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SOUTH AFRICAN PSYCHIATRY

ISSN 2409-5699

ABOUT the discipline FOR the discipline

issue 28 • AUGUST 2021

**COMBATING
COMPASSION
FATIGUE**

**TRANSCRANIAL
MAGNETIC
STIMULATION**
WHERE ARE WE NOW?

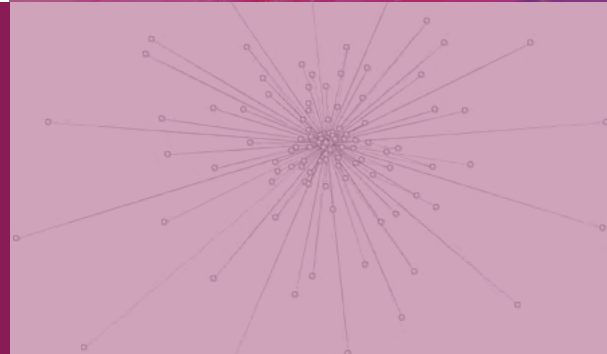
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THRIVING? **BUILDING
YOUR RESILIENCE**

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COVID-19 INFECTION
PREVENTION AND
CONTROL STRATEGIES



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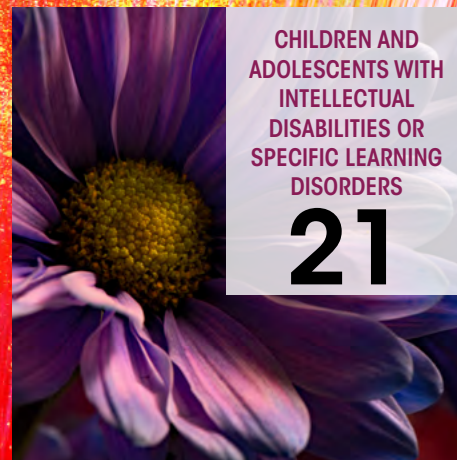
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Dear Reader,

welcome to the late winter, August 2021 issue of *South African Psychiatry*. It has been quite a winter, with spells of freezing weather, an insurrection (depending on which Minister you listened to, and when), as well as the arrival and seeming departure of the third wave (we all know what I'm referring to) which I had mentioned as emerging in the May 2021 issue. In some ways experiencing a real winter, whilst not always pleasant, can be reassuring insofar as the weather is doing what it is supposed to do, when it is supposed to do it. At least nature is behaving, although the climate change activists might point to the extreme heat in Canada and recent floods in Germany and claim differently. The insurrection that devastated parts of the country was a major challenge to our democracy, but it seems we managed to come through what could have been a tipping point for the country's prospects given the havoc that the pandemic has wrought on so many lives, both physically and economically – not to mention psychologically. However, to assume the relative calm signals resolution of underlying issues would be unwise. I recall noting in the May 2020 issue in a piece I wrote entitled ***Eating, or starving, in a time of COVID 19 – consequence of the lock down*** how the pandemic had exposed economic inequality in ways that must compel politicians to address such inequality – and yet there was more corruption and maladministration related to personal protective equipment as one example. Will the Zondo Commission ever get to the bottom of it all? In the wake of everything else happening – the Commission rolls on, with revelations that continue to astound, albeit not necessarily surprise. Of course, a review of current events would be incomplete without adding one more issue that came to the fore once again, with direct implications for mental health professionals– the Life Esidimeni inquest. After two days of testimony it was postponed. One remains hopeful that justice will ultimately prevail. And so dear readers, whilst there is more I could add to this piece maybe it is sufficient to reflect that these are times requiring fortitude and resilience.



In the current issue I am pleased to see a recent MMed graduate convert their dissertation into a *Feature* article (together with her supervisor; Nkhahle & Alison). It would be great to see others follow. We are also very pleased to carry content related to a recent conference (Addiction 2021) as well as content related to imminent ones (1st Marcé Africa Maternal Mental Health (M.A.M.A) Virtual Conference, 2nd Southern Africa Multidisciplinary ADHD Congress and the SASOP 2021 Congress). In addition there are several articles in the current issue that speak to a key component of the aforementioned *fortitude and resilience* – adaptation. How one adapts. As caregivers we bear the responsibility of providing care to others, whilst in the midst of having to deal with certain of the very same issues that impact on our patients. We need to be calm in the face of threat, optimistic in the face of disappointment. It's challenging, there is no other way to understand it. In a sense, whatever one's religious affiliation might be or whether one is agnostic or atheist – faith and hope are important to maintain. I hope you are all doing so.

Take care, and stay safe.

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Acknowledgement: *Thanks to Lisa Selwood for assistance with proof reading*

Advertising: The Source Public Relations, Pharmapreneurs

Design and Layout: Rigel Andreoli

Web: www.southafricanpsychiatry.co.za

Contact Person: Vanessa Beyers - vanessa@thesourcepr.co.za

South African Psychiatry is published quarterly by The Source Public Relations Group.

Its mission is to communicate the latest news and developments in the area of South African Psychiatry.

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DR BILLY MARIVATE

His life continues to inspire

*Dr. Billy
Marivate
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Zwavelstream clinic invites you to join us for
a memorial service to be held at,

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Adress: Midaslaan 15A, Olympus, PTA
09 June 2021 from 13:00 to 15:00

Please RSVP (08 June) via Whatsapp-
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Attendance Restricted to 100 people.



Dear Members and Friends, it is with great sadness that I inform you of Dr Billy Marivate's passing last night (2021/06/03).

Billy together with his wife Anne-Gloria was a very committed member in our congregation and served as one of our pianists in our congregation for many years. Apart from being a Doctor, Billy had exceptional musical skills and we were fortunate that he kindly and graciously shared these with the congregation over the years.

We know Billy has gone to be home with his Maker where he will continue to make music.

Please uphold his family in your prayers. May God's infinite love and healing be with his family and friends during this time of bereavement. The Lord walks beside us even in our darkest times.

He will be missed by many. Go well, brother, another good and faithful servant!

Ryan Johnson ■



DEPARTMENT OF PSYCHIATRY - 32ND ANNUAL RESEARCH DAY 23RD JUNE 2021

Michelle Hungwe

*Research Day Committee: Dr M. Hungwe (Chair), Dr C. Harlies, Dr M. Nemavhola,
Dr S. Reddy, Dr A. Taylor; Advisor: Dr B Marais*

On the 23rd of June 2021 the Wits Department of Psychiatry held its 32nd Annual Research Day, an event that showcases the research achievements of consultants, registrars and allied professionals in the department. This year was unique in that the event was held on an online platform because of the ongoing COVID-19 pandemic. This year was also the first Research Day to be held since the passing of Prof Bernard Janse Van Rensburg who had dedicated much of his life to developing a culture of research excellence in the Department of Psychiatry. Prof Janse Van Rensburg was a visionary and a great inspiration to many generations of WITS graduates and his influence was evident in the research presented this year.

We had the honor of hosting Prof. Soraya Seedat as our keynote speaker. As Executive Head of the Department of Psychiatry at Stellenbosch University, holder of the South African Research Chair in Posttraumatic Stress Disorder and Head of the South African Medical Research Council Unit on the Genomics of Brain Disorders and Global Mental Health, Prof Seedat was at home with our other guests. We were fortunate to have as guests and judges, a highly accomplished panel comprising of Prof Elena Libhaber, Prof Rita Thom and Prof Christopher Szabo.

Prof Seedat started off the day with an impressive and pertinent presentation on COVID-19 and

mental health outcomes and the PHD presenters then enthralled the audience with Dr Samantha Naidoo presenting on *An HIV narrative of female inmates with a lifetime history of mental illness* and Amanda edge with a presentation on *How women come to commit neonaticide: A Constructivist Grounded Theory of criminal cases*. The registrars presentations did not disappoint with several presenting work that they had already published and all presenting work that was both interesting and relevant to the practice of psychiatry today. Below is a list of the presenters and their topics.

DR KELE PITSOANE WALKED AWAY AS THE WINNER OF THE DAY AFTER PRESENTING ON THE TEST-RETEST RELIABILITY OF THE OPIOID TREATMENT INDEX IN NYAOPE USERS IN JOHANNESBURG, SOUTH AFRICA AND SPARKING A LIVELY ACADEMIC DISCUSSION FUELED BY THE QUESTIONS POSED BY INTRIGUED AUDIENCE MEMBERS. SHE WON A GENEROUS PRIZE SPONSORED BY SASOP SOUTHERN GAUTENG SUBGROUP.

The day was overall a success and special mention must be made of Prof Ugasvaree Subramaney and Dr Belinda Marais who not only guided and encouraged

the research committee in preparing for the day but also inspired the presenters with their consistent enthusiasm and dedication to research in Psychiatry. Psychiatry is a field filled with potential for research and to be truly passionate about psychiatry, one must be dedicated to excellence in research. This year's Research day served not only to honour those who have worked hard in the realm of research but to also encourage those who are yet to delve into research to aspire to greater heights.

RESEARCH IS TO SEE WHAT EVERYBODY ELSE HAS SEEN AND THINK WHAT NOBODY HAS THOUGHT – ALBERT SZENT GYORGI

Thank you to the research day committee and our generous sponsors:



KEYNOTE SPEAKER:

PROF SORAYA SEEDAT



Mental Health Outcomes of COVID-19 and Resilience: Moving beyond the volume of data to best practice approaches

This presentation, against the background of global data on rapidly emerging longitudinal evidence of the mental health outcomes of COVID-19, including traumatic stress-related outcomes, will highlight recent data from high- and low- and middle-income countries. The voluminous data, and the rapidity with which they have emerged, has made it difficult for researchers, clinicians, policy makers and the media to distinguish 'signal' from 'noise'.

IN RESOURCE CONSTRAINED SETTINGS, WHERE ACCESS TO AND COVERAGE OF PSYCHOSOCIAL INTERVENTIONS WAS POOR PRE-PANDEMIC, EFFECTIVE IMPLEMENTATION OF INTERVENTIONS TO MITIGATE THE ADVERSE MENTAL HEALTH SEQUELAE IN THE GENERAL POPULATION AND IN HEALTH CARE WORKERS HAS BEEN A PARTICULAR CHALLENGE DURING THE PANDEMIC.

Experiences of setting up a resiliency clinic for frontline workers in a LMIC against the backdrop of low mental health literacy levels and high mental health stigma will be discussed. Lessons leveraged from both high- and low- and middle- income countries can be complementary in informing best practice and in tailoring interventions to different contexts.

Soraya Seedat is a Distinguished Professor of Psychiatry and Executive Head of the Department of Psychiatry at Stellenbosch University
Correspondence: sseedat@sun.ac.za

PRESENTATIONS:



DR SAMANTHA NAIDOO

An HIV narrative of female inmates with a lifetime history of mental illness.

INTRODUCTION: South Africa has the highest prevalence of Human Immuno-deficiency Virus (HIV), with women carrying a larger burden of the disease. However there

remains a paucity of literature describing the lived experiences of HIV among females, particularly inmates. This study explored these experiences and its impact among female inmates with a lifetime history of mental illness in a culturally relevant context in Durban, KwaZulu-Natal, South Africa.

METHOD: This study formed part of a larger two-phased, mixed-methods study. Fourteen female inmates with a lifetime history of mental illness and trauma and who were from culturally diverse backgrounds were purposively selected to participate in individual, in-depth, semi-structured interviews. The sample interviewed included both HIV infected and uninfected women.

RESULTS: Thematic analysis was used to analyse the data. Themes related to contracting HIV included intimate partner betrayal, gender differences regarding sexual behaviour, fear associated with HIV and the importance of pre- and post-test counselling. Themes related to living with HIV involved the challenges women experienced in their home community which contrasted with their experience of living with HIV in the prison community which was perceived as supportive. Eventual acceptance of their HIV diagnosis was also highlighted.

CONCLUSION: This study highlights the cultural contribution to the experiences of contracting and living with HIV in female inmates. It also emphasises that incarceration may serve as an opportunity to educate, train, support and manage HIV in this marginalised population thereby curbing the epidemic. Further research should aim at exploring such strategies. The study also underscores the importance of the continued need for HIV

education in order to eradicate the stigma and discrimination which are still prevalent in SA.



MS AMANDA EDGE

How women come to commit neonaticide: A Constructivist Grounded Theory of criminal cases.

BACKGROUND: Maternal neonaticide, the act of a mother taking the life of her newborn, is a complex human phenomenon. Limited literature exists on the conceptual and emotional processes as well as actions that underpin the act. This negatively impacts on the establishment of prevention and rehabilitation programmes from a mental health perspective.

METHODS: The substantive theory explains how women come to commit neonaticide. The underpinning processes are revealed via a comparison of the women's thoughts, emotions and actions of their neonaticidal pregnancies (NP) and non-neonaticidal pregnancies (N-NP). The theory was constructed via constructivist grounded theory (CGT) methods. Data was collected through iterative interviewing (28 interviews) of eight participants from three correctional centres across South Africa. Participants were all incarcerated for murder. All women had also experienced one or more pregnancy where they did not take the life of their newborn.

RESULTS: Data analysis rendered the construction of one core category, namely, docile gestating. Four major conceptual categories were also constructed, including, a) The vicarious mother; b) Vicarious accessing; c) Contexts of security; and d) Degree of engaging with its associated concepts of vicarious actions, misrepresenting actions and phantomsing actions.

CONCLUSION: The theory reveals how the constructed concepts interact over time in accordance to the NP and N-NPs.

IT SHOWS HOW THE WOMEN NEED TO ENGAGE IN THE PREGNANCY EXPERIENCE VIA CLOSE RELIANCE ON ANOTHER (NON-NEONATICIDE). IN THE ABSENCE OF SUCH SUPPORT, THE WOMEN MAY REFRAIN FROM ENGAGING IN THE PREGNANCY PROCESS AND, ULTIMATELY, ACT TOWARD A NEWBORN THAT NEVER FULLY EXISTED IN THEIR EXPERIENCE AND MIND (NEONATICIDE).

The theory offers insights on the various facets that should be addressed in the establishment of prevention and rehabilitation programmes



DR STACEY-LEIGH LINTNAAR

Comparison of co-morbid psychiatric diagnoses in male adolescent in-patients with a history of cannabis use with those without cannabis use.

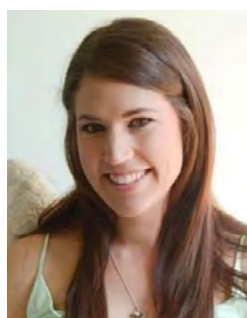
BACKGROUND: Globally, cannabis is one of the most commonly used substances and it is perceived to be harmless. Research confirms that the onset of cannabis use before the age of 16 may predispose the individual to a range of severe psychiatric illnesses.

OBJECTIVE: The aim of this study was to determine the prevalence of cannabis use disorder, to describe the local demographic profile of the participants and to examine the co-morbid psychiatric diagnoses in adolescents admitted to a psychiatric unit.

METHODS: This was a retrospective record review of male adolescents aged 13 to 18 years admitted as in-patients to the psychiatric ward at the Chris Hani Baragwanath Academic Hospital.

RESULTS: The study sample comprised of 51 male adolescents admitted to the adolescent psychiatric ward at the Chris Hani Baragwanath Academic Hospital during an 18-month period. The majority, 84%, were diagnosed on admission with cannabis use disorder and the remaining 16% were not diagnosed with cannabis use disorder. In the cannabis use disorder group (n = 43) the mean level of education was grade 9 and the mean age was 16 years. There was an association found between cannabis use disorder and substance induced psychotic disorder.

CONCLUSION: The most common diagnosis recorded in this study was substance induced psychotic disorder. The findings highlight the need for more integrated services, such as a dual diagnosis treatment programme, targeted particularly at psychiatrically vulnerable adolescents.



DR ASHLEIGH PRIOR

Construct validity of the Brief Psychiatric Rating Scale - Expanded Version in a South African community psychiatry setting using Rasch Model Analysis.

INTRODUCTION: In mental health care monitoring of psychiatric symptoms and signs is needed to assess treatment response. The Brief Psychiatric Rating Scale Expanded version (BPRS-E) is a clinician administered scale widely used as an outcome measure in psychiatric research and clinical settings. However, the construct validity has not

been tested in a South African community setting. The BPRS-E is a 24-item objective measure which rates severity of psychopathology on a 7-point Likert scale. Rasch model analysis is a statistical tool that measures construct validity by assessing conformity with modelled expectations.

METHOD: A retrospective record review was conducted at three community psychiatric clinics in the Sedibeng District. Clinical records of patients 18 years and older with completed BPRS-Es were selected by purposive sampling and construct validity was investigated using the Rasch model.

RESULTS: 192 records were reviewed. The age range was 18 to 79 years; with approximately equal male to female representation. Total BPRS-E scores ranged from 24 to 93; just over half (52%, n=100) had total BPRS-E scores of 40 or less. Rasch analysis found the 24 BPRS-E items clustered as expected and correlated correctly. However, analysis of the severity scoring categories revealed excessive disorganisation of the threshold curves and inconsistent differential item functioning.

CONCLUSION: Rasch model analysis findings of good item fit and unidimensionality supports construct validity of the BPRS-E items in a South African community psychiatric setting. The scoring of severity using the BPRS-E anchor points in this setting requires further investigation.

The prevalence of each MBI-HSS subscale was compared to normative data. 68 percent scored high in one or more subscales. Significant factors associated with burnout included poor work and non-professional life balance (p=0.017), utilising annual leave days for work-related tasks (p<0.001), irregular holidays (p=0.003) and financial debt (p=0.026). A possible protective factor was an amicable relationship with fellow psychiatric registrars.

CONCLUSION: There is evidence of some degree of burnout in more than two-thirds of participants. Associated factors lie largely at an organisational level, and while optimising individual resilience is important, systemic support plays a key role.



DR ANNETTE ANTWI-ANYIMADU

The demographic profile and referral of preschoolers with attention deficit/hyperactivity disorder (ADHD) attending a child, adolescent and family psychiatric unit.

INTRODUCTION: Attention deficit/hyperactivity disorder (ADHD) is one of the most frequently investigated childhood psychiatric illnesses, but data on the condition in Africa is generally lacking, particularly in the under-six age group. The aim of this study was to investigate the socio-demographic profile and referral patterns for preschool children attending a psychiatric clinic in Soweto, Johannesburg.

METHODS: A retrospective descriptive review was conducted to analyse data abstracted from files of under six-year-old children with a diagnosis of ADHD who attended Chris Hani Baragwanath Academic Hospital's (CHBAH) Child, Adolescent and Family Unit's (CAFU) 'Under-six ADHD Clinic' from 1 January 2017 to 31 December 2017. Abstracted data included information on socio-demographics, referral sources and reasons for referral.

RESULTS: A total of 152 files meeting the inclusion criteria for the study were reviewed. There were significantly more males (n=117, 77%) than females. The majority (n=116, 76%) attended preschool, and more than half (n=78, 51%) hailed from dual parent homes. For most preschoolers with ADHD, household income was derived from a single source (n=65, 43%). Health professionals referred 53% (n=81) of the participants. The main reasons for referral were hyperactivity (n=65, 43%), followed by behavioural problems (n=22, 14%), and developmental delay (n=15, 10%).

ALLIED HEALTH PROFESSIONALS REFERRED A SIGNIFICANTLY GREATER NUMBER OF PRESCHOOLERS WITH DEVELOPMENTAL DELAY (N=9), COMPARED TO HEALTH PROFESSIONALS WHO REFERRED MAINLY FOR HYPERACTIVITY (N=44).



DR TEJL MORAR

Exploring burnout among psychiatric trainees at a South African University.

INTRODUCTION: The mental health of doctors is increasingly topical, internationally and locally. Of importance is the phenomenon of burnout, a far-reaching repercussion of chronic work-related stress. Psychiatrists are more vulnerable to stress, burnout and suicide in comparison to other medical specialities. There is a void in published research relating to South African psychiatric trainees. The aim of the study was to investigate burnout and associated factors among psychiatric registrars in the Department of Psychiatry at the University of the Witwatersrand (WITS).

METHODS: A cross-sectional study, via an anonymous self-administered questionnaire. The questionnaire comprised three sections: demographics, the Maslach Burnout Inventory Human Services Survey (MBI-HSS) and questions relating to contributing factors, protective factors and consequences of burnout. The MBI-HSS is recognised as the leading measure of burnout, consisting of three subscales: emotional exhaustion, depersonalisation and personal accomplishment.

RESULTS: The questionnaire was completed by 33 out of 58 psychiatric registrars (57% response rate).

CONCLUSION: Most of the findings of this study correlated with other studies conducted worldwide. Screening for ADHD at the preschool age is imperative, as early intervention is likely to interrupt the trajectory of the illness, which ultimately results in a high cost to the economy. Interventions such as the specific support programme for Grade R teachers on ADHD recently developed in South Africa (SA) for this very indication should be further explored and expanded to different appropriate settings in creating awareness of ADHD.



DR THATO KALANE

The neurocognitive profile of HIV positive adults attending Lufuno Neuropsychiatric clinic as measured by the BNCE.

BACKGROUND: Sub-Saharan Africa is home to the largest population of individuals infected with the Human Immunodeficiency Virus (HIV). Therefore, there is a high number of individuals who are at risk of developing HIV Associated Neurocognitive Disorder (HAND) and HIV Associated Dementia (HAD).

THIS HIGH NUMBER MAKES THE NEED FOR NEUROPSYCHOLOGICAL SCREENING IN PUBLIC HEALTHCARE VITAL. SOUTH AFRICAN CLINICIANS ARE CHALLENGED BY FEW NEUROPSYCHOLOGICAL TESTS THAT ARE AVAILABLE TO SCREEN FOR HAND AND HAD, AS NOT ALL SCREENING TESTS CAN BE USED ON ALL POPULATIONS AND CULTURES, AND FOR ALL BUDGETS AND CLINICAL PRACTICES.

Furthermore, South Africa is predominantly populated with Clade C HIV which has a specific neurocognitive profile.

AIM: Consequently, the aim of this study was to explore the neurocognitive profile of HIV infected adults attending the Lufuno Neuropsychiatric Clinic at Tara H. Moross Hospital as measured by the Brief Neuropsychological Cognitive Examination (BNCE) as an alternative screening tool for HAND and HAD.

METHODS: The results were then compared to the neurocognitive profiles of the Montreal Cognitive Assessment (MoCA) and International HIV Dementia Scale (IHDS) as they are currently the most widely used screening tools for HAND and HAD in South Africa. Demographic data were also included to determine whether they had an impact on the patients' neurocognitive screening test outcomes. All statistical analyses were conducted using R software. All tests were two-tailed, and statistical significance was accepted when alpha was smaller than or equal to 0.05.

RESULTS: When screening for HAND using the BNCE, the results showed that more individuals scored significantly low for Constructive Praxis, Shifting Set, Incomplete Pictures, Similarities, Attention, and Working Memory. For the MoCA, individuals scored significantly low on Visuospatial, Abstraction, and Delayed Recall subtests; while Attention, Language, Orientation, and Naming were relatively intact. For the IHDS, significantly more patients scored low for Psychomotor Speed, and Memory Recall, while Motor Speed was relatively intact. Comparing the BNCE and the MoCA showed similar results in the same cognitive domains except for Attention, which was not significant in the MoCA. Comparing the IHDS was difficult as it only has 3 subtests and is largely biased towards Memory and Motor Speed, nevertheless for total scores, it was in keeping with the BNCE and the MoCA.

CONCLUSION: The results showed that the BNCE was an adequate screen for HAND when compared to the MoCA and IHDS as the degree of impairment was equally measured across all three tests. With regards to demographics, all the participants were adults infected with HIV, with more of the sample being middle-aged individuals, the majority were black, female and had a higher education.

MORE WERE EMPLOYED, DID NOT HAVE A SUBSTANCE HISTORY, DID NOT HAVE CO-MORBIDITIES, AND HAD BEEN ON ANTIRETROVIRAL DRUGS (ARVS) FOR ONLY A SHORT PERIOD OF TIME. FEMALES HAD POORER BNCE SCORES WHILE PARTICIPANTS WITH A MATRICULATION HAD BETTER BNCE SCORES. DURATION OF TREATMENT AND CD4 COUNT DID NOT IMPACT THE OUTCOME OF BNCE SCORES.



DR BIANCA HART

A retrospective review of psychiatric admissions of females of childbearing age to a Gauteng hospital, comparing those in the peripartum period to the general population.

INTRODUCTION: Pregnancy and the peripartum period can be challenging, especially for women who have or are susceptible to mental illness. Mental illness in the peripartum period impacts on the mother and the family as a whole. There is a paucity of data from South Africa regarding inpatient admissions of women during the peripartum period. The aim of this study is to compare peripartum with non-pregnant female psychiatric inpatients at Chris Hani Baragwanath Academic Hospital.

METHODS: A retrospective record review of patient

admissions to the female psychiatric wards in 2017. Patients within the reproductive age group (15-49 years) were included in the study.

RESULTS: Within the peripartum sub-group 46.2% had a diagnosis of bipolar and related disorders, while only 11.5% were diagnosed with a depressive disorder. For the overall study cohort, bipolar and related disorders were shown to be the most frequently diagnosed psychiatric disorder (41.4%), followed by psychotic disorders (30.1%), substance-related disorders (21.8%) and depressive disorders (14.4%).

WOMEN IN THE PERIPARTUM PERIOD DID NOT DIFFER FROM THE GENERAL ADMISSIONS BASED ON DIAGNOSIS OR LENGTH OF STAY BUT WERE PRESCRIBED LESS OF THE MOOD STABILISER CLASS OF MEDICATION AND WERE YOUNGER IN AGE.

CONCLUSION: The findings of this study described the common presentation of inpatient female admissions. The most common presentation for women both in the peripartum period and the general population was bipolar disorder. This is considered a severe mental illness and has long-term considerations for both the mother and child. Specialised services should be considered for this high-risk group.



DR FELICITY MARCUS

An assessment of voting knowledge and related decisions amongst hospitalised mental health care users in South Africa.

BACKGROUND: The South African Constitution protects the right to vote for every citizen. The Electoral Act (No. 73 of 1998) limits registration on the voter's roll on the basis of being declared of 'unsound mind' or 'mentally disordered' by the high court or detention under the Mental Health Care Act (No. 17 of 2002). There is limited information regarding voting knowledge and subsequent voting-related decisions amongst South African involuntary mental healthcare users (MHCUs).

AIM: To compare voting knowledge and related decisions between hospitalised MHCUs and non-psychiatric hospitalised patients (controls).

SETTING: Participants were recruited from Sterkfontein Psychiatric Hospital (MHCUs) and Chris Hani Baragwanath Academic Hospital orthopaedic wards (controls) in Gauteng, South Africa.

METHOD: A cross-sectional survey was conducted using a modified Cognitive Assessment Tool for Voting (MCAT-V) questionnaire. Scores on the

MCAT-V were compared between the MHCU and control groups, along with socio-demographic variables and clinical variables.

RESULTS: There was a significant association between group (MHCU vs. control) and HLOE ($p = 0.016$). Although the median overall score for the controls (11; interquartile range [IQR] 10-12) was significantly higher than that for the MHCUs (10; IQR 8-12) ($p = 0.043$), when controlling for education level, there was no significant association between group (MHCU/control) and MCAT-V scores ($p = 0.011$). The MCAT-V scores of the 'Doe questions' between the MHCUs and controls were not significantly different ($p = 0.063$).

THERE WAS A DIFFERENCE IN 'REASONING SCORES' BETWEEN MHCUS AND CONTROLS ($P = 0.0082$) AND THIS WAS ASSOCIATED WITH LEVEL OF EDUCATIONAL ATTAINMENT ($P = 0.013$).

CONCLUSION: The limitations regarding voter registration legislated in the South African Electoral Act, are not supported by the findings of this study. The MCAT-V demonstrates a possible educational bias and therefore is not recommended as a screening tool for assessing voting competency.



DR LIESEL ALDRICH

Screen time use patterns and health trends in children attending a children's psychiatric outpatient department.

BACKGROUND: Screen time use can be defined as time spent on electronic devices. Guidelines recommend screen time use of < two hours/day in school-going children. Increased screen time usage has been associated with physical and mental health conditions amongst children and adolescents.

AIM: To describe screen time use patterns as well as associated family socialisation, sleep and eating patterns, and body mass index (BMI) and psychiatric conditions in a group of children attending the Tara Children's Outpatient Department, Johannesburg.

METHODS: A convenience sample of 71 families with children and adolescents aged five to seventeen were recruited over a nine-month period. A questionnaire was completed by the caregiver, and the psychiatric diagnosis was obtained from records. Body mass index (BMI) measurements were also recorded.

RESULTS: All respondents had access to a device with a screen, most commonly smartphones ($n=45$, 69.0%). Most of the sample used > two hours of screen time/day (weekdays $n=37$, 52.1%, weekends $n=62$, 87.3%), with 73.2% of caregivers reporting restrictions on screen time. There was a significant

association between screen time use of > two hours/day and increased BMI ($p < 0.001$). Those using > two hours/day were also significantly older than those using \leq two hours/day (mean yrs \pm SD 11.8 ± 3.4 vs 9.5 ± 2.9 ; $p = 0.003$).

CONCLUSION: Although most caregivers in this study reported screen time restrictions, most respondents reported use of more than the recommended two hours of screen time per day.

THE ASSOCIATION BETWEEN INCREASED BMI AND INCREASED LEVELS OF SCREEN TIME USE SUGGEST A NEGATIVE IMPACT ON PHYSICAL WELL-BEING. INCREASED USE ASSOCIATED WITH INCREASED AGE SUGGESTS THAT SCREEN TIME USE GUIDELINES SHOULD BE REINFORCED FOR ADOLESCENTS.



DR KELEBOGILE PITSOANE

The test-retest reliability of the Opioid Treatment Index in nyaope users in Johannesburg, South Africa.

BACKGROUND: The Opioid Treatment Index (OTI), a tool developed in Australia and employed in several high,

middle and low-income countries to assess heroin treatment outcomes could be used in South African samples. However, we know little of its test-retest reliability or consistency when measuring the same variable at different points in time.

AIM: This study aimed to assess the test-retest reliability of the OTI in a South African sample.

SETTING: 53 participants were recruited from substance abuse rehabilitation centres in Gauteng.

METHODS: The OTI was administered at baseline and at one week follow up to all 53 nyaope users. The intra-class correlation coefficients (ICC) of the Q-scores from the two data sets of the interviews were calculated. Additional analysis was conducted on the substance use domains using the Brennan-Prediger coefficient.

RESULTS: The ICC for tobacco was 0.91, crack-cocaine - 0.65, nyaope - 0.38, cannabis - 0.42, alcohol- 0.28. Injecting and sexual behaviour had an ICC of 0.94, social functioning, crime and health had ICCs of 0.71, 0.61 and 0.62 respectively. The Brennan-Prediger coefficients for use vs abstinence were: alcohol - 0.96, crack-cocaine - 0.89, cannabis - 0.92, alcohol- 0.66.

CONCLUSION: The test-retest reliability of the Q-scores for the frequency of drug use, in the past month, may have limited reliability in nyaope users. We found excellent test-retest reliability of

the injecting and sexual behaviour domains and moderate reliability of the criminality, general health and social functioning domains. The results of this study provide insight for the reliability of this tool and for its use in future studies in the South African context.



DR JADE BOUWER

Procurement and expenditure of medicines used for mental, neurological and substance use disorders: A secondary analysis of the 2017/2018 Gauteng pharmaceutical database.

BACKGROUND: Access to essential medicines is necessary for an effective, efficient, and equitable health care system. Analysis of the procurement of and expenditure on medicines may assist in the planning of sustainable access.

THE PROCUREMENT OF MEDICINES FOR MENTAL, NEUROLOGICAL, AND SUBSTANCE USE (MNS) DISORDERS IN SOUTH AFRICA HAS TO DATE RECEIVED LITTLE RESEARCH ATTENTION.

AIM: To examine the procurement of and expenditure on medicines used to treat MNS disorders in Gauteng province for the 2017/2018 financial year.

METHOD: A secondary analysis of the Gauteng provincial pharmaceutical database was undertaken. Defined daily doses (DDD) and cost per 1000 population served were calculated to compare procurement across service levels and facilities.

RESULTS: MNS medicines accounted for 3.73% of total provincial medicine expenditure. More than three-quarters of this amount was spent on anti-epileptic medicines (47.5%) and antipsychotics (30.9%). Over 90% of the total DDD issued were issued at general healthcare clinics and hospitals. Chi square contingency testing revealed significant differences in procurement among facilities at each service level.

CONCLUSION: Medicine for the treatment of MNS disorders, primarily epilepsy, psychosis, and bipolar disorder, accounted for less than 4% of total medicine expenditure. Inconsistency in procurement between sites suggests differences in patient populations and treatment approaches. Future studies using patient-linked data are recommended to evaluate medicine utilisation according to treatment outcomes

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TRANSCRANIAL MAGNETIC STIMULATION WHERE ARE WE NOW?

Renata Schoeman, Marcelle Statsny

Transcranial Magnetic Stimulation (TMS) is a non-invasive neurostimulatory and neuromodulatory technique increasingly used in clinical and research practices around the world. It works on Faraday's principle of electromagnetic induction—the process by which electrical energy is converted into magnetic fields. D'Arsonval, as early as 1896, reported that placing one's head inside a powerful magnetic coil could produce phosphenes, vertigo, and even syncope.¹ The first written account of the application of this "TMS" for a neuropsychiatric condition, was by Adrian Pollacksek and Berthold Beer in 1902.² They described the use of an electromagnetic coil, placed over the skull, to pass vibrations into the skull and treat depression and neuroses.

The modern age of TMS started in 1985 with Barker and colleagues.³ The initial TMS devices had difficulties. They were slow to recharge, and the coils would overheat with constant use. Since then, TMS-related research has exploded.

INITIAL STUDIES INVESTIGATING THE CAPACITY OF TMS TO MODIFY MOOD WERE CONDUCTED IN THE EARLY TO MID-1990S. THESE TRIALS WERE OF SINGLE PULSES, OVER SHORT DURATIONS, WITH MIXED BUT PROMISING RESULTS.

The mechanism of action of TMS depends on the creation of a transmembrane potential or nerve depolarisation voltage. If sufficient, this voltage can cause membrane depolarization and initiate an action potential, which then propagates along a nerve like any other action potential. Furthermore, a spatial derivative of the electric field along the nerve (i.e. the change of the electrical field along

the axon) is required which causes stimulation. This stimulation can also occur where an axon bends across the field. Finally, there is evidence that the polarity of the current in the coil can also influence stimulation threshold.⁴ It is known that repeated rTMS stimulation, over the course of weeks, **increases nerve activity** in the area under the coil. It also changes the **strength of connections** between different areas of the brain. The lasting effects on cerebral function can result in an improvement of clinical symptoms, like depression. rTMS is generally regarded as safe and (virtually) without lasting side effects. Isolated reports of transient headaches and hearing loss have occurred, as well as isolated reports of seizures – most of which occurred with combinations of stimulation parameter settings outside of the published guidelines.⁴

HOWEVER, NO SIGNIFICANT (LASTING) COGNITIVE NEUROLOGICAL OR CARDIOVASCULAR ADVERSE SEQUELAE HAVE BEEN REPORTED OF.^{5,6,7}

One of the first proof-of-principle TMS studies specifically focused on a therapeutic application of repetitive TMS in a neuropsychiatric disease was published by Kolbinger et al, who examined the effects of rTMS on 15 patients suffering from drug-resistant depression.⁸ Of the 10 patients receiving non-sham stimulation, all showed significant



Renata Schoeman



Marcelle Statsny

improvement. Initially fraught with safety and ethical concerns (e.g. offering the treatment off-label to patients who have exhausted all other avenues), numerous successful proof-of-principle trials affirmed potential benefits and by 2003 many clinics offered off-label treatment.^{9,10}

Two milestones were reached in 2008: the first consensus conference with the publication of guidelines for the use of TMS¹¹, as well as FDA approval of the NeuroStar TMS device (manufactured by Neuronetics Inc) for the protocol of stimulation employed in the study (high frequency, 10 Hz TMS applied daily for 4 to 6 weeks at suprathreshold intensity) within a highly specific subpopulation of patients (adults who have failed to achieve satisfactory improvement from one, but no more than one, adequate antidepressant medication trial).¹²

CLINICAL APPLICATIONS

A pivotal trial in the history of TMS was published by O'Reardon et al in 2007.¹³ This trial was the first double-blind randomised, sham-controlled multisite study that used rTMS in the treatment of treatment resistant depression. The study included 301 medication-free patients with major depression who had not benefited from prior treatment who were randomized to either active (n = 155) or sham TMS (n = 146) conditions. Sessions were conducted five times per week with TMS at 10 pulses/sec, 120% of motor threshold, 3000 pulses/session, for 4 - 6 weeks. The study found active TMS significantly superior to sham TMS as measured by the MADRS at week 4 (with a post hoc correction for inequality in symptom severity between groups at baseline), as well as on the HAMD17 and HAMD24 scales at weeks 4 and 6. Response rates were significantly higher with active TMS on all three scales at weeks 4 and 6. Remission rates were approximately twofold higher with active TMS (14.2% versus 5.5%) at week 6 and significant on the MADRS and HAMD24 scales (but not the HAMD17 scale).

ACTIVE TMS WAS WELL TOLERATED WITH A LOW DROPOUT RATE FOR ADVERSE EVENTS (4.5%) THAT WERE GENERALLY MILD AND LIMITED TO TRANSIENT SCALP DISCOMFORT OR PAIN. THIS TRIAL WAS ALSO THE ONE THAT LEAD TO FDA APPROVAL.

Another key study is the *Optimization of TMS for the Treatment of Depression Study* (OPT-TMS) funded by the National Institutes of Health – an industry-independent trial.¹⁴ In this prospective, multisite, blinded randomized controlled-trial, 190 antidepressant drug-free patients with unipolar non-psychotic depression were randomised to 3 weeks of daily weekday active or sham rTMS. The active treatment was rTMS delivered to the left prefrontal cortex at 120% motor threshold (10 Hz, 4-second train duration, and 26-second intertrain interval) for 37.5 minutes (3000 pulses per session) using a figure-eight solid-core coil. Sham rTMS used a similar coil with a

metal insert blocking the magnetic field and scalp electrodes that delivered matched somatosensory sensations. Primary efficacy analysis revealed a significant effect of treatment on the proportion of remitters (14.1% active rTMS and 5.1% sham; p=.02). The odds of attaining remission were 4.2 times greater with active rTMS than with sham (95% confidence interval, 1.32- 13.24). The number needed to treat was 12. Important to note that most remitters had low antidepressant treatment resistance.

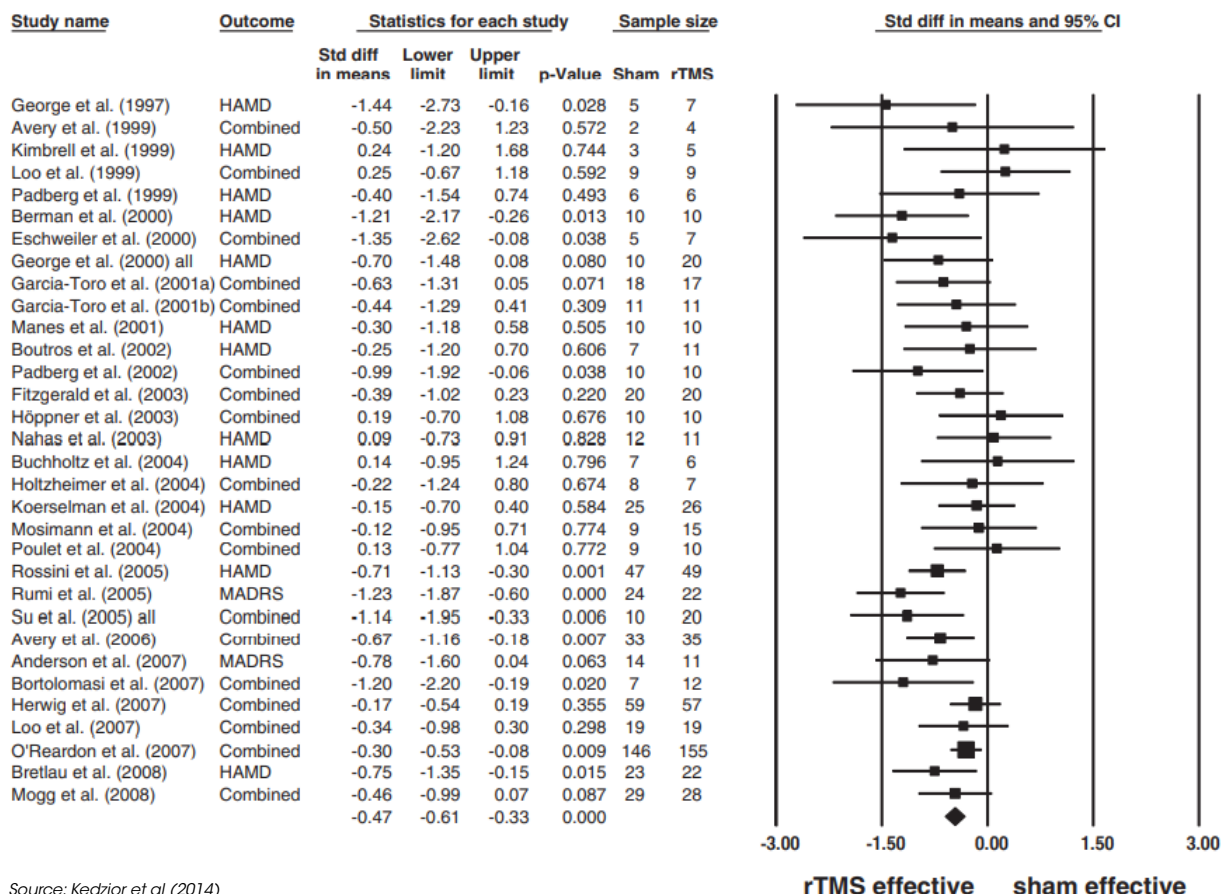
THE AUTHORS CONCLUDED THAT “THE RESULTS OF THIS STUDY SUGGEST THAT PREFRONTAL RTMS IS A MONOTHERAPY WITH FEW ADVERSE EFFECTS AND SIGNIFICANT ANTIDEPRESSANT EFFECTS FOR UNIPOLAR DEPRESSED PATIENTS WHO DO NOT RESPOND TO MEDICATIONS OR WHO CANNOT TOLERATE THEM.”

In a meta-analysis of 40 studies of rTMS for depression conducted between 1985 and 2010, daily rTMS (with any parameters) was found to have a moderate, short-term antidepressant effect.¹⁵ In this meta-analysis, the authors included 40 double-blind, randomised, sham-controlled trials with parallel designs, utilising rTMS of the dorsolateral prefrontal cortex in the treatment of major depression. The studies were conducted in 15 countries on 1583 patients (844 in the active rTMS and 739 in sham groups) and published between 1997–2008. Depression severity was measured using the HAMD, BDI and MADRS at baseline and after the last rTMS. There was a significant and moderate reduction in depression scores from baseline to final, favouring rTMS over sham (overall d = -.54, 95% CI: -.68, -.41, N = 40 studies). Most of these studies (N = 32) were of high-frequency (>1 Hz) left (HFL) rTMS. The antidepressant effect of HFL rTMS was present univariately in studies with patients receiving antidepressants (at stable doses or started concurrently with rTMS), with treatment-resistance, and with unipolar (or bipolar) depression without psychotic features (overall mean weighted d = -.47, 95% CI: -.61, -.33) [See Figure 1]. Interesting to note is that the clinical efficacy of HFL rTMS seems to higher in female patients.

RELATIVE CONTRAINDICATIONS⁴

- Individuals with focal or generalized encephalopathies (i.e., tumor, stroke, meningitis, encephalitis, epilepsy) or severe head trauma, which might be epileptogenic.
- Individuals having first-degree relatives with idiopathic epilepsy
- Individuals with heavy consumption of alcohol or ongoing abuse of epileptogenic drugs such as cocaine.
- Individuals with significant heart disease or increased intracranial pressure who are at increased risk from seizure sequelae
- Children
- Pregnant women

Figure 1: Forest plot of the weighted effect size of rTMS



Source: Kedzior et al (2014)

SPONTANEOUS ADVERSE EVENTS WITH RTMS¹⁴

- Headache (32% in active treatment, versus 23% in sham treatment)
- Discomfort at the stimulation site (18% vs 10%)
- Insomnia (7.6% vs 10%)
- Worsening of depression or anxiety (7% vs 8%)
- Gastrointestinal side-effects (7% vs 3%)
- Fatigue (5% vs 4%)
- Muscle aches (4% in both)
- Vertigo (2% in both)
- Skin pain (1% in both)
- Facial muscle twitching (0 vs 1%)
- Other (20% vs 15%)

In a systematic review and network meta-analysis of 113 studies published between 2009 and 2018, Mutz and colleagues assessed non-surgical brain-stimulation for unipolar and bipolar depression.¹⁶ The analysis included 262 treatment arms that randomised 6750 patients (mean age 47.9 years; 59% women) to either active (ECT, rTMS, theta burst stimulation, magnetic seizure therapy, transcranial direct current stimulation (tDCS)), or sham therapy. Primary outcomes were response (i.e., efficacy) and all cause (i.e., acceptability), presented as odds ratios with 95% confidence intervals. Remission and continuous depression severity scores after treatment were also examined.

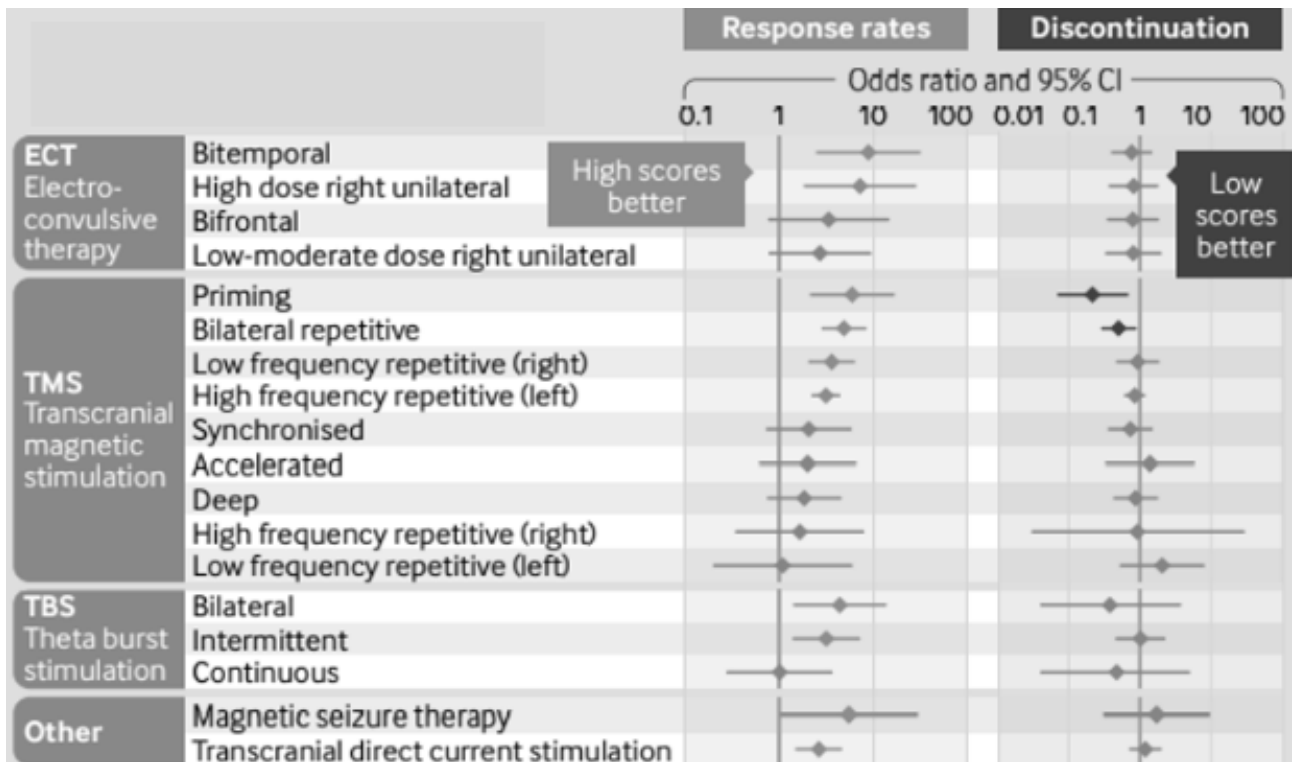
The authors found 10 out of 18 treatment strategies associated with higher response compared with

sham therapy (see Figure 2). With regard to TMS specifically, the analysis supported evidence for the antidepressant efficacy of high frequency left and low frequency right rTMS. Bilateral stimulation provided little evidence for additional benefit when compared to unilateral stimulation.

LOW FREQUENCY LEFT AND HIGH FREQUENCY RIGHT RTMS WERE NOT MORE EFFICACIOUS THAN SHAM THERAPY. THEREFORE, THERE IS EVIDENCE FOR THE USE OF TMS IN THE TREATMENT OF ACUTE DEPRESSION, BOTH AS AN ALTERNATIVE TREATMENT AND AS AN AUGMENTATION STRATEGY.

There is also evidence for the use of TMS in treatment resistant depression (TRD). Papadimitropoulou et al conducted a network analysis of 31 RCTs comparing the tolerability and efficacy of pharmacological interventions (19 RCTs), TMS and ECT (12 RCTs) as augmentation strategies for 5515 adult patients with unipolar TRD.¹⁷ Key outcomes extracted were disease severity change from baseline, response and remission rates at various time points and discontinuation due to adverse events. Response was defined as a reduction in MADRS scores from baseline of at least 50% at study endpoint. Remission was mostly defined as a MADRS score of 7 or lower at study endpoint.

Figure 2: Forest plot of the response and discontinuation for non-surgical brain-stimulation



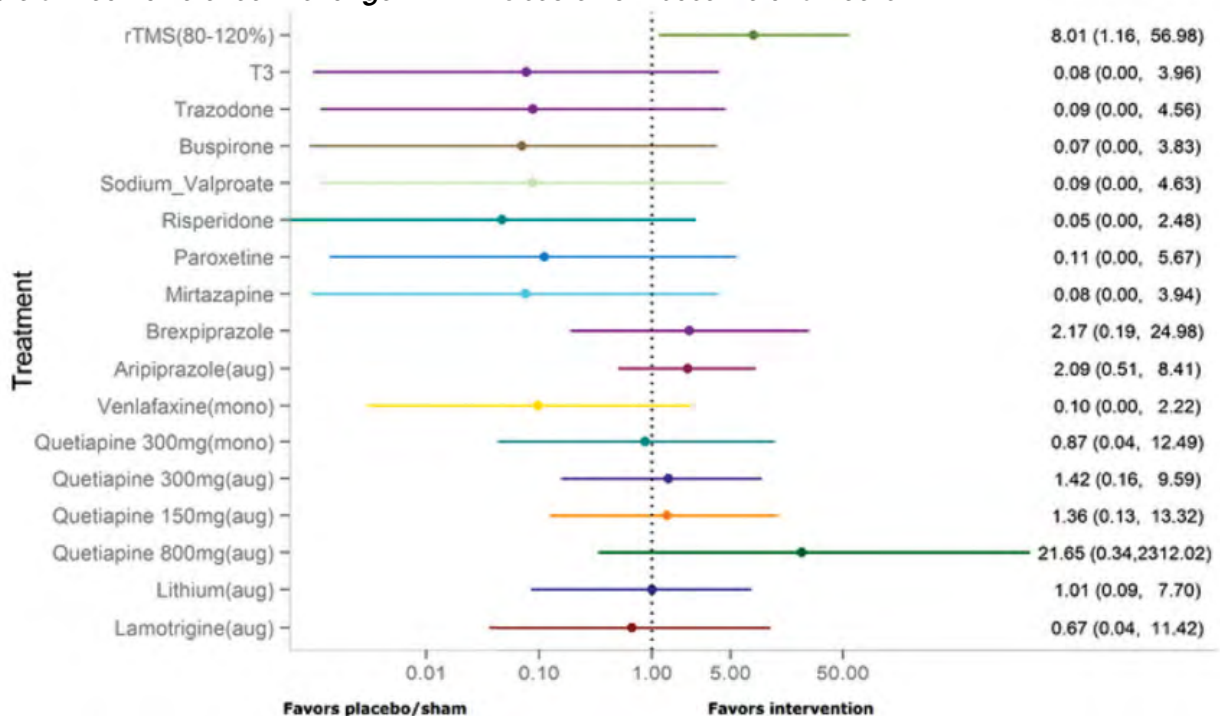
Source: Mutz et al (2018)

In terms of response, the analysis supported the superiority of ketamine during the first 2 weeks of treatment, while at 4 weeks, aripiprazole, rTMS and ECT were the most efficacious augmentation strategies. However, at 6 weeks, rTMS had a 80-120% higher response rate compared to placebo/sham, while brexpiprazole, aripiprazole, quetiapine were also noted to be more efficacious than placebo/sham treatment (See figure 3). At 8 weeks, only

pharmacological intervention studies reported data on response rates, with quetiapine being the most efficacious.

ONLY 6 STUDIES (3 PHARMACOLOGICAL AND 3 SOMATIC INTERVENTIONS) REPORTED DATA ON THE PROPORTION OF PATIENTS THAT REMITTED.

Figure 3: Mean difference in change in MADRS score from baseline at 6 weeks



Source: Papadimitropoulou et al (2016)

Augmentation with aripiprazole and rTMS were found to be more efficacious than placebo/sham with no difference between the two strategies. At 4 weeks after baseline, aripiprazole augmentation, rTMS and ECT treatments were more efficacious than placebo/sham (OR: 2.55, 9.51 and 24.43, respectively). At 6 weeks after baseline, rTMS showed the highest remission rates (OR 8.58 95% CrI 1.15, 112.55) and was superior when compared to brexpiprazole, aripiprazole, and quetiapine. Of the pharmacological interventions, lamotrigine augmentation was the best tolerated with a comparable profile to placebo/sham.

ALTHOUGH MOST OF THE RESEARCH REGARDING THE CLINICAL USE OF RTMS IS IN DEPRESSION, EVIDENCE FOR THE USE OF RTMS IN A VARIETY OF CLINICAL CONDITIONS IS EMERGING, WITH REGISTRATION FOR THE TREATMENT OF OBSESSIVE-COMPULSIVE DISORDER AND MIGRAINE IN THE UNITED STATES. PROMISING DATA IS ALSO EMERGING FOR THE USE IN SCHIZOPHRENIA, PTSD, FIBROMYALGIA, POST-STROKE RECOVERY, SUBSTANCE DEPENDENCE AND OTHER CONDITIONS. HOWEVER, THE BEST APPROACHES ARE NOT YET CLEAR.^{18,19}

THE ROAD AHEAD

Although rTMS has been established as a robust treatment for acute and treatment resistant depression, outperforming many augmentation strategies, accessibility and cost are limiting the use thereof. Layout costs for equipment is very high, resulting in high treatment costs – which (at present) are not covered by medical schemes. There are only a few treatment centres, so from a practical perspective, current recommended treatment protocols (daily treatment for 6 weeks) are also limiting the number of patients who have access.

WORLDWIDE THERE IS A DRIVE TO MAKE TMS MORE ACCESSIBLE AND AFFORDABLE.

One possible strategy is to reduce the duration of a treatment session, thus allowing more people to be treated per day. Theta burst stimulation (TBS), a new treatment protocol, seems to be the way forward in this regard. In preliminary studies, TBS has been shown to produce similar, if not greater, effects on brain activity than standard rTMS.²⁰ TBS protocols run for 3 to 10 minutes, in comparison to standard rTMS which run for 20-45 minutes.

Another strategy is targeted treatment through neuro-navigational methods to ensure consistent placement of the TMS coil such that it results in stimulation of a selected cortical site.²⁰ Two methods currently used are the 'Beam F3' method (which provides reasonable localization to the anterior stimulation site) and the '5 cm method' (which provides reasonable localization of the posterior stimulation site). fMRI- connectivity based approaches to targeting specific circuits in the DLPFC, although theoretically attractive, may not be practical nor affordable. This sort of approach is technically challenging and there are questions as to the reliability of the scan results obtained in individual subjects unless the scans are of extended duration or very high magnet strengths are used. More research demonstrating improved clinical outcomes with these techniques are needed.

THE FINAL STRATEGY IS TO EXPAND THE POSSIBLE TREATMENT SITES. HIGH FREQUENCY STIMULATION OF THE LEFT DLPFC AND LOW FREQUENCY STIMULATION OF THE RIGHT DLPFC ARE WELL ACCEPTED PROTOCOLS BY NOW. HOWEVER, FURTHER RESEARCH IS NEEDED TO ESTABLISH THE EFFICACY, AND OPTIMAL PROTOCOLS FOR STIMULATION OF THE ORBITOFRONTAL, DORSOMEDIAL AND SUPPLEMENTARY MOTOR AREAS AS TREATMENT SITES.

CONCLUSION

The clinical application of TMS will become more acceptable, accessible, and affordable as a treatment option as more clinicians refer patients for treatment or invest in the machines themselves. Practical experience and success stories, together with sound clinical research, will also inform treatment guidelines, and hopefully, improve funding from medical schemes. TMS should be included in the treatment armamentarium psychiatrists have to offer patients, especially those with treatment resistant depression.

PSYCHIATRISTS ARE ALSO OFTEN ENGAGING IN "OFF LABEL" PRACTICES TO ADDRESS TREATMENT RESISTANT CONDITIONS SUCH AS PTSD, PAIN DISORDERS, THE NEGATIVE SYMPTOMS OF SCHIZOPHRENIA - TO NAME BUT A FEW.

It might even be worth attempting TMS in these cases – with the clear understanding that treatment is still experimental and best treatment protocols are not yet established.

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PSYCHIATRIC PROFILES OF CHILDREN AND ADOLESCENTS WITH INTELLECTUAL DISABILITIES OR SPECIFIC LEARNING DISORDERS ATTENDING SPECIALIZED PSYCHIATRIC CLINICS

S'bongile Nkhahle, Heather Alison

The research reported here has been extracted from a larger project on several comorbidities of children and adolescents with intellectual disabilities or specific learning disorders attending specialized psychiatric clinics. The larger project was the first author's MMed dissertation, Department of Psychiatry, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa. The degree was conferred on the 18th December 2020.

Barriers to learning in the South African context include specific learning disorders (SLD) and intellectual disorders (ID). Examples of SLD include dyslexia, which is a difficulty with reading, dyscalculia, which is a difficulty with maths, and dysgraphia, which is a difficulty with writing. SLD used to be known as learning disabilities (LD). Children with a SLD have an average to above-average IQ. These children are usually catered for in remedial classes or schools. In contrast, a child with an ID has a below-average IQ. ID involves problems with general mental abilities that affect intellectual functioning such as learning, problem solving, judgment, and adaptive functioning, which includes activities of daily life such as communication and independent living.

THESE CHILDREN ARE USUALLY CATERED FOR IN SPECIAL CLASSES OR SCHOOLS FOR LEARNERS WITH SPECIAL EDUCATION NEEDS (LSEN).

According to Sahu, Patil, *et al.* (2019), the prognosis for children and adolescents with psychiatric illness comorbid with learning difficulties (LD) is worse than those without learning difficulties. Many children and adolescents attending the Child, Adolescent and Family Unit (CAFU) at the Charlotte Maxeke Johannesburg Academic Hospital (CMJAH) and the Tara H. Moross Children's Clinic (Tara) have

LD together with other psychiatric comorbidities. Many of these children and adolescents are in an inadequate academic environment and are often on high doses of multiple psychotropic medications. Specific learning disorders (SLD) and intellectual disabilities (ID) are the two most common LD that are associated with children and adolescents with comorbid psychiatric illnesses in these two clinics. Both SLD and ID are neurodevelopmental disorders resulting from genetic and environmental factors as well as the interplay of epigenetic factors. The hereditary nature of LD suggests that parents of this population of patients may also have an underlying LD and often have a lower income. Previous studies have associated LD with both internalizing and externalizing behaviours (See, for example, Carroll, Maughan, *et al.*, 2005; Mammarella, Ghisi, *et al.*, 2016.). Both SLD and ID are neurodevelopmental disorders with differing clinical presentations and therefore they require differentiation to be able to apply appropriate interventions.

The current findings focus on both SLD and ID, given that disability tends to be an umbrella term in South Africa, as shown in the use of the term *barriers to learning*, which covers all learning difficulties, including both SLD and ID (Donahue & Bornman, 2014).

PREVALENCE OF SLD AND ID

A survey published in 2014 indicated that in the United States of America, an estimated five percent

of school age going children have a learning disability (Nel & Grosser, 2016). In England an estimated 180 000 children have special school needs (National Centre for Learning Disabilities, 2014). There is a lack of South African prevalence studies on SLD and ID because there is no standardized and accepted tool to measure the prevalence of disability, as discussed by Nel and Grosser (2016). Data are available from the 2001 Census, 2007 community survey and 2009 Annual General Household Survey. In 2009, Stats SA Annual General Household Survey (GHS) used the Washington Group (WG) short sets of questions which evaluated seven domains of functioning. According to this approach, GHS 2009 identified almost 2.1 million children with a disability (11.2 percent of total children population), of which 28 percent were children in the age group under four years, while children between the age group of five to nine years accounted for ten percent. Census 2001 and Community Survey may have under-reported the prevalence of disability because Census 2001 figures indicated that 474 000 children were living with a disability. This could be due to the GHS 2009 being more specific and sensitive in identifying children with disabilities compared to Census 2001. However, it is important to mention that these figures include a summarized version of a variety of disabilities in childhood that interfere with learning (Adnams, 2010; UNICEF, 2012).

PSYCHIATRIC COMORBIDITIES OF SLD AND ID

A cross-sectional study in Tunisia (2018) indicated that there was a high rate of psychiatric comorbidity and SLD. This included both internalizing and externalizing behaviour (Cherif, Ayedi *et al.*, 2018.) Another cross-sectional study conducted in India in 2019 also indicated that psychiatric comorbidities are common in SLD and that an additional psychiatric comorbidity may affect the clinical expression and severity of SLD and impact response to treatment (Sahu, Patil, *et al.*, 2019).

EXTERNALIZING BEHAVIOURS

Externalizing behaviours are negative behaviours directed outward towards others. Bullying, vandalism, and arson are examples of externalizing behaviours (Lui, 2004).

Attention deficit hyperactivity disorder (ADHD) is one of the most common neurodevelopmental disorders of childhood. ADHD is a mental health disorder that includes a combination of persistent problems such as difficulty paying attention, hyperactivity, restlessness, and impulsive behaviour. It is usually first diagnosed in childhood and often lasts into adulthood (Center for Disease Control and Prevention, 2020).

ADHD is the most common psychiatric comorbidity with LD in childhood. A review of seventeen studies by DuPaul, Gormley and Laracy (2013) estimated that 25 to 40 percent of children diagnosed with LD have a diagnosis of ADHD and vice-versa.

In addition to ADHD, children with LD have a threefold risk of comorbid conduct disorder (CD). According to Carroll, Maughan and Meltzer (2005), inattentiveness seems to be the link between LD, ADHD and CD.

Substance use disorder (SUD), previously known as drug addiction, occurs when the recurrent use of alcohol, cannabis, or other legal or illicit drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home (Mental health and substance use disorder, ND). Children and adolescents with LD may have an increased risk of abusing substances and dropping out of school. Whereas Crosnoe's (2006) study indicated that academic failure was associated with adolescent alcohol use, Kepper, Koning *et al.* (2014) indicated that learners with mild academic difficulties were not at increased risk of early onset of tobacco smoking and alcohol consumption, but they were at a higher risk to graduate to harder drugs like ecstasy, cocaine or heroin.

HIGH-RISK BEHAVIOUR AND POOR ACADEMIC PERFORMANCE WERE IMPORTANT PREDICTORS FOR SCHOOL DROPOUTS AMONG HIGH SCHOOL STUDENTS WITH LD, ACCORDING TO A STUDY BY DOREN, MURRAY AND GAU (2014).

Conduct disorder is a serious behavioural and emotional disorder occurring in children and adolescents. They may display disruptive and violent behaviour and have problems following rules. The disorder may be mild, moderate, or severe. There are four general categories, aggressive behaviour such as fighting, bullying, and cruelty, destructive behaviour such as intentional destruction of property, deceitful behaviour such as lying and stealing, and violation of rules where behaviour is not age-appropriate. Children with conduct disorders cannot appreciate how their behaviour can hurt others, nor can they show empathy, and they generally have little guilt or remorse about hurting others (WebMD, 2020).

Oppositional defiant disorder (ODD) is a behavioural condition predominantly occurring in children and adolescents in which one sees an ongoing pattern of an angry or irritable mood, strongly embedded patterns of negative and vindictive reactions to authority, defiant or argumentative behaviour, wilful noncompliance, and negative attention-seeking behaviours (Curtis, Elkins, *et al.*, 2015). These behaviours often disrupt normal daily activities, including activities within the family and at school.

INTERNALIZING BEHAVIOURS

Internalizing behaviours are negative behaviours that are focused inward. They include fearfulness, social withdrawal, and somatic complaints (Liu, Chen, & Lewis, 2011).

Two groups of mood disorders (MD) are relevant to this research, major depressive disorder (MDD) and disruptive mood dysregulation disorder (DMDD). MDD, also known as clinical depression, is a mental health disorder characterized by a persistently depressed mood or loss of interest in activities, causing significant impairment in daily life (Fava & Kendler, 2000). DMDD is a childhood condition of extreme irritability, anger, and frequent, intense temper outbursts. It is a fairly new diagnosis, only appearing in the DSM-5 for the first time. It accounts for children with severe emotional and behavioural problems with the prominent feature of non-episodic or chronic irritability (Copeland, Angold, *et al.*, 2013).

An anxiety disorder (AD) is characterized by feelings of worry, anxiety or fear that are strong enough to interfere with daily activities. ADs include panic attacks, obsessive-compulsive disorder, phobias, social anxiety, and post-traumatic stress disorder. ADs are a common form of emotional disorder affecting anyone at any age (Webmd, 2021).

THE RESULTS OF A STUDY BY WILLCUTT AND PENNINGTON (2000) INDICATED THAT WHILE BOYS WERE MORE LIKELY TO EXHIBIT EXTERNALIZING BEHAVIOUR, GIRLS SHOWED MORE INTERNALIZING BEHAVIOUR.

The girls had more somatic complaints and symptoms of anxiety and depression after ADHD and disruptive behaviour symptoms were controlled. Carrol *et al.* (2005) did not find a significant link between depressed mood and LD but rather that in younger teenage boys the low mood was associated with inattentiveness. After inattentiveness had been controlled for, a significant association between anxiety disorders, namely generalized and separation anxiety disorders, were associated with LD. They proposed that the separation anxiety may be because school was perceived as unpleasant. This was in contrast with a previous study by Maughan, Rowe *et al.* (2003) that showed that boys with reading problems between seven to ten years of age had a threefold chance of reporting a depressed mood, compared to their peers without a reading problem. Adolescent boys had no symptoms of a depressed mood. Mammarella, Ghisi *et al.* (2016) also reported higher levels of depression in learners with reading disorders compared to those with typical development and nonverbal learning disorder, as well as an association between LD and generalized anxiety and social anxiety. A study by Howard and Tyron (2002) stated that guidance counsellors and adolescents with LD rated themselves to have higher rates of clinically significant rates of depressive symptoms and that learners with LD in mainstream schools were more depressed than those in self-contained classes. They postulated that the learners in mainstream schools showed more depressive symptoms because they might be overwhelmed by the

academic demand. Self-report questionnaires were used so depressive symptoms were not clinically assessed.

RATIONALE FOR THE PRESENT STUDY

The multifaceted nature of barriers to learning within the South African context necessitates differentiation at least into the broader areas of SLD and ID. This report explores the psychiatric profiles and treatment interventions of children and adolescents with SLD and ID within the clinic treatment facilities at CAFU and Tara with the intention of informing further clinical intervention options and adding to what is currently a very small body of research of these issues within the South African context. The information reported here has been extracted from a larger project on several comorbidities of children and adolescents with intellectual disabilities or specific learning disorders attending specialized psychiatric clinics, reported in the first author's MMed dissertation (Nkhahle, 2020).

METHOD

This study was a retrospective case review study of children and adolescents in a psychiatric setting. Referrals with SLD or ID comorbid with a psychiatric disorder were compared with those with psychiatric diagnoses without comorbid SLD or ID.

The study settings were the Child, Adolescent and Family Unit (CAFU) at the Charlotte Maxeke Johannesburg Academic Hospital, situated in Parktown, catering for the inner city and more affluent areas of Parktown and Houghton, and the Tara H. Moross Children's Clinic (Tara) situated in Sandton, catering for surrounding areas including Diepsloot, Hyde Park, and as far as Midrand and Tembisa. Both facilities form part of the University of the Witwatersrand psychiatric services and provide training for medical students, psychiatry registrars and child psychiatry fellows.

The population was the records of all children and adolescents seen at CAFU and the Tara children's clinic at all times. The sample drawn from this population was the records of children and adolescents between the ages of 6 to 18 years seen over three years from January 2014 to December 2016. The inclusion criterion was that the record indicated a child or adolescent with a SLD or an ID, or with No LD to be used as a control, while exclusion criteria included children less than six years old and those with severe ID with neurocognitive complications, as well as those with a diagnosis of autism spectrum disorder (ASD). Severe ID and ASD were excluded from the study because both conditions may have comorbid neurological disorders that also contribute to LD.

In total, 400 files were reviewed, 200 from CAFU and 200 from Tara, with 130 No LD records, 165 ID records, and 105 SLD records, the breakdown of which is summarized in Table 1.

TABLE 1: SAMPLE PROFILE

	No LD	ID	SLD	Total
CAFU	54	98	48	200
TARA	76	67	57	200
Total	130	165	105	400

The information collected, which was pertinent to the current article, included the classification of the child or adolescent as No LD, ID, or SLD, and the demographics of age and gender, as well as evidence of speech difficulties. Psychiatric information included evidence of ADHD, ODD, CD, MD, AD and SUD. Therapeutic interventions included pharmacotherapy, psychology, speech therapy, and occupational therapy.

Ethical clearance to conduct the study was obtained from the University of the Witwatersrand Human Research Ethics Committee (Medical), reference number M180469. Permission to carry out the study was obtained from the Gauteng Province Department of Health.

RESULTS AND DISCUSSION

DEMOGRAPHIC INFORMATION

The relevant demographics were age, gender and presence of speech difficulties.

AGE

The ages of children and adolescents considered in this study ranged from 6 to 18 years old. The mean age for the whole sample was 10 years 8 months. Within the groups the mean age was 11 years 4 months for the No LD group, 10 years 5 months for the ID group, and 10 years 4 months for the SLD group. The differences between these mean ages were statistically significant ($F(2;397)=3.957$; $p=0.020$). The children and adolescents in the No LD group were significantly older than other two groups.

FROM THE CHARTS IT WAS NOTED THAT THE MEAN AGE OF FIRST PRESENTATION WAS NINE YEARS. THIS MAY BE EXPLAINED BY THE LEVEL OF WORK INCREASING IN VOLUME, SUBJECT DIFFERENTIATION AND DIFFICULTY.

The learners then struggle to compensate adequately as they had done previously. According to the Department of Education, these learners should be in grade three or four. The transition from the foundation phase (grades 1-3) to grade four requires that the learners change classrooms, write down their homework independently and follow their own timetable. The No LD group was more likely to present after 9 years, while the ID group was more likely to present at a much younger age due to delayed global development.

GENDER

The gender differences were statistically significant ($\chi^2(2)=8.480$; $p=0.014$). There were significantly more boys than girls in both the ID and SLD groups, while the proportions were almost equally balanced in the No LD group. This may be seen in Figure 1.

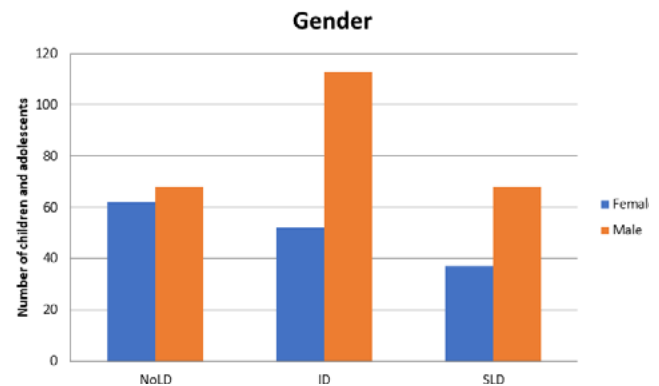


Figure 1: Number of children and adolescents with No LD, ID and SLD of each gender

There were no significant gender differences in the No LD group. The ID group and the SLD group showed significant gender differences. Males were much more likely to be affected than females in the ID and SLD groups. This indicates that the prevalence of ID and SLD is higher in males than females. This is consistent with the findings of Gorker *et al* (2017), where they also indicated that the male proportion in their sample was 17% and that of the females was 10.4%. Their findings were in keeping with the DSM-5, which reports that SLD is two to three times higher in males than in females (American Psychiatric Association, 2013).

Speech Difficulties Present

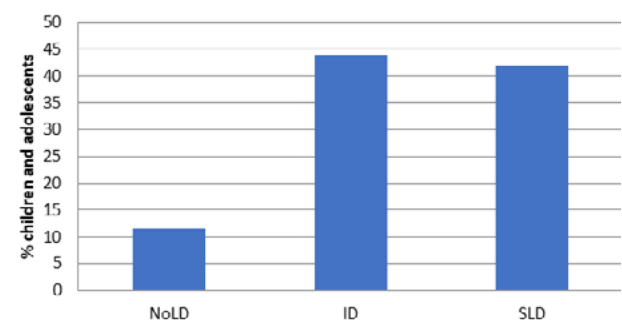


Figure 2: Percentage of speech difficulties present in children and adolescents with NoLD, ID and SLD

Speech difficulties ranged from delayed speech to articulation and pronunciation difficulties. The findings of this study are consistent with previous research which has indicated a link between LD and speech and language impairments.

An earlier study by Catts (1993) indicated that children who experienced language difficulties in pre-school later had reading disorders. The study also indicated that in first grade these children struggled with word recognition and reading and comprehension difficulties in second grade. Furthermore, the study indicated that the degree of reading disability was related to the type of

language impairment. A study by Tomblin, Zhang, *et al.* (2000) also found an association between language impairment, reading disability and behavioural disorders. A more recent study by Sun and Wallach (2014) concluded that most learning disabilities are language disorders that manifest differently over time. SLD is not a new diagnosis that develops when a child starts school, but often a manifestation of a pre-existing language disorder and early intervention often determines the degree and type of SLD.

CHILD AND ADOLESCENT PSYCHIATRIC PROFILE

The psychiatric diagnoses of the children and adolescents were attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder (CD), mood disorder, anxiety disorder, and substance use disorder (SUD). The frequency counts for these variables are represented in Table 2.

ADHD

The number of children and adolescents with ADHD was statistically significant ($\chi^2(2)=41.330$; $p<0.001$). ADHD was present in just over one half of the No LD group (52.31%) and was significantly high in both the ID (76.97%) and SLD (88.57%) groups. This may be seen in Figure 3.

ADHD

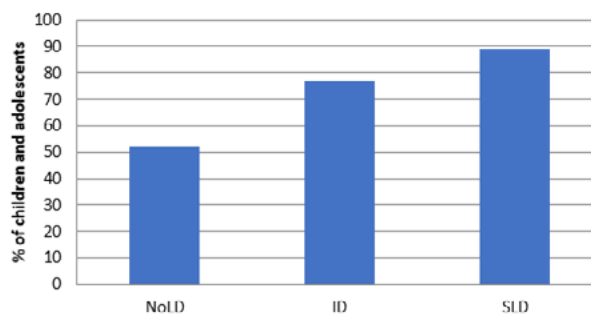


Figure 3: Percentage of ADHD in children and adolescents with NoLD, ID and SLD

ADHD WAS MORE LIKELY TO OCCUR IN CHILDREN AND ADOLESCENTS WITH SLD AND ID THAN IN THOSE WITH NO LD. ADHD WAS THE MOST COMMON DIAGNOSIS AT BOTH CLINICS.

The results of this study are in keeping with previous studies that have also found high rates of comorbidity between ADHD and LD. Comorbidity rates between ADHD and SLD are high, ranging between 39 and 45 percent. DuPaul *et al.* (2013) reviewed historical and recent articles of comorbidities between ADHD and LD and in their

Table 2: Child and Adolescent Psychiatric Profile

Child Psychiatric profile	No LD n=130	ID n=165	SLD n=105	p-value	Significant
Attention Deficit Hyperactivity Disorder (ADHD)					
Yes	68	127	93	<0 .001	Yes
No	62	38	12		
Oppositional Defiant Disorder (ODD)					
Yes	31	32	17	0.334	No
No	99	133	88		
Conduct Disorder (CD)					
Yes	27	31	18	0.777	No
No	103	134	87		
Mood Disorder (MD) Present					
Yes	72	56	35	<0 .001	Yes
No	58	109	70		
Mood Disorder Type					
Major Depressive Disorder	57	41	27	0.006	Yes
Disruptive Mood Dysregulation Disorder	14	15	8		
Anxiety Disorder (AD)					
Yes	76	102	77	0.049	Yes
No	54	63	28		
Substance Use Disorder (SUD)					
Alcohol	3	2	1	0.023	Yes
Cannabis	12	9	1		
Alcohol and Cannabis	5	2	0		
Absent	110	152	103		

results the results were similar ranging between 39 and 45 percent. There are strong hereditary as well as neuropsychiatric links between the disorders that may explain the comorbidity rates. The genetic loading and onset during the developmental stage is part of the reason why the APA included SLD and ADHD under neurodevelopmental disorders in the DSM-5 (American Psychiatric Association, 2013; Pham & Riviere, 2015).

OPPOSITIONAL DEFIANT DISORDER AND CONDUCT DISORDER

While ODD was present for about one-fifth of the children in each of the three groups, the difference between groups was not significant ($p=0.334$).

While CD was present for about one-sixth of the children in each of the three groups, the difference between groups was not significant ($p=0.777$).

There was no statistical significance of the behavioural difficulties of ODD and CD in children and adolescents with SLD, ID or No LD. The SLD group had lowest rates of ODD and CD and the ID group had the highest number of children and adolescents diagnosed with ODD and CD.

PREVIOUS STUDIES HAVE INDICATED THAT CHILDREN WITH READING DISORDERS HAVE A HIGHER RISK OF EXHIBITING EXTERNALIZING BEHAVIOUR LIKE CD AND ODD.

A study by Tomblin *et al.* (2000) looked at the comorbidity patterns between language impairments, behavioural disorders and reading disorders and they concluded that the reading disorder was the link between behavioural difficulties and language impairment. They postulated children with language impairment had a higher risk for later developing reading disorders and that the behavioural difficulties were because of the reading disorder.

A recent review article by Hendren, Haft, *et al.* (2018). also looked at the association between CD, ODD and reading disorders and concluded that there was a link between reading disorders and these disorders and that a diagnosis of ADHD could be the link between the two disorders.

A previous study by Willcutt and Pennington (2000) also reported that ADHD was the link between reading disability and externalising behaviour. A review article by Maughan and Carroll (2006) suggested that the inattentiveness in ADHD was the link between LD and externalising behaviour. The results of this study are not in keeping with previous research, in that there were no significant associations between ODD and CD in all three study groups. The reason is unclear, it could be assessor dependent or other environmental factors are also associated with the expression of behavioural problems.

MOOD DISORDERS

The presence of a mood disorder was statistically significant ($\chi^2(2)=17.094$; $p<0.001$). A mood disorder was present less in one-third of the ID (33.94%) and SLD (33.33%) groups, but in over half of the No LD (55.38%) group.

When looking at the type of mood disorder, major depressive disorder and disruptive mood dysregulation disorder, the difference was again statistically significant ($\chi^2(6)=17.945$; $p=0.006$). There was a much greater occurrence of major depressive disorder, particularly in the No LD group. This can be seen in Figure 4.

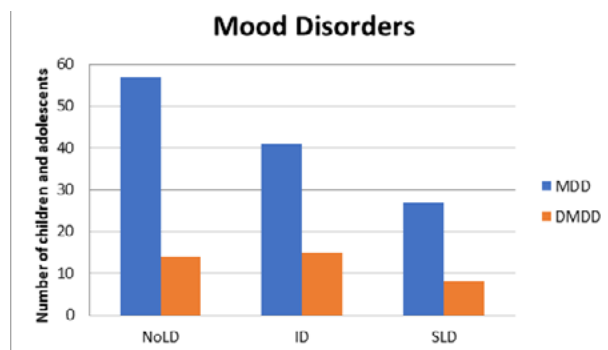


Figure 4: Mood Disorders for children and adolescents with NoLD, ID and SLD

MOOD DISORDERS ARE MORE LIKELY IN CHILDREN AND ADOLESCENTS IN THE ABSENCE OF A LEARNING DISORDER. BEING DIAGNOSED WITH A MOOD DISORDER WAS SIGNIFICANTLY HIGHER IN THE NO LD GROUP, ESPECIALLY WITH RESPECT MDD.

The ID group had higher rates of MDD and mood dysregulation compared to SLD. These findings are consistent with a study by Carroll *et al.* (2005) that found an association between literacy difficulties and all major psychiatric diagnoses except for depression. Hendren *et al.* (2018) reported that children and adolescents with reading disorders that are in a mainstream classroom, are more vulnerable to depressive disorders because of the anxiety associated with their academic difficulties. They associated the low esteem from academic struggle with anxiety and therefore depressive symptoms. In contrast, Maag and Reid (2006) reported that students with learning difficulties were more likely to report depressive symptoms than their peers without learning difficulties, and they speculated further that the depressive symptoms could be related to environmental factors and not necessarily genetic factors.

ANXIETY DISORDERS

The presence of anxiety disorders was statistically significant ($\chi^2(2)=6.013$; $p=0.049$). Anxiety disorders were present in all groups and significantly high, especially in the ID (61.82%) and SLD (73.33%)

groups, and over half of the No LD (58.4%) groups, as can be seen in Figure 5.

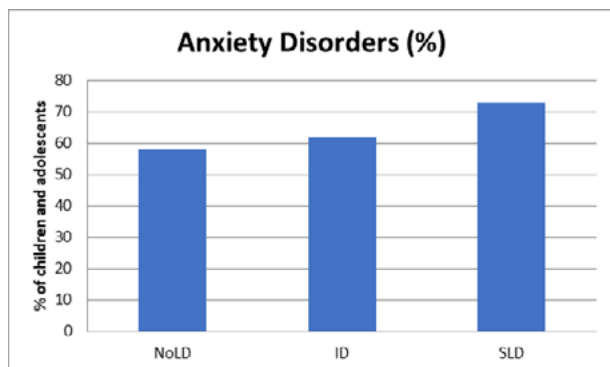


Figure 5: Anxiety Disorders for children and adolescents with NoLD, ID and SLD

THE MOST COMMON ANXIETY DISORDERS AS NOTED ON THE CHARTS WERE SOCIAL PHOBIA AND GENERAL ANXIETY DISORDER (GAD). THE RESULTS OF THE STUDY ARE IN KEEPING WITH OTHER SIMILAR STUDIES.

Carrol et al. (2005) had similar findings that learning difficulties were significantly associated with anxiety disorders. In their study, GAD and separation anxiety persisted even after controlling for inattentiveness.

THEY CONCLUDED THAT IT IS A POSSIBILITY THAT HAVING LEARNING DIFFICULTIES WAS A RISK FACTOR FOR DEVELOPING GAD AND SCHOOL ASSOCIATED ANXIETY.

A recent study by Haft *et al.* (2018) concluded that children with SLD reported higher rates of anxiety compared to typically developing children and furthermore they have more academic and social challenges because of their disorders and this results in emotional distress as well as avoidant behaviour when it came to reading-related tasks.

Table 3: Therapeutic Interventions

Treatment	No LD n=130	ID n=165	SLD n=105	p-value	Significant
Pharmacotherapy					
Yes	111	154	104	<0.001	Yes
No	19	11	1		
Psychotherapy					
Yes	108	133	94	0.149	No
No	22	32	11		
Occupational Therapy (OT)					
Yes	37	73	51	0.004	Yes
No	92	92	54		
Speech Therapy					
Yes	7	48	29	< 0.001	Yes
No	123	117	76		

SUBSTANCE USE DISORDERS

This diagnosis was statistically significant ($\chi^2(6)=14.659$; $p=0.023$), but for the absence rather than the presence of SUD. Indeed, there was not much SUD at all. The most frequently used substance was cannabis, used on its own or in conjunction with alcohol by 13.08% of the No LD group, 6.67% of the ID group, and 1.90% of the SLD group.

THE SLD GROUP WAS LEAST LIKELY TO USE SUBSTANCES. THE REASON FOR THE SLIGHTLY HIGHER PROPORTION IN THE NO LD IS UNCLEAR, HOWEVER IT IS POSSIBLE THAT THE ID AND SLD GROUPS ARE IN A PROTECTIVE ENVIRONMENT AND THEIR LEVEL OF DEVELOPMENT AND CURIOSITY IS LOWER THAN THOSE IN THE NO LD GROUP.

THERAPEUTIC INTERVENTIONS

Therapeutic interventions available for the children and adolescents included pharmacotherapy, occupational therapy, speech therapy and psychotherapy. These can be seen in Table 3.

PHARMACOTHERAPY

The results for the numbers of children and adolescents receiving pharmacotherapy was statistically significant ($\chi^2(2)=15.628$; $p<0.001$). It is to be noted that nearly all were receiving pharmacotherapy.

From reviewing the files it was noted that Methylphenidate and selective serotonin reuptake inhibitors (SSRI) were the most prescribed medication followed by Risperidone and Sodium Valproate. The ID group had a high rate for pharmacotherapy. This may be since children and adolescents with ID have behavioural difficulties that do not respond to

any pharmacological treatment and may be too concrete to respond to behavioural modification.

The increased prescription rates of Methylphenidate are in keeping with the high rates of ADHD diagnoses in the two clinics. A review article by Gray and Climie (2016) looked at the treatment for ADHD together with reading difficulties. In the review they indicated that stimulant type of medication like Ritalin and Concerta were effective in treating the core symptoms of ADHD like attention and focus.

THIS CLASS OF MEDICATION ALSO IMPROVED READING OUTCOMES.

Atomoxetine, a non-stimulant medication also improved core ADHD symptoms as well as improved visuospatial as well as working memory in children with reading disorders.

SSRIs are the mainstay treatment for both depression and anxiety disorders. Risperidone and Sodium Valproate are mainly prescribed for the ID population for behaviour modification. It is concerning that the ID group had such high rates of psychotropic medication prescribed and often at high doses. It is possible that problematic behaviour like self-harming, temper outbursts and aggression is sometimes misunderstood to be externalizing behaviour.

THESE FINDINGS ARE NOT UNIQUE TO THE TWO CLINICS. EVIDENCE AGAINST ANTIDEPRESSANTS SHOWS THAT THEY ARE POORLY TOLERATED AND MAY HAVE INTOLERABLE SIDE EFFECTS LIKE IRRITABILITY AND AGGRESSION.

A review article by Young Ji and Findling (2016) indicated that antipsychotics, especially Risperidone, have better outcomes in treating behavioural problems in children with ID, while very little evidence exists for the use of mood stabilizers for controlling behavioural problems in ID. However, the risk for developing extrapyramidal movement disorders with antipsychotic medications is high with long term use of antipsychotics. A retrospective study by Demirkaya *et al.* (2017), indicated that long-acting Risperidone was effective and well tolerated in patients with CD and was also effective in enhancing compliance.

PSYCHOTHERAPY

This form of treatment was not statistically significant. ($p=0.149$). The majority in all groups were receiving psychotherapy. What is more interesting is that there was a small proportion almost one-fifth of the No LD group (16.92%) and the ID group (19.39%) not receiving psychotherapy, and a smaller proportion of the SLD group (10.48%), although these differences were not significant. In a family clinic setting one would expect all the children and adolescents to be receiving some sort

of psychotherapeutic intervention.

From the chart records it was noted that within the SLD group, some were already receiving psychotherapy at school. The ID group had the most referrals for parental counselling, while the No LD group was referred for individual therapy including play therapy, as well as parental counselling.

OCCUPATIONAL THERAPY

The number of children and adolescents receiving OT was statistically significant ($\chi^2(2)=11.284$; $p=0.004$). The source of this significance was that far fewer with No LD (28.46%) compared to almost half of those with ID (55.24%) or SLD (48.57%) received OT.

Visual perception difficulties as well as developmental coordination disorders are common in children and adolescents that present for OT with learning difficulties. Both these conditions are also classified as a neurodevelopmental disorder. Visual perception is defined as the overall process involved in the sensory and cognitive processes involved in visual stimuli. The visual receptive component is the ability to extract and organize information from the environment and the cognitive component is responsible for organizing, structuring as well as interpreting visual stimuli. Both of these components are necessary to make sense of what is seen.

Visual perception skills involve the ability to recognize and identify objects, shapes and colours. They allow an individual to make precise judgment on the size, layout as well as spatial orientation in relation to each other. Visual perception difficulties become more prominent in grade three, where letters and text are much smaller.

LEARNING DIFFICULTIES RELATED TO VISUAL PERCEPTION MAY PRESENT WITH DEFICIENCIES IN VISUAL EFFICIENCY AS WELL AS VISUAL INFORMATION PROCESSING.

Visual cognitive function deficiencies may present with difficulties in attention, memory, mathematics, reading as well as spelling and difficulties in handwriting and visual motor integration. Evaluation of visual cognitive skills include visual spatial tests, visual perception tests and visual motor integration tests. Intervention is different for different age groups and is modified for different age groups.

Developmental coordination disorder is (DCD) defined as the failure to acquire skills in fine and gross motor skills and there has been adequate stimulation and opportunity to learn these skills. These children struggle with planning and organizational skills. This has a significant impact on academics as well as on the home environment. DCD is highly comorbid with neurodevelopmental disorders including ADHD, SLD and ASD. Intervention for DCD includes sensory integration therapy. The

average presenting age was nine years. Most children should be in grade three or four. This is in keeping with the age of presentation for visual perception and DCD disorders, according to Bazyk and Smith (2010).

SPEECH THERAPY

The number of children and adolescents receiving speech therapy was statistically significant ($\chi^2(2)=28.391$; $p<0.001$). Almost no children and adolescents with No LD (5.38%) had speech therapy. Almost one-third of the children and adolescents with an ID (29.09%) and a SLD (27.62%) had speech therapy. The majority of all three groups did not have speech therapy. Therefore the SLD and ID group were more likely to be referred for speech therapy.

GENERAL FINDINGS

THE CHILDREN AND ADOLESCENTS WITH NO LD THAT PRESENTED TO THE TWO CLINICS WERE MORE LIKELY TO PRESENT WITH MOOD DISORDERS AND BEHAVIOURAL DIFFICULTIES.

This group was also more likely to experiment with cannabis than the other groups. They were least likely to be on polypharmacy or be referred to OT. They had the highest rate of referral for individual therapy, play therapy and parental counselling.

In contrast, the children and adolescents with ID were more likely to present with externalizing behaviour. They were also more likely to have delayed milestones and speech difficulties. Speech therapy was often recommended, and psychological intervention was mainly for parental counselling. Occupational therapy referral was not as common as might be expected. The ID group also had the highest rates of pharmacological intervention that included Risperidone, Sodium-Valproate, Methylphenidate and SSRIs. It is possible that these psychotropic medications were prescribed for behavioural difficulties.

FINALLY, THE CHILDREN AND ADOLESCENTS WITH SLD WERE MORE LIKELY TO PRESENT WITH INTERNALIZING SYMPTOMS. MOST OF THEM HAD A DIAGNOSIS OF ADHD AND WERE LEAST LIKELY TO HAVE ODD AND CD.

This could be because they tended to be shy and insecure in social settings because of their academic challenges, but were more likely to have speech difficulties. The therapeutic interventions included occupational therapy, speech therapy and psychotherapy. SSRIs and Methylphenidate were the most commonly prescribed medications.

CONCLUSION

Both SLD and ID are neurodevelopmental disorders that affect academic achievements and are often comorbid with other psychiatric illness. Particular mention needs to be made of ADHD which was present in almost all children and adolescents with an ID or a SLD. There was also a considerable prevalence of major depressive disorder, although this was more frequent for children and adolescents with No LD. The reverse was the case for anxiety disorders which occurred less in children and adolescents with No LD, and more for children and adolescents with an ID or a SLD. This study has therefore indicated that children and adolescents that present with academic difficulties often have other psychiatric illness. The results of this study are in keeping with previous similar studies. SLD and ID are not new diagnoses that present when a child starts school. There are often other symptoms that precede the learning difficulties like delayed milestones and speech or language impairments. A multi-disciplinary team approach is needed to deal with these conditions.

RECOMMENDATIONS

Clinically it needs to be realized that the umbrella term of *barriers to learning* includes many different learning disorders, and treatment of these needs to focus on a more specific diagnosis or classification. The needs of children and adolescents with an ID are very different to those of children and adolescents with a SLD.

The presence of mood disorders, even if lower in children and adolescents with an ID or children and adolescents with a SLD than children and adolescents with No LD still necessitate appropriate treatment. The higher presence of anxiety disorders in children and adolescents with an ID or children and adolescents with a SLD compared to children and adolescents with No LD necessitates that their appropriate treatment needs are met.

The high prevalence of ADHD overall means that in a clinical setting, when assessing children with ADHD, LD should be excluded, and vice-versa.

The high use of pharmacotherapy and lower use of psychotherapy should be investigated to see whether polypharmacy can be reduced within the resource constraints of available psychological services. There could also be more use of other therapeutic services.

Further research could expand the study setting to include other hospitals and clinics in other areas in South Africa. Additionally, comparison of different therapeutic interventions and their outcomes and efficacy in the different types of learning disorders could be investigated in the future.

Given that learning disorders are the greatest hindrance in the school setting, it would also be very useful for future research to explore the relationship

between the clinics and schools. This study took place in a clinic setting. The school setting with a different focus and purpose may yield different results.

Whether making recommendations for clinical practice or future research, it needs to be remembered that children and adolescents are considered to be a vulnerable population. Psychiatric patients are also considered to be a vulnerable population.

WHEN ONE HAS TWO VULNERABLE POPULATIONS AS ONE, IT IS EVEN MORE IMPORTANT TO REALIZE THAT ANY FUTURE ACTIVITIES NEED TO BEAR THIS IN MIND FIRST AND FOREMOST. THE CHILDREN AND ADOLESCENTS WITH NO LD IN THIS STUDY HAVE OTHER - OFTEN SEVERE - PSYCHIATRIC NEEDS, AND THE CHILDREN AND ADOLESCENTS IN THIS STUDY WITH AN ID OR A SLD HAVE SERIOUS PROBLEMS WITH LEARNING TOGETHER WITH PSYCHIATRIC COMORBIDITIES.

All of their needs need to be at the heart of future clinical practice and research.

ACKNOWLEDGEMENT

The authors would like to thank Dr Noleen Loubser (PhD, Psychology, University of the Witwatersrand) for her contribution of insightful comments, editing services, and statistical analysis.

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S'bongile Nkhahle is a psychiatrist with special interest in learning disorders and the impact they have on mental health. She is interested in the link between psychiatric conditions and their impact on academic difficulties. She believes that if both conditions are treated and diagnosed earlier, the prognosis is much better and will potentially decrease the burden in mental health services in the future. Her research project was part of her MMed (Psychiatry), completed in 2020.
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Heather Alison qualified as a child and adolescent psychiatrist in 2010 and has been employed in various Gauteng government hospitals. She is passionate about and dedicated to the growth and development of child psychiatry as a science and to enhancing the quality of life of those that we have the privilege of having in our care. Dr Alison supervised the research reported here ■



WPA & NCD ACADEMY COURSE ON MENTAL HEALTH CARE

Dear WPA Member Societies,
As president of the World Psychiatric Association, it is my pleasure to make you aware of a new educational initiative to foster better integration of behavioral and mental health services at the primary care level. The WPA is now featured on NCO Academy, a partnership between major medical societies to overcome the geographic and financial barriers that have historically disenfranchised providers in rural and resourceconstrained settings from professional development opportunities. NCO Academy uses elearning to emulate training and offer practice-based learning in a virtual, on-demand environment. Lessons feature interactive cases to model and explain practical strategies to screen for, diagnose, and treat the early symptoms of common medical conditions. Alongside courses in cardiovascular disease and cancer, NCO Academy now offers free education in mental health available on the program app (iOS and Android) and its website, www.acc.org/ncdacademy

Mental Health Care: Increasing Awareness, Erasing Stigmas encompasses roughly three hours of clinical education in five mental health domains: major depressive disorders, unhealthy substance use, memory disorders, psychosexual disorders, and trauma. The course was developed by seventeen experts from WPA member societies around the world to ensure health care practitioners in diverse settings may glean relevant insights and apply guidance in their routine practice. The course is currently offered in English, with plans for translation to Chinese, Portuguese, and Spanish by September.

WPA and other program partners including the American College of Cardiology (ACC), NCO Alliance, and World Heart Federation intend to promote this educational resource far and wide. We are calling all members of the WPA network to support these efforts. Ways in which national societies representing cardiology and cancer have

promoted NCO Academy, and that we kindly ask WPA members to consider replicating, include:

- Posting to your website's catalogue of educational offerings.
- Providing visibility at society meetings.
- Announcing to members through email, newsletters, or other member publications.
- Considering certification for continuing medical education credits.



Dr Afzal Javed

Recognition is available to societies that champion NCO Academy, such as local partner designation and support to produce supplemental content about mental health care in your health system context. Program managers at the ACC are on hand to assist with CME applications, and content may be translated to even more languages for partners who are particularly keen to incorporate NCO Academy as part of their programming.

GIVEN THE MANY MISCONCEPTIONS AROUND MENTAL HEALTH AND THE NEED FOR MORE COMPASSION AND PROACTIVITY AMONG HEALTH CARE WORKERS IN ADDRESSING MENTAL WELLBEING, WE HOPE YOU CONSIDER THIS AN EXCITING UPDATE.

Please be in touch with me should you have any questions, and I look forward to collaborating on this important endeavor.

Dr Afzal Javed
President
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CONCEPT DOCUMENT

ADDICTION 2021 CONFERENCE

Together Igniting a Movement for Change



JOIN OUR MOVEMENT

The ADDICTION 2021 CONFERENCE is the biggest centrally coordinated addiction treatment movement on the African continent. The movement is spearheaded by the South African National Council on Alcoholism and Drug Dependence (SANCA), one of the largest Non-profit organisation dealing with the prevention and treatment of substance use disorders with 30 treatment centres in all 9 provinces.

This conference will ignite a movement incorporating the special skills and insights of like-minded people who are passionate about finding socially inclusive, responsive and individualized solutions to tackle addiction. Together, with contributions from academics, medical professionals, civil society, policy makers, law enforcement, activists, service users, and the wide array of public and community-based resources, we can march forward and achieve comprehensive solutions for addictive disorders.



OUR CHALLENGE

Substance use disorders have long been perceived as indicative of personal deficit. This has resulted in much self- and community-stigmatization for those affected. Some existing strategies for tackling substance dependence have been remarkably successful in achieving recovery for those affected.

The evidence is however clear that substance dependence is a medical disorder. In order that we may reach the remaining affected, the narrative needs to change to one that is less punitive and more socially inclusive. Affected individuals, along with their families must be empowered to regain their sense of self-worth and dignity, and become active collaborators in the design, implementation, and evaluation of treatment plans. The narrative needs to change. In managing addiction, which refers broadly to psychosocial effects, it is essential that substance dependence, which refers to the physiological dependence, is a key part of the conversation and at the forefront of comprehensive intervention strategies at the individual, community and societal level.

The ADDICTION 2021 CONFERENCE will be an independent international platform to ignite a transformative movement across sectors concerned with substance use and addiction in Africa. The World Drug Report, released in June 2019 by the United Nations Office on Drugs and Crime (UNODC) stated that globally 35 million people are estimated to suffer from substance use disorders and only 1 out of 7 people are accessing treatment. The picture is no different for South Africa and the severity of the substance use disorder epidemic is not fully understood or defined.



MEET THE TEAM

The chairperson of the ADDICTION 2021 CONFERENCE is Dr Goodman Sibeko MBChB, PhD is the Director: International Technology Transfer Centre South Africa - HIV ATTC and head of the Division of Addiction Psychiatry at UCT.

Dr Lochan Naidoo is an internationally recognised Addiction Medical Professional and Family Medical Practitioner from Durban, South Africa and is the chairperson for the research into practice track.

Prof. Solomon Tshimong Rataemane is retired but still involved with the Department of Psychiatry at Sefako Makgatho Health Sciences University and serves on various structures and committees and spearheads the capacity building and advocacy track.

Prof Zuki Zingela is an Associate Professor at the Nelson Mandela Central Hospital and Head of Psychiatry at Walter Sisulu University. She will be the chairperson for the Legislation, policy and Enforcement track.



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CONFERENCE PURPOSE

The overall aim of the conference is to address stigma and discrimination towards people using substances. Substance use disorders have long been perceived as indicative of personal deficit. This has resulted in much self- and community-stigmatization for those affected. Some existing strategies for tackling substance dependence have been remarkably successful in achieving recovery for those affected.

The evidence is however clear that substance dependence is a medical disorder. In order that we may reach the remaining affected, the narrative needs to change to one that is less punitive and more socially inclusive. Affected individuals, along with their families must be empowered to regain their sense of self-worth and dignity, and become active collaborators in the design, implementation, and evaluation of treatment plans. The narrative needs to change.

In managing addiction, which refers broadly to psychosocial effects, it is essential that substance dependence, which refers to the physiological dependence, is a key part of the conversation and at the forefront of comprehensive intervention strategies at the individual, community and societal level.



THE TRACKS OF THE CONFERENCE

Track 1: Research into Practice	<p>This track is focused on demand and harm reduction strategies, aiming to explore current and best practice approaches and models in the prevention and management of SUD, including the recovery stage.</p> <p>The integration of addiction theory and research into practice has been a challenging task in the treatment of substance use disorders. The gap between the evidence-base and what transpires in practice has been addressed through the development of evidence-based practices. Evidence-based practice may be defined as the integration of best evidence with clinical expertise and patient perspectives.</p>
Track 2: Capacity Building and Advocacy	<p>This track is focused on training, teaching and advocacy activities geared towards demand and harm reduction strategies. It is essential for demand and harm reduction strategies to be successful, that relevant sectors are empowered with appropriate evidence- and outcomes -based teaching and training resources and curricula. Increased competency is key to the safe and ethical provision of SUD management. This includes programmes ranging from undergraduate level to ongoing professional development and postgraduate teaching and training, while providing adequate space for informal training, teaching, and mentorship. Prevention is increasingly seen as a Science whereas it is conversely also considered once-off talk by some. Some potential approaches for integration of more pervasive prevention strategies may take some inspiration from programmes such as the Colombo plan, which has resources like the Universal Prevention Curriculum (UPC).</p>
Track 3: Legislation, policy and Enforcement	<p>Legislative requirements govern availability of resources and delivery of demand and harm reduction strategies, as well supply demand reduction. Legislative serves to protect not only the practitioner, but also the rights of service users. Professionals are in a unique position to influence the delivery of services by addressing the acute and chronic needs of service users with SUDs, including co-occurring disorders. Changes in legislation and policy can promote standardized and ethical practices, facilitating a reduction in discrimination against people who use substances. The enforcement of these policies remains a challenge and this has implications for practice; as borne out in the decriminalisation of cannabis; the prohibition of alcohol and nicotine sales in SA during the COVID-19 outbreak; public health vs individual rights; law enforcement and community engagement; funding models for treatment and prevention; NHI vs medical aid schemes; etc.</p>





THE EXPECTED OUTCOMES OF THE CONFERENCE

The ADDICTION 2021 CONFERENCE strives to achieve the following:

- Create a movement that discusses and engages in topics of concern in the treatment of addiction.
- An appraisal of current strategies employed in management of addiction in South Africa and internationally (In-patient, outpatient, home-based).
- A review of policy frameworks governing the delivery of addiction treatment in South Africa.
- Review of South African and international evidence for patient-centred comprehensive care, and the extent to which these align with Batho Pele principles.
- Promotion of practical skills development through training of clinicians and addiction counsellors with the aim of bridging the gap between evidence and practice.
- The recognition of culture as a key consideration in the management of dependence.
- Engagement with civil society and advocacy groups around best strategies for client and community engagement on the back of the reviewed evidence base.
- Engagement with Departments of Health and Social Development around comprehensively responsive packages of care for various addictive disorders.

In taking the conversation forward towards the transformation of the treatment landscape and to break with stigma, the ADDICTION 2021 CONFERENCE is collaborating with local and international partners such as the Department of State, Clinical Governance Services, ISSUP - South African Chapter, UCT, SANCA and ITTC.

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MEDIA RELEASES

ADDICTION TREATMENT: CAN MINDFULNESS REPLACE THE TWELVE STEPS?

Mindfulness isn't utilised enough in South Africa in the treatment of Substance Use Disorders (SUDs), more commonly known as addiction.

"Modern-day mindfulness programs are often viewed with suspicion in South Africa, where Christianity is the dominant religion. Meditation is perceived with distrust here, even if the programs are designed for Western countries. Mindfulness however has the potential to address the stress and trauma that people with Substance Use Disorders are experiencing, without estranging them from their culture," says Nanette Minnaar, one of the speakers at the upcoming ADDICTION Conference 2021.

THE CONFERENCE IS SCHEDULED FOR 21-23 JULY AND HOSTED BY SANCA, THE SOUTH AFRICAN NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE.

This inaugural platform will bring together SUD treatment and other medical professionals to

collaborate with providers, policy makers and regulators to create effective and long-lasting solutions to address the public health crisis of SUDs.

MINDFULNESS AND ITS ROLE IN POSITIVE PSYCHOLOGY

According to Minnaar, mindfulness is the ability to be intensely aware of where we are and what we are doing – like our thoughts, feelings, and bodily sensations – without judgement.

"The practice of mindfulness is used as one of the constructs of positive psychology, as it has been linked to increased positive feelings, a greater sense of coherence, improved quality of life, greater empathy, greater satisfaction in relationships, and more hope," she adds.

"Other constructs in positive psychology include – amongst others – gratitude journaling, reframing from negativity to positivity, self-compassion, and personal strengths."

Minnaar says another link between mindfulness and positive psychology is that mindfulness increases well-being and positive mental qualities, including compassion.



"Mindfulness-based meditation has been used in compassion training, which would result in increased sensitivity to oneself and others' needs. By being empathetic, we would be more motivated to help others. In return, this facilitates greater compassion and gives us feelings of joy and satisfaction."

YET SHE CAUTIONS THAT DEVELOPING ONE'S OWN MINDFULNESS PRACTICES IS NO QUICK FIX. IT SHOULD RATHER BE SEEN AS BECOMING A WAY OF LIFE.

"People with Substance Use Disorders and their families often want a miracle cure when they enter treatment. But what I have personally found is that people who are able to develop these mindfulness practices and skills often have better outcomes. They can therefore refrain from using alcohol and opioids. They are also more resilient and manage stressful situations and conflict better."

COMBINING MINDFULNESS WITH MORE CONVENTIONAL SUD TREATMENT

MINNAAR BELIEVES MINDFULNESS CAN BE USED IN COMBINATION AS AN AID IN CONVENTIONAL TREATMENT PROGRAMMES, TO EFFECTIVELY HELP THE PEOPLE THEY TREAT ACHIEVE MEANINGFUL, LONG TERM SUCCESS.

New research by Bowen and colleagues (2021) confirmed that their Mindfulness-Based Relapse Prevention (MBRP), and the standard relapse-prevention program, were both more successful at reducing relapse than the well-known 12-step program. The MBRP however combines practices like sitting meditation with standard relapse prevention skills, such as identifying events that trigger relapse.

"Traditional treatment for Substance Use Disorders often focus on avoiding or controlling triggers that result in negative emotion or craving," Minnaar says. "But combining this with mindfulness aims to help participants to name and tolerate craving and negative emotion, rather than fighting or avoiding the difficult states of mind that arise when withdrawing from a substance."

"Mindfulness is a skill that the person with a Substance Use Disorder can continue using for the rest of his or her life," she says. "The role of Substance

Use Disorder treatment is, after all, for a person to obtain skills to live a life of sobriety. And one such a tool that aids sobriety, is learning how to change the mindset of one's thoughts. This could result in the end of suffering. A change in mindset also teaches a person in treatment how to cope with thoughts and emotions without using a substance."

She adds that mindfulness in this regard is not only useful for people living with Substance Use Disorders, but can be successfully applied and practiced by others in the field as well.

"THOSE WORKING WITH SUBSTANCE USE DISORDERS IN SOUTH AFRICA ARE OVER-WORKED AND TRAUMATISED. PRACTICING MINDFULNESS MAY ALSO OFFER AN EFFECTIVE WAY FOR THEM TO DEAL WITH DAILY CHALLENGES AND WORK-RELATED STRESS.

This may have a positive impact on their relationships with people with Substance Use Disorders, which in turn plays a vital role in recovery," concludes Minnaar.

ADDICTION: THE MYTH OF FUNCTIONAL ALCOHOLISM

"The myth of 'functional alcoholism' is one that we continuously try to dispel," says Thembekile Msane from SANCA, the South African National Council on Alcoholism and Drug Dependence.

"The misnomer 'functional alcoholism' is described as Alcohol Use Disorder in a clinical sense," explains Msane. "People who consider themselves 'functional alcoholics' should be warned that this could develop into a more severe Substance Use Disorder if their drinking patterns become more frequent or intense."

SYMPTOMS OF AUD CAN INCLUDE TREMBLING HANDS, NUMBNESS, A LOSS OF MEMORY, HALLUCINATIONS, AND DEMENTIA.

Even with these symptoms present, people who consider themselves 'functional alcoholics' often believe that they are still able to fulfil their responsibilities and they will often give different reasons of why they drink, such as relieving stress.



"Some of the warning signs of Alcohol Use Disorder (AUD) include appearance changes, weight fluctuations, mood swings, secretive behaviour and aggression," explains Msane. "People who suffer from AUD might sometimes borrow money from colleagues, friends, and family or they will start to distance and isolate themselves from friends and family."

"IF A LOVED ONE LIES ABOUT THEIR DRINKING, OR THEIR BEHAVIOUR AND DRINKING PATTERNS CHANGES, OR THEY OFTEN EXPERIENCE A HANGOVER OR BLACKOUTS, THIS KIND OF PATTERN AND BEHAVIOUR REQUIRES AN INTERVENTION," SAYS MSANE. "THIS INTERVENTION SHOULD CREATE AN OPPORTUNITY TO ADDRESS THE MATTER AND GET HELP."

Keeping record of the person's drinking behaviour will assist in getting professional help for them. Employers should look out for absenteeism and the inability to stick to deadlines often as these could be signs that the person is struggling with AUD.

"This type of monitoring enables a family or employer to access the proper referral channels if they need to resort to involuntary admission for the co-occurring disorder," explains Msane. "Involuntary admission should be pursued if the alcoholic can no longer help themselves and they are at risk of endangering themselves or others."

KEEPING AN EYE ON THE BEHAVIOUR PATTERNS OF LOVED ONES MUST START FROM AN EARLIER AGE THAN MOST PEOPLE THINK. ACCORDING TO MSANE, MANY CHILDREN START EXPERIMENTING WITH ALCOHOL FROM AS EARLY AS TEN YEARS OLD.

"AUD happens in stages, and if children start to drink this early in life, they are at risk of progressing from mild to severe alcohol abuse disorder by the time they are in their twenties," warns Msane.

While it is illegal in South Africa for people under eighteen years of age to purchase or drink any form of alcohol, peer pressure often leads to the start of experimenting with alcohol.

Msane advises those who consider themselves 'functional alcoholics' to weigh up their behaviour



with the health consequences of alcohol dependency: nerve and liver damage, arthritis, gout, larynx cancer, heart failure, and irreversible brain damage.

The incidences of AUD in South Africa are not well recorded due to a variety of complex reasons. One of these reasons is that the stigma assigned to Substance Use Disorders (SUD) – more commonly known as addiction – prevents those suffering from an SUD to seek help.

THE FIGHT AGAINST THE STIGMATISATION OF SUDS IS ONE OF THE MAIN DRIVERS BEHIND SANCA'S DECISION TO HOST THE ADDICTION CONFERENCE 2021 ON 21-23 JULY. THIS INAUGURAL PLATFORM WILL BRING TOGETHER SUD TREATMENT AND OTHER HEALTHCARE PROFESSIONALS TO COLLABORATE WITH PROVIDERS, POLICY MAKERS AND REGULATORS TO CREATE EFFECTIVE AND LONG-LASTING SOLUTIONS TO ADDRESS THE PUBLIC HEALTH CRISIS OF SUDS.

For individuals, families and employer in need of assistance, SANCA can be contacted via their website, www.sancanational.info, via email on sancanational@telkomsa.net, or via phone on 011 892 3829.

ADDICTION: MEDICAL AIDS HAVE TO SEE IT FOR WHAT IT IS

Medical aid benefits are often only provided for patients who qualify for institutionalisation related to a Substance Use Disorder (SUD) – more commonly known as addiction. "This makes it impossible to know how big the problem of SUDs in South Africa really is," says Dr Johann Van Zyl, EXCO Member of the ADDICTION Conference 2021.

"Substance dependency often presents as an underlying or associated mental health or psychiatric condition and therefore remains unreported," says Van Zyl. "This, combined with the stigma attached to receiving treatment for drug abuse, means that patients who aren't institutionalised aren't reported on as part of the SUD epidemic."



Without knowing the extent and true impact of the problem, it is nearly impossible to motivate why the SUD public health crisis urgently requires focus and funding.

This is one of the drivers behind the upcoming ADDICTION Conference 2021, scheduled for 21-23 July and hosted by SANCA, the South African National Council on Alcoholism and Drug Dependence. This inaugural platform will bring together SUD treatment and other healthcare professionals to collaborate with medical aid representatives, healthcare providers, policy makers and regulators to create effective and long-lasting solutions to address the public health crisis of SUDs.

EARLY DETECTION IS KEY

The role of medical aid schemes has to start even before treatment is required.

THERE ARE A VARIETY OF APPROACHES THAT MEDICAL AIDS COULD CONSIDER TO EDUCATE THEIR MEMBERS AND THE GENERAL PUBLIC ON SUDS. PATIENTS THAT HAVE EARLY-SUD OFTEN DEMONSTRATE SPECIFIC HEALTH-SEEKING AND CLAIMS BEHAVIOURS, SO IT IS POSSIBLE TO ANALYSE CLAIMS DATA AND DESIGN SCREENING PROGRAMS TO IDENTIFY AT-RISK PATIENTS. THIS CAN LEAD TO EARLY INTERVENTION, APPROPRIATE TREATMENT AND A REDUCTION OF DOWNSTREAM COSTS.

Medical aids can also play an imperative role in reducing the stigma around SUDs by providing educational material through their existing communication channels.

"I'm not aware of any specific educational programs on substance abuse that are currently presented by medical aids," comments Van Zyl. "At best, they occasionally run articles in the funds' newsletters, but much more can be done."

SUBSTANCE USE DISORDERS OFTEN HIDE BEHIND OTHER DIAGNOSES

To better report on the true number of SUD diagnoses, and assist members in combating SUDs, medical aids need to acknowledge that



the disorder is often complex and requires a multi-disciplinary approach.

PATIENTS WITH SUD OFTEN PRESENT WITH UNRELATED PHYSICAL OR MENTAL HEALTH CONDITIONS WHICH THEN AFFECTS THE DIAGNOSIS AND PRESCRIBED TREATMENT PROTOCOL. THIS UNINTENTIONAL SUBOPTIMAL TREATMENT OF THE SUD COULD LEAD TO ASSOCIATED HEALTHCARE COSTS WHICH COULD HAVE BEEN AVOIDED IF THE SUDS WERE APPROPRIATELY MANAGED AT FIRST.

Van Zyl also says patients do not necessarily relapse due to a deliberate lack of compliance. "Substance Use Disorder is a chronic illness in its own right and it will unlikely be resolved sustainably through a conventional 21-day in-patient program as is prescribed by the Regulations to the Medical Schemes Act."

"Recognising this and aligning medical aid benefits accordingly will aid with earlier diagnoses and interventions, with better associated clinical outcomes that can be measured by long-term sobriety - the only true indicator of program effectiveness."

"MEDICAL AIDS MUST SHIFT THE EMPHASIS FROM A BENEFITS-BASED APPROACH OF A THREE-DAY DETOX AND 21-DAY TREATMENT PLAN TO A PATIENT-ORIENTED APPROACH," SAYS VAN ZYL. "THIS WOULD MEAN THAT BENEFITS WOULD BE MORE INDIVIDUALISED IN RELATION TO ASSOCIATED MEDICAL CONDITIONS AND THE TYPES OF DEPENDENCIES."

"Patients with SUDs require long-term maintenance treatment and support in addition to the minimum benefits prescribed in the legislation. Failing this there will always be the risk of relapse and repeated admissions," says van Zyl.

"LONG-TERM SOBRIETY WILL HELP MORE PEOPLE RETURN TO ECONOMIC ACTIVITY AND HAVE A POSITIVE IMPACT ON MEMBERS' HEALTH AND LIVES."



MINISTERS TO ADD VOICES TO FIGHT AGAINST ADDICTION

Alcohol bans as part of lockdown regulations continue to spark controversy. Alcohol misuse among South Africans is however of such great concern that the Minister of Social Development Lindiwe Zulu will be the opening keynote speaker and Deputy Minister Dr Joe Phaahla the closing keynote speaker at the upcoming ADDICTION 2021 Online Conference.

"The participation of the two ministries places the public health crisis of Substance Use Disorders in the much-needed spotlight," says Adrie Vermeulen, National Coordinator of the conference host SANCA – South African Council on Alcoholism and Drug Dependence.

"LIMITING THE USE AND POTENTIAL MISUSE OF ALCOHOL BY IMPOSING RESTRICTIONS MIGHT BE EFFECTIVE IN THE SHORT TERM, BUT A MORE SUSTAINABLE SOLUTION IS NEEDED TO PREVENT SUBSTANCE MISUSE FROM DESTROYING LIVES AND LIVELIHOODS."

Substance Use Disorder (SUD) – more commonly known as addiction – is a diagnosable, treatable medical condition. "It is not a personal weakness or a lack of character. It is not something that needs to be punished by law but an illness that deserves well-researched treatment as much as any other illness does," says Vermeulen.

In South Africa, the fourth National Drug Master Plan (NDMP 2019 – 2024) was drafted in accordance with the Prevention of and Treatment for Substance Abuse Act (Act No. 70 of 2008). Other independent programmes and projects focus on specific elements addressed in the NDMP.

DESPITE THIS, A GAP REMAINS BETWEEN THE EXISTENCE OF THE FORMAL DOCUMENTATION AND ITS PRACTICAL, COORDINATED IMPLEMENTATION BY DOCTORS, NURSES, SOCIAL WORKERS, LAW ENFORCEMENT, THOSE UNDERGOING TREATMENT AND THEIR FAMILIES.

"We urgently need to work together to significantly reduce the impact of Substance Use Disorders on society, communities, families, healthcare and law enforcement," says Vermeulen.

The conference programme will – in addition to the speeches by the Ministers – feature highly respected prevention and treatment specialists. The programme has been designed to inspire attendees to collaborate in creating practical, evidence-based SUD solutions relevant to the unique African context.

ADDICTION AND WORKING FROM HOME – THE ROLE OF EMPLOYERS

The annual economic impact of Substance Use Disorders (SUD) on the employment sector amounts to millions in lost time, productivity and income. And according to the Achkar Law company, employees are at greater risk to develop unhealthy habits while working from home during the Covid pandemic.

"The challenge to determine whether an employee experiences SUD problems is indeed much bigger when working remotely," says Dr Breggie Smook, one of the speakers at the upcoming ADDICTION Conference 2021.

"THE OPTIONS FOR FACE-TO-FACE MEETINGS AND OPEN DISCUSSION ARE LESS. EMPLOYERS SHOULD, HOWEVER, TREAT THE SITUATION THE SAME AS AT THE PHYSICAL WORKPLACE. THEY STILL HAVE AN OBLIGATION TO PROVIDE THE OPPORTUNITY FOR APPROPRIATE PREVENTION, TREATMENT, COUNSELLING, AND REHABILITATION."

The conference is scheduled to take place from 21-23 July and is hosted by the South African National Council on Alcoholism and Drug Dependence (SANCA). This inaugural platform will bring together SUD treatment and other medical professionals to collaborate with providers, policy makers and regulators to create effective and long-lasting solutions to address the public health crisis posed by SUD.

MANAGING SUDS WHEN WORKING FROM HOME

Smook says employers need to focus on reinforcing the open-door-policy when employees work remotely.

"This can be achieved by creating work-from-home-



guidelines, including those on risky substance use behavior," she notes. "Arrange regular private discussions to monitor their performance and wellbeing during the pandemic."

She adds that it is much more difficult to identify the obvious SUD signs and symptoms in the absence of physical contact, therefore managers and employees should be educated on early signs and symptoms, and the devastating impact SUD has on the business.

"COLLABORATION IS THE GOLDEN THREAD TO INTENTIONALLY CREATE AND SUSTAIN CHANGES TO COMBAT THE PROBLEM OF SUD MORE EFFECTIVELY IN THE WORKPLACE," SMOOK URGES.

STRATEGIES TO DEAL WITH SUD STIGMATISATION IN THE PHYSICAL WORKPLACE

According to Smook, South Africa took a step in the right direction by decentralising mental illness care to primary health care workers.

"BUT ONE ELEMENT OF MENTAL HEALTH THAT IS STILL VERY MUCH STIGMATISED IS ADDICTION, EVEN THOUGH IT IS MEDICALLY RECOGNISED AS A PREVENTABLE, TREATABLE CHRONIC DISEASE."

She cites Brohan and Thornicroft (2010), McCann et al (2011), and Roche et al (2018) when recommending strategies to reduce SUD-related stigma at work. "Firstly, companies should adopt a culture of concern for employees within a broad health and wellbeing framework."

SMOOK ADDS THAT EMPLOYERS SHOULD ALSO ENSURE THAT STAFF IS INFORMED ON THE DIFFERENT LABOUR LAW ACTS REGARDING THEIR RIGHTS AND RESPONSIBILITIES.

"Policies and procedures must be established to formalise the company's commitment to support people living with SUD. This can be achieved by promoting the use of factual, rather than emotive and discriminatory language in discussions and personal files. Also ensure similar treatment of staff with SUD related problems and those with other health conditions."



Smook advises that a list of external treatment resources should be accessible for all employees if they need professional and specialised guidance.

MINISTERS COMMIT TO FOCUS ON CURBING SUD CRISIS

Minister of the Department of Social Development, Lindiwe Zulu, and Deputy Minister of the Health Department, Dr Joe Phaala, acknowledged the urgency of focusing on the public health crisis of Substance Use Disorders (SUD) at the ADDICTION 2021 online conference 21-23 July. The online event was hosted by the South African National Council on Alcoholism and Drug Dependence (SANCA).

"Substance Use Disorders – more commonly known as addiction – is a diagnosable, treatable medical condition," explains Adrie Vermeulen, National Coordinator of SANCA. "While the first instance of alcohol or drug use is a choice, these substances have the powerful potential of changing the brain's physical structure so that the body needs the substance for survival."

"THESE PHYSICAL CHANGES TO THE BRAIN STRUCTURE ARE IRREVERSIBLE AND THAT'S WHY SUD IS A CHRONIC, INCURABLE DISEASE."

"This wicked social problem impairs our citizens' social, cultural, innovative technological and economic contribution to South Africa's collective fabric," said Minister Zulu. "Our efforts in addressing the burden of Substance Use Disorders is a national priority as part of South Africa's commitment to the United Nations 2030 Agenda for Sustainable Development."

WESTERN CAPE PROVINCIAL MINISTER OF SOCIAL DEVELOPMENT, SHARNA FERNANDEZ, ADDED HER SUPPORT TO THE CAUSE DURING HER ADDRESS. "THE SOCIAL SECTOR NEEDS TO REGROUP IF WE WANT TO BE INTENTIONAL ABOUT PREVENTING AND TREATING SUBSTANCE USE DISORDERS – WE NEED TO LOOK AT IT IN A DIFFERENT WAY THAN IN THE PAST."

Key themes across most of the presentations



included the need to destigmatise the illness, collaborate across medical disciplines, and funding from both public and private sectors to enable individualised evidence-based treatment.

DESTIGMATISE THE ILLNESS

Several presenters asserted that substance abuse should be seen as a healthcare problem, not as a criminal justice problem. This mindset shift will allow facts – rather than beliefs based in tradition, culture, or religion – to inform the early detection and treatment of SUD.

“WE NEED TO INVEST IN INNOVATING WORKING STRATEGIES THAT WILL LEAD TO THE DESTIGMATISATION OF SUBSTANCE USERS,” SAID MINISTER ZULU. “THIS WILL ENABLE THE SUBSTANCE USERS TO REGAIN THEIR SENSE OF SELF-WORTH, DIGNITY, AND EXPLOIT THE SOCIO-ECONOMIC PROSPECTS OF CONTRIBUTING TO SOCIETY.”

“Anger and shaming have no place in addiction treatment,” warned Dr Raju Hajela from Calgary-based Health Upwardly Mobile during his presentation.

COLLABORATE TO REDESIGN PREVENTION AND TREATMENT

AS SUD IS A CHRONIC AND INCURABLE DISEASE THAT REMAINS EVEN AFTER THE INITIAL ACUTE TREATMENT, PATIENTS WITH SUD REQUIRE ONGOING CHECK-UPS FROM HEALTHCARE AND SOCIAL WORK PROFESSIONALS. THE RAPID ADOPTION OF TELEMEDICINE DURING THE PANDEMIC MAKES THIS ONGOING CARE MUCH EASIER, ESPECIALLY FOR PATIENTS LOCATED FAR FROM HEALTHCARE FACILITIES.

The treatment of the disease is complex; it needs to be created for each individual's unique circumstances and involves a variety of specialist caregivers. As SUD is an incurable disease, patients often require the assistance of their families, friends and communities to support their holistic treatment protocol.



Collaboration between the various parties is therefore crucial to the creation of prevention and treatment strategies that have a direct, effective and lasting impact on instances of SUD.

PUBLIC-PRIVATE PARTNERSHIPS NEEDED TO TRAIN ADDICTION SPECIALISTS

SUD IS A PUBLIC HEALTH CRISIS THAT HAS AN IMPACT ON COMMUNICABLE DISEASES, CRIME, TERRORISM AND POVERTY. THE FAR-REACHING IMPACT OF THE SUD CRISIS CAUSED A RISING NEED FOR PUBLIC-PRIVATE PARTNERSHIPS TO FUND SUB-SPECIALTY TRAINING TO INCREASE THE TRAINING OF ADDICTION SPECIALISTS.

Her Excellency Amira Elfadil, Commissioner of the African Union, said during her presentation: “Africa is no longer just a transit region for drugs but a major consumption market. I cannot over-emphasise the need for well-trained professionals able to apply evidence-based SUD treatment protocols.”

The ADDICTION 2021 online conference had 610 delegates from 41 countries watch presentations from 95 speakers.

MINISTER ZULU LABELLED THE CONFERENCE AS “THE LITERAL EMBODIMENT OF THE MOVEMENT THAT WILL IGNITE OUR COLLECTIVE CREATIVITY AND SOLUTION CO-CREATION IN THIS AREA.”

In his closing keynote speech Deputy Minister Phaala said: “I'm looking forward to the report of this conference, so that it can help map our way forward.”

MEDIA CONTACT: Idele Prinsloo, 082 573 9219, idele@thatpoint.co.za

For more information on the ADDICTION 2021 Conference:

Website: www.addiction.org.za

LinkedIn: <https://www.linkedin.com/events/6764476872391712768/>

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ARE YOU SURVIVING OR THRIVING? BUILDING YOUR RESILIENCE

Renata Schoeman

2 020...do we need to say more? COVID-19 has flipped our world upside down and changed a world that was safe, secure and known, even with all its life challenges, overnight to one of unfamiliarity, chaos and an enormous amount of discomfort and additional stressors.

The pandemic, and the significant impact it has had, and continues to have, on all aspects of our lives, contributes to many feelings of uncertainty and anxiety. We have all had to adapt at rapid speed. The past couple of months, whilst facing adversity, we have been working from home, physically distancing, tolerating financial hardships, embracing technology, or even dealing with illness and loss related to health, finances. This has become our 'new normal'. These overnight changes and challenges have left most people despondent. However, despite facing similar stressors, there are many who seem to have "glided" through it all, unaffected. How is that possible, you might ask.

"THE TRUTH IS THAT OUR FINEST MOMENTS ARE MOST LIKELY TO OCCUR WHEN WE ARE FEELING DEEPLY UNCOMFORTABLE, UNHAPPY, OR UNFULFILLED. FOR IT IS ONLY IN SUCH MOMENTS, PROPELLED BY OUR DISCOMFORT, THAT WE ARE LIKELY TO STEP OUT OF OUR RUTS AND START SEARCHING FOR DIFFERENT WAYS OR TRUER ANSWERS." (PECK, 1978).

The message here is that we should not shy away from stress – stress can be a powerful motivator and fertiliser for growth. However, we need to manage our stress and build our resilience. According to the American Psychological Association (2014), resilience is "the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of threat".

But what makes some more resilient than others?

Prevention includes a wide range of activities — known as "interventions" — aimed at reducing risks or threats to health. Primary prevention specifically refers to preventing disease or injury before it occurs. In the context of resilience, primary prevention refers to limiting exposure to work-related hazards that contribute or cause disease (workplace intervention), altering unhealthy and unsafe behaviours (improving selfcare and healthy lifestyle choices), and increasing resistance to illness, should exposure occur.



Renata Schoeman

The most effective prevention is therefore building resilience through strengthening your internal resources and focussing on selfcare.

TEN HABITS OF RESILIENT PEOPLE

1. Be optimistic

Optimism is a future-oriented attitude, involving hope and confidence that things will turn out well. Positive emotions reduce physiological arousal and broaden our visual focus, our thoughts, and our behaviour. Although we may feel overwhelmed by the current situation and our anxieties (health, financial, etc.), our thinking is more creative, flexible, holistic, effective and future-focussed, when we are optimistic.

2. Face your fear

Mandela said "I learned that courage was not the absence of fear, but the triumph over it. I felt fear myself more times than I can remember, but I hid it behind a mask of boldness. The brave man is not he who does not feel afraid, but he who conquers that fear".

Fear can be a warning and a guide – it helps us to focus on what we need to address and to master the skills necessary for conquering the "enemy".

3. Have moral courage

Actively identifying your core values, assessing the degree to which you are living by these values, and challenging yourself to adopt a higher standard can strengthen character and build resilience. To be morally courageous, we must be willing to do what we know to be right, even if it means loss, disapproval, or shame.

Kidder (2006) describes moral courage as the “willingness to take a tough stand for right in the face of danger...the courage to do the right thing... the quality of mind and spirit that enables one to face up to ethical challenges firmly and confidently without flinching or retreating”.

4. Have faith

Religion and spirituality draw on faith. Not only is faith associated with better physical and mental health, but also with longevity. In a meta-analysis of 42 studies (n = 126000), those who actively practiced a religious faith lived slightly longer than those who did not (McCullough et al., 2000).

We can include the practice of meditation and mindfulness here. Mindfulness is a state of active, open attention on the present - observing your thoughts and feelings from a distance, without judging them as good or bad. Mindfulness means living in the moment and awakening to the experience. Mindfulness has been associated with an increase in the areas of the brain regulating mood, anxiety, memory and wellness - through increasing the size of the hippocampus and reducing the size of the amygdala.

5. Get social support

Social connectedness decreases perceived stress, depression, ischaemic heart disease and mortality. The effect of social support on life expectancy may be as strong as the effects of obesity, cigarette smoking, hypertension, or level of physical activity (Salpolsky, 2004).

Fowler and Christakis (2008) have also found that social connectedness improves our happiness by up to 40%. This is one of the biggest challenges for us during the current COVID-19 pandemic and the call for social distancing. I would strongly recommend that we replace “social distancing” with “physical distancing” - and ensure that we remain socially connected.

6. Find role models

The mirror neurons in our brain enable us to learn through observation. Identify resilient role models and imitate and practice their best qualities. Rosen (2014) and Sharma (2018) give good examples of resilient people and their practices.

7. Train diligently

Physical exercise directly benefits the brain. Not only does it improve immunity, positive emotions (e.g.

happiness, joy and pleasure) and concentration, but it also creates new cells in the hippocampus which underlies learning and memory. Aim to exercise five times per week for at least 30 minutes.

8. Sleep regularly

Various studies have confirmed the health benefits of sleep. It improves your immunity, stabilises hormones directly linked with metabolism, improves emotional resilience and is necessary to consolidate information during learning for memory formation.

9. Cultivate a growth mind set and never stop learning.

The more we think, the better our brain functions - regardless of age. An active brain produces new connections between neurons, so-called neuroplasticity. Even if we train one cognitive skill, it can improve performance of other cognitive skills and protect us against cognitive decline later in life. However, it is important that we cultivate a growth mindset in which we see failure and challenges as opportunities for growth - both at personal and organisational levels. Resilience also requires us to think creatively and with flexibility.

10. Find meaning

Nietzsche famously said “He who has a why can endure almost any how”. In *Man’s search for meaning*, Frankl (2008) emphasised that finding meaning is an active pursuit: “It must be searched for, found and discovered in the concrete experiences of our daily lives”.

We need to make sense of our circumstances and believe that we have the ability to exert influence over it. This underlies one of the core requirements of resilience: our consistent and deliberate practice of resilience and the engaging in work that is “excellent in quality, socially responsible, and meaningful to its practitioners” (Gardner, Csikszentmihalyi, & Damon 2001). This will help us to translate the benefit of the inner work we are doing to the external challenges we are facing.

SIEBERT (2005) STATED THAT “WE ARE MOST RESILIENT WHEN WE SCAN NEW CIRCUMSTANCES WITH CURIOSITY, NOT KNOWING IN ADVANCE WHAT WE WILL DO, BUT CONFIDENT THAT WE WILL INTERACT IN WAYS THAT LEAD TO THINGS WORKING WELL.”

The COVID-19 pandemic has transformed our lives - and it has the potential to transform us. It is crucial that we accept and embrace change as part of living, and that we avoid seeing crises as insurmountable problems. Stress can be good for you. It can compel you to thrive and not merely survive - if you commit to setting aside time to work on your resilience, keep things in perspective, focus on your goals and take care of yourself.

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FREEDOM IN A 7 LETTER PRISON

Claudia Campbell

Every month I hand over a fairly regular looking script to my pharmacist. My scripts have been written at the hand of the same doctor for a dozen years – unusually, his writing is fairly legible. Collecting my medication, bringing it home, and packing it into 28 days’ worth of little pill organizers has become a tedious ritual. I feel that after packing out 4380 days’ worth of capsules and tablets it should feel like nothing more than a requisite, dull routine. However, every month I find myself avoiding it, and I mean, really, really avoiding it.

One might link this to the droning, monotonous popping of blister packs and counting of hundreds of dispersible tablets that have a faux blackcurrant-yoghurt whiff to them, but this is not the cause of my avoidance. The reason is linked to one word on my script: *chronic*.

‘CHRONIC’, IT’S A SIMPLE TERM AND AT ITS CORE IT REALLY JUST MEANS ‘TIME’.

However, written on a script it carries so much more

weight – not just diagnostically, but emotionally. It’s a word I try not to look at too much, because it can feel like a 7-letter prison. The twice-daily procedure of spit-the-toothpaste-swallow-the-tablets feels quite devoid of emotion. But, the script and a bag of blister-packs make the spot behind my gut, underneath my lungs, close to my heart thud uncomfortably.

Fortunately, for the most part, once the blackcurrant yoghurt whiff has drifted away and the blister packs are little void plastic shapes, the thud dissipates and my gut, lungs and heart begin to idle along fairly contentedly again.

A COUPLE OF WEEKS AGO I WENT FOR MY REGULAR, COMPREHENSIVE PANEL OF BLOOD TESTS. GETTING MY MEDICATION INTO THE THERAPEUTIC RANGE TOOK YEARS. IT WAS A HARD SLOG, BOTH FOR MY DOCTORS AND ME.



Claudia Campbell

7 LETTER PRISON

The gruelling process gradually gave way to the much longed for sustained stability and functionality.

After my initial arrival at the haloed ground of The Therapeutic Level, every blood test that came back in range felt like a celebration. However, a half-dozen blood tests later I simply expected good results, the sparkle had worn off and I stopped my continual doubt that I was about to slip backwards. However, my last result was not so good, still in range but only just in range. The 'chronic' churn began again. However, 'chronic' also provides a plan and the plan effectively deals with the churn. Because in its 'chronic-ness' my illness is not an unknown now, we know how it behaves and we understand what needs doing to get back to where we need to be. It's truly not a big deal anymore.

PERHAPS A MONTHLY MOOD OVER HAVING A CHRONIC ILLNESS MIGHT SEEM DRAMATIC - IT DOES TO ME ANYWAY, BUT IT HAS AN OFF-BEAT PURPOSE TOO. A DOZEN YEARS AGO I WAS SO ILL AND DYSFUNCTIONAL. HOSPITAL ADMISSIONS CAME AND WENT MORE FREQUENTLY THAN THE SEASONS. EVERY TIME I FELT LIKE I WAS GAINING HEALTHY MOMENTUM SOMETHING WOULD KNOCK ME BACK.

Getting up each time required a certain stick-at-it-ness, and this led to the start of understanding that I needed to figure out how life could happen and be joyful within, or perhaps, around a chronic illness. To do that I had to stop overanalysing it, fighting it, I needed to stop searching for a permanent fix and I had to start simply walking next to it. I stopped focusing solely on treatment and started focusing on living. I managed to lift my head, look up and plan my next steps.

Thus, the process of acknowledging the limitations of having a chronic illness began. Because of the 7-letter word 'chronic' I began to accept that I was not separate from my illness. Even though it's a

persistent and very real part of me, it is merely a part, and all of me is so much more than just one part. The things that, without doubt, make my life worth living need to take up most of my mind's eye, because they are plentiful and beautiful.

THAT SAID, I AM REQUIRED TO ADMIT THAT CHRONIC ILLNESS IMPOSES LIMITATIONS AND DEFINES NUMEROUS BOUNDARIES THAT MUST, AT ALL TIMES, BE RESPECTED.

Boundaries and limitations sound so very restricting. However, for the most part, it is these very restrictions that allow me, a person with a chronic illness, to experience freedom too. I learnt, often the hard way, to stop trying to break through my limitations - to conquer boundaries, but instead embrace the freedom that exists within those precincts. I began to stop feeling restricted and realise how freely I can live within a safe space. Boundaries: the frontiers to freedom! Well, relative freedom.

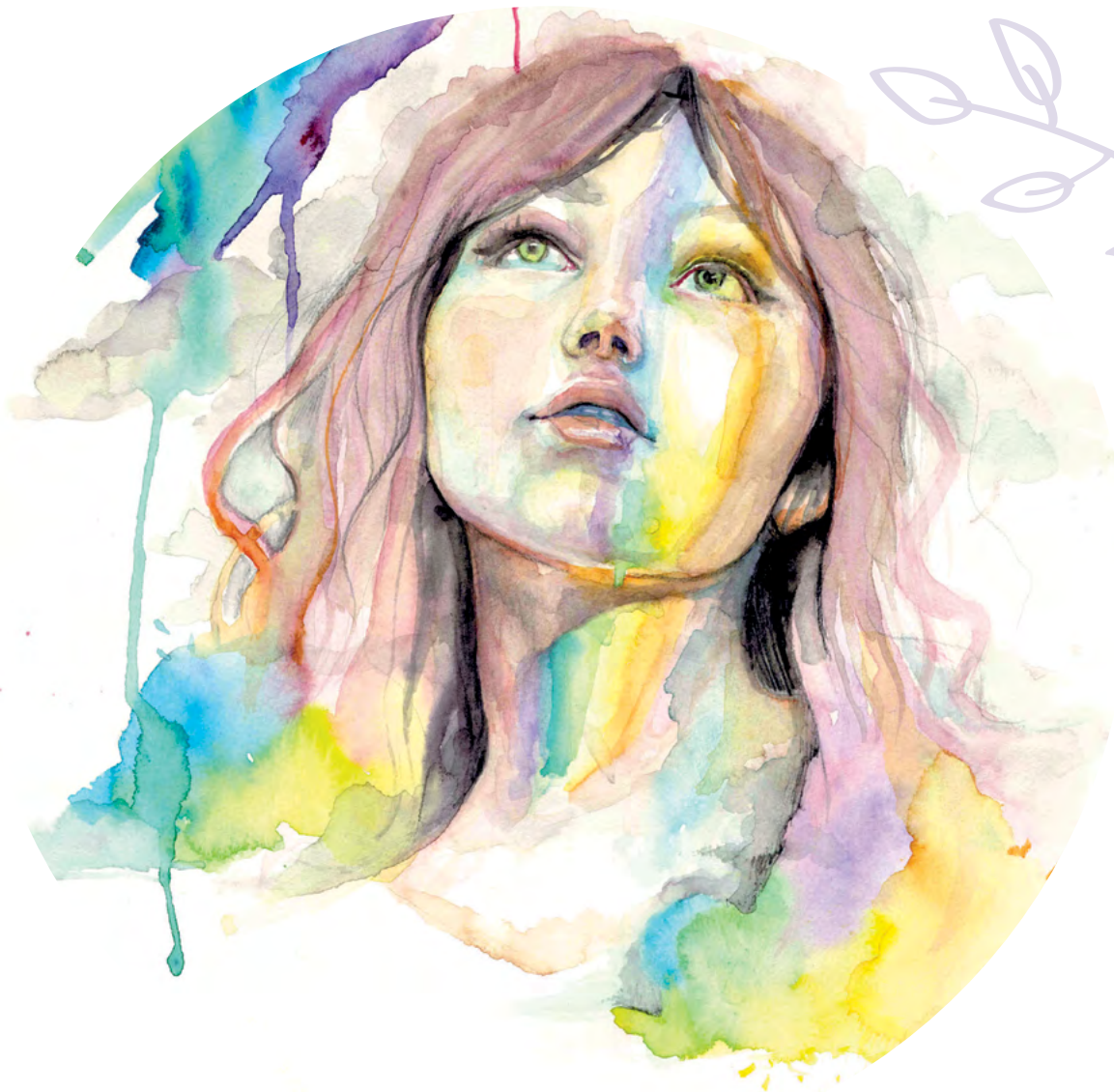
IF I DON'T CROSS THE BOUNDARY LINES, THEN I REMAIN HEALTHY AND FUNCTIONAL - SO MUCH SO THAT FOR MOST OF EACH MONTH I CAN ALMOST FORGET I HAVE A CHRONIC ILLNESS. THAT IS, UNTIL I HAVE TO PACK MY MEDICATIONS OUT AGAIN.

So somehow, every 28 days, when my freshly filled pill organisers and empty blister packs are scattered around me, I need to force my self-pitying mind to muscle its way to gratitude. 'Chronic illness' and its offspring, 'chronic prescription', can be terms of incarceration or gateways to bounded freedom. I choose the latter.

Claudia Campbell holds a post-graduate degree in psychology and has 10 years experience in the field of corporate transformation strategy. Claudia works in a voluntary capacity as a psychosocial facilitator, public speaker, and consultant. Due to various health challenges, Claudia's personal life includes many experiences from the patient's side of the consultation room. **Correspondence:** claudia@redbench.co.za ■



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KETAMINE CLINICS BEYOND THE HILLS

Alan Howard

In the August 2020 edition of *South African Psychiatry*, I penned two articles titled *Ketamine COVID & Suicidality – a perfect fit for a perfect storm* and *A Ketamine Clinic in the Hills*, the latter describing the establishment of our flagship outpatient ketamine infusion clinic in the Natal Midlands.

Ketamine Clinics of South Africa (KCSA) currently has three established outpatient clinics in KZN (Hilton and Umhlanga) and Gauteng (Bedfordview), with a new clinic opening shortly in Cape Town and further branches planned for Pretoria and the Garden Route.

ACCEPTANCE OF NMDA ANTAGONISTS LIKE KETAMINE, AS AN EFFECTIVE AND NO LONGER REALLY 'NOVEL' APPROACH TO TREATING AN ARRAY OF MOOD DISORDERS, CHIEF AMONG THEM TREATMENT RESISTANT DEPRESSION (TRD) AND SUICIDALITY, IS GAINING TRACTION AND MORE UNIVERSAL ACCEPTANCE.

That the launch of our clinics in early 2020 coincided with the start of the COVID pandemic and lockdowns was a bitter blow yet, inevitably (as discussed in a prior article), the prevalence of suicidality, newly diagnosed mood disorders and exacerbations in patients with existing diagnoses have given new impetus and significance to the treatment we offer.

Throughout lockdowns, and more recently the riots and unrest, infusion days have been limited and most clinics operational two-days a week. Still, in 18-months, our clinics have administered almost 2000-ketamine infusions.



Alan Howard

Most of our patients are referred with a diagnosis of Treatment Resistant Depression (TRD), many with established suicidal ideation. We also treat several patients with anxiety disorders and PTSD and have seen remarkable results in OCD. Wherever possible, a 'successful outcome' is quantified using a subjective scale (PHQ-9, GAD-2 or 7, YBOCS) and patients provide feedback after an infusion series.

OUTPATIENT KETAMINE INFUSIONS ARE INCREASINGLY BEING USED TO TREAT REFRACTORY NEUROPATHIC PAIN.

We have also noticed more acceptance amongst physicians, neurologists, neurosurgeons, and oncologists who increasingly turn to ketamine as an outpatient option to treat refractory neuropathic pain, the role of NMDARs in chronic pain states being more clearly understood. In this regard, progress is monitored using the Defense and Veterans Pain Rating Scale (DVPRS), as this focuses not only on an analogue pain scale, but on four other biopsychosocial parameters. It is not unusual to see oncology patients with Cancer related Neuropathic Pain (CNP), either neoplastic in origin or related to chemotherapy, reduce their DVPRS

score to single digits after only a few ketamine infusions, as well as concurrently reducing their opioid requirement.

THE APA HAS PUBLISHED INTERNATIONAL GUIDELINES ON KETAMINE USE FOR DEPRESSION.

At last, the American Psychiatric Association (APA) has published international guidelines on Ketamine use for depression (*American Journal of Psychiatry, March 17, 2021*). Only intravenous or intranasal ketamine is advocated by the panel and it is pertinently noted that insufficient evidence exists for administration by other routes. The likelihood that the intravenous route is superior to the intranasal route is also pointed out. The requirement for a safe clinical environment is stressed.

Shortly after the release of the APA Guidelines, the South African Society of Anaesthesiologists (SASA) released a statement on outpatient ketamine infusions. Their comment, they say, was necessitated by the fact that ketamine is a registered anaesthetic drug and its outpatient use consequently led to legitimate patient safety concerns, concerns echoed by the APA in the aforementioned guidelines. (*The statement can be accessed on our website*).

SASA HAS RELEASED A STATEMENT ON OUTPATIENT KETAMINE INFUSIONS.

KCSA is proud of our commitment to patient safety first. In our clinics, ketamine is only administered by anaesthetists and doctors with life-support skills, and in a clinical environment with resuscitation equipment and experienced nurses immediately on hand. All of our doctors are members of SOSPOSA (Society of Sedation Practitioners of South Africa), a special interest group of SASA, and we apply for accreditation of our clinics by this group, as recommended by SASA.

THE DICHOTOMY THAT EXISTS BETWEEN THE FIELDS OF PSYCHIATRY AND ANAESTHESIOLOGY WHERE KETAMINE IS CONCERNED IS OFTEN AN UNFORTUNATE STUMBLING BLOCK BUT NOT, I BELIEVE, AN INSURMOUNTABLE PROBLEM.

Administration of outpatient ketamine in 'nurse-run' clinics or via the intramuscular route in an unmonitored environment, are practices starkly at odds with the recommendations of both the APA and SASA, but sadly a reality. These practices should be roundly condemned.

ADMINISTRATION OF OUTPATIENT KETAMINE MUST BE IN ACCORDANCE WITH ESTABLISHED PATIENT SAFETY GUIDELINES.

SASA makes specific mention in its statement on

ketamine infusions for depression that guidelines have yet to be issued by The South African Society of Psychiatrists (SASOP), something that would be welcomed, particularly following the recent APA release.

KCSA has partnered with the Department of Psychiatry at the University of KwaZulu Natal Nelson R Mandela School of Medicine in research on outpatient ketamine infusion for depression, for which ethics approval was obtained in May 2021. The Principal Investigator (a specialist psychiatrist) is conducting retrospective chart reviews from our Hilton clinic, collating data from several hundred outpatient infusions.

Further exciting research in which KCSA is involved is our collaboration with Inkosi Albert Luthuli Academic Hospital Burns Unit. An RCT is planned to investigate the effect on major depressive symptoms in severe burns victims (60% of whom are clinically depressed one-year post trauma), by substituting traditional sedation cocktails used for dressings changes (usually opiates and benzodiazepines) with ketamine.

INCREASINGLY, MEDICAL AID SCHEMES ARE RECOGNIZING THE BENEFIT OF OUTPATIENT KETAMINE INFUSIONS FOR THEIR MEMBERS AND AUTHORIZING FUNDING. PARTICULARLY IN PATIENTS WITH CONCERNING LEVELS OF SUICIDALITY, HOSPITALIZATION CAN FREQUENTLY BE AVOIDED FOLLOWING REVERSAL OF SUICIDAL IDEATION IN UP TO 80% OF CASES FOLLOWING A SINGLE KETAMINE INFUSION.

In the recent past, patients referred for ketamine infusions (often in desperation), were consigned to noisy ECT-theatres, day clinics, ill-equipped consulting rooms and denied the added benefit of a milieu that undoubtedly enhances outcomes. Still they benefitted. Associated expense was high, often driven by the requirement for formal 'admission' to such a facility and a fee for specialist anaesthetic services. Patients have (and still do) endure administration of ketamine by intramuscular injection while in a 'bean-bag', intravenous blousing of ketamine in a chair in a GP's surgery, ketamine infusions while seated in a room with four other patients receiving ketamine. (A KCSA patient described to me how he would take toilet paper along to such sessions, to stick in his ears, as no headphones were provided to reduce ambient noise and mitigate potential negative effects of synesthesia.)

Strange indeed are the experiences of most patients receiving this remarkable drug. Strange too is the fairly sudden requirement for synergy between two

most diverse medical specialities, psychiatry and anaesthesiology, in the dawn of a new psychedelic era. As an emergency physician

I AM NEITHER ONE NOR THE OTHER AND CAN THEREFORE, ATOP MY FENCE, CLEARLY UNDERSTAND AND APPRECIATE THE RELEVANCE AND IMPORTANCE OF BOTH. THEY ARE NOT MUTUALLY EXCLUSIVE YET PATIENT SAFETY CLEARLY REMAINS THE FOREMOST CONCERN.

KETAMINE CAN BE A TURNING POINT IN A PATIENT'S JOURNEY TOWARDS MENTAL WELLNESS.

Teams at KCSA clinics around the country stand ready to partner with our psychiatry colleagues by offering their patients safe, regulated, and affordable outpatient ketamine infusions. Ketamine is a remarkable adjunct to traditional medication and therapeutic techniques and in no way replaces these or obviates the need for continued monitoring and therapy by treating psychiatrists and other mental health specialists. Ketamine is a treatment, not a cure – but it can be a turning point in a patient's journey towards mental wellness.


"Ketamine is the best decision I have ever made. I feel my life is worth living again" (KCSA patient July 2021)

Alan Howard is an Emergency Physician who returned permanently to South Africa at the end of 2019 after working as a Consultant in Emergency Medicine in Donegal, Ireland for 12-years. He is author of the medical textbook 'Emergency Management of Acute Poisoning'.¹ Dr Howard has served as an instructor and examiner for the American College of Surgeons Advanced Trauma Life Support Course (ATLS) for over 25-years and was published by the BMJ in their subsidiary journal the Emergency Medicine Journal (EMJ) following his pioneering work in pre-transfer cranial trephination for traumatic extradural haemorrhages in the Emergency Department.²

Dr Howard founded Ketamine Clinics of South Africa (KCSA) in August 2019 and is president of the Society of Ketamine Practitioners of South Africa (SOKePSA). He is a member of the American Society of Ketamine Physicians (ASKP).

¹ Van Schaik Publishers 2006 ISBN 0 627 0263 1 1
² Howard A, et al, Cranial burr holes in the Emergency Department: to drill or not to drill? *Emerg Med J* 2019;0:1-4. doi:10.1136/emered-2019-208943

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BEND DON'T BREAK:

COVID-19 INFECTION PREVENTION AND CONTROL STRATEGIES FOR THE INPATIENT PSYCHIATRIC POPULATION AT CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL, SOWETO.

Moodley S, Maisto A, Jeenah FY, Moosa MYH

ABSTRACT

The psychiatric inpatient setting presents unique challenges regarding COVID-19 environmental controls for infection and prevention controls. The increased risk of transmission in this setting is due to multiple factors. There is a dearth of evidence regarding potential strategies to navigate infection control measures in the psychiatric inpatient population within resource limited settings. We discuss lessons learnt and the implementation of a practical strategy at Chris Hani Baragwanath Academic Hospital's acute inpatient psychiatric unit. We hope that in sharing this strategy we are able to facilitate the development of generalisable psychiatric guidelines for resource limited settings by way of encouraging information sharing. Thus improving patient outcomes and service delivery challenges whilst navigating the ever-changing milieu of the COVID-19 pandemic.

On 11 March 2020, the Director-General of the World Health Organization (WHO) declared coronavirus disease 2019 (COVID-19) as a pandemic.¹ COVID-19 is caused by the novel beta coronavirus SARS-CoV-2, which is genetically similar to but distinct from other coronaviruses responsible for global outbreaks.² On 5 March 2020, The Minister of Health, Dr Z Mkhize, reported the first case of COVID-19 in South Africa.³ In response to a growing concern of a possible local pandemic, the South African Government responded by enacting a State of Disaster on 15 March 2020.⁴ On 14 July 2021, the National Health Institute for Communicable Diseases reported that 2 236 805 cases of COVID-19 have been identified in South Africa, with a positivity rate of 31.0% and total fatalities of 65 595.⁵

The emergence of COVID-19 has created a great deal of stress and uncertainty for many patients, families, communities and healthcare providers⁶

and remains a rapidly evolving situation worldwide. The psychiatric population's susceptibility and vulnerability to COVID-19 infection requires particular consideration. Mental illness adversely affects outcomes of various medical conditions because individuals with mental illness are less likely to undergo screening for medical comorbidities, have a higher mortality and a poorer prognosis compared to the general population.^{7,8}



Sanushka Moodley

THERE IS A PAUCITY OF EVIDENCE REGARDING SUSCEPTIBILITY TO SARS-COV-2 INFECTION AND CLINICAL OUTCOMES AFTER INFECTION AMONGST INDIVIDUALS WITH SEVERE MENTAL ILLNESS. IN ADDITION TO SUSPECTED IMMUNE MEDIATED BIOLOGICAL MECHANISMS OF VIRUS SUSCEPTIBILITY IN SEVERE MENTAL ILLNESS⁹; THERE ARE INCREASED RISKS OF TRANSMISSION SECONDARY TO POSSIBLE COGNITIVE IMPAIRMENT AND A REDUCED AWARENESS OF RISKS.¹⁰

Individuals with mental illness are more vulnerable to the impact of lockdown restrictions such as the socio-economic effects of job losses, reduced educational opportunities, psychosocial effects of isolation, challenges regarding accessing healthcare and reduced social support.¹¹ Further, discrimination and stigma associated with mental illness affects timeous access to health services as well as the quality of care received.^{12,13} Further, there are concerns over risk of relapse or exacerbation

of an existing mental illness secondary to the heightened stress response to the COVID-19 pandemic compared with the general public.¹⁴

INDIVIDUALS WITH ACUTE SERIOUS MENTAL ILLNESS MAY STILL NECESSITATE INPATIENT PSYCHIATRIC CARE; HOWEVER, THE PREPAREDNESS OF INPATIENT FACILITIES DURING THE COVID-19 PANDEMIC HAVE GENERALLY BEEN OVERLOOKED. PSYCHIATRIC WARDS ARE AT HIGH RISK FOR OUTBREAKS AND NEED CONTINGENCY PLANS TO DETECT AND CONTAIN OUTBREAKS IF THEY OCCUR.^{6,15}

Chris Hani Baragwanath Academic Hospital (CHBAH) is a tertiary hospital in Soweto, Johannesburg and serves a large catchment area in Southern Gauteng. The psychiatry department offers acute adult, adolescent and child in-patient services, as well as general and specialist outpatient clinics. The acute inpatient bed capacity is 165 beds. Admissions are on a referral basis from district hospitals and specialized psychiatric clinics in the catchment area, as well as "walk in" patients from the community. The aim of this report is to describe the challenges associated with providing inpatient psychiatric services at Chris Hani Baragwanath Academic Hospital in the face of the COVID-19 pandemic and to discuss some of the measures implemented to manage these challenges.

DISCUSSION

a) Challenges associated with providing inpatient psychiatry services

The NICD has made recommendations regarding environmental controls for infection and prevention control in an inpatient setting.¹⁶ Some of these recommendations include natural ventilation (providing 17-40 air exchanges per hour) or well-functioning mechanical ventilation (providing 12 air exchanges per hour); sufficient space in these areas to minimize transmission whilst allowing for workflow activities (no more than 6-8 beds per unit with at least 1.2m² of unobstructed space between beds); at least two isolation/single rooms with en-suite ablution facilities per 24 beds; shared ablution facilities to be cleaned every 2-4 hours and all consultation rooms to have a hand wash basin. However, these recommendations do not take into cognisance the unique and inappropriate infrastructure design of the country's psychiatric inpatient wards.¹⁷

Inpatient psychiatric settings present unique challenges due to open space ward design, nature of the illness and the need for close contact treatment. Prior to the COVID-19 pandemic, published reports highlighted the complex nature and the systemic neglect of mental health services in South Africa, which include lack of access, underfunding, inadequate human resources and

infrastructural inadequacies.^{18,19,20} The additional burden of the COVID-19 pandemic has exacerbated these deficiencies in most psychiatric facilities and placed it under further pressure, whilst also testing the resilience of healthcare providers.²¹

Similar to most psychiatric wards in the country, the psychiatric wards at CHBAH are dormitory style and designed to hold as many patients as possible.²² There is limited opening of windows resulting in less than adequate ventilation within the wards and no open outdoor areas, leading to an increased risk of transmission.²³ In addition, the average length of in-patient stay is 42 days, with new admissions daily. The average length of stay of psychiatric patients in South African tertiary psychiatric facilities is generally much longer than that of other disciplines at 54.8 days.²⁴ Infection control is more challenging due to the prolonged interpatient contact and results in a higher risk of infectious disease outbreaks.¹⁵ In addition to the crowded ward conditions, there are communal dining areas and ablution facilities, which further increases the risk of spread of infection.⁶ There are no designated and fully equipped cubicles for isolation against infectious respiratory illness and there is a lack of proper training on the correct use of personal protective equipment.²⁵

Due to the nature of their illness, patients may have altered mental states, impaired insight, poor judgement, poor self-care and self-control that may render them unable to appreciate the risk of infection and vulnerable.⁶ Important preventative measures such as social distancing, avoiding close physical contact, wearing of masks and regular hand washing is difficult to implement.

THERE IS OFTEN A DELAY IN THEM REPORTING SYMPTOMS OF COVID-19 DUE TO ALTERED MENTAL STATE. PATIENTS WITH MENTAL ILLNESS ARE ALSO AT INCREASED RISK OF CHRONIC DISEASES SUCH AS HYPERTENSION, DYSLIPIDAEMIA, CHRONIC OBSTRUCTIVE AIRWAY DISEASE AND DIABETES MELLITUS^{26,27,28} WHICH MAY AFFECT THE PROGRESSION, SEVERITY AND PROGNOSIS OF COVID-19 INFECTION.^{25,28}

The nature of the multidisciplinary team approach to the inpatient management of our patients include psychology groups, occupational therapy groups and multidisciplinary team ward rounds. These activities, which are crucial to the biopsychosocial management of our patients, result in prolonged close contact and increased risk of transmission between patients.⁶ Additionally, the staff are not allocated to a single ward but rather on shift rotations between wards, increasing the risk of cross-contamination and are specialised in providing psychiatric care and not always on early detection and management of infectious diseases.²⁹

The previously mentioned challenges make complying with the NICD's COVID-19 prevention strategies difficult, if not near impossible to implement.

b) Measures implemented by CHBAH to overcome these challenges

The first step was to establish a dedicated psychiatry COVID-19 team to provide appropriate guidance and support to manage the overall process. During the first and second wave, the team implemented measures that were similar to those of psychiatric hospitals and psychiatric units in general hospitals in other countries.^{6,21,30}

THE CRITERIA FOR ADMISSION INTO THE PSYCHIATRIC WARDS WERE MADE STRICTER AND ONLY VERY ILL PATIENTS WHO COULD NOT BE MANAGED AS OUTPATIENTS WERE ADMITTED.

Aggressive management of patients by the multidisciplinary mental health professionals was instituted to shorten the length of hospital stay. Daily, and if possible twice-daily, screening and symptom monitoring of all inpatients was conducted. If a patient screened positive, then a formal nasopharyngeal PCR swab was performed and the patient isolated from other patients whilst awaiting results. If the patient tested positive, the patient remained in isolation and all other patients in that ward, and who may have had contact with the COVID positive patient, were subject to a formal nasopharyngeal PCR swab after 5-7 days. Close collaboration with the hospital's COVID-19 medical teams was established for the urgent transfer of any positive patient who became medically unstable and required specialist care including oxygen support. In addition, all group activities in the ward were suspended and all patients were educated with regards to prevention measures and health promotion.

ALL STAFF WERE TRAINED ON COVID-19 PROTOCOLS AND APPROPRIATE USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE) WHILST ALL OTHER NON-ESSENTIAL TRAINING WAS SUSPENDED. THE WARDS WERE CLOSED TO VISITORS, AND WEEKEND LEAVE OF ABSENCE WERE HALTED. PATIENTS WERE ONLY PERMITTED TO LEAVE THE WARD ON DISCHARGE.

Despite these measures, the first and second wave saw multiple outbreaks within the wards. In total, from June 2020-June 2021 there have been 12 outbreaks in the psychiatric wards. One positive patient quickly snowballed into dozens of patients testing positive and being symptomatic – some requiring transfer to medical wards for further care. This resulted in the closure of entire wards for the

quarantine period required. The consequences of which were far reaching as the demand for inpatient psychiatric beds remained unchanged in the face of the pandemic.

In the face of the third wave, it became apparent that there would need to be a review of above strategies to mitigate against some of these outcomes. On 25 June 2021, the psychiatry COVID-19 team revised their plan to include the reorganisation of the existing wards into a dedicated COVID-19 positive ward only for the isolation of positive patients, a dedicated cubicle within this COVID-19 positive ward for persons under investigation (PUI) for COVID-19 and COVID-19 negative wards. This was complemented with a more efficient redistribution of available human resources within these wards and with appropriate levels of PPE and the training of the use thereof.

In addition, all patients were now subjected to the point of care Panbio™ COVID-19 Antigen Rapid test (nasopharyngeal swab) prior to admission. The Panbio™ COVID-19 Antigen Rapid test has a reported 100% specificity and a 72.6% sensitivity, which is appropriate for use as a screening test.³¹

Benefits of utilizing point of care testing included: use of a portable instrument, rapid results available within 15-20 minutes and decreasing the burden on laboratory testing and sample processing.³² If the antigen rapid test is positive, the patient is cared for in the dedicated COVID-19 ward. If the antigen rapid test is negative and the patient had no symptoms of COVID-19 then they were admitted to COVID-19 negative wards. If the antigen rapid test was negative and the patient had any symptoms of COVID-19, then they underwent a formal nasopharyngeal swab PCR test and admitted to the PUI cubicle whilst awaiting results. All patients are screened daily for symptoms of COVID-19 regardless of which ward they were admitted to.

Both patients and health care professionals experience the negative psychological ramifications of the COVID-19 pandemic, resulting in increased rates of anxiety, depression, post-traumatic stress disorder and psychological distress.³³ Health care workers may experience psychological distress from providing direct care to patients with COVID-19, knowing someone who has contracted or died of the disease, or being required to undergo quarantine or isolation.^{34,35,36} They also experience stress due to the high workload, frequent shift changes, inadequate sleep and rest, which can lead to fatigue, discomfort, helplessness, and anxiety.³⁷

IT IS VITAL TO ENSURE PSYCHOLOGICAL WELLNESS AND IN TURN ENSURE A HEALTHY AND ROBUST CLINICAL WORKFORCE.

It was therefore also important for the dedicated team to address the psychological impact of a

pandemic on the hospital's health care workers, patients and their families. The team established a hospital psychosocial team, comprising a wide range of disciplines and skills. Psychological counselling and supportive therapy groups were implemented for healthcare professionals to identify early, support and treat these potentially long term and persistent psychopathological sequelae.³⁷ Unfortunately, no psychological support was provided to patients and their families because of resource constraints. However, psychiatric nurses who are trained in counselling skills will be earmarked to address this going forward.

This revised plan precludes the need to close entire wards for the period of quarantine, as was found in the first and second waves. This limited any further impact on the already insufficient number of available inpatient beds in the province.

IT ALLOWED FOR THE CONTINUED PROVISION OF TERTIARY LEVEL PSYCHIATRIC SERVICES TO PEOPLE WITH SERIOUS MENTAL ILLNESS, DESPITE THE ADDITIONAL DEMANDS OF COVID-19.

It also allowed for management of mentally ill patients who were COVID-19 positive in an inpatient setting with some degree of compliance to the NICD guidelines notwithstanding the existing infrastructure challenges of the wards. In addition, the plan required that all inter-hospital referrals follow the same procedure to minimize cross contamination between hospitals.

CONCLUSION

Despite the escalating COVID-19 infections reported at both a community and hospital level there is a dearth of relevant COVID-19 guidelines that address the specific needs of the psychiatric population. The profound negative effects of COVID-19 outbreaks in hospital wards and its resultant impact on psychiatric admission capacity is further compounded by our strained resource-limited environment. Thus, the need for the development of innovative strategies that are applicable to low to middle-income settings.

The use of point of care testing for all mental health care users who require acute psychiatric admission and a more defined protocol of subsequent actionable steps aims to improve infection control measures and potentially minimize the transmission of COVID-19 within the inpatient psychiatric population. Thus obviating the need for closures of entire wards due to outbreaks and allow for early interventions regarding comorbid COVID-19 infection.

The intervention has been successfully implemented in our setting and in future we aim to measure the outcomes of new case presentations during admission as well as measure resultant disruptions to provision of care.

GIVEN THE PAUCITY OF EVIDENCE REGARDING POTENTIAL STRATEGIES TO NAVIGATE INFECTION CONTROL MEASURES IN THE PSYCHIATRIC INPATIENT POPULATION IN RESOURCE LIMITED SETTINGS; WE HOPE TO SHARE A PRACTICAL STRATEGY THAT HAS BEEN APPLIED WITH SPECIFIC CONSIDERATIONS FOR THE PSYCHIATRIC SERVICES IN THE SOUTH AFRICAN CONTEXT.

We recommend that similar strategies be considered and information on the successes and difficulties be shared. Thus, facilitating the development of generalisable psychiatric guidelines that will help improve patient outcomes and service delivery challenges whilst navigating the ever-changing milieu of the COVID-19 pandemic.

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HEALING THE HEALER - COMBATING COMPASSION FATIGUE AMONGST MENTAL HEALTH PRACTITIONERS

Elmarie Du Plessis

“ **C**ompassion is not a relationship between the healer and the wounded. It’s a relationship between equals. Only when we know our own darkness well can we be present with the darkness of others. Compassion becomes real when we recognize our shared humanity.” Pema Chodron

Promoting and caring empathetically for the wellbeing of others are amongst the reasons we chose this profession in the first place. We are passionate about improving the quality of living for the patients we treat and are wholeheartedly invested in finding solutions to unbind our patients from what holds them back from living abundantly.

Patients rely on us to be sincerely interested, to show empathy, to listen attentively, to be always available and unfailingly consistent in our caretaking. We are expected to be perfectly knowledgeable, to diagnose quickly and prescribe accurately, to be their unfailing experts and wave an imaginary magic wand that would secure their long-term mental and overall health instantly.

PATIENTS ALMOST EXPECT US TO BE SUPERHUMAN AND IN SOME WAY ABOVE AND IMMUNE TO THE DAY-TO-DAY STRUGGLES OF LIFE IN 2021.

Let us be frank – some of us are completely burnt out and mentally and emotionally exhausted. Since

the World Health Organization (WHO) on 11 March 2020 declared COVID-19 a pandemic, it has had an immense impact on the way we live and work. Add to the mix adjusting to consulting on-line; ensuring POPIA compliance and coding challenges; as well as increased case-loads and the lack of PPE and support for a lot of health care practitioners working in hospital and clinic settings.



Elmarie Du Plessis

FURTHER SOME OF US HAVE HAD TO COPE WITH FINANCIAL LOSS AND THE LOSS OF COLLEAGUES AND FAMILY MEMBERS DUE TO THE PANDEMIC - IT MAKES FOR A PERFECT STORM TO BECOME COMPLETELY EMOTIONALLY AND PHYSICALLY DEPLETED.

In some ways our training and profession also often lacks the awareness and acknowledgement that we are in fact at times facing the same challenges as the patients we serve and that caring too much for too long can become dangerous to ourselves and our patients. Unfortunately, mental health concerns can be heavily stigmatized in the medical field, whereby admitting our own need for help is challenging and often pushed aside for fear of seeming weak.

The reality is that as mental health practitioners we are highly susceptible to *burnout*, *secondary traumatic stress* and *compassion fatigue*. The work of helping requires us to open our hearts and minds to our patients and it is this very process of empathy that make us vulnerable to being profoundly affected and even harmed by our work.

Compassion Fatigue has been described as the “cost of caring” for other’s emotional pain and is a term coined to describe the phenomenon of stress resulting from exposure to a traumatized individual rather than exposure to the trauma itself (Figley,1982). The term further refers to the disengagement of caregivers from their patients, which culminates in a reduction or inability to feel empathy and compassion towards patients and an inability to provide the patient care deemed appropriate. It leads to a loss of meaningful and purposeful interactions between care-givers and patients (Coetzee & Klopper, 2010; Ledoux, 2015).

THE TERM, COMPASSION FATIGUE IS OFTEN USED INTERCHANGEABLY WITH VICARIOUS TRAUMATIZATION, SECONDARY TRAUMATIC STRESS AND BURNOUT.

Vicarious traumatization according to McCann & Pearlman (1991) refers to the transformation in one’s cognitive schema and beliefs systems resulting from empathetic engagement with a client’s traumatic experiences that may result in significant disruptions in one’s sense of meaning, connection, identity and world-view, as well as affecting one’s affect tolerance, psychological needs, beliefs about the self and the other, interpersonal relationships, and sensory memory.

Figley (1995) defines *Secondary Traumatic Stress* as the natural and consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person. With the exception that the traumatic exposure is indirect, it is nearly identical to post traumatic stress disorder (PTSD).

According to WHO, *Burnout* is characterized by "feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy." *Burnout* is now according to the International Disease Classification (ICD-11) categorized as a “syndrome” that results from “chronic workplace stress that has not been successfully managed.”

A 2013 cross-sectional study reported that 70% of psychotherapists employed by the UK’s NHS were vulnerable to chronic levels of secondary traumatic stress and average levels of burnout. It is further alarming that the estimated prevalence of *Compassion Fatigue* among healthcare workers

ranges from 21.8% to 44.8% depending on the setting (Jin et al. 2021) Settings with fewer resources pose higher risk (Sprang et al. 2017). A 2020 study by Summers et al. reports that psychiatrists experience burnout and depression at a substantial rate. The presence of depressive symptoms; female gender; an inability to control one’s work schedule and work setting were associated with significantly higher levels of burnout.

WE CAN EXPECT THAT THE LEVELS OF COMPASSION FATIGUE AMONGST MENTAL HEALTH CARE PRACTITIONERS WILL RISE SIGNIFICANTLY POST COVID-19.

Compassion Fatigue includes experiences of both burnout and secondary traumatic stress. (Maila et al. 2021) and fatigued healers might display the following symptoms:

Emotional symptoms: irritability, anxiety, dread at having to care for another person and a diminished sense of fulfillment in helping another. Mental health practitioners might feel detached apathetic and depressed. Physical symptoms include insomnia, headaches, weight loss, overeating and substance abuse. Compassion fatigue can also lead to a decline in the quality of the care we provide, more errors can occur and judgment and discernment might be poor, leading to less desirable interactions with patients.

So, it seems that we as mental health practitioners are caught in a conundrum - empathy and compassion is argued as necessary to form a therapeutic relationship and it seems inevitable that we at some point during our careers could become fatigued, but not all practitioners do. According to Stamm (2002), many practitioners continue to be committed to the work and find that trauma work sustains and nourishes them.

THESE PRACTITIONERS ARE MOTIVATED BY A SENSE OF SATISFACTION DERIVED FROM HELPING OTHERS – AN EXPERIENCE LABELED COMPASSION SATISFACTION.

Empirical studies have been equivocal in linking empathy to either the development of or protection from compassion fatigue (Turgoose & Maddox, 2017). Figley (1995) and Stamm (2002) proposed a continuum of responses that range from *Compassion Satisfaction* to *Compassion Stress* and *Compassion Fatigue*. It is postulated that there is a balance between the two polar experiences (Stamm, 2002).

So now, how do we as mental health practitioners keep a balance, an internal equilibrium and continue to experience *Compassion Satisfaction*?

Here are some ideas on how to be an effective healer in the face of others adversity:

TAKE RESPONSIBILITY FOR YOUR OWN SELF-CARE

Lombardo & Eyre (2011) identify healthy nutrition, sleep, and exercise as important ways to recover from compassion fatigue, suggesting as we know, that negative health related behaviours may coexist with the presence of compassion fatigue. Therefore, create a plan for what recharges you - regular exercise, a healthy balanced eating plan and sufficient hydration and good sleep hygiene. Practice regular mindfulness or meditation, spend time in nature. Remember to breathe. Spend quality time with loved ones and pursue a hobby. Schedule time off, away from work responsibilities. Basically, set a good example for the patients under your care by practicing what you preach.

BE MINDFUL OF WHAT YOU ALLOW IN

With so much information and news that is constantly available it is pivotal to be mindful of how much time you spend on social platforms, groups and on-line-reading.

WE CAN ONLY TAKE SO MUCH BAD NEWS. DECIDE WHEN TO SWITCH IT OFF. ALSO INTENTIONALLY CHOOSE WHAT TO FOCUS ON, WHAT YOU READ AND LISTEN TO.

Some people might find engaging in spiritual activities sustaining. According to Phelps et al. (2009) beliefs in a higher power and that of a shared religious community may have an influence on how we cope with compassion fatigue.

FOCUS ON WHAT YOU CAN CONTROL

Especially in the current situation most mental health practitioners are overbooked and it seems as if the need for mental health assistance far outweighs the availability of practitioners.

WE KNOW FOR CERTAIN, THAT THE MENTAL HEALTH FALL-OUT FROM COVID-19 WILL CONTINUE WAY BEYOND THE ACTUAL CURBING AND MEDICAL MANAGEMENT HEREOF. THIS CAN BECOME EXCEPTIONALLY OVERWHELMING.

Therefore, focus on the patient in front of you right now. Go back to basics and keep it simple. Think of the starfish analogy of picking up the stranded creatures and throwing them back into the ocean one at a time, feeling satisfied and proud that you made a difference to that one.

SET HEALTHY BOUNDARIES IN YOUR PROFESSIONAL AND PERSONAL LIVES

Robert Frost's poem, "Mending Wall" states that "good fences make good neighbors" and a lack of boundaries invites a lack of respect.

Acknowledge that is not possible to "save" everyone and be mindful of your professional boundaries i.e., availability to patients outside of consultation times, set a clear limit to work hours and the number of patients you take on. Sprang et al. (2007) revealed that the case-load of PTSD patients predicted the levels of compassion fatigue and burnout in practitioners.

Boundaries become blurred when health practitioners step in for patients in tasks that they are capable and age-appropriately should be doing for themselves. It is about learning when and how to say: "No!", which is according to Ann Lamott a complete sentence. Brene Brown states that "Daring to set boundaries is about having the courage to love ourselves even when we risk disappointing others"

ACTIVELY MAKE TIME FOR PROFESSIONAL CONNECTIONS

Realizing that you are not alone will increase a sense of solidarity, curb feelings of isolation and reduce emotional exhaustion. Peer review and support groups can be invaluable to help keep you accountable to solid clinical practice and adequate self-care. Sprang et al. (2007) found that specialized trauma training enhanced Compassion Satisfaction and reduced levels of burnout. This suggests that trauma knowledge and training might provide some protection to the deleterious effects of trauma exposure, as it cultivates more effective assessment and treatment of the trauma and thus practitioners might have better treatment outcomes. Supervision and / or personal psychotherapy can provide a space for personal growth and building resilience and compassion satisfaction.

To conclude, in 2021 more so than maybe ever before, it is pivotal that we as mental health practitioners acknowledge our own humanity and develop more self-compassion. Our own sorrow and wounds are healed only when we touch them with compassion. So, we'd be wise to follow the words of Mahatma Gandhi, "You must be the change you wish to see in the world". We can emerge from this immensely stressful and challenging time as more effective and valuable healers, when we realize that "Healing is an inside job" (Dr BJ Parker).

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ADVERSE INCIDENTS, COMPLAINTS & APOLOGIES

Volker Hitzeroth

In this article, the second of a medicolegal series of articles, Dr Volker Hitzeroth will clarify how a healthcare practitioner should respond when they receive correspondence from a patient expressing dissatisfaction about an aspect of the treatment and care that they received. The article will also address common misconceptions about apologizing to a patient in the event of an adverse incident occurring.

Healthcare Practitioners (HCP) are, after all, only human and delays, misunderstandings and errors can occur despite their best efforts, particularly when they are working under pressure in a stressful environment. When a patient or their family believe their needs have not been addressed, their expectations have not been met and their experience has been disappointing they may choose to raise the issues with the HCP directly in order to discuss their concerns. Whilst this might be done informally during a clinical consultation it is more frequent that a patient will email their complaint directly to the HCP and invite them to respond to their grievance and clarify the issues. Most patients, in the event of an adverse event or outcome, will usually attempt to reach out to their HCP in some way to alert them to their plight and request an explanation and appropriate follow up care.

Many HCPs will have to deal with a complaint during their professional career; some of these could come from a patient, their family or even an employer and could relate to any aspect of clinical practice. Complaints against HCPs have unfortunately become more common in South Africa in recent years.

THIS IS LIKELY DUE TO THE INCREASING COMPLEXITY OF MEDICINE AND AN EMERGING COMPLAINTS CULTURE AMONGST THE PUBLIC, RATHER THAN ANY DECREASE IN DOCTORS' PERFORMANCE.

PREVENTING COMPLAINTS:

"Prevention is better than cure". It's a well-known phrase in medicine, and it's also true where medicolegal issues are concerned. HCPs can help protect

themselves from future complaints by being aware of potential risks and taking steps to mitigate these before an incident occurs. Most patient complaints relate to one or more of the following areas:

1. Competence
2. Communication
3. Consent
4. Confidentiality
5. Conduct



Volker Hitzeroth

Being aware and knowledgeable about potential risk will have a positive impact on a HCP's behaviour and clinical performance.

Here are some further suggestions:

1. Stay up to date: keep abreast of the latest developments in healthcare, such as new treatments and medication regimes, news, policy announcements and important changes to regulations and legislation.
2. Work on your "soft" skills: are your organizational and administrative skills up to scratch? It is common for medicolegal cases to involve poor record-keeping, for example.
3. Do you communicate effectively? Patients will usually appreciate honest, open doctors who communicate effectively, explain issues clearly and apologize appropriately when things don't go to plan. It's also key that you communicate clearly and fully with colleagues at all levels.

WHAT IF A HCP MAKES A MISTAKE?

Sometimes prevention isn't enough and even the best, most diligent doctors find themselves facing complaints and possible legal action. At this early stage there are still steps that a HCP can take to protect themselves.

1. Recognize and report early: contact your Medical Defence Organization (MDO) as soon as possible as they may be able to prevent the matter from escalating to a more serious problem.
2. Rectify the mistake and prevent further harm: take appropriate responsibility for what's happened and do what you can to rectify the situation. While you may not be able to undo the mistake entirely, you may be able to prevent the patient coming to any further harm.
3. Speak to the patient and family: be open and honest, listen carefully and respond to their concerns.
4. Learn from mistakes: resilience and continuous development are part and parcel of being a HCP. Use negative experiences as learning opportunities and take steps to ensure the same errors are not repeated.

RESPONDING TO A COMPLAINT:

Many minor concerns and complaints may be addressed merely by explaining the facts of the matter and taking steps to rectify any mistakes. If the issues escalate it may be best to send a written response, either in reply to a letter or email of complaint or following a meeting with the complainant.

1. Consider sending an initial "holding response" – It may be appropriate to acknowledge receipt of the complaint and inform the complainant you aim to respond within a particular timeframe. Diarize this timeframe and ensure any updates are sent in a timely manner.
2. Identify and respond – Identify the concerns that have been raised and respond to the complaint. It is often helpful to set out an account of what took place, even if this is background information, but do not lose sight of the issues.
3. Be courteous, objective and professional – The purpose of your response is to try and resolve the complaint, not to perpetuate further correspondence.
4. Establish the facts – Take time to present a measured, considered, and considerate response, bearing in mind the timescales. Familiarize yourself with all relevant medical records before you draft your letter. Do not refer to another colleagues' contribution unless this is relevant in which case you should do so in a factual and non-judgmental manner.
5. Respect patient confidentiality – Not all complaints are made by the patient personally. Where a complaint is made about the service provided to a patient who has the capacity to give a valid consent, that patient's confidentiality must be respected.
6. Try to be sympathetic and understanding – Offer condolences if these are due. Do not be afraid of apologizing if an error has been made.
7. Avoid blaming or judging others – Do not cast aspersions on the character or conduct of a fellow HCP, the patient or family members.
8. Avoid jargon – Use plain language that a non-medical professional would understand.

9. Review your response prior to sending it to the complainant – Confide in a senior colleague, supervisor or mentor and request them to comment on the situation and your written response.

APOLOGIES:

Unfortunately, things do go wrong in healthcare and sometimes patients are dissatisfied, disappointed, or upset with the care that they have received. In general, open communication, and an apology where things have gone wrong, regardless of fault, is appropriate, welcomed and accepted.

An apology, expressing regret about the patient's experience or emotions, is not an admission of liability and is appropriate when a patient has suffered harm from their healthcare or experienced disappointment. It is an acknowledgement that something has gone wrong and a way of expressing empathy. Contrary to popular belief, apologies tend to prevent formal complaints rather than the reverse.

IT IS BEST TO OFFER AN APOLOGY AS SOON AS IT BECOMES APPARENT THAT AN ADVERSE INCIDENT HAS OCCURRED, OR THE PATIENT EXPRESSES THEIR DISSATISFACTION WITH THE CARE THEY RECEIVED.

It is important that patients, or their families, receive a meaningful and timely apology. It may be sometime before all the facts are understood. Until these are established, speculation should be avoided as this is unhelpful to all involved. However, this consideration should not hinder a prompt apology being forthcoming. At such an early stage the doctor may not have all the answers to the patient's concerns. If so, the doctor should say so, but commit to establish the facts and report back to the patient.

The culture in a hospital, GP or specialist practice, day clinic and so forth, should permit doctors the freedom to apologise. It is ethically and professionally the right thing to do – irrespective of the cause. An appropriate apology should be tailored to the situation – reflecting the patient's perception of the issue. It should also be put into context, so all parties understand the purpose of the apology. Fundamentally, an apology should be offered willingly, and not perceived to have been given reluctantly.

It is always good practice to discuss an unintended adverse outcome with a senior colleague, your supervisor or mentor as well as your MDO prior to meeting with the patient and their family.

On occasions it may be appropriate to waive the consultation fees or follow up costs as a gesture of good will.

Volker Hitzeroth is Medicolegal Consultant at Medical Protection Society in London, United Kingdom.
Correspondence: Volker.Hitzeroth@medicalprotection.org ■



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Wednesday 1 September – Saturday 4 September 2021

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Programme Outline:

Wednesday 1 September – Friday 3 September:

- 08:00 – 09:00 Trade sponsored morning symposia
- 12:30 – 13:30 Trade sponsored afternoon symposia
- 14:00 – 18:00 Scientific Sessions
- 19:30 – 20:30 Trade sponsored evening symposia

Saturday 4 September:

- 08:30 – 09:30 Trade sponsored morning symposium
- 10:00 – 13:00 Scientific Sessions
- 14:00 – 16:00 Parallel Sessions
- 18:00 – 19:00 Ethics panel discussion
- 19:00 – 20:00 Live Entertainment

Congress Convenor: Prof Renata Schoeman: renata@renataschoeman.co.za
Congress Organiser: Sonja du Plessis: sonja@londocor.co.za

2ND SOUTHERN AFRICA MULTIDISCIPLINARY VIRTUAL ADHD CONGRESS – LETTER FROM THE COVENOR

Renata Schoeman

Dear Delegate

We are excited to welcome you to the **2nd Southern African Multidisciplinary ADHD Congress**, which aims to bring together psychiatrists, paediatricians, general practitioners, psychologists, and occupational therapists – the whole team involved with the optimal management of ADHD across the lifespan.

It is estimated that ten to twenty percent of children and adolescents experience mental health problems worldwide, while in Sub-Saharan Africa, epidemiological studies indicated that 40.8% of adolescents struggles with emotional and behavioural problems.

INTERNATIONAL STUDIES ESTIMATE THE PREVALENCE OF ADHD AS FIVE PERCENT OF SCHOOL-AGED CHILDREN, WITH 65% OF PATIENTS HAVING SYMPTOMS THAT PERSIST INTO ADULTHOOD. HOWEVER, IT IS POSSIBLE THAT THE PREVALENCE RATES IN SOUTHERN AFRICA MAY BE HIGHER.

Furthermore, access to care remains a challenge, and care delivery – in both the public and private sector – remains fragmented.

Through a strong partnership, state of the art IT infrastructure and support from the University of Stellenbosch Business School, this will again be a live and interactive virtual event. On registration, delegates will receive detailed log in instructions for the event. You will also receive details for downloading the congress app where you will be able to find all the relevant information about the programme, speakers, and sponsors.



Renata Schoeman

Last year's inaugural congress was attended by more than 300 delegates representing seven countries. We hope that you will participate in this year's event and are looking forward to welcoming you to the 2nd Southern Africa Multidisciplinary ADHD Congress.

Please do not hesitate to contact us should you require any further information or assistance.

Prof Renata Schoeman
Convenor

WHEN ADHD DISRUPTS THEIR LIVES AND FUNCTIONING



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References: 1. De Bruyckere K, Bushe C, Bartel C, Berggren L, Kan C, Dittmann R. Relationships Between Functional Outcomes and Symptomatic Improvement in Atomoxetine-Treated Adult Patients with Attention-Deficit/Hyperactivity Disorder: Post Hoc Analysis of an Integrated Database. *CNS Drugs* 2016; 30:541-558. 2. Young JL, Sarkis E, Qiao M, Wietecha L. Once-Daily Treatment With Atomoxetine in Adults With Attention-Deficit/Hyperactivity Disorder: A 24-Week, Randomized, Double-Blind, Placebo-Controlled Trial. *Clin Neuropharm* 2011; 34:51-60. 3. Lenzi F, Cortese S, Harris J, Masi G. Pharmacotherapy of emotional dysregulation in adults with ADHD: A systematic review and meta-analysis. *Neurosci Biobehav Rev* 2018; 84:359-367.

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2ND SOUTHERN AFRICA MULTIDISCIPLINARY ADHD CONGRESS PRELIMINARY PROGRAMME

WEDNESDAY 1 SEPTEMBER 2021

08:00 - 09:00	MORNING SYMPOSIUM - DR REDDY'S Topic TBC	Speaker TBC
12:30 - 13:30	AFTERNOON SYMPOSIUM - ACINO SWISS Topic TBC	Speaker TBC
14:00 - 16:10	SCIENTIFIC SESSION 1 - GENERAL	
14:00 - 14:10	Official Welcome & Opening	Prof Mark Smith (USA)
14:10 - 14:15	Introduction of speakers	Prof Renata Schoeman (Convenor)
14:15 - 14:55	Keynote Address: International Consensus Statement on ADHD	Prof Steve Faraone (USA)
14:55 - 15:00	Q & A	
15:00 - 15:30	An update on the genetics and neurobiology of ADHD - and the positioning of pharmacogenetics	Dr Suntheran Pillay (SA)
15:30 - 15:35	Q & A	
15:35 - 16:05	The big and small of ADHD (weight related matters)	Dr Richard Sykes (SA)
16:05 - 16:10	Q & A	
16:10 - 16:35	<i>Break / News from the sponsors</i>	
16:35 - 18:00	SCIENTIFIC SESSION 2 - PSYCHIATRIC COMORBIDITY	
16:35 - 16:40	Introduction of speakers	Dr Lerato Dikobe-Kalane (SA)
16:40 - 17:20	The psychiatric comorbidity in ADHD (excluding SUD)	Dr Larry Klassen (Canada)
17:20 - 17:25	Q & A	
17:25 - 17:55	The management of ADHD in patients with comorbid substance use disorders (SUD)	Dr Lize Weich (SA)
17:55 - 18:00	Q & A	
19:30 - 20:30	EVENING SYMPOSIUM - VIATRIS Topic TBC	Speaker TBC

THURSDAY 2 SEPTEMBER 2021

08:00 - 09:00	MORNING SYMPOSIUM - SANDOZ Cannabis, Cognitive Effects, and Clinical Considerations: Approaching the Treatment of ADHD in a Changing Legal Climate	Assoc. Prof Jason Kilmer (USA)
12:30 - 13:30	AFTERNOON SYMPOSIUM - LIFE PATH HEALTH Topic TBC	Speaker TBC
14:00 - 16:10	SCIENTIFIC SESSION 3 - GENERAL	
14:00 - 14:05	Introduction of speakers	Dr Karen Vukovic (SA)
14:05 - 14:45	New pharmacological developments and alternative delivery strategies for ADHD	Prof Jeffrey Newcorn (USA)
14:45 - 14:50	Q & A	
14:50 - 15:30	ADHD and sleep disorders	Dr Andreia Hazewinkel (Netherlands)
15:30 - 15:35	Q & A	

*Subject to change

THURSDAY 2 SEPTEMBER 2021 (continued)

15:35 - 16:05	Exercise as treatment for ADHD	Dr Eileen Africa (SA)
16:05 - 16:10	Q & A	
16:10 - 16:35	Break / News from the sponsors	
16:35 - 18:00	SCIENTIFIC SESSION 4 - CONTROVERSIES	
16:35 - 16:40	Introduction of speakers	Dr Frans Korb (SA)
16:40 - 17:20	The diversion of stimulants and the prevention thereof	Assoc. Prof Jason Kilmer (USA)
17:20 - 17:25	Q & A	
17:25 - 17:55	The non-medical use of stimulants	Dr Francois Esterhuizen (SA)
17:55 - 18:00	Q & A	
19:30 - 20:30	EVENING SYMPOSIUM - CIPLA Topic TBC	Speaker TBC

FRIDAY 3 SEPTEMBER 2021

08:00 - 09:00	MORNING SYMPOSIUM - PHARMA DYNAMICS Strategies for improving ADHD medication adherence	Speaker TBC
14:00 - 16:00	SCIENTIFIC SESSION 5 - MEDICAL COMORBIDITY	
14:00 - 14:05	Introduction of speakers	Dr Jacobus Roux (SA)
14:05 - 14:40	ADHD in the geriatric population	Dr Lindokuhle Thela (SA)
14:40 - 14:45	Q & A	
14:45 - 15:20	The management of ADHD during palliative care (incl HIV)	Dr Michelle King (SA)
15:20 - 15:25	Q & A	
15:25 - 15:55	ADHD and epilepsy	Prof Renata Schoeman (SA)
15:55 - 16:00	Q & A	
16:00 - 16:30	Break / News from the sponsors	
16:30 - 18:00	SCIENTIFIC SESSION 6 - TECHNOLOGY	
16:35 - 16:40	Introduction of speakers	Dr Sebo Seape (SA)
16:40 - 17:20	A review of neuromodulation for the treatment of ADHD	Prof Katya Rubia (UK)
17:20 - 17:25	Q & A	
17:25 - 17:55	The pros and cons of technology in the management of ADHD	Dr Brendan Belsham (SA)
17:55 - 18:00	Q & A	
19:30 - 20:30	EVENING SYMPOSIUM - NOVARTIS Topic TBC	Speaker TBC

SATURDAY 4 SEPTEMBER 2021

08:30 - 09:30	MORNING SYMPOSIUM - SANOFI The presentation of Adult ADHD	Dr Sebolelo Seape (SA)
10:00 - 13:10	SCIENTIFIC SESSION 7 - THE CASE FOR EARLY INTERVENTION	
10:00 - 10:05	Introduction of speakers	Dr Mvuyiso Talatala (SA)
10:05 - 10:45	ADHD and juvenile offenders	Dr Yumna Dhansay (Australia)
10:45 - 10:55	Q & A	
10:55 - 11:25	A diagnostic journey of misunderstood children through the Goldilocks and The Bear Foundation	Claire Tobin and Tawni Voges (SA)
11:25 - 11:30	Q & A	
11:30 - 11:55	Break / News from the sponsors	

SATURDAY 4 SEPTEMBER 2021 (continued)

11:55 - 12:00	Introduction of speakers	
12:00 - 12:30	Complexities of emotional dysregulation in ADHD	Dr Rene Nassen (SA)
12:30 - 12:35	Q & A	
12:35 - 13:05	The pros and cons of extended versus interrupted treatment of ADHD	Dr Chris Schuler (SA)
13:05 - 13:10	Q & A	
	SCIENTIFIC SESSION 8: PARALLEL SESSIONS	
13:55 - 16:00	EDUCATION	
13:55 - 14:00	Introduction of speakers	Dr Anersha Pillay (SA)
14:00 - 14:25	Inclusive versus specialised education for pupils with learning disorders	Berenice Daniels (SA)
14:25 - 14:30	Q & A	
14:30 - 14:55	ADHD/Autism: the overlap and differentiating features	Dr Merryn Young (SA)
14:55 - 15:00	Q & A	
15:00 - 15:25	Classroom tips for educators relating to ADHD	Elize Janse van Rensburg (SA)
15:25 - 15:30	Q & A	
15:30 - 15:55	Social skills training for children with ADHD	Marele Venter (SA)
15:55 - 16:00	Q & A	
13:55 - 16:00	THERAPY	
13:55 - 14:00	Introduction of speakers	Dr Michelle King (SA)
14:00 - 14:25	ADHD, marriage and interpersonal violence	Dr Lerato Dikobe-Kalane (SA)
14:25 - 14:30	Q & A	
14:30 - 14:55	Parenting with ADHD	Dr Derine Louw (SA)
14:55 - 15:00	Q & A	
15:00 - 15:25	Parenting for ADHD	Jessica Cheesman (SA)
15:25 - 15:30	Q & A	
15:30 - 15:55	Workplace interventions for ADHD	Linda Hiemstra (SA)
15:55 - 16:00	Q & A	
13:55 - 16:05	NEW TECHNOLOGIES	
13:55 - 14:00	Introduction of speakers	Dr Eleanor Holzapfel (SA)
14:00 - 14:40	Non-invasive neuromodulation in ADHD (part 1)	Dr Leon Morales-Quezada (USA)
14:40 - 14:45	Q & A	
14:45 - 15:25	Non-invasive neuromodulation in ADHD (part 2)	Dr Diana Martinez-Huerta (USA)
15:25 - 15:30	Q & A	
15:30 - 15:55	Apps and Games for managing ADHD	Dr Hugo Theron (SA)
15:55 - 16:00	Q & A	
13:55 - 16:00	A PRACTICAL APPROACH TO THE TREATMENT OF ADHD	
13:55 - 14:00	Introduction of speakers	Dr Kali Tricoridis (SA)
14:00 - 14:20	The practical positioning of methylphenidate	Dr Karen Vukovic (SA)
14:20 - 14:30	Q & A	
14:30 - 14:50	The practical positioning of atomoxetine	Dr Frans Korb (SA)
14:50 - 15:00	Q & A	
15:00 - 15:20	The practical positioning of lisdexamphetamine	Dr Suntheran Pillay (SA)
15:20 - 15:30	Q & A	
15:30 - 15:55	Treatment of ADHD during pregnancy and lactation	Dr Lavinia Lumu (SA)
15:55 - 16:00	Q & A	
18:00 - 19:00	SCIENTIFIC SESSION 9: ETHICS (PANEL DISCUSSION)	
18:00-18:05	Introduction of speakers	Prof Renata Schoeman (SA)
18:05-19:00	Should the scheduling of methylphenidate be changed?	Prof Christopher Szabo (SA) Dr Chris Verster (SA)
19:00 - 20:00	CLOSING OF CONGRESS & LIVE ENTERTAINMENT	

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References: 1. Sandoz SA (Pty) Ltd. TPM/IMS data; January, 2021, and data on file; March, 2021. 2. Who we are | sandoz. Accessed February 24, 2021. <https://www.sandoz.com/about-us/who-we-are>. 3. Mefedinel™. Professional Information. Sandoz SA (Pty) Ltd; 2021. 4. Schappeler E, Daumann H, Lamouche S, et al. Bioequivalence of sandoz methylphenidate osmotic-controlled release tablet with Concerta® [Janssen-Cilag]. Pharma Res Per. 2015;3(1). e00072:1-8. 5. Katzmann MA, Sierant T. A review of OROS methylphenidate [Concerta®] in the treatment of attention-deficit/hyperactivity disorder. 2014;28(11):1005-1033. 6. Sandoz SA (Pty) Ltd. Data on file. March, 2021. 7. Dettwiler W for Novartis. How a leader in healthcare was created out of Ciba, Geigy and Sandoz. Profile Books; 2014.

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HIGHER DEGREES

The Department had a record 18 MMeds graduating in July 2021 and one PhD.

PhD: Amanda Edge

MMeds: Tando Melapi, Jade Bouwer, Tejil Morar, Bianca Hart, Annette Antwi Anyimadu, Sibulele Zuma, Felicity Marcus, Jessica Meddows Taylor, Kabo Letseli, Caroline Serebro, Stacey Lintnaar, Nikki

Eklektos, Omphemetse Mahuma, Sharne O'Brien, Sibongile Mondlana, Priscilla Vythilingham, Rebone Sebothoma, Nabila Veyej ■

DEPARTMENTAL RESEARCH DAY

The 32nd annual Research Day took place on Wednesday 23rd June 2021 (as per the full report which appears on page 7 of this issue) ■

SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY



PSYCHIATRY HOD NEWS



Taiwo Akindipe

Dr. Taiwo Akindipe was appointed as Chief Specialist and Head of Psychiatry Department at Sefako Makgatho Health Sciences University (SMU) Pretoria, with effect from November 2020.

He obtained his undergraduate medical degree at the University of Ilorin, Nigeria in 2000. He trained in Psychiatry, and got his FMCPsych and FWACP qualifications in 2009/10 from the National Postgraduate Medical College of Nigeria as well as the West African College of Physicians.

He is an alumnus of University of Cape Town where he obtained MPhil (Addiction psychiatry) in December 2011. He had his subspecialty training in Addiction Psychiatry at Groote Schuur Hospital, Cape Town. He spent the following two years (2012-2013) providing clinical support to drug users at Kensington Treatment Centre (KTC), Cape Town.

Prior to this current appointment, he had worked as a Specialist Psychiatrist and Senior Lecturer on the

joint appointment of Dr. George Mukhari Academic Hospital and SMU.

Taiwo has authored peer-reviewed scientific articles in the areas of Substance use disorder, Dual diagnosis and Consultation-Liaison Psychiatry; collaborating with researchers within and outside South Africa.

He is a recipient of the John Hamilton Award in Community Medicine (2000); a member of Golden Key Honours Society at UCT; and a focal point person for TREATNET, a UNODC project (2014-2017). He also serves as a Non-alcoholic Trustee for the Alcoholic Anonymous (AA) group.

Taiwo is interested in the interphase between substance use and other mental disorders. He advocates for an integrative approach to service delivery, training and research in low and middle income countries.

"In an historically disadvantaged institution like SMU, my mission is to transform and rebrand the psychiatry department in tandem with the needs of a previously marginalised population"

"I am putting my nose to the grindstone with my sleeves rolled up to accomplish this mission. Please join me on this train of change." ■



UNIVERSITY OF CAPE TOWN

IN MEMORIAM: PROF JULIAN LEFF



Sadly, on 23rd February 2021, Prof Julian Leff (pictured above) passed away at the age of 82 years.

Prof Leff, an emeritus professor in the department, was prominently known for his innovative work as a psychiatrist in the treatment of schizophrenia, where he pioneered group and individual sessions with patients. He was also known for his classic research and work on expressed emotion to prevent relapse. Post retirement, he invented the highly effective avatar therapy, in which patients create computer avatars of their auditory hallucinations to be able to engage with the voices ■

WELCOME

The Alan J Flisher Centre for Public Mental Health would like to welcome **Miriam Mkhize** and **Chesney Ward-Smith**, the first two Sue Struengmann Initiative (SSI) PhD Fellows. The purpose of the Initiative is to address the mental health implications of childhood and adolescent adversity and trauma by providing a base for research, capacity building and policy development ■

GOODBYE TO COLLEAGUES

WE BID FAREWELL TO THE FOLLOWING COLLEAGUES:

1. **Prof Sean Kaliski** (pictured right) was a longstanding member of the department, a stalwart in the Forensic Psychiatry field and a charismatic personality, known for his interesting ties and even more interesting talks. He will be hugely missed by those who worked with him. Sean Kaliski will stay on as Emeritus and continue to supervise MMed students.



2. **Dr Wendy Vogel** recently retired as Head of the Division of Child and Adolescent Psychiatry (DCAP), a position she held since 2011. She was, among others, the National Chairperson of the South African Association of Child and Adolescent Psychiatry (SA-ACAPAP) between 1999-2001.

Her interest in neurodevelopmental disorders was central to the development of a neurodevelopmental clinic at the Red Cross Children's Hospital. Wendy's interest in autism and working with others to arrive at a diagnosis, particularly for girls where it had been missed, was a knack often remarked on!



Wendy Vogel

3. **Dr Kate Mawson** has moved to Tygerberg Hospital/Stellenbosch University to head up the Eating Disorders unit. **Drs Mawson** and **Nisaar Dawood** both worked tirelessly on the frontlines in district services remain champions for patients in the community. We thank them for their efforts and wish them well for their next endeavours.

4. **Shareefa Dalvie**, with a keen interest in neuropsychiatric genetics research in South Africa, has published a host of high-impact papers and book chapters on psychiatric genomics; and is on the editorial board of the journals, "Complex Psychiatry" and "Frontiers in Psychiatry".

She has also led multiple international collaborations, including with the Psychiatric Genomics Consortium, in which she co-heads the Systems Biology Working Group. In recognition of her work and contributions, she was promoted ad hominem to a Senior Lecturer in 2019.

We wish Shareefa well in her new position as Specialist Scientist in the Biomedical Research and Innovation Platform at the South African Medical Research Council.

5. **Maggie Marx**, a Communications Specialist who joined CPMH in 2015 as part of the Programme for Improving Mental Health Care (PRIME) project, quickly made her mark at CPMH and rapidly increased the visibility of CPMH projects.

Maggie is passionate about mental health research and specifically how research evidence translates into policy. We are excited for Maggie in her new position at the central Research Office at UCT ■

C O N G R A T U L A T I O N S

1. **Dr Papani Gasela** is congratulated on being appointed as Head of Division for Child and Adolescent Psychiatry. She takes the reins from Wendy Vogel and we wish her and the Division all the best going forward.

2. **Prof Jackie Hoare** is the first and only doctor to be registered on the General Medical Council (GMC) UK register as a Neuropsychiatrist.

The Royal College of Psychiatrists have extended their congratulations and have published an interview with Prof Hoare in their Summer 2021 edition of RCPsych Insight. It can be accessed on the following link:

https://www.rcpsych.ac.uk/docs/default-source/members/rcpsych-insight-magazine/rcpsych-insight-16---summer-2021.pdf?sfvrsn=4c99894_8

3. We congratulate **Dr Nyameka Dyakalashé** (pictured below) on being appointed as Head of Division of Forensic Psychiatry. No doubt the division will thrive under her leadership and we wish her and the division all the best going forward.



4. **Babalwa Tyabashe-Phume**, a Social Worker by profession, was awarded 3-year funding for her doctoral degree from the Bongani Mayosi Fund. Her study intends to develop a conceptual framework

that will support persons with intellectual disabilities to self-advocate for inclusion of their priorities in social and health related policy in South Africa.

5. Congratulations to **Drs Idorenyin Akpabio, Sybrand de Waal, E.J. Smith, Imraan Tayob, Jasper van Zyl, Elizabeth Vogts and Allanah Wilson** who have been successful in passing their FC Psych(SA) Part II exit examinations. We wish them well with their future career plans.

6. Congratulations to **Drs Charles Crookes, Lisa Dondashe, Mpho Mhlahakametsa, Tinashe Mangozho, Devina Nair, Haseena Sablay, Inette Swart and Joshu Tippoo**, who have been successful in their CMSA FCPsych (SA) Part 1 exams in the First semester and are due to start 1st August 2021.

7. **Miriam Mkhize and Simphiwe Simelane** are congratulated on being selected for the accelerated transformation programme of the Faculty of Health Sciences, which aims to identify and nurture highly talented Black South African students, and to support them with mentoring throughout their academic careers. We wish them every success for their studies.

8. **Siyabulela Mkabile** has been awarded substantial funding this year (a SAMRC Bongani Mayosi National Health Scholars Program Scholarship; funding from Kings College, for a four-month PhD Student Fellowship, London; and an UCT Research and Development Grant) to support the completion of his PhD entitled: "Explanatory models of child intellectual disability: Views of caregivers, spiritual healers and traditional healers in Khayelitsha, Cape Town".

9. **Hayley Julius** received an award from the review committee. The award was granted for her research project that explores disability grant utilisation, and barriers to access for patients with personality pathology through the use of a mixed-methods study. The topic demonstrates how research and clinical service delivery objectives work best when both are fully aligned with the other ■

THE 2021 LOREN LECLEZIO LECTURE

Prof Lionel Green-Thompson (pictured right), Dean of the Health Sciences Faculty, was invited to speak and share with us his thought-provoking presentation "To Whom shall we account", at this year's annual 'Loren Leclezio Lecture'.

Prof Green-Thompson reflected on how we hold stakeholders accountable and how to shorten the gap between ordinary people and the institutions they wish to hold accountable. He highlighted the challenge in defining community, while sharing reflections on his doctoral study focusing on social accountability and medical doctors. He also reminded us of the importance of equity underpinning all thinking around global health ■



PUBLICATION : PROBLEMS OF LIVING

More than a decade ago, Dan Stein published a volume, "Philosophy of Psychopharmacology", in which he addressed some of the "hard problems" faced by mental health clinicians, with a particular focus on philosophical issues raised or addressed by advances in psychiatric medication.

This year he has published his second volume at the intersection of psychiatry and philosophy, "Problems of Living", in which he looks at a range of "hard problems" raised by life as a whole, with a particular focus on philosophical issues raised or addressed by advances in the cognitive-affective sciences including psychology and neuroscience.

"Philosophy of Psychopharmacology" argues that psychiatry is precisely the sort of field that should on the one hand acknowledge its own fallibility, while at the same time try to make a positive difference - even though we have still so much to learn about the brain-mind and its disorders, and even though our interventions are far from ideal. "Problems of Living" argues that any answers to the problems of living can only be partial and tentative, but that we should nevertheless persist in trying to live meaningful lives - even though we have still so much to learn about human nature and the world, and despite life's apparent absurdity ■

RAPID AND AUTOMATIC SCREENING FOR DEMENTIA

The poorly resourced South African healthcare system is concerned by what appears to be steadily increasing rates of dementia. Therefore, a brief cognitive assessment tool that can be administered by non-experts or lay providers to improve clinical care and outcomes.

An interdisciplinary team, headed by **Dr Hetta Gouse** (Division of Neuropsychiatry, UCT) and **Prof Reuben Robbins** (HIV Center for Clinical and Behavioral Studies, Columbia University), has launched a research study (Alzheimer's Disease NeuroScreen; ADiNS) that is designed to adapt and investigate the validity of a brief, tablet-based neuropsychological test battery for use in the assessment of older South African adults with suspected cognitive decline and/or dementia.

The app, NeuroScreen, takes approximately 30 minutes to administer and has previously been validated for use in South African adults with HIV. It assesses cognition in six cognitive domains. NeuroScreen is portable, self-contained and highly automated; it has standardized audio-visual instructions, requires minimal training to administer, and can yield test results immediately.

The ADiNS study is the first step in addressing the need for a culturally acceptable, reliable, and valid tablet-based cognitive screening tool for use in older South African adults ■

LECTURE: THE NEEDS OF AUTISTIC PEOPLE IN AFRICA

Extracted from UCT News article

Prof De Vries delivered the opening lecture at the International Society of Autism Research (INSAR) global conference in May 2021. He is the founding director of the Centre for Autism Research in Africa (CARA).



Prof de Vries (front middle) and the CARA team (Photograph by Izak de Vries © CARA)

Prof De Vries focused his lecture on the question of what research should be done and where it should be done, highlighting that the vast majority of people with autism and other developmental disabilities live in low-to middle-income countries in the context of inadequate services, expertise and research.

He encouraged socially responsive research which should be done in collaboration with families and community stakeholders and where their needs could drive meaningful, relevant and innovative research. He also challenged the autism research community to address research inequities by building improved research capacity in these countries.

The full article can be accessed on <https://www.news.uct.ac.za/> ■

MINDFULNESS AT VALKENBERG HOSPITAL

Mindfulness is everywhere and has been promoted in almost every setting although it is not yet part of formal medical or psychiatry training in South Africa. A useful definition is 'the awareness that arises from paying attention, on purpose in the present moment, non-judgmentally.' (Kabat-Zinn J, Full Catastrophe Living, 1990, 2013).

Tessa Roos (psychiatrist and member of the UCT department of Psychiatry and Mental Health) and **Jacqui Wigg** (teacher working in educational program research) have completed the two year post graduate certification in Mindfulness Interventions through Stellenbosch University.

As part of their training, they needed to teach a mindfulness course. Tessa and Jacqui chose to teach Mindfulness Based Stress Reduction (MBSR) as the original program developed by one of the founders of secular mindfulness, Jon Kabat-Zinn, at the University of Massachusetts Medical school in the 1970's. The online mindfulness course has worked well during the pandemic and both Tessa and Jacqui are now planning a pilot mindfulness programme as an elective to fourth year students during their psychiatry rotation later in 2021 ■



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*The TREVICTA® Plan is the initiation of XEPLION® then moving to TREVICTA® when stabilised - in line with the approved indications for both treatments.⁷ XEPLION® is indicated for maintenance treatment of schizophrenia and for the prevention of recurrence of symptoms of schizophrenia. TREVICTA®, a 3-monthly injection is indicated for the maintenance treatment of schizophrenia in adult patients who are clinically stable on 1-monthly paliperidone palmitate injectable product.⁷

References: 1. Schreiner A, Bergmans P, Cherubin P, et al. A Prospective Flexible-Dose Study of Paliperidone Palmitate In Nonacute But Symptomatic Patients With Schizophrenia Previously Unsuccessfully Treated With Oral Antipsychotic Agents. *Clinical Therapeutics* 2014;36(10):1372-1388e1. 2. Berwaerts J, Liu Y, Gopal S, et al. Efficacy and Safety of the 3-Month Formulation of Paliperidone Palmitate vs Placebo for Relapse Prevention of Schizophrenia: A Randomized Clinical Trial. *JAMA Psychiatry* 2015;72(8):830-839. 3. Savitz A, Xu H, Gopal S, et al. Efficacy and Safety of Paliperidone Palmitate 3-Monthly Formulation for Patients with Schizophrenia: A Randomized, Multicenter, Double-Blind, Noninferiority Study. *International Journal of Neuropsychopharmacology* 2016;19(7):1-14. 4. Hargarter L, Bergmans P, Cherubin P, et al. Once-monthly paliperidone palmitate in recently diagnosed and chronic non-acute patients with schizophrenia. *Expert Opinion on Pharmacology* 2016;17(8):1043-1053. 5. Caroli F, Raymondet P, Izard I, et al. Opinions of French patients with schizophrenia regarding injectable medication. *Patient Preference and Adherence* 2011;5:165-171. 6. Gopal S, Vermeulen A, Nandy P, et al. Practical Guidance for Dosing and Switching from Paliperidone Palmitate 1-Monthly to 3-Monthly Formulation in Schizophrenia. *Current Medical Research and Opinion* 2015;31(1):2043-2054. 7. TREVICTA® Professional Information Leaflet. December 2020. 8. Xeplion Professional Information Leaflet. May 2019. 9. INVEGA® Professional Information Leaflet. January 2010.

☐ TREVICTA® 175 mg, 263 mg, 350 mg, 525 mg prolonged release suspension for injection. 175 mg prolonged release suspension for injection: Each pre-filled syringe contains 273 mg paliperidone palmitate equivalent to 175 mg paliperidone. 263 mg prolonged suspension for injection: Each pre-filled syringe contains 410 mg paliperidone palmitate equivalent to 263 mg paliperidone. 350 mg prolonged release suspension for injection: Each pre-filled syringe contains 546 mg paliperidone palmitate equivalent to 350 mg paliperidone. 525 mg prolonged release suspension for injection: Each pre-filled syringe contains 819 mg paliperidone palmitate equivalent to 525 mg paliperidone. Marketing Authorisation Number/s: EU/1/14/971/007; EU/1/14/971/008; EU/1/14/971/009; EU/1/14/971/010. For full prescribing information, refer to the latest professional information leaflet. December 2020.

☐ XEPLION® 50, 75, 100 or 150mg Prolonged release suspension for intramuscular injection. Each pre-filled syringe contains sterile paliperidone palmitate equivalent to 50, 75, 100 or 150mg of paliperidone respectively. Reg. Nos.:44/2.6.5/0866; 44/2.6.5/0867; 44/2.6.5/0868;44/2.6.5/0870. For full prescribing information, refer to the latest professional information insert. May 2019.

THE 1ST MARCÉ AFRICA MATERNAL MENTAL HEALTH (M.A.M.A) VIRTUAL CONFERENCE THURSDAY 16 SEPTEMBER 2021 17:00 - 20:00 CENTRAL AFRICAN TIME

INVITATION FROM THE CONVENOR

The International Marcé Society for Perinatal Mental Health is an international, interdisciplinary organisation dedicated to supporting research and assistance surrounding prenatal and postpartum mental health for mothers, fathers, and their babies.

THE OVERALL MISSION OF THE INTERNATIONAL MARCÉ SOCIETY IS TO SUSTAIN AN INTERNATIONAL PERINATAL MENTAL HEALTH COMMUNITY TO PROMOTE RESEARCH AND HIGH-QUALITY CLINICAL CARE AROUND THE WORLD.

The Society aims to promote, facilitate, and communicate about research into all aspects of the mental health of women, men/partners, infants, and their families throughout pregnancy and the first two years after childbirth. This involves a broad range of research activities ranging from basic science through to health services and development of best practice care and prevention. The Society is multidisciplinary and encourages involvement from all disciplines including psychiatrists, psychologists, paediatricians, obstetricians, midwives, nurses, early childhood specialists.

As one of the board members of the executive committee, the current vision is to expand the society and develop a regional group on the African continent. The development of the Marcé Africa regional group would be in line with existing regional groups in Europe, North and South

America and would be part of the overall mission of establishing international multidisciplinary perinatal mental health care for all.

In line with this mission, and to ensure safety for all during the COVID-19 pandemic, a virtual conference will be held on Thursday 16 September to allow for speakers from various African countries to present aspects of perinatal mental health in Africa and hopefully result in the development of a Marcé-Africa regional group. The conference will be an excellent platform for information exchange and exposure to the latest developments in perinatal mental health from an African perspective.

The virtual conference is free for any health care provider with an interest in Perinatal Mental Health. Please see registration details below and attached scientific programme.

We hope you will join us.

Yours sincerely,

Dr Lavinia Lumu
Board member, Executive committee
The International Marcé Society for Perinatal Mental Health
lavinia.lumu@yahoo.com

Registration is free for any health care provider with an interest in Perinatal Mental Health

For any further information, please contact the congress secretariat:
Sonja du Plessis on e-mail sonja@londocor.co.za or cell: +27 82 455 7853
You will receive a zoom link and further instructions from the congress secretariat ■

M.A.M.A VIRTUAL CONFERENCE

INVITED FACULTY



Keynote speaker: Assistant Professor Saira Kalia, MD
University of Arizona College of Medicine, USA

Dr. Saira Kalia, is the Adult Psychiatry Outpatient Medical Director at Banner - University Medical Center South. She is also a perinatal psychiatrist, an educator, and serves as the Associate Training Director for the Department of Psychiatry Residency program at the University of Arizona College of Medicine - Tucson. She currently runs the Psychiatry Department's Perinatal Psychiatry Track. Dr. Kalia is well regarded in the Tucson community and has earned numerous accolades for her role as an educator and for her patient-centered care. Most recently, she earned the Arizona Psychiatric Society's Howard E. Wuslin Excellence in Education Award.



Dr Olatunde Olayinka Ayinde (MBBS, MS, FWACP) is a Lecturer and Consultant Psychiatrist at the University of Ibadan and University College Hospital, respectively. He is a recipient of several undergraduate and postgraduate scholarship awards, including the World

Bank Scholarship, Heller School Merit Scholarship, Chevron-NNPC scholarship and Federal Government of Nigeria Scholarship. His research interest is in global mental health with particular emphasis on scaling up services for persons with mental disorders in low- and middle-income countries. In the last few years, his research has focused on scaling up services for perinatal depression in Nigeria.



Dr Juliet Nakku (MD) is a Consultant Psychiatrist and Executive Director at Butabika National Referral Teaching hospital and a lecturer in Psychiatry at Makerere University college of health sciences (MUCHS). She holds an MBChB (MUCHS) and Master of Medicine in Psychiatry of

Makerere University. She teaches mainly Psychiatry residents in the maternal mental health module and does research in this and other areas of mental health. She was Principal investigator in the recently concluded PRIME study where she led the maternal mental health component in Uganda. In this study she evaluated the impact of integrating evidence-

based interventions in primary care in low resource settings. Currently she is a co-investigator in the MDEPTH project which is a trial of Problem-Solving Therapy (PST) for maternal depression in Central Uganda. Dr Nakku has published a number of papers in maternal as well as other areas of mental health particularly in primary care settings.

SHE IS ALSO A LEADER IN PSYCHIATRY IN THE AFRICA REGION AS THE WORLD PSYCHIATRIC ASSOCIATION (WPA) ZONAL REPRESENTATIVE AND PRESIDENT OF THE UGANDA PSYCHIATRIC ASSOCIATION.



Dr Katie Rose Mahon Sanfilippo is currently a postdoctoral fellow in psychology at Goldsmiths, University of London. She is also an associated lecturer in music at The University of Cambridge. Her overall research interests concern the perception, function and application of music. She

has undergraduate degrees in psychology and music from Loyola Marymount University, an MSc in Music Mind and Brain and a PhD in psychology from Goldsmiths, University of London. Her PhD, under the supervision of Prof Lauren Stewart and Prof Vivette Glover, investigated the potential of a community-based music intervention to reduce anxiety and depression symptoms in pregnant women from The Gambia, West Africa. Her current research is exploring the application of music-based interventions to support maternal mental health across different cultural contexts in Africa and the UK. She has worked with various policymakers, charities and health organisations to promote maternal mental health in the educational and health policy agendas in The Gambia. She also has experience working in the charity sector in the UK. She has helped to design and conduct evaluations for organizations that use music to aid in the well-being of different marginalized populations.



Professor Salome Maswime is an associate professor, Obstetrician and Gynaecologist, and Head of Global Surgery at the University of Cape Town. She is the President of the South African Clinician Scientists Society, vice-president of the Women in Global Health South Africa, trustee of the Board

of the Health Systems Trust in South Africa, member of the leadership team of UNITARs Global Surgery Foundation and Associate editor of the South African Journal of Obstetrics and Gynaecology. Salome completed her MBChB at the University of KwaZulu Natal, and qualified as Fellow of the Colleges of Obstetrics and Gynaecology South Africa at the University of the Witwatersrand, and thereafter completed her Masters in Medicine and PhD also at Wits. She was awarded the prestigious Discovery MGH fellowship in 2018 and did postdoctoral research at the Harvard Medical School and Massachusetts General Hospital in the United States. Maswime has worked in various hospitals in South Africa, including Chris Hani Baragwanath Academic Hospital and currently Groote Schuur Hospital. She is currently a Next Einstein fellow and a World Economic Forum Young Scientist.

MASWIME'S RESEARCH INTERESTS ARE OBSTETRIC SURGERY AND PLACENTAL CAUSES OF STILLBIRTHS. SHE HAS PUBLISHED HER WORK AND PRESENTED IN NUMEROUS CONFERENCES INTERNATIONALLY.

She has served in numerous international committees, boards, and technical working groups. She was recognized as a trailblazer and young achiever by the President of South Africa in 2017, Destiny magazine for Excellence and Tenacity in public service in 2017; and Contribution to maternal health by Africa Forbes, CNBC Africa and Africa Business News in 2018, and received the Research in Health Award in 2020 from the OneAfrica organization



Associate Professor Simone Honikman is the Director, Perinatal Mental Health Project and Associate Professor, University of Cape Town (Ashoka Fellow). Simone has a medical degree and an MPhil in Maternal and Child Health from the University of Cape Town (UCT).

She has worked as a medical officer in psychiatry, paediatrics, obstetrics and gynaecology and HIV medicine. In 2002, she founded the Perinatal Mental Health Project, currently located within the Alan J Flisher Centre for Public Mental Health, Department of Psychiatry and Mental Health at UCT. She has collaborated in several global mental health research consortia and has published journal papers and book chapters on maternal mental health. Simone is actively involved in policy writing, advocacy work and multi-media resource development for maternal mental health in low resource settings. She conducts trainings and develops capacity building resources for a wide range of service providers and organisations. She offers executive oversight of an integrated and comprehensive mental health service model that operates at a community-based midwife unit in Cape Town. She is actively involved with the

International Marcé Society for Perinatal Mental Health, the Global Alliance for Maternal Mental Health and the African Alliance for Maternal Mental Health and has contributed to several World Health Organisation initiatives.



Dr Bibilola Oladeji (MBBS, MSc, FWACP) is a Senior Lecturer, College of Medicine, University of Ibadan, and a Consultant Psychiatrist to the University College Hospital, Ibadan and is currently the head of the Department. Her main

research interest is in Psychiatric Epidemiology and Implementation Research. She has a special interest in Maternal Mental Health and is a member of the Marce Society. She has been involved with trials exploring the integration of mental health care with primary and maternal and child health care using a task sharing approach with funding from the Fogarty International Centre, Grand Challenges Canada and the IDRC. In the context of this work, she has trained hundreds of frontline healthcare providers to identify and provide evidenced based care for common mental disorders. She has several peer reviewed publications in high impact journals.



Dr Linnet Onger is a researcher in the field of mental health working at the Centre for Clinical Research in the Kenya Medical Research Institute (KEMRI). She recently completed her postdoctoral fellowship in the Global Initiative for Neuropsychiatric Genetics Education in Research (GINGER)

program, hosted jointly by the Harvard T.H. Chan School of Public Health and the Stanley Center for Psychiatric Research. She is currently pursuing her PhD studies examining suicidality in Kenya. Having worked in Kenya for the last 10 years as a medical doctor and later as a psychiatrist, she believes innovative programs that tap into already existing physical and human resources can go a long way to addressing the mental health treatment gap. It is for this same reason that she has been drawn to research approaches that strive to design culturally and regionally appropriate models of integrating mental health care in primary health care. In her prior research work she was the principal investigator of a study on postpartum depression, which sought to establish the magnitude of late pregnancy and postpartum depression among women seeking care at maternal and child health clinics (MCH) in Nairobi and validated a postpartum depression screen in the local language. Most recently, she has served as site-PI for an effectiveness-implementation hybrid type I study of Interpersonal Therapy (IPT) delivered by non-specialists for HIV-positive women facing gender-based violence. Aside from her research role, Dr. Onger is additionally engaged in policy work. She is a member of the presidential mental health national task force as well as various technical working groups at the Ministry of Health ■

M.A.M.A VIRTUAL CONFERENCE

SCIENTIFIC

PROGRAMME

#THEMAMACONFERENCE

THURSDAY 16 SEPTEMBER 2021

17:00 – 20:00 CENTRAL AFRICAN TIME

- | | |
|---------------|---|
| 17:00 – 17:05 | Introduction and opening
Dr Lavinia Lumu (South Africa) |
| 17:05 – 17:25 | Women's health and Mental health - Providing integrated care
Prof Salome Maswime (South Africa) |
| 17:25 – 17:45 | Screening women for common mental disorders in the perinatal period: Developing a tool for South Africa and practical considerations
Prof Simone Honikman (South Africa) |
| 17:45 – 18:05 | Edinburgh Postnatal Depression Scale (EPDS) screening in Kiswahili: Overcoming the language and cultural barrier
Dr Linnet Ongeru (Kenya) |
| 18:05 – 18:25 | Common perinatal mental disorders -The depressed mother
Dr Bibilola Oladeji (Nigeria) |
| 18:25 – 18:35 | Understanding Music's Role in Maternal Mental Health in The Gambia
Dr Katie Rose Sanfilippo |
| 18:35 – 18:55 | Outcomes of group problem solving therapy on maternal depression in primary health care settings in rural Uganda: An interventional cohort study
Dr Juliet Nakku (Uganda) |
| 18:55 – 19:15 | What about the fathers? - Paternal perinatal mental health
Dr Olatunde Ayinde (Nigeria) |
| 19:15 – 19:45 | Psychopharmacology in pregnancy: Keynote speaker from The International Maré Society
Assistant Professor Saira Kalia (University of Arizona College of Medicine) (Arizona, USA) |
| 19:45 – 20:00 | Discussion & Close |

HOW TO REGISTER:

Registration is free for any health care provider with an interest in Perinatal Mental Health

For any further information, please contact the congress secretariat:
Sonja du Plessis on e-mail sonja@londocor.co.za or cell: +27 82 455 7853

You will receive a zoom link and further instructions from the congress secretariat ■

Depression can
make keeping
on top of daily
tasks a struggle



Brintellix[®] can help with her mood,
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able to organise her day again^{1,2}

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Brintellix[®]
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References: 1. Baune BT et al. *Int J Neuropsychopharmacol* 2018; 21 (2):97-107.2. Fagiolini A et al. *Journal of Affective Disorders*. Nov 2020. **South Africa:** S5 Brintellix[®] 10 mg film-coated tablets. Each tablet contains vortioxetine hydrobromide equivalent to 10 mg vortioxetine. Reg No. 48/1.2/0430 **Namibia:** NS3:15/1.2/0071 **Botswana:** S2: BOT 1502705 **Mauritius:** PB/13008/04/2018. Lundbeck SA (Pty) Ltd. Unit 9, Blueberry Office Park, Apple Street, Randpark Ridge Extension T14 Tel: +27 11 699 1600. For full prescribing information refer to the professional information approved by the medicines regulatory authority. ZA-BRIN-0143 July 2021

RESET EXPECTATIONS WITH REXULTI® (BREXPIPIRAZOLE)

Lisa Selwood

Lundbeck is proud to announce REXULTI® (brexpiprazole) tablets are now available in South Africa. REXULTI® is indicated in adult patients for the treatment of schizophrenia. Two virtual launch events were streamed live from a studio to a combined audience of over three hundred psychiatrists. Prof Leslie Citrome, a Clinical Professor of Psychiatry and Behavioural Sciences at New York Medical College, New York, USA, provided insight into the brexpiprazole molecule, the clinical trial development program and prescribing practicalities.

REXULTI® is a distinct chemical entity; it is not a precursor, a metabolite or an enantiomer of another product. It has a unique mode of action - it acts as a partial agonist at serotonin 5-HT_{1A} and dopamine D₂ receptors, which contributes to its antipsychotic activity. It is an antagonist at serotonin 5-HT_{2A} and noradrenaline α_{1B}/α_{2C} receptors and differs from all other antipsychotics in its pharmacologic profile and intrinsic activity.

ITS PHARMACOLOGIC PROFILE INDICATES A LOW PROPENSITY TO INDUCE SIDE EFFECTS ASSOCIATED WITH DOPAMINE ANTAGONISM. PROF CITROME HIGHLIGHTED THAT PARTIAL AGONISM DOSE NOT EQUATE TO PARTIAL EFFICACY!

REXULTI® is backed by a robust clinical development program. In two six-week, fixed dose studies in patients with acute schizophrenia, brexpiprazole improved symptoms of schizophrenia, as measured by the change in the Positive and Negative Syndrome Scale (PANSS). The Number Needed to Treat (NNT) in the short-term trials for brexpiprazole was 7. In a 52-week maintenance study, brexpiprazole demonstrated superiority over placebo on the time to impending relapse. The time to impending relapse was significantly delayed compared to placebo, and the risk of impending relapse was significantly reduced by 71% versus placebo. Furthermore, the long-term efficacy was further

supported in a 52-week open label safety study, where patients demonstrated a sustained/continued improvement of their symptoms of schizophrenia.



Lisa Selwood

In addition, a good safety and tolerability profile was demonstrated in both the short- and long-term studies and brexpiprazole was associated with a low rate of discontinuation due to adverse events. Of importance is the effect on metabolic parameters, as patients with schizophrenia have an increased propensity for metabolic problems as they age. However, REXULTI® had only a small effect on metabolic parameters and was associated with a mean weight gain of 1.2kg over six weeks, and 2.1kg over 52 weeks versus placebo. There was a low incidence of EPS related adverse events and a low incidence of activating and sedating side effects.

The recommended dose titration of REXULTI® is as follows:

Day 1 – 4: 1 mg/day

Day 5 – 7: 2 mg/day

Day 8+: 2 – 4mg/day

Peak plasma concentration occurs within four hours of a single dose, and steady state is reached within 10 to 12 days. It can be given without regard for meals, at any time of the day.

Patients who have symptoms that are not fully controlled, or those who continue to experience bothersome side effects from their antipsychotic medication, may not be functioning at their potential and may become non-adherent over time. REXULTI® offers an alternative option with clinically proven efficacy in schizophrenia, without tolerability trade-offs. Isn't it time you reset your expectations of what a medication for schizophrenia could - and should - offer?

Lisa Selwood is the Medical Affairs Manager at Lundbeck, South Africa. **Correspondence: LIEW@lundbeck.com** ■

RESET EXPECTATIONS WITH



REXULTI[®] is indicated in adult patients for treatment of schizophrenia

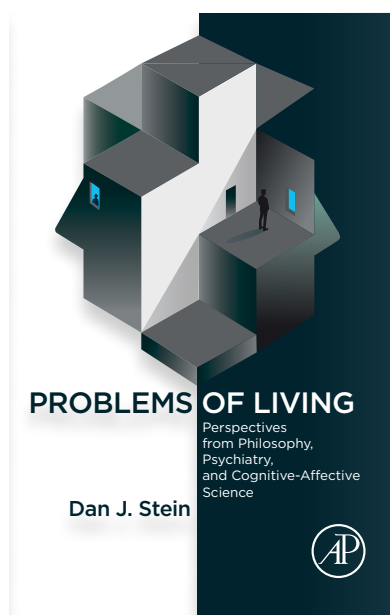


South Africa: S5 REXULTI[®] film coated tablets. Each tablet contains brexpiprazole. Reg No. 0,5 mg: 51/2.6.5/0501; 1 mg: 51/2.6.5/0502; 2 mg: 51/2.6.5/0503; 3 mg: 51/2.6.5/0504; 4 mg: 51/2.6.5/0505. Lundbeck SA (Pty) Ltd. Unit 9, Blueberry Office Park, Apple Street, Randpark Ridge Extension 114 Tel: +27 11 699 1600. For full prescribing information refer to the professional information approved by the medicines regulatory authority. ZA-REXU-0093 July 2021

PROBLEMS OF LIVING

PERSPECTIVES FROM PHILOSOPHY, PSYCHIATRY,
AND COGNITIVE-AFFECTIVE SCIENCE

Sean Baumann



Title: Problems of Living
Publisher: Academic Press
Author: Dan Stein
ISBN: eBook ISBN: 9780323904391
 Paperback ISBN: 978032390239

Philosophy is largely neglected in the practice of clinical psychiatry and this has problematic consequences. Divisions arise and false dichotomies distract from the need to examine the underlying assumptions in the way psychiatric disorders are conceptualized and treated. Reductive biomedical models might claim to bring psychiatry into the fold of orthodox medicine yet neglect social, economic and cultural factors that have an important bearing on symptom formation and management. These various tensions, between limited and broader models, and of the shifting boundaries between psychiatric illness and what might be described as problems of living are philosophical issues that are rarely addressed explicitly and too often contribute to arid conflicts within the profession

and misperceptions in the general public about the nature and scope of psychiatric practice.

The neurosciences are too often relegated to a burdensome requirement of post-graduate training, a necessity for the understanding of basic psychopharmacology, and as a separate discipline rather than intrinsic to clinical psychiatry. This disjunction contributes to a lag or failure to translate research findings into practice, perhaps especially outside academic settings.



Sean Baumann

THE LACK OF INTEGRATION OF PHILOSOPHY, THE NEUROSCIENCES AND CLINICAL PRACTICE IMPOVERISHES PSYCHIATRY. IT ALSO IN ALL LIKELIHOOD CONTRIBUTES TO THE UNCERTAIN STATUS OF PSYCHIATRY, BOTH WITHIN AND BEYOND THE CONFINES OF MEDICINE.

Psychiatry is perceived as philosophically incoherent, fraught with conflicts and controversies, and lacking an adequate scientific foundation. In these, and many other, respects Dan Stein's *Problems of Living* makes an important, and timely contribution.

As indicated in the subtitle, the book addresses perspectives from philosophy, psychiatry and cognitive-affective sciences. An early chapter on the brain-mind problem examines one that is central to psychiatry, how to define the mind and how to explain the relation of mind to brain. A perhaps rather gruesome metaphor of wet-ware is proposed, reaching beyond a more familiar distinction between hard-ware and soft-ware models. Stein throughout the text makes an interesting argument for the usefulness of metaphors in making sense of difficult concepts. That the mind is embodied in the brain and is embedded in a social context is a recurrent motif. The tension between reason and

passion is considered: a dichotomous formulation is inadequate and both emotion and reason are necessary for optimal decision making. A chapter on the pleasures of life discusses contributions from Aristotle to Wittgenstein and proposes that happiness entails both pleasure and purpose.

A thoughtful and critical evaluation of the problem of addiction emphasizes the need for public health interventions. A chapter on pain and suffering stresses the importance of both meanings and mechanisms: science is theory bound and value laden. Pain, and in particular chronic pain is problematic in that both in medicine and in the general public a false dichotomy as to whether the problem is physical or psychological is very often unthinkingly imposed, which is unhelpful and harmful, and neglectful of valuable philosophical and neuroscientific insights. Pain is inherently subjective, and therefore the more open and constructive notion of human suffering is invoked. A chapter on the good and the bad includes a discussion on the vexed issue of psychopathy, and the extent to which the medicalization of badness confuses ways of dealing with the problem in a helpful and just way. This chapter also addresses in an imaginative way a theme that is unusual for a text of this nature, but of special relevance to this country, being that of forgiveness and reconciliation. The nature of human nature is investigated in a further chapter, a subject that most clinicians probably do not consider explicitly, or take for granted, but which has important implications for psychiatric practice. Throughout history philosophy has been grounded in science, but addresses issues that the sciences sometimes cannot. Psychiatry needs to be understood as a bridge between the sciences and the humanities.

A concluding chapter considers the meaning of life, and includes a review of the fraught but critically important problem of free will. Beauty, goodness spirituality and generativity, or creativity, are imaginatively and insightfully discussed in this final section. Both objectivist and subjectivist approaches are described. A balance needs to be found between vagueness and imponderability, and rigidity and reductiveness, reflected both in eastern philosophy as the middle path and in western philosophy in Aristotle's golden mean.

The text is organized in a taut and rigorous structure. For the most part the psychiatric, philosophical and neuroscientific or cognitive- affective perspectives are articulated, followed dialectically by concluding remarks which seek to "sharpen" our ways of thinking about these centrally important subjects. A number of tables describing classical, critical and integrative approaches may be considered overschematic but provide useful summaries of the subjects under discussion. Stein throughout adopts a non-technical, lucid style of writing that is free of jargon. He admirably renders accessible at times difficult and controversial topics. Personal accounts of the development of his thinking, and recurrent reference to the South African context add interest and depth to what might otherwise have become a formidably academic study. Importantly he inspires interest in dimensions of psychiatry that are too often either neglected or insufficiently addressed. Over

two thousand references give an indication of the breadth and depth of his reading. The text makes a valuable contribution in integrating perspectives from clinical psychiatry and philosophy and the neurosciences to foster a more creative and helpful way of addressing problems of living and human suffering.

This is an ambitious undertaking. In the breadth of its scope, the clarity of its exposition and in its modest and humane tone it is also a remarkable achievement. The book elaborates on some of the themes of a previous, perhaps more provocative work, 'Philosophy of Pharmacology', subtitled 'Smart Pills, Happy Pills and Pep Pills'. In this text he raised questions about the philosophy of pharmacology, but also addressed a range of perspectives on science, language and medicine.

GIVEN THE IMPRESSIVELY WIDE RANGE IT IS UNDERSTANDABLE THAT A NUMBER OF ISSUES ARE NOT ADDRESSED THAT ARE NEVERTHELESS IMPLICIT IN THE AREAS OF INTEREST UPON WHICH STEIN PLACES FOCUS.

The tone is optimistic, and there is a perhaps cautious optimism that in integrating these different perspectives it can be expected that the difficult problems described should be resolved. It is perhaps then not appropriate to this project to draw attention to controversies, but the very title of the book raises a number of questions including whether or not psychiatry should be concerned with the problems of living, and whether or not in doing so problems of living are medicalized with the assumption that there is some medical solution, or cure. These difficulties are described rather than critically addressed, and this is consistent with the general aim of finding a middle ground. This is commendable but can at time seem rather predictable, and at least in some areas a more polemical approach might have struck another kind of balance. A concluding reference is made to the aphorism 'everything in moderation including moderation'. The lack of progress in the understanding and treatment of the schizophrenia spectrum disorders, for example, is not dealt with, and again it is possibly not within the remit of this work, but attending to the neuroscientific and the philosophical perspectives does provide a basis for the hope of the better understanding and treatment of these and many other complex and enigmatic psychiatric disorders.

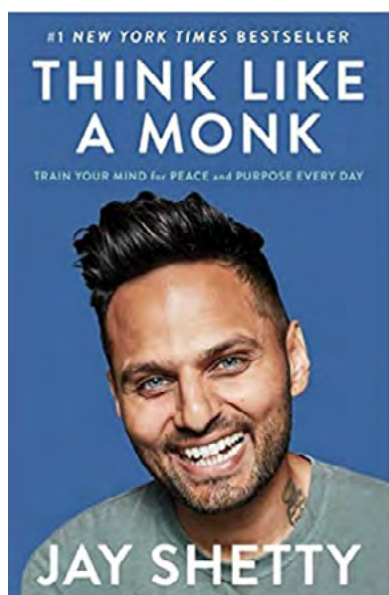
For further information : <https://www.elsevier.com/books/problems-of-living/stein/978-0-323-90239-7>

Sean Baumann worked for 25 years as a consultant to the male acute service at Valkenberg Hospital and was a senior lecturer in the department of Psychiatry and Mental Health where he holds an honorary position. He is the editor of *Primary Care Psychiatry: A Practical Guide for Southern Africa* (1988, 2007, 2015). His cantata *Madness: Songs of Hope and Despair* was performed at the Baxter Theatre in Cape Town in 2017. His book *Madness: Stories of Uncertainty and Hope* was published by Jonathan Ball Publishers in 2020. **Correspondence: sean.baumann7@gmail.com** ■

THINK LIKE A MONK: TRAIN YOUR MIND FOR PEACE AND PURPOSE EVERY DAY

A BOOK REVIEW Q&A CONVERSATION
WITH MY DAUGHTER, NIANKA KOUAKOU

Koffi Kouakou



Title: Think Like a Monk: Train Your Mind for Peace and Purpose Every Day
Publisher: Thorsons, HarperCollins Publishers
Author: Jay Shetty
ISBN: ISBN: 978-0-00-838642-9
 ISBN: 978-0-00-835556-2

DISCLOSURE:

My daughter enjoyed this book and suggested I consider reviewing it. I did. But I thought I would ask her to share her take on the book. Below is the summary of our Q&A conversation

Why did you choose this book? Who is Jay Shetty and why should we care about his message, today?



Koffi Kouakou

Jay Shetty is a well-renowned podcaster, former monk, motivational speaker and life coach. Having been an avid listener to his podcast On Purpose, I was curious to see if he would articulate his message as well in writing as he does in speech. I learned a lot, reflected on many topics and discussions on his podcast.

I ALSO VALUE A DIFFERENT PERSPECTIVE, MORE IN-DEPTH TOPICS AND ESPECIALLY ON HOW TO TRAIN MY MIND FOR PEACE AND PURPOSE EVERY DAY.

His message carries a lot of value because he speaks about subjects that affect us daily and talks about the power of meditation, the breath, creating healthy routines, having a deep understanding of compassion and giving back through service.

What's its main message for you?

Jay Shetty's Think Like a Monk delves into how any ordinary person, with no desire to become a monk can learn from and practice valuable principles that knowledgeable experts in peace, purpose and calm have dedicated their lives to. Here are 10 things I've learnt from the book and the reasons why you should read it:

- Understanding oneself, one's reality and how perspective plays an important role in dealing with one's hardships.
- How one's viewpoints on fear and negativity affect one's lived experiences.
- Understanding the meaning of purpose and exploring one's deeper reason for being and asking oneself "Why?"
- How to define oneself by our intentions, services, understanding, compassion and growth rather than our achievements.
- The importance of failures, healthy habits and routines, the power of meditation and the value of challenges in our lives.
- Discovering one's purposes which are interlinked with passions, skills, usefulness and compassion.
- The profoundness in being present and living life, as opposed to just existing. (Practicing being present with tools such as meditation, writing gratitude lists, being compassionate letting go of ego through service).
- The role of the ego and humility in one's life.
- The beauty of coexisting paradoxes that one experiences and how one's life journey is not linear and is unexpected at times.
- THE GREAT VALUE THAT PRACTICING GRATITUDE AND FORGIVENESS CAN ADD TO ONE'S LIFE. IT GENERATES PRESENCE, CLARIFIES PERSPECTIVES AND GARNERS COMPASSION, RESPECT, LOVE, APPRECIATION AND IN TURN, SERVICE TO MAKE A POSITIVE IMPACT SOMEWHERE IN THE WORLD.

Define thinking like a monk, and how can it be applied to our modern world? What does it take to think like a monk?

To me, thinking like a monk means implementing healthy, sustainable and wholesome ways into your everyday life. This includes doing breathwork, letting go, growing, giving, understanding fear, realising the ego, understanding personal purpose, respecting and dedicating parts of our life to service, while being fully present. We can learn something great from the happiest and calmest people on earth.

Koffi Kouakou is a senior lecturer at the Wits School of Governance, where he teaches strategic government communications and scenario planning. He is the former director of the Unilever Mandela Rhodes Academy for Communications and Marketing (UMRA), a Storyteller, Social Commentator, Business Strategist, Author and Futurist. He specialises in information communications technologies for development and telecommunications adapted to environmental issues in Africa. He has been a regular contributor to international, local media and business magazines on the BBC, VOA, Deutsche Welle, The People Daily, eNCA, Africa 360 degrees, SAFM, 702 Radio, Power FM, China, Brainstorm, The Media, CIO.COM and Intelligence in South Africa. He co-authored a book titled AfricaDotEdu: IT Opportunities and Higher Education in Africa, 2003. **Correspondence:** koffizulu@gmail.com ■

What does it mean to be a modern monk like Jay Shetty in times of crises and trauma?

Being a modern monk involves implementing these monk morals, values and principles mentioned above into one's daily life. It's not just about "lighting up candles in your home, walking around barefoot and posting pictures of yourself doing tree pose on a mountaintop." It entails adopting certain elements of a mindset that bring great value, deep meaning, purposeful routines and an enriched life.

AS HUMAN BEINGS, WE ARE FACED WITH TRAUMA, TRAGEDY AND DESPAIR DAILY, AND THINKING LIKE A MONK CAN PROVIDE US WITH NOT ONLY KNOWLEDGEABLE INFORMATION ON THESE SKILLS BUT ALSO PRACTICAL TIPS TO ACHIEVING CONTENTMENT.

What is your favourite part of the book and why?

It is undoubtedly the practicality, succinctness and clarity of its message that are my favourite. Shetty doesn't dawdle with his words. Every section, chapter and page are relevant.

MANY SELF-HELP BOOKS TELL YOU WHAT YOU NEED TO DO TO LIVE A BETTER LIFE BUT OFTEN EXCLUDE THE MOST SIGNIFICANT PART, WHICH IS HOW TO ACTUALLY HAVE THE MINDSET AND PRACTICE TO ACHIEVE THAT. SHETTY CUTS STRAIGHT TO THE CHASE TO PROVIDE PRACTICAL EXAMPLES AND TOOLS TO LIVE A MEANINGFUL LIFE WITH PURPOSE.

What are your takeaways from the book?

Overall, the most important takeaway for me is letting go of fear, negativity and understanding oneself while creating an intention through everything you do with deep meaning. In addition, by harnessing one's power of the mind, creating healthy routines, realising one's purpose, understanding one's ego, engaging in mindful breathwork and meditation, peace can be achieved. Finally, by practicing gratitude and being compassionate to all, one can live a meaningful life.

M O V I E S



Title: Black Widow
Release Date: 13-Aug-21

Avenger Natasha Romanoff (Scarlett Johansson) becomes separated from the rest of her crime-fighting team in the wake of a significant battle. Natasha must reconnect with her former allies Yelena Belova (Florence Pugh)



Title: Cry Macho
Release Date: 17-Sep-21

A one-time rodeo star and washed-up horse breeder takes a job to bring a man's young son home and away from his alcoholic mom. On their journey, the horseman finds redemption through teaching the boy what it means to be a good man.



Title: Old
Release Date: 06-Aug-21

This summer, visionary filmmaker M. Night Shyamalan unveils a chilling, mysterious new thriller about a family on a tropical holiday who discover that the secluded beach where they are relaxing for a few hours is somehow causing them to age rapidly - reducing

their entire lives into a single day.



Title: Off the Rails
Release Date: 24-Sep-21

Now in their 50's, four friends recreate an inter-rail journey across Europe, but this time 18-year-old Maddie is taking her mother's place, fulfilling her dying wish.



Title: Ice Road
Release Date: 27-Aug-21

After a remote diamond mine collapses in the far northern regions of Canada, an ice driver leads an impossible rescue mission over a frozen ocean to save the lives of trapped miners despite thawing waters and a threat they never see coming.



Title: Summer of Soul
Release Date: 01-Oct-21

Summer Of Soul (...Or, When The Revolution Could Not Be Televised) is a feature documentary about the legendary 1969 Harlem Cultural Festival which celebrated African American music and culture, and promoted Black pride and unity.

Title: Respect
Release Date: 13-Aug-21

This film follows the rise of legendary R&B singer, Aretha Franklin, from a child singing in her father's church's choir to her international superstardom ■

REVIVAL & RESURGENCE IN THE TOURISM LANDSCAPE OF THE EASTERN CAPE

COFFEE BAY - PATERSON - GQEBERHA

Mandisa Magwaxaza

The Eastern Cape is yours to explore. We invite you to do so to contribute to your well-being and the well-being of the tourism industry.

SOULFUL ADVENTURES IN WILD COAST

My first trip in 2021 was a road trip from Gqeberha to Coffee Bay. As the odometer rolled into the 500s, I was deep in the old Transkei. The villages are vast grasslands dotted with homesteads that tell of educated hard workers in the cities that send money back home so they can return to modern conveniences in December. Herds of livestock are ushered along the N2 and given right-of-way as the valuable commodity securities that they are.

IT'S NOT LIKE ANYBODY CAN SPEED THROUGH THESE PARTS IN ANY CASE AS THE POTHOLES CAUSE LONGER TRAFFIC JAMS THAN THE GOATS. THE SLOW-PACED DRIVE THROUGH MQANDULI TOWARDS COFFEE BAY PUTS YOU STRAIGHT INTO HOLIDAY GEAR.



Once we navigated safely beyond the adventurous terrain, the green valleys, sandy shores, black rock faces and frothy ocean ahead of me affirmed my being. I was present and my holiday was a real thing. At last. As I took in the scene of children running along the side of the road towards the fields and recalled former President Thabo Mbeki's poem about being an African. Indeed, I owe my being to this land that holds the secrets of my ancestors.

Waking up at the Ocean View Hotel in Coffee Bay, I sat at the table in front of my room which was perched on a hill. I had a cinematic view of the rising sun as it filled in the space between the sea and the sky. The resort-like hotel is sprawled out on





the edge of a cove – giving the appearance that the hotel has a private beach. It sure felt like it does because the only people I saw on our beach strolls were the faces I met at breakfast.

The Ocean View Hotel has direct access to the beach cove through a small gate in the garden where you will find a games room, wellness centre, an outdoor play area and a swimming pool. These facilities were all closed because the hotel was operating according to the Tourism Industry safety protocols for Covid19.

The restaurant serves a la carte lunches, buffet dinners and cold and hot breakfasts fit for royalty. Packed lunches are made on request for those who want to spend the day exploring the surroundings. Hole in the Wall is a 5-minute drive from the hotel, and there are guided hikes and kayaking experiences operated by locals from the surrounding villages.

Bashing about in a 4x4, trekking my wanderlust down steep escarpments, and gliding across the Mthatha river are my bucket list activities in the Wild Coast of the Eastern Cape. I had intermittent connectivity, which I came to appreciate and used to reset my mind and my priorities to the here-and-now.

THE WILD COAST'S CHARM IS IN ITS PEOPLE'S HUMILITY AND THE DOMINANT ROLE OF THE NATURAL WORLD IN EVERYDAY LIFE. NOTHING EXPLAINS THIS BETTER THAN HAVING MY PERFECT BEACH VIEW ANIMATED BY A PIGLET CHASING CATTLE ACROSS THE SHORE.

Book the Ocean View Hotel while exploring Coffee Bay: <https://www.oceanview.co.za/>

RESURGENCE THROUGH NATURE WITH MANTIS

As the world emerges from covid induced bafflement, many people need to heal the battle scars left by financial, social, and emotional stress. For some people, a holiday would be enough to defog the mind. However, this particular perplexity calls for a double dose of whatever it takes for high-functioning people to evolve from so many 'new normals'.



Mantis, together with a highly qualified medical team, has developed a revitalising burnout treatment programme for executive-level individuals and couples. Hosted in the Eastern Cape at No5 Boutique Art Hotel (Gqeberha) and Founders Lodge, adjacent to Shamwari, **Resurgence through Nature with Mantis** will be offering 4 programmes that focus on the treatment and prevention of burnout and a lifestyle reset program focusing on weight loss.

PROGRAMMES CURRENTLY AVAILABLE:

The Twofold Burnout Prevention Programme:

Two connected programmes that are run consecutively, but separately. The first programme is a 6-day burnout prevention programme: **The Lifestyle Enrichment Programme**. The second, and follow-up programme is **The Immersion and Maintenance Programme**, a 5-day programme that is a more focused psychological process that aims to enhance and develop the initial programme learnings and way of being. During both processes, doctors and psychologists guide you through the programme to develop a unique individualised process that creates the right experience to feel re-connected and re-vitalised. As part of the nature experiences, you are shown how to use nature to re-connect to yourself and feel re-vitalised. Nature walks and animal experiences will anchor you into an enhanced awareness of your relationships to self, and others.





The Lifestyle Enrichment Programme:

The Lifestyle Enrichment Programme is the initial and targeted wellness process that takes key aspects of the 14-day Resurgence through Nature Programme to treat and prevent 'executive burnout' and corporate fatigue, as well as lifestyle stresses. The Lifestyle Enrichment Programme is an individual 6-day process using psychological processes, nature-based interactions and rest-enhancing activities. Together, these applications assist the person or couple to become emotionally and physically enriched. The programme will leave you better equipped to manage stress, feel relieved of fatigue and be able to walk back into your day-to-day lives with confidence. As part of the process, the medical team uses the latest medical advances to assist in ongoing lifestyle resetting and weight-management issues that often play a role in physical fatigue and psychological confidence, enriching the potential for growth and re-energising.

The Lifestyle Enrichment Programme begins with a day at Mantis No5 Boutique Art Hotel in Nelson Mandela Bay. Here, you will be introduced to the programme, undergo basic medical screening included to see where you are physically and



provide time to get to know you and what brought you to this place of exhaustion, fatigue, and stress in your life.

With this, we will be able to understand, plan and guide you to your healing process. From Mantis No5 you will leave to spend 4 nights at Mantis' Founders Lodge in the Eastern Cape Bushveld to engage with nature and be guided by experienced psychologists and eco-therapists towards an experience that will leave you re-connected to yourself, rested, and revitalised.

THE PROCESS AT FOUNDERS LODGE AIMS TO HELP YOU BECOME MORE AWARE OF THE CAUSES OF YOUR TIREDNESS AND STRESSES AND, PROVIDE BASIC CHANGES TO YOUR WAY OF BEING THAT WILL LEAD YOU TO FEEL MORE ENRICHED IN YOUR LIFE. RETURNING TO MANTIS NO5 FOR THE FINAL NIGHT, WHERE YOU WILL BE EQUIPPED TO USE THE EXPERIENCE TO MAINTAIN YOUR NEWFOUND VITALITY AND RE-CONNECTED SENSE OF SELF.

The Immersion and Maintenance Programme:

The Immersion and Maintenance Programme is a 5-day follow-up that deepens the experience of the Lifestyle Enrichment Programme. This essential process of emotional growth affirms your sense of self in the world. This 5-day programme strengthens your awareness of your relationship with self, nature and others. Starting at Mantis No5, you will spend a day under the guiding hand of our medical professionals assessing your current physical and psychological processes and needs. From Mantis No5, you will head to Founders Lodge for three nights. This portion of your resurgence journey is a psychological process that is unique to your needs. On your final night at Mantis No5, you will be equipped with tools to maintain the process as a way of being in your day-to-day life. Confident and re-connected ■

CONTACT:

Web: <https://resurgencethroughnature.co.za>

e-mail: tracy-admin@resurgencethroughnature.co.za



**SOUTH AFRICAN SOCIETY OF
PSYCHIATRISTS**

SASOP NATIONAL CONGRESS 2021 REGISTER NOW



20th National Congress
of the
South African Society of Psychiatrists
20 - 24 October 2021
Champagne Sports Resort
Central Drakensberg
- Shaping our own future -

The 20th National Congress will be held from 20 – 24 October 2021 at Champagne Sports Resort. At this stage, the organizing committee is confident that an in-person congress will be possible. If we need to postpone the congress (due to a change in Covid legislation), you will be notified immediately.

If you are interested to apply for POSSIBLE sponsorship from the trade, you may give sonja@londocor.co.za permission to circulate your name to the participating trade for sponsorship. Once Londocor receives confirmation from a company, you will be notified in writing of the extent of such sponsorship (e.g. registration, accommodation and/or travel) - which may often also be partial sponsorship. If you have already registered and paid your registration fee by the time you receive sponsorship, then Londocor will contact you to obtain your banking details for a refund. Please note that no guarantee can be provided that you will receive sponsorship.

To register for SASOP 2021, go to: <https://medmail.med-bay.com/servlet/link/235762/1119384/99613495/5753044>

DELEGATES WHO DO NOT RECEIVE SPONSORSHIP FROM A COMPANY, MAY QUALIFY FOR THE SASOP DISCOUNTED REGISTRATION FEES THAT ARE ONLY AVAILABLE TO SASOP MEMBERS WHO ARE FULLY PAID UP FOR THE PRECEDING 24 MONTHS AND MAY ONLY BE UTILIZED ONCE PER 2 YEAR CYCLE.

Those who have utilized their discount in 2019 for the Biological Psychiatry Congress, will not be eligible for the SASOP Discounted Registration Fees in 2021.

If you are unsure of your discounted registration fee, then please contact sonja@londocor.co.za

Should you wish to have your details circulated to the trade for possible sponsorship, please e-mail the following information to: sonja@londocor.co.za

- Title, First Name and Surname
- State or Private Practice
- Profession: Psychiatrist or Registrar

We look forward to seeing you at SASOP 2021.

Eugene Allers & Kobus Roux
On behalf of the SASOP 2021 Organising Committee ■



**SOUTH AFRICAN SOCIETY OF
PSYCHIATRISTS**

SASOP NATIONAL CONGRESS 2021

INVITATION FROM THE ORGANISING COMMITTEE

Dear SASOP member,

The 20th National Congress will be held from 20 – 24 October 2021 at Champagne Sports Resort. At this stage, the organizing committee is confident that an in-person congress (with safety protocols) will be possible. If we need to postpone the congress (due to a change in Covid legislation), you will be notified immediately.

The hotel has also given us a written undertaking (available on the website www.sasop2021.co.za) that there will be no penalties (including paid accommodation) should the congress be postponed. Registration fees will also be refunded (or transferred) should the congress be postponed due to a change in Covid legislation.

The organisers are planning an event designed for the needs of psychiatrists in the academic sector, the public sector, the private sector, for psychiatric registrars, general practitioners with an interest in psychiatry and the rest of the psychiatric multi-professional team.

WE DO NOT SIMPLY WANT TO COPY AND PASTE FROM PREVIOUS CONGRESSES, BUT REALLY WANT TO ASSESS THE NEEDS OF THE PARTICIPANTS OF THE NATIONAL CONGRESS.

Results from a survey have shown that 90% of SASOP members would prefer an in-person congress.

We are also planning an event around networking with colleagues. The daily program will start at 07:30 in the morning with breakfast symposia and will end at approximately 14:00 or 15:00 every day to give time for delegates to relax, network and enjoy their surroundings. The international faculty will join the congress virtually with an interactive Q&A

discussion following each presentation.

A dedicated CPD accredited “Art & Culture” programme related to psychiatry, has also been included. This will include presentations & discussion relating to movies, poetry, music, art, etc with a psychiatric theme.

The aim of the SASOP 2021 Congress is to drastically reduce its’ carbon and plastic footprint, and enhance future sustainability. We have launched a project with great enthusiasm from our sponsors to suggest novel ideas of building sustainable, non-plastic stands, with the aim of re-using the materials in a building project of school classrooms at a local community. Without “letting the cat out of the bag”, this alone would be an inspiration to attend the conference.

To further reduce our paper footprint, we are planning to move to more digitally inspired marketing and poster presentation areas.

The organising committee warmly invites you and is looking forward to hosting you for this event. We have therefore also created special tariffs for early bird registrations with a marked reduction off the normal registration fee. We want you to make use of the time created to fulfil not only your academic needs but the need to spend some time with your colleagues.

We hope to see you in the Berg in October!

Eugene Allers

The Organising Committee:

Dr Eugene Allers (Convenor) & Dr Kobus Roux (Co-Convenor) Dr Connie Mataboga, Prof Gerhard Grobler (Chair of Scientific Committee) Prof Bonga Chiliza (SASOP President) Dr Hoepie Howell, Dr Marius Pretorius, Dr Matlala Mabeba, Dr Mvuyiso Talatala & Dr Kim Laxton ■



SOUTH AFRICAN SOCIETY OF
PSYCHIATRISTS

SASOP NATIONAL CONGRESS 2021 PRELIMINARY PROGRAMME*

WEDNESDAY 20 OCTOBER 2021

14:00 - 15:00 REGISTRATION FOR WORKSHOP DELEGATES
LUNCH FOR PRE-CONGRESS WORKSHOP DELEGATES

PRE-CONGRESS WORKSHOPS (PARALLEL)

15:00 - 18:00	WORKSHOP 1: ADHD: update on diagnosis and clinical management Facilitators: Dr Frans Korb & Prof Andre Venter	
15:00 - 18:00	WORKSHOP 2: Neuromodulating therapies: TMS, ECT and deep brain stimulation Facilitator: Dr Shaquir Salduker	
15:00 - 18:00	WORKSHOP 3: Update on psychopharmacology (SASOP Training and Development Institute) Facilitator: Dr Kobus Roux The pharmacology of addiction The pharmacology of antidepressants, anxiolytics and antipsychotic medication	Dr Kobus Roux (SA) Dr Kim Outhoff (SA)
15:00 - 18:00	WORKSHOP 4: Coding and forensic Investigations for psychiatrists Facilitator: Dr Eugene Allers	Dr Eugene Allers, Dr Ian Westmore & Ms Mardi Roos (SA)
15:00 - 18:00	WORKSHOP 5: Independent medical examination & disability assessment Facilitators: Prof Gerhard Grobler & Prof Stoffel Grobler	
16:15 - 16:30	TEA/COFFEE FOR WORKSHOP DELEGATES - served outside each w/shop venue	

OPENING KEYNOTE ADDRESS AND WELCOME CEREMONY

18:15 - 18:30	Official opening of congress	Dr Eugene Allers (Convenor)
18:30 - 19:15	Keynote Address 1: Computational psychiatry	Prof Manfred Spitzer (Germany) - virtual
19:15	REGISTRATION FOR CONGRESS OPENS & WELCOME COCKTAIL FUNCTION	

THURSDAY 21 OCTOBER 2021

TRADE SPONSORED BREAKFAST SYMPOSIA

07:00 - 08:00	TRADE SPONSORED BREAKFAST SYMPOSIUM 1 (DR REDDY'S) Walking with the President - a mindful morning. No rush, no place to get to, no hurry	Prof Bonga Chiliza
08:00 - 08:45	Breakfast	
07:00 - 08:00	TRADE SPONSORED BREAKFAST SYMPOSIUM 2 (ZYDUS) Topic TBA	Speaker TBA
08:00 - 08:45	Breakfast	

PLENARY SESSION 1

08:45 - 09:30	Keynote address 2: How can we develop innovative therapies for psychiatric disorders	Prof Michael Berk (Australia) - virtual
09:30 - 10:15	Keynote address 3: Psychosocial response to Covid 19 in an African nation : Strategies in the pandemic and lessons for tomorrow	Dr Yewande Oshodi (Nigeria) - virtual

10:15 - 11:00 TEA/COFFEE

*Subject to change

THURSDAY 21 OCTOBER 2021 (CONTINUED)

PARALLEL SESSION 1

11:00 - 12:30	SESSION 1 (A): POPIA: A PRACTICAL WORKSHOP Chairperson: Dr Sebo Seape	Natalia Pereira (SA) & Virene Etsebeth (SA)
11:00 - 12:30	SESSION 1 (B): ADULT ADHD Facilitator: Prof Renata Schoeman A practical approach to the treatment of ADHD	Prof Renata Schoeman, Dr Karen Vukovic Dr Frans Korb & Dr Suntheren Pillay (SA)
11:00 - 12:30	SESSION 1(C): EARLY CAREER PSYCHIATRISTS Facilitator: Dr Ian Westmore How to write a scientific paper	Prof Christer Allgulander (Sweden) - virtual
11:00 - 12:30	SESSION 1 (D): WOMEN'S HEALTH Facilitator: Dr Bavi Vythilingum	
11:00 - 11:30	Glow Clinic - a perinatal wellbeing clinic	Dr Adaobi Udechuku (Australia) - virtual
11:30 - 12:00	Unplanned pregnancy and mental health outcomes	Dr Elsa du Toit (SA)
12:00 - 12:30	Mother Baby Units	Dr Zeyn Green-Thompson (UK) - virtual
11:00 - 12:30	SESSION 1 (E): SUBSTANCE USE & ADDICTION Facilitator: Dr Lize Weich Topics TBA	Speakers TBA
11:00 - 12:30	SESSION 1(F): FEMALE FORENSIC MENTAL HEALTH Facilitator: Dr Indrin Chetty	
11:30 - 12:00	Women with mental illness who commit violent offences: Pathways towards rehabilitation.	Prof Ugash Subramaney (SA)
12:00 - 12:30	Mental illness and HIV among female inmates in Durban, South Africa	Dr Samantha Naidoo (SA)
12:30 - 11:00	Behind the wall: A review of women who have perpetrated domestic violence	Dr Rodhie Sapinoso (SA) - virtual
11:00 - 12:30	SESSION 1(G): RELIGION/SPIRITUALITY AND PSYCHIATRY Facilitator: Dr Kobus van der Walt	
11:00 - 11:20	Belief systems and the bio-psycho-social clinical assessment	Dr Lennart Eriksson (SA)
11:20 - 11:40	Pandemic resilience: Lessons from Islamic history	Dr Khalid Dhansay (SA)
11:40 - 12:00	The WPA Spirituality and Psychiatry SIG Position Statement	Dr Judy Ludwick (SA) - virtual
12:00 - 12:30	Annual General Meeting (AGM)	
11:00 - 12:30	SESSION 1(H): THE ART OF PSYCHIATRY AND THE THERAPY OF PLAY Psychiatry, science and art/play. What to enjoy... Facilitators: Dr Hoepie Howell & Dr Kim Laxton Welcome and introduction	Dr Hoepie Howell & Dr Kim Laxton (SA)
11:00 - 11:40	Chess and psychiatry (clinical presentation)	Dr Hemant Nowbath (SA)
11:40 - 11:55	The Beautiful Game - Let's play (workshop with demonstration) - chess anatomy	Dr Hemant Nowbath (SA)
11:55 - 12:20	Madness vs Brilliance - not small-minded; just a small-screen (clinical presentation)	Dr Kim Laxton (SA)
12:20 - 12:30	Discussion	Dr Kim Laxton & Dr Hemant Nowbath (SA)

12:30 - 13:15 TEA/COFFEE

PARALLEL SESSION 2

13:15 - 14:15	SESSION 2(A): VALUE BASED CARE Facilitator: Dr Eugene Allers An overview of VBC and the implementation thereof in psychiatry	Prof Renata Schoeman (SA)
13:15 - 14:15	SESSION2(B): PILOSOPHY & PSYCHIATRY: HOW MUCH DO RELATIONS REVEAL ABOUT MENTAL DISORDERS? Facilitator: Prof Werdie Van Staden	
13:15 - 13:45	Lacking identity and solidarity with others in mental disorders: an insight from Africa	Prof Thaddeus Metz (SA)
13:45 - 14:15	What and where is the self (in psychopathology)?	Prof Werdie van Staden (SA)
13:15 - 14:15	SESSION 2(C): CELLULAR & MOLECULAR PSYCHIATRY Facilitator: Dr Kobus Roux Topics TBA	Speakers TBA
13:15 - 14:15	SESSION 2(D): WOMEN'S HEALTH Facilitator: Dr Bavi Vythilingum	
13:15 - 14:00	Pharmacotherapy in pregnancy and breastfeeding	Dr Shari Lusskin (USA) - virtual
14:00 - 14:15	Q & A	
13:15 - 14:15	SESSION 2 (E): ABSTRACT PRESENTATIONS & CLINICAL RESEARCH	Adjudicators: TBA
13:15 - 13:45	A response to Life Esidimeni recommendations and strategy to strengthen district mental health services in Gauteng province	Prof Lesley Robertson (SA)
13:45 - 14:15	The Esidimeni Inquiry - What lessons for Psychiatry	Dr Lennart Eriksson (SA)

THURSDAY 21 OCTOBER 2021 (CONTINUED)

13:15 - 14:15	SESSION 2 (E): ABSTRACT PRESENTATIONS & CLINICAL RESEARCH	Adjudicators: TBA
13:15 - 13:45	A response to Life Esidimeni recommendations and strategy to strengthen district mental health services in Gauteng province	Prof Lesley Robertson (SA)
13:45 - 14:15	The Esidimeni Inquiry - What lessons for Psychiatry	Dr Lennart Eriksson (SA)
13:15 - 14:05	SESSION 2(F): ABSTRACT PRESENTATIONS & CLINICAL RESEARCH	Adjudicators: TBA
13:15 - 13:45	Is unipolar mania a distinct entity worthy of research?	Prof Stoffel Grobler (SA)
13:45 - 14:05	Exploring stigma towards patients with major depressive & substance use disorders amongst non-specialist health workers in South Africa	Dr Richard Goncalves (SA)
13:15 - 14:15	SESSION 2(G): ABSTRACT PRESENTATIONS & CLINICAL RESEARCH	Adjudicators: TBA
13:15 - 13:35	Tackling Mental Health in Club Rugby: How Best to Screen our Athletes	Dr James Burger (SA)
13:35 - 13:55	Subintelligitur and ineffabilities in mental care consultations	Dr Chris Ellis (SA) - virtual
13:55 - 14:15	Fronto-temporal cortical atrophy in 'nyaope' combination heroin and cannabis use disorder	Dr Tanya Calvey (SA)
13:15 - 14:15	SESSION 2(H): THE ART OF PSYCHIATRY AND THE THERAPY OF PLAY	
	The Big Screen	
	Facilitators: Dr Hoepie Howell & Dr Kim Laxton	
	Welcome and introduction	Dr Hoepie Howell (SA)
13:15 - 14:05	The Psychiatrist in the Cinema: Do we contribute to stigma in psychiatry? (clinical presentation)	Dr Leverage Mountay (SA)
14:05 - 14:10	Discussion	
14:15 - 16:00	LUNCH	
14:20 - 15:00	POSTER PRESENTATIONS & ADJUDICATION (SESSION 1) ** see posters on last page of programme	
15:00	ADHD SIG AGM	

PLENARY SESSION 2

17:15 - 18:00	Keynote address 4:	
	Topic TBA	Prof Martin A. Katzman (Canada) - virtual

TRADE SPONSORED DINNER SYMPOSIA

19:00 - 21:00	TRADE SPONSORED DINNER SYMPOSIUM 3 (JANSSEN)	
	Rapid-acting antidepressant treatment	Speaker TBA
19:00 - 21:00	TRADE SPONSORED DINNER SYMPOSIUM 4 (CIPLA)	
	Topic TBA	Prof Stephen Stahl (USA) - virtual

FRIDAY 22 OCTOBER 2021

TRADE SPONSORED BREAKFAST SYMPOSIA

07:00 - 08:00	TRADE SPONSORED BREAKFAST SYMPOSIUM 6 (JANSSEN)	
	Endophenotypes of schizophrenia and what they mean for treatment	Speaker TBA
08:00 - 08:45	Breakfast	
07:00 - 08:00	TRADE SPONSORED BREAKFAST SYMPOSIUM 6 (ACINO SWISS)	
	Topic TBA	Speaker TBA
08:00 - 08:45	Breakfast	

PLENARY SESSION 3

08:45 - 09:30	Keynote address 5:	
	Topic TBA	Prof Lukoye Atwoli (Kenya) - virtual
09:30 - 10:15	Keynote address 6:	
	Transforming mental health services' response to intimate partner violence	Prof Louise Howard (UK) - virtual

10:15 - 11:15	SASOP AGM	
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11:15 - 12:00	TEA/COFFEE	
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PARALLEL SESSION 3

12:00 - 13:30	SESSION 3(A): THE PHARMACOLOGY OF STIMULANT MEDICATION	
	CIPLA SPONSORED WORKSHOP	
	Topics TBA	Prof Stephen Stahl (USA) - virtual
12:00 - 13:30	SESSION 3(B): ABSTRACT PRESENTATIONS & CLINICAL RESEARCH	Adjudicators: TBA
12:00 - 12:30	Ethical and clinical dilemmas in 4 baby swap cases	Prof Cora Smith (SA)
12:30 - 13:00	Ethical and legal aspects of end-of-life care for older people with serious mental illness in South Africa	Prof Carla Kotze (SA)
13:00 - 13:30	Construct Validity of the Brief Psychiatric Rating Scale – Expanded Version in a South African community psychiatry setting using Rasch Model Analysis	Prof Lesley Robertson (SA)

FRIDAY 22 OCTOBER 2021 (CONTINUED)

12:00 - 13:20	SESSION 3(C): ABSTRACT PRESENTATIONS & CLINICAL RESEARCH	Adjudicators: TBA
12:00 - 12:20	Retain Rural Doctors: Burnout, depression and anxiety in medical doctors working in rural KwaZulu-Natal	Dr Shaun Hain (SA)
12:20 - 12:40	Clinical Use of Neuro-imaging in Psychiatric Patients at the Charlotte Maxeke Johannesburg Academic Hospital	Dr Bokang Lipuo Letlotlo (SA)
12:40 - 13:00	An HIV narrative of female inmates with a lifetime history of mental illness in Durban, South Africa	Dr Samantha Naidoo (SA)
13:00 - 13:20	Longitudinal course and predictors of depression in schizophrenia spectrum disorders: A 24-months follow-up study	Dr Lebogang Phaladira (SA)
12:00 - 13:20	SESSION 3(D): ABSTRACT PRESENTATIONS & CLINICAL RESEARCH	Adjudicators: TBA
12:00 - 12:20	The changing landscape of addiction medicine during the COVID-19 pandemic- Perspective of early career professionals in 17 countries	Dr Tanya Calvey (SA)
12:20 - 12:40	Rates of and factors associated with atopy and allergies in posttraumatic stress disorder as compared to controls	Dr Zulfa Rykielf (SA)
12:40 - 13:00	Prenatal depression exposure alters white matter integrity and development in 2-3-year-old children	Dr Annerine Roos (SA)
13:00 - 13:20	A Retrospective study of outcomes after referral to the Early Intervention in Psychosis programme at Valkenberg Psychiatric Hospital	Dr Sewela Setjie (SA)
12:00 - 13:20	SESSION 3(E): ABSTRACT PRESENTATIONS & CLINICAL RESEARCH	Adjudicators: TBA
12:00 - 12:20	Psychedelic-assisted psychotherapy and psychiatry in South Africa: a policy analysis	Dr Kobus van der Walt
12:20 - 12:40	Posttraumatic stress symptoms after a romantic relationship breakup versus a DSM-5 A trauma: A case-case-control analysis	Ms Albert van der Watt (SA)
12:40 - 13:00	A diagnostic journey of misunderstood children	Ms Tawni Voges (SA)
13:00 - 13:20	Differences between unipolar mania and bipolar-I disorder: Demographic, clinical and familial findings from nine epidemiological studies	Dr Caroline Van de Leur (Switzerland) - virtual
13:30 - 15:30	LUNCH	
14:30 - 15:30	PSYCHOTHERAPY SIG SESSION - TBC	
13:50 - 14:30	POSTER PRESENTATIONS & ADJUDICATION (SESSION 2) ** see posters on last page of programme	
15:00	SPECIAL INTEREST GROUPS (AGMS)	

PLENARY SESSION 4

17:15 - 18:00	Keynote address 7: Topic TBA	Prof David Henderson (USA) - virtual
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TRADE SPONSORED DINNER SYMPOSIA

19:00 - 21:00	TRADE SPONSORED DINNER SYMPOSIUM 7 (SUN PHARMA) Topic TBA	Speaker TBA
19:00 - 21:00	TRADE SPONSORED DINNER SYMPOSIUM 8 (NOVO NORDISK) Obesity & weight management in psychiatry	Speaker TBA

21:15 **A MOVIE EVENING UNDER NON-VIRTUAL STARS: "THE ARTISTS' WIFE"**

SATURDAY 23 OCTOBER 2021

TRADE SPONSORED BREAKFAST SYMPOSIA

07:00 - 08:00	TRADE SPONSORED BREAKFAST SYMPOSIUM 9 (SANOFI) Benzodiazepines debate: The appropriate and inappropriate use	Dr Eugene Allers, Dr Shaquir Salduker (SA) & Dr Alison Bentley (SA)
08:00 - 08:45	Breakfast	
07:00 - 08:00	TRADE SPONSORED BREAKFAST SYMPOSIUM 10 (AKESO) Topic TBA	Speaker TBA
08:00 - 08:45	Breakfast	

PLENARY SESSION 4

08:45 - 09:30	Keynote address 8: The Psychology of pandemics	Prof Steven Taylor (Canada) - virtual
09:30 - 10:15	Keynote address 9: A current perspective on the long-term neuro-psychiatric outcomes of Covid-19	Dr Leigh Janet (SA)

10:15 - 11:00 PSYCHMG AGM

10:15 - 11:30 **TEA/COFFEE**

PARALLEL SESSION 4

11:30 - 13:00	SESSION 4(A): SEXUAL HEALTH Chairperson: Dr Kali Tricoridis Clinical updates	Speaker: Dr Elna Rudolph (SA)
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SATURDAY 23 OCTOBER 2021 (CONTINUED)

11:30 - 13:00	SESSION 4(B): CELLULAR & MOLECULAR PSYCHIATRY: Do I have a mental disorder or am I a mental disorder? Facilitator: Dr Kobus Roux Genotypes, endophenotypes and clinical phenotypes The clinical utility of genetic biomarkers and mental health disorders	Dr Kobus Roux (SA) Dr Eugene Allers (SA)
11:30 - 13:00	SESSION 4(C): BIOLOGICAL PSYCHIATRY Facilitator: Prof Soraya Seedat	
11:30 - 12:00	Antipsychotic Treatment Effects and Structural MRI Brain Changes in Schizophrenia	Prof Robin Emsley (SA) - virtual
12:00 - 12:20	Topic TBA	Prof Soraya Seedat (SA)
12:20 - 12:40	The effects of harmful alcohol use on reward processing in people living with HIV	Dr Leigh van den Heuvel (SA)
12:40 - 13:00	Pain perception and physiological correlates in body-focused repetitive behaviour disorders	Prof Christine Lochner (SA)
11:30 - 13:00	SESSION 4(D): CLINICAL PSYCHOLOGY FORUM (CPF): PSYCHOTHERAPY Facilitator: Dr Linda Blokland Topic TBA Topics TBA	Prof Steven Taylor (Canada) - virtual Speakers TBA
11:30 - 13:00	SESSION 4(E): STIGMA, DISABILITY AND THE IMPAIRED PSYCHIATRIST Facilitator: Prof Gerhard Grobler	
11:30 - 11:45	"Me too": a story about a psychiatrist who lost her mind and how she found it again	Dr Farzana Mohideen-Botes (SA)
11:45 - 12:00	"First do no harm": Belittled, avoided, ignored, and denied: the consequences of stigma	Prof Renata Schoeman (SA)
12:00 - 12:15	Assessing psychiatric impairment in the highly functioning individual	Prof Stoffel Grobler (SA)
12:15 - 12:30	Role of the occupational therapist in assessing an impaired healthcare practitioner	Ms Matty van Niekerk (SA)
12:30 - 12:45	The HPCSA and the impaired practitioner	Prof Gerhard Grobler (SA)
12:45 - 13:00	Discussion	
11:30 - 13:00	SESSION 4(F): EARLY CAREER PSYCHIATRISTS Facilitator: Dr Lavinia Lumu	
11:30 - 12:00	Survival Guide: Conquering Exams	Dr Lavinia Lumu (SA)
12:00 - 12:30	Running on Empty: Is Burnout inevitable in Psychiatrists?	Dr Antoinette Miric (SA)
12:30 - 13:00	Crisis/Control: An Eriksonian perspective to the journey in psychiatry	Dr Rodhie Sapinoso (SA)
11:30 - 13:00	SESSION 4(G): OLD AGE PSYCHIATRY: The Conundrum of Mild Cognitive Impairment Facilitator: Prof Felix Potocnik	
11:30 - 11:45	A look at the diagnostic criteria for MCI	Dr Sinhle Nhlabathi (SA)
11:45 - 11:55	Cognitive reserves as a concept	Dr Charnotte Gabriels (SA)
11:55 - 12:10	The use of cognitive testing in MCI	Ms Erine Brocker (SA)
12:10 - 12:35	Informed consent and advanced planning in MCI	Prof Carla Kotze (SA)
12:35 - 13:00	Early supplementation in MCI	Prof Felix Potocnik (SA)
11:30 - 13:00	SESSION 4(H): THE ART OF PSYCHIATRY AND THE THERAPY OF PLAY Facilitators: Dr Hoepie Howell & Dr Kim Laxton	
11:30 - 12:20	Professional experiences, lived stories, narrative, mindfulness & play	Prof Gerard Labuschagne (SA)
12:20 - 12:55	"If I can write a book, so can you"	Dr Leverne Mountany (SA)
12:55 - 13:00	Closing and thank you	Dr Hoepie Howell & Dr Kim Laxton (SA)

PLENARY SESSION 5

13:05 - 13:45	Keynote address 10: Adherence to treatment with psychoactive medications	Prof Christer Allgulander (Sweden) - virtual
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13:45 - 15:30 LUNCH
13:50 - 14:30 POSTER PRESENTATIONS & ADJUDICATION (SESSION 3) ** see posters on last page of programme
15:00 SPECIAL INTEREST GROUPS (AGMS)

19:00 - 23:00	CONGRESS DINNER & AWARDS Performance by Drakensberg Boys' Choir (25 minutes)	
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SUNDAY 24 OCTOBER 2021

06:30 - 08:00	Breakfast	
PLENARY SESSION 6 (ETHICS)		
08:00 - 08:45	Keynote address 11: Social media and mental health: a psychiatrist's perspective	Prof Noeline Nakasujja (Uganda) - virtual
08:45 - 09:30	TEA/COFFEE	
09:30 - 10:15	Keynote address 12: Epilepsy and the Law: "The Henry van Breda Case"	Dr James Butler (SA) - virtual
10:15 - 11:00	Keynote address 13: Using mental illness as a defense for criminal acts - case profiles of a former police psychologist and head profiler	Prof Gerard Labuschagne (SA)
11:00 - 11:15	CLOSING OF CONGRESS	
11:15 - 13:00	LIGHT LUNCH & DEPARTURE	

POSTER PRESENTATIONS & ADJUDICATION

14:20 - 15:00

THURSDAY 21 OCTOBER 2021

Brockner, Mrs Erine*Department of Psychiatry, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa***Feasibility and Acceptability of a Clinician Monitored PTSD Coach intervention: Findings from a Two Pilot Randomised Controlled Trials in a Resource Constrained Setting****Burger, Mrs Marlette***Physiotherapy Division; Department of Health and Rehabilitation Sciences; Faculty of Medicine and Health Sciences; Stellenbosch University; South Africa***Maternal Perinatal Mental Health and Infant and Toddler Neurodevelopment - Evidence from Low and Middle-Income Countries. A Systematic Review****Chhagan, Dr Usha***Department of Psychiatry, School of Clinical Medicine, College of Health Sciences, University of KwaZulu-Natal, Durban, South Africa***A correlation of HIV status with clinical features and duration of untreated psychosis in patients with first episode psychosis****Dawood, Dr Bilkis***Postgraduate Programme (Master of Medicine), Discipline of Psychiatry, School of Clinical Medicine, College of Health Sciences, University of KwaZulu-Natal, Durban, South Africa***'Unheard,' 'uncared for' and 'unsupported': The Mental Health Impact of Covid -19 on Frontline Healthcare Workers in KwaZulu-Natal Province, South Africa****Hornsby, Ms Nancy***Alcohol, Tobacco and Other Drug Research Unit, South African Medical Research Council, Cape Town, South Africa***The Use Of Magnetic Resonance Imaging Techniques In Assessing The Effects Of Alcohol Consumption And Heavy Drinking On The Adolescent Brain: a Scoping Review****Luckhoff, Dr Hilmar***Department of Psychiatry, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa, 7550.***Metabolic syndrome associations with cortical thickness and subcortical brain volumes in first-episode schizophrenia patients and controls****Makofane, Dr Lerato***Department of Psychiatry, University of the Witwatersrand***Demographic and clinical profile of HIV infected and non-infected children and adolescents attending two community psychiatric clinics in Gauteng province**

14:20 - 15:00

FRIDAY 22 OCTOBER 2021

Mngadi, Dr Sithmbisile*Department of Psychiatry, Nelson R. Mandela School of Medicine, Durban, South Africa***The profile of suspected criminal offenders referred for psychiatric evaluation on an outpatient basis at Ngwelezana Hospital****Morar, Dr Tejil***Department of Psychiatry, University of the Witwatersrand***Exploring burnout among psychiatric trainees at the University of the Witwatersrand****Narsi, Dr Kalpesh***Department of Psychiatry, University of KZN***Cognitive Health and Reserve in anti-retroviral therapy naïve HIV-positive adults****Ndlangisa, Ms Ziyanda***University of KwaZulu Natal***Antipsychotic dose reduction/discontinuation on metabolic syndrome in patients with first episode psychosis treated with a long-acting injectable antipsychotic****Prosad Singh, Dr Nikita***Department of Psychiatry, Nelson R. Mandela School of Medicine, University of KwaZulu-Natal, Durban, South Africa***The prevalence of adverse childhood experiences, substance use and depression in people with HIV infection during the COVID-19 pandemic****Robertson, Prof Lesley***Department of Psychiatry, School of Clinical Medicine, University of the Witwatersrand, Johannesburg, South Africa***1) A comparison of Gauteng province psychotropic medicine procurement and expenditure during 2017-2018 between districts and facilities at each service level****2) Gauteng provincial psychotropic medicine procurement in general and specialised healthcare settings during 2017-2018****Schultz, Dr Megan***Department of Psychiatry, Walter Sisulu University***Prevalence of Vitamin B12 deficiency in psychiatric inpatients in Nelson Mandela Bay**

13:50 - 14:30

SATURDAY 23 OCTOBER 2021

Spies, Dr Georgia*DSI/NRF South African Research Chairs Initiative, PTSD Program, Department of Psychiatry, Stellenbosch University, South Africa***1) Attitudes of patients and mental health professionals towards Serious Games in Psychotherapy****2) Patterning of individual variability in neurocognitive health among South African women exposed to childhood maltreatment****Steyn, Dr Petrus***Department of Psychiatry, Faculty of Medicine and Health Sciences, Stellenbosch University***1) Characteristics of inpatients in Dialectical Behaviour Therapy modified for a resource-limited setting****2) Cut it out or wait it out? Case series of middle fossa arachnoid cysts presenting with psychiatric symptoms and the ethics of neurosurgical management****Suliman, Dr Sharain***Department of Psychiatry & MRC Genomics of Brain Disorders Unit, Stellenbosch University***The association of cognition and perceived body weight in overweight and obese adults****Van den Heuvel, Dr Leigh***Department of Psychiatry, Faculty of Medicine and Health Sciences, Stellenbosch University & South African Medical Research Council, Stellenbosch University**Genomics of Brain Disorders Research Unit, Faculty of Medicine & Health Sciences, Stellenbosch University, Cape Town, South Africa.***The association between hair cortisol levels, inflammation and cognitive functioning in females****Yerriah, Dr Jacqueline***Department of Psychiatry, University of KwaZulu Natal, Durban***Caregiver burden and quality of life for caregivers of patients with schizophrenia**



SOUTH AFRICAN SOCIETY OF
PSYCHIATRISTS

SASOP 2021 CONGRESS

COVID-19 HEALTH AND SAFETY PROTOCOLS

OUR COMMITMENT TO SAFETY

As we are nearing the date of the SASOP 2021 Congress (20 – 24 October 2021), we want to assure all delegates that SASOP and Champagne Sports Resort are fully aware of the enormous responsibility this entails to provide a safe environment that will protect both delegates and hotel staff from the threat of the Covid-19 virus and further spreading thereof.

THE HEALTH AND SAFETY OF ALL GUESTS AT THE SASOP 2021 CONGRESS WILL BE A TOP PRIORITY FOR US, AND WE WILL ADHERE TO THE HIGHEST STANDARDS IN THIS VITAL AREA. IN THE LIGHT OF THE CORONAVIRUS PANDEMIC, WE HAVE ELEVATED OUR PROCESSES AND PROTOCOLS TO FIGHT THIS DISEASE.

SASOP PROGRAMME:

- The programme has been designed in such a manner that we will have up to 8 parallel sessions per day. Each venue will be set up to occupy only 50% of its seating capacity with sufficient social distancing in place. Once the venue's capacity has been reached, no one else will be allowed further entry.
- Tea times will be longer than usual and we will end each day with lunch – serving stations will be scattered inside the exhibition hall, but also outside in the fresh air. No rush to get your plate of food or cup of tea and maintain social distancing in the venues!
- The Plenary Venue (Butress) can seat up to 1200 delegates and we will only use 25% of the capacity which would allow for 300 delegates to attend. If the need arises for plenary sessions, a second venue can be opened and the presentation be streamed to the second venue.
- We will constantly stay abreast of new recommendations to ensure that our congress operates at the highest safety levels.

On behalf of the organising committee, we would like to bring the following to your attention:

1. All participants and hotel staff are encouraged to be vaccinated immediately!

2. No congress delegate, partner or spouse will be allowed to attend the congress unless they have proof of full vaccination or a negative PCR test not older than 48 hours. Proof thereof must be presented upon arrival at the hotel/ conference centre.
3. An on-site RAPID COVID TEST station will be available for all hotel staff and participants at the congress and results will be available within 30 minutes of the test. These tests will be carried out by registered healthcare professionals.

Champagne Sports Resort follows a comprehensive set of cleaning and safety measures - compiled in line with the recommendations of the South African Department of Health, the Tourism Business Council of South Africa (TBCSA) and the Federation of Hospitality Association of South Africa (FEDHASA). Please visit their website for a complete list of their Health and Safety Protocols:

<https://www.champagnesportsresort.com/wp-content/uploads/2020/06/CSR-Covid19-protocols-poster.pdf>

1. GUEST ARRIVAL

On delegate/guest arrival for check-in, CSR will be doing a drive through check-in into their accommodation by following these steps:

- Delegate /guest to remain in their vehicle whilst the Front Office Team will assist them.
- Screening form, preferably pre-populated, to be completed by the CSR Team by adding in your personal temperature on arrival.
- Accommodation registration form to be completed with sanitised stationary.
- Sanitise and plastic wrapped accommodation key handed over to delegate / guest.
- Delegate / guest to be dropped at their accommodation by the shuttle driver, or self-park outside your allocated accommodation.

2. CSR PERSONNEL ARRIVAL AT RESORT EACH DAY

Every employee has their temperature taken on entering and leaving the Resort which is recorded in writing. Anyone reporting for shift feeling unwell is not allowed entry to the Resort and sent home to isolate. Covid testing, if required, is paid for by the company and the employee will remain at home on full pay until such time the isolation period is over. Only once cleared will the employee be allowed to return to work.

3. PERSONNEL PROTECTIVE EQUIPMENT (PPE)

All CSR personnel are provided with uniforms and PPE by the Company. PPE in the form of masks are available for sale to delegates/guests in the hotel shop. **All delegates are encouraged to pack sufficient masks to the congress** Biohazard boxes are available to dispose of used PPE in all front and back of house areas.

4. FREQUENCY OF CLEANING AND SANITATION.

Efficacy of all chemicals and sanitisers

AREA	APPLICATION AND PRODUCT USED
Pillows & Mattresses	Surfaces are sprayed lightly with Polycide X at a 1:10 dilution and left to dry.
Bathrooms	Surfaces are deep cleaned and sprayed with Polycide X at a 1:10 dilution
Floors	Are sprayed with a 1:10 solution of MICROBAC and mopped with a clean mop.
Carpets	Sprayed with a 1:20 solution of Polycide X and then vacuumed.
Bedside Tables & Desks	Surfaces are sprayed with a 1:10 dilution of MICROBAC and wiped.
Door Handles	Surfaces are deep cleaned and sprayed with SD ST, left to dry.
TV Remote Controls	Deep cleaned and sprayed with SD ST, left to dry.
Counters and Work Surfaces	Surfaces are sprayed with Polycide X at a 1:10 dilution
Linen	Dosed with Stainex in the standard washing process.
Verandah Furniture	Surfaces are sprayed with a 1:10 dilution and wiped.
Tea Station	Surfaces are sprayed lightly with Polycide X at a 1:10 dilution and left to dry.

PRODUCT INFORMATION:

Polycide X	Food safe surface sanitizer.
Microbac	QAC Based detergent and disinfectant
SD ST	Long term surface sanitizer (lasts 90 days)

All kitchens are cleaned in line with HACCP (Hazard Analysis and Critical Control Points) and External Verification is done by FCS (Food Consulting Services), which enhances guest satisfaction, limits dissatisfaction and contributes to the guest's

peace-of-mind regarding food safety, quality and hygiene of company's product.

5. MONITORING OF THE COVID-19 PROTOCOLS THROUGHOUT CONGRESS

There will be a Covid Protocol Officer (CPO) with specific allocated Personnel that monitors daily the frequency and quality checks of the COVID-19 Protocols that have been put in place by CSR with a constant daily written record of all documents.

6. PHYSICAL AND SOCIAL DISTANCING, AND TEMPERATURE CHECKS

- Floor decals at queuing points used to indicate spacing between each person
- Wherever possible in public areas furniture will be positioned to adhere to physical distancing guidelines
- Maximum capacities in a given space, as indicated by the Department of Health will be enforced.
- No congress attendee will be allowed to participate in any organised event without a mask or in any public area of the Resort.
 - All meeting rooms will be set up with a maximum of 50% seating capacity.
 - Temperature checks conducted at all points of entry on a DAILY basis
 - Sanitizer stations installed at all entry points into the buildings

7. CSR PERSONNEL EDUCATION AND TRAINING

- Hard copy signage is established through the Resort particularly in Public Areas
- Monitoring of the COVID-19 Protocols throughout Congress by a dedicated person and Team will encourage CSR Personnel and Guests alike to be constantly aware of the role all have, in keeping each fellow person safe.

Every accommodation sleeping facility has a dedicated hand sanitiser wall mounted dispenser.

8. TRANSPORTATION AND SHUTTLE SERVICE

The transportation company will transfer guests from King Shaka International Airport to the various congress hotels and will also provide the daily shuttle service between the various congress hotels listed on the website www.sasop2021.co.za

- All drivers have been vaccinated and will carry their vaccination cards with them and wear a mask
- All vehicles will be properly sanitized before and after each load of passengers
- All drivers will be fully compliant with PPE and no passenger will be allowed into a vehicle without a mask
- Hand sanitizing will be compulsory for all passengers before entering a vehicle

In conclusion, we will be complying with all the requirements of relevant authorities. Collectively, we can beat this virus and enjoy a safe and "in person" SASOP Congress 2021 in the Central Drakensberg. With kindest regards

Dr Eugene Allers

Congress Convenor: SASOP 2021



SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

PSYCHIATRIST POSITION AT VALKENBERG HOSPITAL

A fulltime Specialist post in Psychiatry is available immediately at Valkenberg Hospital.

The post is a joint appointment of the Department of Psychiatry & Mental Health, University of Cape town and the Provincial Government of the Western Cape (see attached).

DUTIES INCLUDE:

- The clinical assessment, management and supervision of adult patients referred to a general adult psychiatry unit.
- Provide a direct clinical service and manage a psychiatric adult inpatient unit.
- Clinical governance and administrative organization of a general psychiatry team.
- Provide outreach services to District Health services and District hospitals.
- Teaching of under- and postgraduate students in relevant degrees and diplomas in psychiatry.
- To stimulate, assist with and conduct research relevant to the Western Cape Department of Health and University of Cape Town Department of Psychiatry & Mental Health.
- Support to the Head of the Clinical Unit with respect to clinical, management, teaching and administrative matters.

REMUNERATION PACKAGE:

Grade 1: R1 106 040 per annum,
Grade 2: R1 264 623 per annum,
Grade 3: R1 467 651 per annum (A portion of the package can be structured according to the individual's personal needs).

The position does not come with commuted overtime. Approval to conduct Remunerative work outside the employee's employment (RWOEE) may be applied for.

REQUIREMENTS:

1. Specialist registration with the HPCSA to practise as a Specialist Psychiatrist
2. FC(Psych)SA, MMed(Psych) or equivalent recognised by HPCSA
3. Clinical, teaching, research, management and communication skills
4. Ability to serve patients in at least two of three official languages of the Western Cape

Please submit applications including the following documents by **13 June 2021** to Amanda Stephens at Amanda.Stephens@westerncape.gov.za or by post/courier to The Chief Executive Officer, Valkenberg Hospital, Private Bag X1, Observatory 7935 (Attention: Ms A Stephens).

REQUIRED DOCUMENTS:

1. CV
2. Certified copy of ID and driver's license
3. Z83 completed - use 'as per block advert' for specific post
4. Certified copy of matric certificate and degrees
5. HPCSA registration

ENQUIRIES:

Dr Qhama Cossie
qhama.cossie@westerncape.gov.za
021 826 5829 ■



SPECIALIST POSTS IN PSYCHIATRY AVAILABLE

Three fulltime Specialist posts in psychiatry are available immediately for the Klipfontein/Mitchell's Plain Sub-Structure (x1), Mitchell's Plain District Hospital (x1) and Khayelitsha/Eastern Sub-Structure (x1).

Two of the posts are **contract posts** and are renewable for **three years**. The post at the **Klipfontein/Mitchell's Plain Sub-Structure** includes commuted overtime. Commuted overtime can be negotiated for the **Khayelitsha/Eastern** position depending on operational requirements. The **3rd post** is a **permanent** post at **Mitchell's Plain District Hospital**.

Institution: Metro Health Services

REMUNERATION

- **Grade 1:** R 1 106 040 per annum
- **Grade 2:** R 1 264 623 per annum
- **Grade 3:** R 1 467 651 per annum

(A portion of the package can be structured according to the individual's personal needs)

REQUIREMENTS

Minimum Educational Qualification:

Appropriate qualification that allows registration with the Health Professions Council of South Africa (HPCSA) as a Medical Specialist in Psychiatry.

Registration with a Professional Council:

Registration with the HPCSA as a Medical Specialist in Psychiatry.

Experience:

Grade 1: None after registration with the HPCSA as Medical Specialist in Psychiatry.

Grade 2: A minimum of 5 years appropriate experience as Medical Specialist after registration with the HPCSA (or recognised foreign Health Professional Council in respect of foreign qualified employees) as Medical Specialist in Psychiatry.

Grade 3: A minimum of 10 years' appropriate experience as Medical Specialist after registration with the HPCSA (or recognised foreign Health Professional Council in respect of foreign qualified employees) as Medical Specialist in Psychiatry.

Inherent Requirements of the Job:

Valid (Code B/EB) driver's license, as well as willingness and ability to travel.

Competencies (knowledge/skills):

- Ability to (read, write, and speak) in at least two of the three official languages of the Western Cape.
- Knowledge of a public health approach to delivering integrated psychiatric services.
- Ability to work in integrated multi-disciplinary teams across platforms.
- Clinical, leadership, administrative, teaching, and mentoring skills.
- Computer literacy in MS Office mandatory.
- Creativity to develop new ideas which can result in positive changes to existing processes.

Duties (key result areas/outputs):

Specialist psychiatric care to patients (all age groups) and at specific district hospitals and selected outreach sites in the respective sub-structures. Participate in clinical governance of a growing integrated district mental health service.

Please submit applications including the following documents by **30 July 2021** by post/courier to:

The Director, Khayelitsha/Eastern Sub-Structure, Metro Health Services, c/o Steve Biko and Walter Sisulu Drive, Khayelitsha, 7784 (Attention: Ms J Collins).

The Director, Klipfontein/Mitchell's Plain Sub-Structure, Metro Health Services, Lentegeur Hospital, Highland Drive, Mitchells Plain, 7789 or Private bag X7 Mitchell's Plain, (Attention: Assistant Director People Management).

REQUIRED DOCUMENTS:

1. CV
2. Certified copy of ID and driver's license
3. Z83 completed - use 'as per block advert' for specific post
4. Certified copy of matric certificate and degrees
5. HPCSA registration

Enquiries:

Khayelitsha/ Eastern Sub-Structure

Mr James Kruger (James.Kruger@westerncape.gov.za)

Klipfontein/Mitchell's Plain Sub-Structure/ Mitchell's Plain District Hospital

Ms Patti Olckers (Pattie.Olckers@westerncape.gov.za) ■



SOUTH AFRICAN SOCIETY OF
PSYCHIATRISTS

SASOP SOUTHERN GAUTENG CONGRESS SPONSORSHIP

Dear SASOP Southern Gauteng Members
The SASOP Southern Gauteng Subgroup wishes to invite applications for part sponsorship to the **20th National Congress 2021**, which will be taking place at **Champagne Sports Resort, Drakensburg** from **20-24th October 2021**; www.sasop2021.co.za

THE SPONSORSHIP IS VALUED AT R5000.

Invitations for applications are extended to registrars and consultants who have been fully paid-up SASOP members for at least the last 2 years in the Southern Gauteng subgroup. Preference will be granted to

those who have not received sponsorship recently, preferably to those who have received no other sponsorship for this congress, Senior Registrars, and those with evidence of service to the profession.

Please forward your name and brief (not more than half page) motivation to rama.anusha@gmail.com, by **30th June 2021**.

We look forward to hearing from you.

Regards

Dr Anusha Rama
Treasurer SASOP Southern Gauteng ■

ICD-11 ONLINE TRAINING COURSE

The Online Training Course on ICD-11 Mental, Behavioural and Neurodevelopmental Disorders is being pilot-tested and is currently accessible only to members of the Global Clinical Practice Network (GCPN). To access the online units, please first join the GCPN using the instructions below:

- 1.) Visit: <http://www.globalclinicalpractice.net/en/> to complete the GCPN registration form.
- 2.) Once you have completed step 1, go to: <https://gmhacademy.dialogedu.com/icd11> and click on Login at the top right. Then click Sign Up to register for the online course. Here you will be asked to select your own password that you can use the next time you log in.
- 3.) Even though step 2 will allow you to log into the site, you will need to wait 24 hours for us to verify you as a GCPN user so that you can get full access to all the available online units.

- 4.) Return to <https://gmhacademy.dialogedu.com/icd11> 24 hours after you first signed up and you can start any of the available online units.

The following units are available online, with others to be released in the near future:

- Unit 1: Welcome to the ICD-11
- Unit 3: Schizophrenia and Other Primary Psychotic Disorders
- Unit 4: Mood Disorders
- Unit 5: Anxiety or Fear-Related Disorders
- Unit 6: Obsessive-Compulsive and Related Disorders
- Unit 7: Disorders Specifically Associated with Stress
- Unit 10: Feeding or Eating Disorders

If you have any questions or require assistance with registering, please e-mail: gmhahelp@cugmhp.org ■



PROTECTION OF PERSONAL INFORMATION ACT

POPIA

ORGANISATION: THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS (SASOP)

Dear member
Health Management and Networking Services (Pty) Ltd ("HealthMan") acts as consultants and administrators of the Organisation and in its role as such, it is the Organisation's appointed processor to process your personal data for the purpose of any or all of the undermentioned actions, being the legitimate reasons for processing and/or using your personal data;

Your personal information is stored and secured in the centralised database of the Organisation and/or HealthMan;

We will always ensure that your information remains secure and that it is dealt with in line with the new POPI legislation.

AUTHORISED ACTIONS BY THE ORGANISATION AND HEALTHMAN

1. To collect and have access to your personal information;
2. To collect and process this personal information for the purpose of rendering services to you as well as, where relevant, processing claims with medical schemes or insurance funders;
3. To use your personal information to communicate with you in person / via telephone / email / video call / fax / WhatsApp / any form of social media;
4. To use your personal information to render certain administrative and financial services

to you, including coding queries, billing issues and audit assistance.

We hereby encourage you to perform an update of your personal information on a regular basis.

Should you not wish to receive our communications at this time, please click on the unsubscribe button at the bottom of communication emails.

CONSENT WITHDRAWAL

1. You may withdraw your consent at any time by using the relevant Data Subject Consent Withdrawal Form.
2. Your personal information will only be utilized for the purpose it was collected; the information will only be retained for as long as is necessary and required by law; you have the right to view such information at any time, as well as request correction or deletion of your personal Information held by the Organisation and/or HealthMan.

ACCEPTANCE

Should you not advise us that you disagree with any of the authorised actions in writing, it will be accepted that you have provided your consent to such authorised actions and to the processing and/or use of your personal information as explained above.

Regards
The South African Society of Psychiatrists ■

INSTRUCTIONSTO AUTHORS

South African Psychiatry publishes original contributions that relate to South African Psychiatry. The aim of the publication is to inform the discipline about the discipline and in so doing, connect and promote cohesion.

The following types of content are published, noting that the list is not prescriptive or limited and potential contributors are welcome to submit content that they think might be relevant but does not broadly conform to the categories noted:

LETTERS TO THE EDITOR

- * Novel experiences
- * Response to published content
- * Issues

FEATURES

- * Related to a specific area of interest
- * Related to service development
- * Related to a specific project
- * A detailed opinion piece

REPORTS

- * Related to events e.g. conferences, symposia, workshops

PERSPECTIVES

- * Personal opinions written by non-medical contributors

NEWS

- * Departments of Psychiatry e.g. graduations, promotions, appointments, events, publications

ANNOUNCEMENTS

- * Congresses, symposia, workshops
- * Publications, especially books

The format of the abovementioned contributions does not need to conform to typical scientific papers. Contributors are encouraged to write in a style that is best suited to the content. There is no required word count and authors are not restricted, but content will be subject to editing for publication. Referencing - if included - should conform to the Vancouver style i.e. superscript numeral in text (outside the full stop with the following illustration for the reference section: *Other AN, Person CD. Title of article. Name of Journal, Year of publication; Volume (Issue): page number/s. doi number (if available)*). **Where referencing is not included, it will be noted that references will be available from the author/authors.** All content should be accompanied by a relevant photo (preferably high resolution - to ensure quality reproduction) of the author/authors as well as the event or with the necessary graphic content. A brief biography of the author/authors should accompany content, including discipline, current position, notable/relevant interests and an email address. Contributions are encouraged and welcome from the broader mental health professional community i.e. all related professionals, including industry. All submitted content will be subject to review by the editor-in-chief, and where necessary the advisory board.

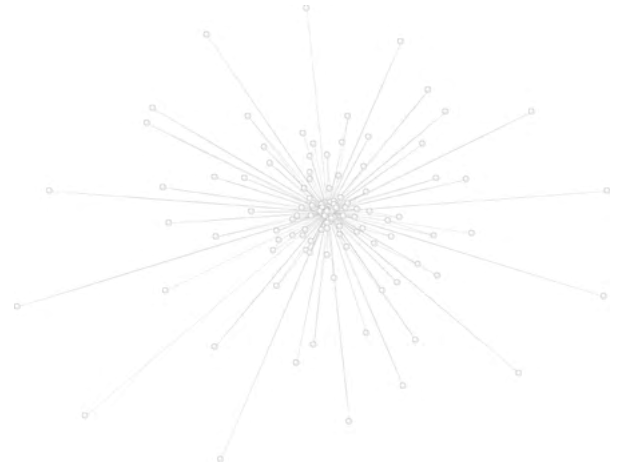
REVIEW / ORIGINAL ARTICLES

Such content will specifically comprise the literature review or data of the final version of a research report towards the MMed - or equivalent degree - as a 5000 word article

- * A 300 word abstract that succinctly summarizes the content will be required.
- * Referencing should preferably conform to the Vancouver style i.e. superscript numeral in text (outside the full stop with the following illustration for the reference section: *Other AN, Person CD. Title of article. Name of Journal, Year of publication; Volume (Issue): page number/s. doi number (if available)*); Harvard style or variations of either will also be acceptable
- * The submission should be accompanied by the University/Faculty letter noting successful completion of the research report.

Acceptance of submitted material will be subject to editorial discretion

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References: 1. [https://www.sahpra.org.za/registered-health-products/\[Online\]\[cited 2020 July 17\]](https://www.sahpra.org.za/registered-health-products/[Online][cited 2020 July 17]). 2. Wilson SJ, Nutt DJ, Alford C, Argyropoulos SV, Baldwin DS, Bateson AN, et al. British Association for Psychopharmacology consensus statement on evidence-based treatment of insomnia, parasomnias and circadian rhythm disorders. *J Psychopharmacol* 2010;24(11):1577-1600. 3. Wade AG, Crawford G, Ford I, McConnachie A, Nir T, Laudon M, et al. Prolonged release melatonin in the treatment of primary insomnia: evaluation of the age cut-off for short- and long-term response. *Curr Med Res Opin* 2011;27(11):87-98. 4. Lemoine P, Nir T, Laudon M, Zisapel N. Prolonged-release melatonin improves sleep quality and morning alertness in insomnia patients aged 55 years and older and has no withdrawal effects. *J Sleep Res* 2007;16:372-380. 5. Luthringer R, Muzet M, Zisapel N, Staner L. The effect of prolonged-release melatonin on sleep measures and psychomotor performance in elderly patients with insomnia. *Int Clin Psychopharmacol* 2009;24(5):239-249. 6. Wade AG, Ford I, Crawford G, McMahon AD, Nir T, Laudon M, et al. Efficacy of prolonged release melatonin in insomnia patients aged 55-80 years: quality of sleep and next-day alertness outcomes. *Curr Med Res Opin* 2007;23(10):2597-2605.

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