophy (MSA). LBD, MSA and indeed PD share a similar alpha-synucleinopathy. The authors concluded that in the setting of degenerative dementia or parkinsonism, RBD often reflects the presence of synucleinopathy. Interestingly, in their series RBD preceded dementia or parkinsonism in 10 of the 15 patients by a median of 10 years (range 2 to 29). The findings suggest clinicians should have a greater awareness of RBD, its detection, and implications for diagnosis and neuropathology.

Dementia, pain and depression

Identifying and managing pain in someone with advanced dementia is difficult. Frampton (*Age and Ageing* 2003; 32:248-251) reviewed the literature over a 10-year period. She found that unidentified pain may lead to depression, possible inhibition of immune function and declining medical health. Nonverbal pointers include agitation, shouting, fluctuating cognition, withdrawal, unexpected decline in functional abilities, sweating and tachycardia. The main factors in non-detection were the difficulty carers have in identifying pain and the inappropriateness of many of the scales used to detect it. Tranquilizers may mask pain. There is no consensus about how to manage suspected pain in a person with dementia but some clinicians advocate a therapeutic trial of non-opioid analgesia in people displaying non-verbal pain cues perhaps accompanied by therapeutic massage.

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Caregivers and their reasons not to treat a relative with Alzheimer's disease

There are many influences on the journey a patient with Alzheimer's disease (AD) makes from diagnosis to treatment. Carers are often at the forefront of this journey and can express a range of opinions, values and beliefs that effect therapeutic decisions. To investigate carers' attitudes to AD-slowing medicines Karlawish et al (*J Am Geriatr Soc* 2003; 51:1391-97) interviewed 102 carers of patients with mild to severe AD (52 patients having severe dementia). Carers (17%) did not want their relative to receive medicine that would slow AD, even if the drug was risk-free. Carers who would opt out or forgo such treatments were older, more depressed, had relatives in nursing homes, and rated their relative's quality of life as poor. Patients were also more likely to be advanced to a severe dementia. Overall, the authors conclude that there was a general willingness to use medication to slow the illness, but there needs to be an awareness of the carer factors, such as depression, that might influence whether to treat or not.

DEPRESSION

Prevalence and correlates of major depression

Large epidemiological studies of the prevalence of depression in adult life are rare. Wilhelm and colleagues (*Journal of Affective Disorders* 2003; 75:155-162) used the Australian National Survey of Mental Health and Well-being database, which included 10,641 adults from 18 years to well into later life. Total rates for adults aged over 65 were 1.2% compared to the overall population-weighted average of 3.2. Consistent with other data, female rates were higher in every age period. The findings held true whether DSMIV or ICD10 criteria were used. This will re-open the debate as to whether depression becomes less prevalent in later life and especially the appropriateness of DSM and ICD to detect it among older people. However, the authors also examined correlates for depression and found that smoking and having a medical condition, especially heart disease or asthma, were significant. Direction of causality cannot be ascertained but these findings are important in the light of current interest in vascular depression.

Guidelines for depression

Guidelines have a mixed record in terms of their ability to influence practice. The UK Faculty of Old Age Psychiatry of the Royal College of Psychiatrists has attempted to bring together in one document evidence on which to base the treatment of late-life depression in primary care (Baldwin et al *Int J Geriatr Psychiatry* 2003; 18:829-838). The good news is that there is reasonable quality evidence to support the use both of antidepressants and psychological therapies in acute and continuation therapy but less encouragingly, there is little specific evidence of efficacy in primary care as opposed to specialist care settings. There are obvious gaps in the literature, such as how to classify and manage 'minor' depressions and what to do with patients who do not get better with first line medication management. Regarding the latter, the authors point out that augmentation treatment should now include an option to prescribe a psychological therapy and not only antidepressants or mood stabilizers. Of course the difficulty is that psychological treatments are often either not available or only available after unacceptable waits. Some policy action is needed.

Drugs...

Knowing how best to target antidepressants does not mean we can be sure who takes them. According to the Medical Expenditure Survey (MEPS) sponsored by the Agency for Healthcare Research and Quality (AHRQ) 6 million community dwelling older people were being prescribed antidepressants in 1996 (Aparasu et al *J Am Geri Soc* 2003; 51:671-677). This amounted to about 1 in 5 of the older population. Antidepressants, the most commonly prescribed psychotropic, were

given to 9.1% and anxiolytics to 7.5%. The latter is a lower figure than earlier surveys, suggesting a decline in use. Tricyclics were marginally more prescribed than SSRIs although practice will have moved on in the intervening 7 years. Predictors of usage seemed largely to be non-clinical-race, geography, educational status, access to health insurance. Self-perceived health status and reduction in instrumental activities of daily living were strongly associated with psychotropic use. Gender and marital status findings were quite striking. Elderly women were one and a half times more likely to use antidepressants compared to men; and, elderly patients who were married were four times more likely to take antidepressants than those who were unmarried. But becoming a hermit does not help- elderly patients who lived alone were three times more likely to be on antidepressants compared to those who did not live alone.

...and psychotherapy?

If psychological therapies are to gain ground in the management of late-life mood disorder, more people need to be trained to deliver them. Acknowledging the legacy of pessimism toward psychotherapy, Lee and colleagues (2003; 7: 133-141) sent a questionnaire to psychology trainees in the UK and received responses from a little over a third. There were positive attitudes to working with older people and respondents thought the tools of their trade were applicable to older adults, although with some modification. It seems that negativity about working with older people psychologically may be on the wane but of course those who did not return the questionnaire may be the sceptics.

Events Calendar

Wai-chi Chan

6-8 Sept 2004 (tentative) Seoul, Korea	HKPGA Study Visit to Korea <i>cum</i> 2nd KAGP-HKPGA Joint Scientific Meeting	Contact: Email: hkpga@hongkong.com <i>Details will be announced shortly</i>
8-11 Sept 2004 Seoul, Korea	IPA Asia Pacific Regional Meeting <i>Conference Theme: "Mental Health of the Elderly in Rapidly Aging Societies"</i>	Contact: Email: info@ipa-online.org Web: http://www.ipa-online.org
28-31 Oct 2004 Hong Kong	XI Scientific Meeting of the Pacific Rim College of Psychiatrists <i>Conference Theme: "Innovation & Development in Mental Health in the Pacific Rim"</i>	Contact: Email: PRCP@mphk.com Web: http://www.prcp.org



Editorial Committee Members:

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

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