A BRIEF HISTORY OF DIGNITY IN MENTAL HEALTH

MORBID ANXIETY

PSYCHOTHERAPY IN A PRIMARY HEALTH CARE SETTING

SASOP PRESIDENTIAL TERM 2016 - 2018

WPA INTERNATIONAL CONGRESS
CAPE TOWN, 18-22 NOVEMBER 2016

www.southafricanpsychiatry.co.za
FEBRUARY 2017

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Dear Reader,

The publication of the first issue of 2017 coincides with a significant event: the release of the Health Ombudsman’s report detailing the findings of the inquiry into the loss of life associated with the transfer of Life Esidimeni patients (Gauteng) from the facility to Non-Governmental Organizations, together with a list of recommendations/courses of action to be taken http://www.politicsweb.co.za/documents/the-life-esidimeni-disaster-the-makgoba-report. The designation of a Health Ombudsman is a positive development and augurs well for the future. The report is clear in terms of accountability, with the MEC – Health as well as senior staff within the Provincial Department of Health named together with pronouncements on action to be taken. At the time of going to press the MEC had resigned and senior staff had been served with precautionary suspensions. Such accountability is necessary, but does not change the outcome of ill-advised action. The efforts of family, civil society, advocacy groups, professional bodies and clinicians in holding authorities accountable has been critical and should signal a shift in ethos towards a truly collaborative approach to patient care. It remains to be seen what follows. It is well to note the issue of deinstitutionalization, which had been cited as a basis for the closure and transfer, and to emphasize that such an approach to care does not mean closure of institutions. There is a concern that the pendulum has swung too far and that the time has come for sober reflection and consideration of not only a more balanced approach in terms of the spectrum of care\(^1\) but also a sharper focus on ensuring that institutions are held accountable for the provision of services in keeping with their mandate\(^2\) and in this regard the South African Government’s Office of Health Standards Compliance warrants a specific mention.\(^3\) Whilst managing patients in the least restrictive way and as close to their point of origin is the aim, and a guiding principle of our Mental Health Care Act, this is not always possible based on the unique circumstances of any particular patient. Further, the availability of comprehensive community mental health care remains an elusive ideal.

The current issue provides a detailed account of the recent WPA IC 2016 – an event worthy of documenting given the significance to South African psychiatry. A range of reports once again provide information on events around the country. This issue also sees the beginning of a form of peer review through the publication of an open commentary (Stein) with the Feature article by Allgulander. This will continue. In addition it is anticipated that the first literature reviews of successfully examined research reports towards the MMed degree will be published in the May 2017 issue.

On many fronts there is progress. We look forward to a positive year ahead.

References
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Message from the Secretary General

Dear Colleagues and Friends,

Delighted to keep in touch with you! WPA had a very active period during the last three months. The most important event was the WPA International Congress, Cape Town, November 18-22, 2016. Theme: “Psychiatry: Integrative Care for the Community”. With more than 2,000 delegates attending, it was one of the most outstanding WPA Congresses ever held in Africa. The WPA Executive Committee, the Council and the Board also met at Cape Town and considered several matters concerning mental health and our Association. Heartiest congratulations to the South African Society of Psychiatrists, Bernard van Remburg and their dedicated team for their excellent work.

Many of our leaders and members also participated in the International Conference on Schizophrenia held at Chennai, September 8-10, 2016, the International Mental Health Congress, Moscow, October 7-9, 2016 and the 22nd World Congress of Social Psychiatry, New Delhi, December 1-4, 2016. These events were co-sponsored by the WPA and I could participate in all of them and interact with our members. We also held a meeting of the member societies in Zone 10 at Moscow on October 8th, which was very well coordinated by Peter Morozov. We now look forward to the WPA meetings to be held at Cuenca, Ecuador, February 8-11, 2017, Vilnius in May 2017, and above all to the World Congress of Psychiatry, October 2017.

Please visit our newly designed website www.wpanet.org and send us your valuable comments. Wishing you happiness, peace and prosperity in the New Year.

Roy Abraham Kalidossy
Secretary General
World Psychiatric Association

Message from the President

Dinesh Bhugra

The Second World Mind Matters Day on 5th September saw the launch of the WPA Report on Social Discrimination against individuals with mental illness. This report was launched formally in the House of Lords in London. A Bill of Rights for people with mental illness was also launched. It has the support of 61 international organisations and if your organisation has not signed this please add your support.

Full details of the discrimination survey were published in a special issue of International Review of Psychiatry volume 28(4). The contents are available online.

On the International Children’s Day on 20th November, WPA launched a Bill of Rights for children and young people. Developed by Dr Gordana Milavic and Professor Benet Leventhal and colleagues, it is available on the WPA website.

WPA-Lancet commission on Psychiatry report is expected to be published by Lancet Psychiatry early next year.

Recent Position Statements include one on environmental sustainability and on high quality training.

We had a very successful round table meetings on violent radicalisation hosted by the WPA Collaborating Centre in London and another one on early Interventions in Psychiatry hosted by Hong Kong College of Psychiatrists.

The work on setting up Diploma in Psychological Medicine aimed at psychiatrists continue apace and we hope to launch it next year.

We are still looking for examples of good clinical practice so that we can learn from each other. Please keep them coming.

Please check the website regularly and get involved.

Season’s Greetings to you and your loved ones and all stakeholders.

Dinesh Bhugra, CBE
President
World Psychiatric Association

St. Moritz - Mirror-like lakes, glaciers, jagged peaks, alpine forests, and patches of sunshine make St. Moritz (in Switzerland) one of the world’s top mountain destinations. Luxurious hotels and pricey restaurants are part of the course at this chic resort town, which has hosted two Winter Olympics. In an alpine valley 1,800 meters above sea level, the town is divided into two parts: St. Moritz Dorf sits on a sunny terrace overlooking the Lake of St. Moritz. The other part of town, Lakeside St. Moritz Bad on the valley floor, is a health resort with less expensive lodging.
It was a great pleasure to welcome more than 2000 delegates from 84 countries to the World Psychiatric Association’s International Congress in Cape Town (WPA2016), which took place from 18-22 November 2016 in the CTICC. The organizers worked hard to ensure a comprehensive program aimed at setting the agenda on a number of issues, including Psychiatry’s and Psychiatrists’ Social Contract, as well as forming continental alliances for integrated mental health in Africa.

The congress program had five main tracks, including neuroscience, psychotherapy, social involvement, cultural-religious-spiritual contexts in which clinical problems present, as well as integrative care - systems and the networking required to provide different levels of services in a multi-sectoral environment. The program included pre-congress lectures in Johannesburg and Cape Town, 10 pre-congress workshops, 69 lectures (8 key-note, 23 invited and 38 parallel), 125 symposia (regular, sectional, zonal and workshops), 38 oral presentation sessions and 176 poster presentations. Considering the congress theme of Psychiatry: Integrated Care for the Community, through the WPA2016 Local Organising Committee’s Creative Arts Sub-Committee, the organizers prepared a significant creative arts component integrated into the congress proceedings.

PRE-Congress Lectures

Pre-congress lectures on Schizophrenia – A “state of the art” update, were hosted by the WITS Department of Psychiatry on Wednesday, 16 November 2016 at the Faculty of Health Sciences Building in Parktown, Johannesburg, as well as by the Stellenbosch University Department of Psychiatry, at the Faculty of Medicine and Health Sciences on Thursday, 17 November 2016 at the Tygerberg Campus. The lecture of Prof Andreas Meyer-Lindenberg from Mannheim, Germany was entitled “Biological mechanisms of schizophrenia: Genetic indicators and neuroimaging” and Prof Wolfgang Gaebel’s (Duesseldorf, Germany) lecture was on “Quality assurance and treatment guidelines: Best practice management of schizophrenia”.

AFRICAN MENTAL HEALTH FORUM

On Friday, the 18th November 2016, the World Psychiatric Association (WPA) and the World Health Organization (WHO) also hosted an Africa Mental Health Forum on Continental Alliance for Integrated Mental Health Care in Africa. The meeting was also addressed by Dr Matshidiso Moeti, the WHO African Regional Director, who spoke on “The Transformation Agenda and the Global Mental Health Action Plan: Policies and targets for Africa”.
Prof Dinesh Bhugra, WPA President, and Dr Shekhar Saxena, Director WHO Department of Mental Health and Substance Abuse co-chaired this forum, while participants included members of the WPA Executive Committee and Board, psychiatric associations in Africa, managers of national mental health programs and mental health advocacy groups. Plenary and breakaway round table discussions were held with the aim to develop a position statement on mental health issues in Africa. Four panels were discussing and presenting content in terms of the four subthemes of the current WHO’s Global Mental Health Action Plan, namely: I. Leadership and governance; II. Health and social services; III. Prevention and promotion; and IV. Information, evidence and research.

PRE-CONGRESS WORKSHOPS

Ten workshops were presented on Friday the 18th November on a range of topics, including:

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Leadership Academy - a group of young dancers from Khayelitsha. The introduction to this presentation and its conclusion was done by Cape Town psychiatrist Dr Ian McCallum. Musicians participating included the WALLS Ensemble (Roché van Tiddens, Ncebakazi Mnukwana, Visser Liebenberg, Brydon Bolton), Brittany Smith (soprano), Yanga Jadezweni (tenor) and Michael Smith (violinist). Diana Ferrus, a Cape Town poet, recited her poem on the homecoming of Sarah Baartman, which tells the story of her exile, exploitation and dispersion to Europe in the early 1800’s and the physical fragmentation of Sarah’s body which remained on display in a French museum until 1986 and was only returned and buried in 2002. This collaboration between psychiatrists, artists and activists, using spoken word, poetry, music and dance, as the first event of the congress, breathed life into the congress themes by being a “demonstrating the social contract in action,” and was intended to springboard a formal creative arts program by the South African Society of Psychiatrists (SASOP), as a legacy project of the WPA 2016 International Congress.

Congress Opening and Welcome Cocktail

The Opening Presentation - “Coming Home” was a 30-minute presentation demonstrating aspects of Psychiatry’s Social Contract, directed by local psychiatrists in association with local artists, including a number of musicians and the INDONI Art Dance and Leadership Academy - a group of young dancers from Khayelitsha. The introduction to this presentation and its conclusion was done by Cape Town psychiatrist Dr Ian McCallum. Musicians participating included the WALLS Ensemble (Roché van Tiddens, Ncebakazi Mnukwana, Visser Liebenberg, Brydon Bolton), Brittany Smith (soprano), Yanga Jadezweni (tenor) and Michael Smith (violinist). Diana Ferrus, a Cape Town poet, recited her poem on the homecoming of Sarah Baartman, which tells the story of her exile, exploitation and dispersion to Europe in the early 1800’s and the physical fragmentation of Sarah’s body which remained on display in a French museum until 1986 and was only returned and buried in 2002. This collaboration between psychiatrists, artists and activists, using spoken word, poetry, music and dance, as the first event of the congress, breathed life into the congress themes by being a “demonstrating the social contract in action,” and was intended to springboard a formal creative arts program by the South African Society of Psychiatrists (SASOP), as a legacy project of the WPA 2016 International Congress.
A number of officials and dignitaries participated in the congress opening by delivering opening addresses, including: Dr Mvuyiso Talatala (SASOP President) on behalf of SASOP, Prof Dinesh Bhugra (WPA President) on behalf of the WPA, Mr Ian Neilson (Executive Deputy Mayor) on behalf of the city of Cape Town, Dr Nomafrench Mbombo (Western Cape Province MEC Health) on behalf of the Western Cape, Dr Shekhar Saxena (WHO Director Mental Health and Substance Abuse) on behalf of the WHO Regional Director, African Region, Dr Matshidiso Moeti, and H.E. Dr. Nkosazana Dlamini Zuma, Chairperson of the African Union Commission, on behalf of the EU and Africa.

The opening was followed by a welcome cocktail in the Strelitzia Restaurant and Conservatory Area of the CTICC and was a celebration of the African, South African and Western Cape context of the congress, sponsored by Dr Reddys.
WPA INTERNATIONAL CONGRESS
CAPE TOWN, 18-22 NOVEMBER 2016
WPA IC 2016 INDUSTRY PARTICIPATION

For more information, please visit the congress website
www.wpacapetown2016.org.za
Dear Colleagues, dear Friends,

I hope that you had a restful period over holidays. I am writing to you with some key issues and need your support.

1. The preparations for the World Congress in Berlin in October are moving rapidly. I would strongly encourage your association to support medical students and early career psychiatrists. There will be special academic tracks for them to enjoy along with meeting senior leaders.

2. I would like to draw your attention once again to the Bill of Rights attached herewith again. In addition, please look at the findings of the Discrimination Survey.

Full details of the discrimination survey were published in a special issue of International Review of Psychiatry volume 28(4). The contents are available online, [http://tandfonline.com/toc/lirp20/28/4?ref=tocList](http://tandfonline.com/toc/lirp20/28/4?ref=tocList)

On the International Children’s Day on 20th November, WPA launched a Bill of Rights for children and young people. Developed by Dr. Gordana Milavic and Professor Bennet Leventhal and colleagues, I am attaching this for your reference. Please sign up to it as well.

The logo above is the symbol of the social justice campaign lasting all of next year. Please use it wherever you can.

3. Please find attached herewith two recent WPA Position Statements on high quality training and Preventive Psychiatry for your information and wider dissemination within your organisation.

4. You may know that there is a proposal to shift diagnosis of Dementia from Mental Health and Behavioural Disorders to Neurology section of ICD-11. I know that many organisations have please do so. I would suggest that please write to Dr. Saxena directly and copy the WPA in. It will strengthen the case if you were to contact your WHO country expert as well as your representatives on ICD-11 working groups.

5. I am also attaching a paper from Professor Graham Thornicroft and colleagues for your information and action.

6. We had very successful round table meetings on early Interventions in Psychiatry hosted by Hong Kong College of Psychiatrists in December and the findings are being collated in a book.

7. As agreed in the WPA Action Plan I am delighted to let you know that a forthcoming Special issue of International Review of Psychiatry presents key papers translated from Portuguese into English.

8. Dr. Greg Shields in collaboration with University of Melbourne has been working on the Diploma curriculum and we are hopeful to launch this later this year.

9. Please keep sending examples of good clinical practice so that we can learn from each other.

Please check the WPA website regularly and get involved.

Best wishes,

Dinesh Bhugra, CBede
President, World Psychiatric Association
A BRIEF HISTORY OF DIGNITY IN MENTAL HEALTH
AND AN INTRODUCTION TO THE CONCEPT OF “MENTAL HEALTH FIRST AID”

Yvette Nel

Mental health has been poorly understood through the ages, and as a result, often surrounded by mysticism, superstition and fear. Treatment for mental illness was often painful, humiliating and grossly undignified.

To summarise Alison Foerschner’s, “the History of Mental Illness: From Skull Drills to Happy Pills”, there is archaeological evidence of attempts to treat mental illness as early as 5000BC, with trephined skulls representing a practice where holes were drilled in skulls to release “spirits or demons” thought to be trapped in the head and causing the behaviour. In Europe, from the Middle Ages onward, shame and stigma dominated mental illness, and families of those with a mental illness hid their relatives in cellars and cages.

Those with a mental illness were often destined to live as vagrants. Fears of evil forces, punishment for past sins and even contagion resulted in mistreatment and loss of dignity for those with mental illness, and the creation of large mental asylums.

Reforms started in the late 1800s, with Pinel in Paris arguing that patients should be unchained and allowed to walk freely around the gardens of the asylums. Sigmund Freud and colleagues offered new hope in terms of new forms of therapies available. Electroconvulsive therapy, psychosurgery and psychopharmacology introduced in the early 1900s further changed the course of treatment. Initially, ECT was administered without anaesthetic, and early practices such as insulin shock therapy were abandoned. Frontal lobotomies became widely used but this practice has fortunately since been discontinued. The advent of psychotropic medications, with lithium in 1948 and chlorpromazine in 1952 brought new hope in the successful treatment of patients, and the possibility of deinstitutionalisation was widely propagated, with at times unintended negative consequences for those with severe mental illness. This much summarized account of the history of mental health care demonstrates that dignity on mental health is not a well-recognized historical concept.

The Importance of History

It is important to highlight that fear and lack of knowledge, as well as lack of effective treatment options lead to centuries of undignified management for those with mental illness. Understanding history, and learning from the mistakes of the past, helps us to plan effectively for the future. We need to recognise how far we have come in terms of humane treatment, while still being aware of the current challenges facing “dignity” in mental health.

Although we understand much more about the causation of mental illness, we still have much to learn. We now know that mental illness is complex, with an interplay between genetic predisposition, other biological factors as well as environmental and social stressors. Those of us working in the mental health profession know that there are many on-going challenges, there is still stigma around mental illness, and there is still fear and discrimination. We know that those impacted by mental illness still have challenges relating to social support and basic human rights issues. We also know that there are still varying ideas around causation of mental illness within the community, which promote fear and discrimination.
“MENTAL HEALTH FIRST AID”

The World Federation for Mental Health (www.wfmh.com) reports that every 40 seconds somebody dies by completed suicide worldwide. This is just one example of a mental health care emergency situation. However, most of the lay public have no training, knowledge or skills required to detect early warning signs and administer appropriate first contact care in a mental health care emergency situation.

As a result, the first contact in an emergency situation is with a poorly equipped family member or community member, and families often express that “they just don’t know what to do” in a crisis situation. Fear of mental illness and lack of skills leads to escalation of urgent situations and worsening of psychiatric emergencies in the community setting, prior to contact with health care professionals.

THE MENTAL HEALTH FIRST AID PROGRAM

ESSENTIALLY, THE CONCEPT OF MENTAL HEALTH FIRST AID IS TO EQUIP FIRST RESPONDERS WITH THE NECESSARY SKILLS TO PROVIDE FIRST CONTACT CARE IN A MENTAL HEALTH CARE EMERGENCY OR CRISIS SITUATION. IT IS THOUGHT OF AS THE CPR OR BASIC LIFE SUPPORT OF MENTAL HEALTH.

A training program was developed in Australia in 2000 offering training to the lay public in Australia. This was then disseminated worldwide. The USA has recently passed the Mental Health First Aid act of 2015, providing funding for the lay public for training in mental health first aid. There is some evidence that mental health first aid training improves mental health care knowledge, attitude and health care provisions and thereby reduces stigma.

AIMS OF MENTAL HEALTH FIRST AID?

The World Federation for Mental Health states the following aims for mental health first aid

- To preserve life where a person may be at risk of harm
- To provide help to prevent the mental health care problem from becoming more serious
- To promote recovery of good mental health
- To provide comfort to a person with a mental health problem (www.wfmh.com)

KEY COMPONENTS OF MENTAL HEALTH FIRST AID GUIDELINES

There are numerous resources available online and even apps that can be downloaded onto smartphones and tablets, with specific guidelines for many emergency situations. These guidelines offer practical advice in terms of what signs to look out for, what to do, with examples of de-escalation techniques, and importantly, what not to do, with examples of common mistakes that are unhelpful in a crisis.

THE MENTAL HEALTH CARE PRACTITIONERS

The concept of mental health first aid seems like an “ideal world” concept. The reality is that most of our patients’ families, particularly within the government sector health care system, struggle with basic necessities such as food, clothing and a place of shelter. Often the mental health care crisis explodes before any appropriate interventions are made and steps are taken to access health care. Access to health care is then often achieved in an undignified manner with the involvement of force, physical restraint and escalation of the situation.

That said, we should be striving for the ideal. Our role as mental health care professionals is to be advocates for mental health care, promoting training and appropriate legislation. We need to provide the community with access to resources including training programs on mental health first aid. We need to provide support and training to families of how to deal with mental health care emergencies. We also need to be aware of resources and programs available to up skill communities. Lastly, we should examine evidence critically, looking for effective strategies to improve mental health care and lessen the burden of stigma.

CONCLUSION

We have come a long way, from trephined skulls and asylums and frontal lobotomies, to Freud and the pharmacological management of psychiatric illness, with deinstitutionalisation and the rise of dignity in mental health. The concept of mental health care first aid is designed to promote dignity and improve outcomes by equipping the community with appropriate first aid skills and decreasing fear and helplessness within the community. Perhaps we can start small by providing appropriate training to the families of our own patients, giving them the necessary tools to deal with a crisis and making them aware of resources available to them.

Yvette Nel is a psychiatrist at Tara Hospital and a lecturer in the Department of Psychiatry at the University of the Witwatersrand, Johannesburg, South Africa. References are available from the author. Correspondence: yvette_nel@hotmail.com
In its morbid form anxiety is grounded in functional and structural aberrations converging on an excessively vigilant amygdala.¹

Recently, regional brain volume changes were noted in patients with generalized anxiety disorder, correlating to explicit memory tasks.² Morbid anxiety has been thought of as a potent driver of somatic morbidity, contributing to a considerable excess mortality in somatic diseases among patients in mental asylums as well as in outpatients.³ ⁴ In Monroe County, New York State, between 1960-1966, when psychoactive medications had become available, the relative risks of dying for different reasons were estimated in all 39,475 psychiatric patients.⁴ The risk of death was 3 times that of the general population, controlling for age, sex, marital and socioeconomic status.

The authors noted the potential for selection bias in that physical illness increases the likelihood of becoming a psychiatric patient. Interestingly, they also observed another unrelated finding; that only 133 of 408 suicides during the study period occurred among the psychiatric patients.

In a more recent study, household interviews using CIDI were conducted in >50,000 subjects in 19 countries.⁵ After adjusting for comorbidity, DSM-IV diagnoses of depression, panic disorder, specific phobia, post-traumatic stress disorder and alcohol use disorder were associated with heart disease onset (ORs 1.3-1.6). The associations with anxiety were greater in magnitude than those with depression.

There is a vast literature on depression as a risk factor for cardiovascular disease.⁶ ⁷ Both premorbid and postmorbid depression onsets were found to be potentially hazardous to cardiac patients in a meta-analysis.⁸ Since anxiety is prominent in depression, there is reason to believe that anxiety may work as a risk factor even through depression. Prospective studies of men and women in Europe and in the United States support this view, and their findings will be presented with a selection of other elucidating studies.

GENERAL POPULATION STUDIES

A nationwide cohort of 49,321 Swedish men 18-20 years old, undergoing interviews for military conscription, were followed up in national registries during 37 years.⁹ In spite of the young age at follow-up, the multi-adjusted hazard ratios for anxiety, as diagnosed by ICD-8 criteria, were 2.17 (95% CI: 1.28 to 3.67) for having been diagnosed with coronary heart disease and 2.51 (95% CI: 1.38 to 4.55) for having been hospitalized with an acute myocardial infarction, respectively.

Interestingly, the hazard ratios for depression were lower than for anxiety, probably as depression usually emerges at a later age than anxiety disorders that often are manifest by the age of 18.
be identified and targeted for anxiety management in the rehabilitation following a myocardial infarction. A prospective study in Montreal of 804 cases with stable coronary heart disease monitored cardiac events in patients over a 2-year period following a diagnosis of GAD, (5.3% of the patients), and in depression (7.1%). GAD assessed at 2 months after an acute coronary syndrome incurred an odds ratio of 2.29 (95% CI 1.07 to 4.88) for a major adverse cardiac event, i.e. the same magnitude of risk as a current major depressive disorder, and the magnitude of risk of having had a previous myocardial infarction, coronary bypass surgery, or angioplasty.

In a study of United States veterans, 4,256 were interviewed to determine diagnoses of major depression and generalized anxiety disorder (GAD), with a 15-year mortality follow-up. Comorbid conditions, affecting 3.6% of the participants conferred the highest risk for all-cause and cardiovascular mortality, while the risks attributed to depression and GAD were attenuated by low household income and other socioeconomic conditions.

To assess whether GAD increased risks in patients with stable coronary heart disease, 1,015 cases were followed over a 2-year period in the Netherlands. The age-adjusted annual rate of cardiovascular events, particularly acute myocardial infarction, was 9.6% in cases diagnosed with GAD, versus 6.6% without, i.e. an adjusted hazard ratio of 1.74 (95% CI 1.13 to 2.67). Myocardial infarction was also a consequence of anxiety as determined in a 12-year prospective study of 735 men 60 years and older, after controlling for a number of known risk factors, health behaviour and medication.

With primum est non nocere in mind, a Scottish cohort of 14,784 adults with no cardiovascular disease were monitored for an average of 8 years to assess whether antidepressant treatment was linked to cardiovascular disease. Use of tricyclic antidepressants was associated with emerging cardiovascular disease and a non-significant increase of coronary events, even when adjusting for psychological distress as measured with the GHQ-12 questionnaire. This may indicate that 1st generation antidepressant drug treatment increased cardiovascular risk, not depression per se or other residual confounders, perhaps related to tricyclic-induced weight gain, orthostatic hypotension, hypertension, and reduced heart rate variability. Treatment with the SSRIs was not associated with cardiovascular disease, attesting to a greater cardiac safety margin.
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**INDICATIONS**

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INTRIGUING CONDITIONS

Takotsubo, (“broken heart” syndrome), resembles an acute coronary syndrome, with a typical shape of the left ventricle during systole. Takotsubo is a vessel used to trap octopus in Japan. Comorbid factors include psychological distress, considered the chief precipitator. An international review of 951 men and 158 women with takotsubo found emotional stressors in 39%, physical stressors in 35% and no identifiable stressor in 13%. Psychological disorders were noted in 24%. A retrospective case-control study at the Mayo Clinic of 25 women with takotsubo found a premorbid anxiety disorder in 14 cases, depression in 12, and a family history of either in 11 cases. The intriguing takotsubo condition deserves more research into precipitating mechanisms and prognosis, including antecedent anxiety disorders.

White coat hypertension (WCH) has baffled physicians since it was first described in 1896 as a rise in blood pressure during a physician visit, while normotension is found in the home setting. WCH is frequently encountered in clinical settings, and hard to predict. It increases with age, while there is no influence of gender and ethnicity, and is believed to be attributable to sympathetic activation. It is not benign though. Similarly to masked hypertension, it is associated with glucose intolerance, organ damage, cardiovascular risk and mortality. Some investigators propose automated blood pressure readings to eliminate the human factor in white coat hypertension and, assumedly, an anxiety component. At the time of writing, no study had been published on whether anxiety has anything to do with white coat hypertension, a subject that merits a proper investigation. There may be a social anxiety component that triggers sympathetic activation including sweating and blushing.

INTERVENTIONS

Turning to cardiovascular interventions, such procedures can cause distress as well as maladjustment. Cardiothoracic transplant recipients experience substantial distress prior to and following the surgical procedure. Following a successful transplant they need to take immunosuppressant medications daily with regular dose adjustments, or risk acute organ rejection. Studies point to a need for postoperative diagnosing and psychological support. Adherence is literally of vital importance. From another point, implantable cardioverter defibrillators can cause panic attacks when activated. Coronary artery bypass grafting is another procedure that may cause adjustment problems. Rehabilitation programs should recognize anxiety and depressive components among the patients.

CONCLUSION

The interface of anxiety and cardiovascular disease has emerged as an important arena for research and therapeutic intervention.

ANXIETY AS AN ANTECEDENT RISK FACTOR INFLUENCES THE PROGNOSIS IN PATIENTS WITH CARDIOVASCULAR DISEASE AND NEEDS TO BE RECOGNIZED AND MANAGED AT EVERY STEP

Anxiety may actually drive other risk factors such as the metabolic syndrome, depression, smoking, sedentary life style, and substance use. There is a research arena defined as MSIMI: Mental Stress-Induced Cardiac Dysfunction or Myocardial Ischemia. MSIMI occurs in up to 70% of patients with CHD and physical stress test-induced ischemia. Depressive symptoms appear to be associated with MSIMI. Anxiety and anxiety disorders should be included as potential risk factors for MSIMI. A randomized study of collaborative care intervention for anxiety and depression following an acute cardiac illness showed improved life quality and cost-effectiveness.

KEY POINTS

• Among typical risk factors for cardiovascular disease, anxiety has emerged as perhaps the most important one.
• Anxiety needs to be further studied in white coat hypertension and in takotsubo.
• Anxiety management should be offered in cardiac rehabilitation programs, particularly after organ transplant.
• Although sympathetic activation appears to play a role in the pathophysiology of anxiety in cardiovascular disease, more research into the mechanisms may aid in developing specific therapies.
First, although a number of interesting findings have emerged from the epidemiological literature, the causal relationship between anxiety and cardiovascular disease requires further investigation.

It’s always astonishing to me that so many have interpreted the association between moderate alcohol intake and improved cardiovascular health as indicating that alcohol is causally beneficial; it seems much more intuitive to me that alcohol is generally toxic, and that those with moderate alcohol intake have characteristics that also provide them cardiovascular protection.

Adjustment for relevant co-variates may well diminish associations between anxiety and cardiovascular outcomes. 1

A good deal more community and clinical epidemiological work is needed in order to address the precise pathways between anxiety and cardiovascular disorder; this should include studies in low- or middle-income countries 2, and investigations delineating the relationship between early adversity, anxiety disorders, and subsequent cardiovascular function. 3

Second, and relatedly, while several hypotheses have been put forwards about the psychobiological basis of the relationship between anxiety and cardiovascular disease, much additional work is needed in this area. A translational approach requires good animal models. While there is certainly anecdotal data that exposure to stressors can lead to heart arrhythmias in animals, there is relatively little systematic laboratory-based work on how exposure to stressors may impact on cardiovascular function. Other components of a translational approach may include delineating the relevant neurocircuitry and neuro genetics of the link between anxiety and cardiovascular function. Work on the neuroanatomical mediators of cardiovascular responses to threat, for example, may be particularly relevant. 4

There is a need for more detailed translational investigation of the relationship of anxiety and stressors with key physiological and behavioural processes relevant to cardiovascular outcomes, including sympathetic arousal, inflammation, heart rate variability, and endothelial dysfunction. 5

Third, while findings of an association between anxiety and cardiovascular raise the question of appropriate clinical interventions, there is relatively little work on the feasibility and utility of screening for anxiety 6, and a dearth of randomized controlled trials in this area. Although absence of evidence does not equate to evidence of absence, such work has not yet convincingly shown a positive impact on cardiovascular outcomes. 7 Ideally, interventions should target those mechanisms that emerge from the epidemiological and psychobiological work outlined above.
However, given that a range of pharmacological and psychological interventions are already available for individuals suffering from anxiety symptoms and anxiety disorders, it is arguably worth already undertaking trials of such interventions in the context of patients with cardiovascular disease. Rigorously controlled and appropriately powered trials of feasible interventions, addressing clinically meaningful endpoints, are needed in order to ensure that clinical recommendations in this area are evidence-based and worth scaling up.

References


Dan Stein is Professor and Head, Department of Psychiatry and Mental Health, University of Cape Town, Cape Town, South Africa. Correspondence: dan.stein@uct.ac.za
Major Depressive Disorder (MDD) is a rapidly increasing morbidity among adults and children. One in six adults will experience major depression during their lifetime. Women are more commonly affected, with a lifetime prevalence 1.5 to 3 times that of men.

Although it is commonly regarded as a mood disorder, the pathogenesis and course of MDD is far more complex than previously thought.

Comorbid depression is pervasive among patients consulting the general practitioner with seemingly unrelated conditions and significantly impacts on the patient’s perception of health. It is present in more than one third of patients with respiratory disorders, one in 4 patients with arthritis or cardiovascular disorders, and is common among patients with other psychiatric disorders, chronic pain, insomnia, headache, cancer and diabetes.

Treatment goals in the management of depression. In the acute phase, the first 6 to 12 weeks of treatment, the initial goal of therapy is to improve symptoms and induce remission.

Thereafter, treatment aims to preserve remission with careful monitoring of disease course and the effects of treatment. Clinician-rated and/or self-rated scales can help to monitor for signs of relapse and assess side effects, adherence and functional status.

Response to therapy is defined as a reduction by 50% in the measured severity of depression from baseline for ≥3 weeks. Remission is characterized by at least 3 weeks of the absence of both sad mood and reduced interest, and no more than 3 remaining symptoms of the major depressive episode (MDE). In clinical trials, Montgomery-Asberg Depression Rating Scale (MADRS) ≤10 is often used to define remission.

The goal of maintenance therapy is to prevent relapse with reemergence of significant depressive symptoms or dysfunction. The course of depression may vary; some patients may experience MDEs separated by years of normal functioning, while others may experience MDEs in clusters. Consequently it is essential to carefully identify and monitor patients at high risk of relapse (e.g. ≥3 prior MDEs or presence of residual symptoms).

The ultimate aim of treatment is, of course, complete recovery, characterized by an extended period of remission ((≥4 months), such that an MDE is unlikely to occur in the near future.

The multifactorial nature of MDD

An understanding of the complex aetiology and pathogenesis of depression is key to successful prevention and treatment.
MDD is a multifactorial condition in which genetics are estimated to contribute only around 50%. The environment into which the individual is born, develops during childhood and adolescence, and lives in as an adult plays a significant role in the development of MDD. As such, childhood experiences, relationships, occupational experiences and society impact profoundly on brain development and function, and mental health.

The areas of the brain and monoamine neurotransmitter pathways that are affected in depression are those which also maintain sleep, appetite and weight control, energy levels and motivation, and importantly, executive function, including cognition, attention, problem-solving, memory, self-control and decision-making (Table 1). It is therefore intuitive that these aspects of wellness may be affected during MDEs and need to be addressed by management strategies, both pharmacological and nonpharmacological. In terms of pharmacological alternatives, all drugs that boost serotonin, noradrenaline or both can improve the emotional and vegetative symptoms of depression.

Through the common pathways linking the brain, hypothalamic-pituitary-adrenal (HPA) axis, autonomic nervous system and inflammatory pathways, depression is associated with significant morbidity and mortality associated with primary manifestations of the disease beyond those related to disturbed affect. Depressed patients have a significant loss of cells in the prefrontal cortex, a brain area important in discerning reward versus punishment, in shifting mood from one state to the other, and in exerting cortical restraint on the amygdala fear system through the HPA axis and the sympathetic nervous system. Compromised homeostatic function of prefrontal cortical-limbic circuitry disrupts autonomic, neuroendocrine and neuroimmune regulation.

<table>
<thead>
<tr>
<th>BRAIN AREA</th>
<th>SYMPTOMS</th>
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</thead>
<tbody>
<tr>
<td><strong>SEROTONERGIC PATHWAYS</strong></td>
<td></td>
</tr>
<tr>
<td>Frontal cortex</td>
<td>Depressed mood, difficulty concentrating</td>
</tr>
<tr>
<td>Limbic area</td>
<td>Emotional symptoms, e.g. feelings of guilt and thoughts of death or suicide</td>
</tr>
<tr>
<td>Motor cortex</td>
<td>Psychomotor retardation, agitation</td>
</tr>
<tr>
<td>Hypothalamus, sleep centers</td>
<td>Vegetative symptoms, e.g. changes in appetite or weight, lack of pleasure, sleep abnormalities</td>
</tr>
<tr>
<td><strong>NORADRENERGIC PATHWAYS</strong></td>
<td></td>
</tr>
<tr>
<td>Locus coeruleus</td>
<td>Integration of behaviour, cognition, mood, emotion and movement</td>
</tr>
<tr>
<td>Hypothalamus</td>
<td>Insomnia, hypersomnia, loss of weight or appetite</td>
</tr>
<tr>
<td>Dorsolateral prefrontal cortex</td>
<td>Changes in executive function and cognition</td>
</tr>
<tr>
<td>Amygdala</td>
<td>Changes in memory, emotional reaction to events, changes in socialisation</td>
</tr>
</tbody>
</table>

In depression, disturbances of serotonin, noradrenaline & dopamine transmission impair regulatory feedback loops of the stress response, leading to excessive and untimely release of corticotropin-releasing hormone (CRH), adrenocorticotropic hormone (ACTH) and glucocorticoids.

Sympathetic over-activity, combined with diminished parasympathetic tone, contributes to immune activation and release of proinflammatory cytokines (e.g. TNF-alpha, IL-1, IL-6) from macrophages and other immune cells. These abnormalities may contribute to many different pathologies, including altered fat metabolism and increased visceral fat, insulin resistance, increased inflammation, enhanced blood coagulation, deficient fibrinolysis, decreased bone formation, increased bone resorption and chronic pain. Consequently, it is possible that depression may present primarily with symptoms of medical disease. Similarly it may contribute to pathology and influence morbidity and survival in comorbid medical conditions, such as coronary heart disease, diabetes, osteoporosis and chronic pain states.

The converse is also true. Through the immune response, conditions associated with peripheral inflammation and stress affect brain function.
Cytokines produced by peripheral macrophages cross the blood-brain barrier or influence brain function via activation of afferent nerve fibres (e.g. sensory vagus nerve). Cytokine signals interfere with serotonergic and noradrenergic signalling in the hippocampus, amygdala, prefrontal cortex, limbic system and other areas of the brain. They may also influence other processes known to be involved in the development of MDD by reducing neurotrophic support and increasing the production of excitotoxic/oxidative species that damage the neurons and glial cells. In addition, cytokines may down-regulate central glucocorticoid receptor sensitivity, leading to further disruption of feedback control of the hypothalamic-pituitary-adrenal (HPA) axis and the immune system. These pathways, at least in part, provide an explanation for the tiredness, irritability, sleep and mood alterations associated with psychosocial adversity, common inflammatory conditions and visceral pathologies (Table 2).6-8

<table>
<thead>
<tr>
<th>Table 2. Factors associated with depression that increase peripheral inflammatory markers6</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Psychosocial stress</td>
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<tr>
<td>• Medical illness</td>
</tr>
<tr>
<td>• Obesity</td>
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<tr>
<td>• Sedentary lifestyle</td>
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<tr>
<td>• Diet (e.g. low omega 3:omega 6 fatty acid ratio, high fructose sugars)</td>
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<tr>
<td>• Diminished sleep</td>
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<tr>
<td>• Social isolation</td>
</tr>
<tr>
<td>• Low socioeconomic status</td>
</tr>
<tr>
<td>• Female sex</td>
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<tr>
<td>• Smoking</td>
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</table>

THE ROLE OF NORADRENALINE

Noradrenaline has a central role in health and illness, acting both as a neurotransmitter and as a hormone. In addition to the stress ‘fight or flight’ response it influences a wide range of physiological processes, including mood, cognition, memory and learning, immune function and inflammation, insulin secretion, sleep-wake cycle, aggression and dominance, fat metabolism (and weight gain) and also bone metabolism through its effects on osteoclasts and osteoblasts.

In the brain, the principle site of noradrenaline synthesis is the locus coeruleus (LC). Two firing patterns are identified in the LC, tonic and phasic. Tonic phase firing is a steady-state, background firing that occurs at rest while awake and alert. In depression, low tonic firing correlates with fatigue and cognitive dullness. Chronic stress and depression with low tonic activity and low inhibitory auto regulation allows excessive phasic noradrenaline firing. In contrast, phasic firing occurs in response to a strong stimulus. It correlates with threat or a significant stressor and results in increased vigilance, enhancement of sensorimotor reflex responses, increased acoustic startle reflex, reduced immobility and it primes the ‘fight or flight’ response. In pathological states, excessive phasic firing is associated with anxiety and panic disorders.9

CROSS-TALK BETWEEN SEROTONIN, NA AND DOPAMINE-PRODUCING NEURON PATHWAYS

NA, dopamine and serotonin pathways have a direct influence on the activity of each other. In the prefrontal cortex (PFC), NA and dopamine are closely related. The NA transporter has similar affinities for NA and dopamine, and dopamine is co-released with NA in the PFC. Dopamine is relatively abundant in comparison to the availability of its transporters in that area and can be taken up nonselectively by NA transporters. Therefore, selective inhibitors of NA uptake (e.g. reboxetine, atomoxetine), which have no affinity for dopamine transporters, increase NA and dopamine in the PFC, but do not increase dopamine in the nucleus accumbens.

Because serotonin inhibits neuronal release of NA in the LC, drugs that increase serotonin activity may, at the same time, reduce the activity of NA. Changes in NA activity may produce unintended effects, because adrenergic receptors occur widely throughout the body, influencing numerous different physiological systems, including cognition and memory, cardiovascular regulation, both fat deposition and lipolysis, and insulin resistance.

Because of the lack of specificity of NA transporters, and positive feedback signals between dopaminergic and noradrenergic neurons, increases in NA activity are also associated with an increase in dopamine activity. Consequently, increased NA activity may be associated with dopamine-related adverse effects, including agitation and excitability.

Therefore, because changing the activity of one neurotransmitter will also alter the activity of the others, drug therapy that influences any of these neurotransmitter pathways needs to be carefully considered.

Full text of this article is available as a pdf version on the website www.southafricanpsychiatry.co.za

Rakesh Jain is a Clinical Professor, Department of Psychiatry, Texas Tech University School of Medicine, Midland Texas; Psychiatrist in Private Practice, Austin, Texas, USA. References available from Prof. Jain. Correspondence: jaintexas@gmail.com
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* As measured by the WPAI (Work Productivity and Activity Impairment) scale.


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- Schizophrenic Psychoses¹,
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- Dementia related behavioural disturbances¹,
- Disruptive behaviour (Paediatrics aged 5-12 years)¹.

Revive Normality
The Southern Gauteng Subgroup held a CPD event on Child and Adolescent Psychiatry on Saturday 17th September 2016. Approximately 40 people attended, including registrars, public and private sector psychiatrists, and a few psychologists. The programme was interesting and informative and generated much discussion!

**R RONELLE PRICE-HUGHES,** child and adolescent psychiatrist, presented on Complex Trauma in youth, outlining the biological and psychological consequences of this disorder. She described the primary domains of impairment in this disorder, including attachment difficulties, physiological difficulties, difficulties with affect regulation, dissociative states, behavioural and cognitive difficulties, and described the management of some of the children with this disorder treated in an inpatient setting.

**DR WENDY DUNCAN,** child and adolescent psychiatrist, followed with a presentation on the treatment of affect dysregulation in adolescents. Using Dan Siegal’s model of brain development, she outlined in some detail the neurobiology of affect dysregulation, the clinical manifestations as well as the Dialectical Behaviour Therapy-informed approach used in treatment. Again, her presentation was enlivened by her extensive clinical experience in this area.

**MS VANESSA HEMP,** clinical psychologist, spoke about the impact of social media and gaming in adolescence. She described the significant changes that technology has brought about in the development of children and adolescents, but emphasised that most adolescents negotiate the use of technology in a constructive way, but vulnerable individuals are more likely to experience significant consequences from injudicious use of technology & social media. She highlighted the serious consequences of impulsive behaviour in this arena, as well as the implications for violation of people’s privacy. This generated some lively debate which continued into tea time!

**DR HELEN CLARK,** child and adolescent psychiatrist, presented on the use of stimulants as cognitive enhancers, outlining the mechanism of action of these drugs in the ADHD brain and in the “normal” brain. She presented the limited evidence that exists, both for and against the use of these medications in people who do not have ADHD, and outlined the ethical debates in this arena. Again, much discussion ensued.

All in all a most “stimulating” morning, with much cognitive enhancement!
Rita Thom is a psychiatrist in private practice (Johannesburg) and an honorary adjunct professor in the Department of Psychiatry at the University of the Witwatersrand. Correspondence: Rita.Thom@wits.ac.za
The *Journal of Child and Adolescent Mental Health* seeks to publish work of relevance to both clinicians and academics, attracting international scholars and expanding the scope to encourage psychiatry papers. The journal’s expanded aims and scope covers topics that are pertinent to child and adolescent psychiatry and psychology, such as epidemiological, neurobiological, genetic, diagnostic, psychopathological, parent-child-family, ethical, social, and treatment aspects of childhood disorders.

Original research, critical reviews on topics relevant to practitioners, clinical perspectives comprising analysis and discussion, clinical case series with in-depth discussion and letters to the editor are welcome.

The *Journal of Child and Adolescent Mental Health* seeks to promote coverage, representation and dissemination of high quality work from around the world that traverses high-, middle- and low – income contexts.

The journal is included in Medline, Scopus and the Web of Science Emerging Sources Citation Index.

Read more about the journal, instructions for authors and submission procedure at www.nisc.co.za

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MOVEMENT FOR GLOBAL MENTAL HEALTH
SECRETARIAT 2017 - 2020

Charlene Sunkel

The Secretariat will be based at the SA Federation for Mental Health in Randburg, South Africa with Charlene Sunkel as Principal Coordinator, MGMH.

MY VISION FOR THE MGMH 2017-2020

The focal point of the Movement for Global Mental Health is to upscale services in mental health globally through an approach that involves scientific evidence and the protection and respect for the human rights of people with mental health problems and psychosocial disability. Striving towards achieving its goals, the Movement for Global Mental Health brings together key role players, from organisations to individuals from all over the world who unite and contribute their expertise, skills, experiences and passion to take mental health to the top of the general health agenda.

The Movement for Global Mental Health has grown into a reputable global organisation since its establishment in 2008, and owes its status to the dedication and drive of the Secretariat, Advisory Committee, members or member organisations. My predecessor, Jagannath Lamichhane, has taken the lead as Principal Coordinator for the past 3 years and ensured that the Movement grow from strength to strength. I am committed to sustain that momentum.

As a person with a psychosocial disability and working in the field of mental health and advocacy, I am very passionate about improving the lives of persons living with mental health problems and psychosocial disability, empowering them and giving them a voice to speak for themselves. My vision for the term (2017-2020) that I will be serving as the Principal Coordinator of the Movement for Global Mental Health is to work towards enhancing the voice of persons with mental health problems and psychosocial disability globally and where they can create valued partnerships with key role players in the mental health field to upscale mental health services and improve the quality of life of mental health care users.

During my time in office I would like to focus on the following activities as a means to realise my vision:

- To reach out to all corners of the world and not to leave anyone behind – building onto the membership of the Movement to expand and create a more diverse mental health community that enhances the value of sharing initiatives and experiences
- To strengthen the voice of people with mental health problems and psychosocial disability through joining them up with the Movement and create a platform for them to share their views, opinions and experiences
• Continue to encourage sharing and dissemination of evidence-based information, and showcasing innovation in the field, amongst members, higher educational institutions, Governments, policymakers, stakeholders, people with mental health problems and psychosocial disability, the media and the public – that adds value and guidance to planning of upscaling services in diverse settings globally

• To emphasise the importance of protecting and respecting the rights of persons with mental health problems and psychosocial disability by promoting international treaties and human rights laws

• To promote the Movement by expanding on social media by, in addition to Twitter, creating a Facebook page

• The SA Federation for Mental Health to host the Biannual Global Mental Health Summit 2017 in Johannesburg, South Africa with the theme considered, “Leaving no one behind”. I propose to bring in a strong element of empowerment of persons with mental health problems and psychosocial disability globally and how to ensure that they are key partners in upscaling of mental health services, among other related topics

I am looking forward to taking over the reins and with great honour to lead the Movement for the next 3 years. In advance, I thank you for your support and commitment. My “virtual” door will always be open should anyone wish to communicate with the Secretariat, for any comments, suggestions, ideas, submissions of articles, volunteering, opportunities for members, etc. The Secretariat will be based at the SA Federation for Mental Health in Randburg, South Africa, where I am employed as Programme Manager for Advocacy and Development.

Charlene was diagnosed with paranoid schizophrenia in 1991 where her journey that followed exposed her to the challenges experienced by persons with mental disorders within and outside of the mental health sector. This encouraged her to commit herself to fighting the cause for mental health and human rights. In 2003 she got involved in volunteer work in the field of mental health, in 2006 accepted a position in mental health advocacy and awareness with a Gauteng based organisation, in 2014 she joined the South African Federation for Mental Health as Programme Manager for Advocacy and Development. She has written and produced theatre plays on life stories of persons living with mental disorders (including one on her life with schizophrenia), and written and produced a short feature film based on the storylines of the theatre plays – to destigmatise mental disorders. She has written articles for medical journals like The Lancet (Empowerment and Partnership in Mental Health), The Lancet Psychiatry (Mental Health Services – Where do we go from here?), amongst other publications. She serves on a number of national and international boards and committees: Editorial Advisory Board of the Lancet Psychiatry; Board of Management of Human Rights in Mental Health (Federation Global Initiative on Psychiatry); Presidential Working Group on Disability; Ministerial Advisory Committee on Mental Health; Disability Empowerment Concerns Trust; and on the Advisory Committee to the Lancet Commission on Global Mental Health, amongst others. She received a number of awards since 2006, and the latest being the Jim Birley Scholarship Award (Netherlands, 2015); Tributes Excellence Awards, Disability Rights category (South Africa, 2015). She has recently been appointed as the Principal Coordinator for the Movement for Global Mental Health, to serve a 3 year term.

Correspondence: charlene@safmh.org
DEPARTMENTS OF PSYCHIATRY
UNIVERSITY OF THE WITWATERSRAND

MMED GRADUATES

Dr Venera Stancheva  
Dr Odita Vahed  
Dr Zeneida Tenea  
Dr Nirvana Morgan

Dr Keshika Mangrey  
Dr Masese Beke  
Dr Kim Laxton  
Dr Kerry Leigh Balson

HPCSA SUBSPECIALITY REGISTRATION: FORENSIC PSYCHIATRY

Drs Chetty, Pak and Armstrong have been registered as sub specialists in Forensic Psychiatry by the HPCSA. All are staff at Sterkfontein Hospital.

Dr Indhrin Chetty  
Dr Eddie Pak  
Dr Bridget Armstrong

PSYCHOTHERAPY WORKSHOP

The Department hosted a 3 day workshop (27th - 29th July 2016) presented by Julian Stern, Director of Adult and Forensic Services; and Consultant Psychiatrist in Psychotherapy at the Tavistock Centre London, UK. The workshop comprised a series of lectures related to an innovative Primary Care Psychotherapy Consultation Service located in the London Boroughs of Hackney and the City (Stern J, Hard E, Rock B. Paradigms, Politics and pragmatics: psychotherapy in primary care in City and Hackney - a new model for NHS. Part 1: the historical, political and economic drivers behind the creation of the service. Psychoanalytic Psychotherapy 2015; 29(2): 117-138) as well as case presentations by staff within the Department.
UNIVERSITY OF THE WITWATERSRAND

UNITED NATIONS MEETING

On the 15th and 16th of November 2016, Ethelwyn Rebelo was invited to attend a meeting of the United Nations African Development Programme focusing on Transgender People, HIV, Health and Human Rights in Africa.

The meeting was held at the Hotel Capital Empire in Sandton. The overall objective of the meeting was to support increased understanding of the issues transgender people face that reduce their access to health and other services and increases their vulnerability to HIV and AIDS, and the specific integration of transgender health and HIV related issues in important national planning and implementation processes such as national strategic plans, national health plans, etc.

Ethelwyn Rebelo spoke at the first session on Gender Dysphoria, DSM-5 and latest research and experience that genes are insufficient factors in determining biological sex.

HPCSA SUBSPECIALITY: NEUROPSYCHIATRY

Dear Dr Bracken

APPLICATION FOR REGISTRATION AS SUBSPECIALIST IN NEUROPSYCHIATRY UNDER THE “GRANDFATHER CLAUSE” DISPENSATION IN THE CATEGORY INDEPENDENT PRACTICE

We refer to the aforementioned matter and wish to advise that your application, was reconsidered by the Sub-committee for Postgraduate Education and Training (medical) PETM in September 2018.

We are pleased to inform you that your application for independent practice subspecialist registration in Neuropsychiatry through the “grandfather clause” dispensation was approved.

Yours sincerely

[Signature]

MR JAMEL VAN MARHAYE
CHIEF OFFICER, SECRETAIRE ACIS (SL)
BOARD MANAGER: MEDICAL AND DENTAL BOARD
UNIVERSITY OF KWA-ZULU NATAL

APPOINTMENT: HEAD OF DEPARTMENT

Prof. Bonga Chiliza has been appointed as Head of the Department of Psychiatry at UKZN as of 1st February 2017.

Bonga Chiliza was previously an Associate Professor and Senior Specialist Psychiatrist in the Department of Psychiatry, Stellenbosch University and Tygerberg Hospital. His research interests include schizophrenia, consultation-liaison psychiatry, health services and medical education. Prof Chiliza has received a number of awards including the Hamilton Naki Clinical Research Fellowship and the CINP Rafaelsen Young Investigators Award. He has authored over 50 peer reviewed articles and book chapters. He has also served on a number of NGO Boards, including the SA YMCA, Life Choices and Harambee.

UNIVERSITY OF STELLENBOSCH

CERTIFICATE CHILD PSYCHIATRY

Senior registrar, Dr. Yewande Oshodi has successfully passed the Certificate Child and Adolescent Psychiatry (College of Psychiatrists, College of Medicine of South Africa).

SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY

HONORARY FELLOW

Prof. S Rataemane was recently elected an Honorary Fellow of the World Association of Social Psychiatry.
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Working with Groups
Introductory Course Outline 2017

This course outline describes the year-long Introductory Course of UBUBELE’s Working With Groups Programme, which is offered in association with the Institute of Group Analysis, London.

Courses which build human capacity in the field of group work, particularly developing the skills and knowledge of group facilitators and leaders, as well as trainers of group work, are urgently needed to deal with the challenging mental health issues in our society. This introductory course has been designed to meet South African realities, requirements and resources. It is influenced by the models developed by the London-based Institute of Group Analysis and the Tavistock Clinic.

Ububele has run the Introductory Course to Working with Groups annually since 2004.

These are some comments about the course made by past participants:
“I got to interact at the same level with people from different professional backgrounds and found common interests, particularly regarding client groups.” (Community-based social auxiliary worker)
“I learnt and grew on an emotional level, especially about understanding emotions and expressing them.” (Hospital-based psychologist)
“I learnt that every person has potential to grow and change and how to have an open mind about other people without judging.” (Community-based lay counsellor)
“Being in a small group was the most significant learning experience.” (High school teacher)

Rationale for the Introductory Course

Many mental health workers wish to, and are called upon, to work with groups. The training at universities and other institutions is, however, often too limited to equip people with the experience, knowledge, skills and confidence required to undertake successful group work. This course seeks to enrich those beginnings.

Ububele’s rationale for the Working with Groups training programme includes:
• Group work can be as therapeutically effective as individual counselling;
• It is more cost effective
• Group work has a natural acceptance in African culture
• With the severe shortage of mental health services in South Africa, group work is able to reach more people in need, effectively and affordably.

Patrons: Mr Denis Goldberg; Ms Bongi Dlomo-Mautloa
Trustees: Mr Zwelakhe Mankazane (Chair); Mr Tony Hamburger; Ms Thabisile Levin;
Ms Laliefa Moba; Mr Charles Nupen;Ms Hannah Ylima

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It was with much excitement and some trepidation that I arrived at the venue for the beginning of the Psychotherapy workshop at 09h00 on Wednesday the 27th July 2016.

I was grateful not only to Christopher Szabo, who as academic Head of the Department of Psychiatry at Wits had invited me over a year previously to teach there, but also to Ugash Subramaney and Cora Smith who had helped me put together a programme that would both describe aspects of our work in the Tavistock and Portman NHS Trust in London, and also make it as relevant and appropriate as possible for a South African audience. But it was also 30 years since I had graduated from Medical school in South Africa (UCT), and almost 30 years since beginning my Psychiatry training at the Maudsley hospital in early 1988.

WHAT WOULD THE ISSUES BE OF RELEVANCE TO SOUTH AFRICAN PSYCHIATRIC AND PSYCHOLOGY PRACTICE? WHAT PROFESSIONAL AND PHILOSOPHICAL LANGUAGE(S) WOULD BE SPOKEN, AND HOW WOULD CURRENT SOUTH AFRICAN MENTAL HEALTH CARE PROFESSIONALS RESPOND TO PSYCHOTHERAPEUTIC AND PSYCHIATRIC APPROACHES LEARNED AND REFINED IN RELATIVELY SPEAKING “AFFLUENT” ENGLAND, ALBEIT IN SOME DEPRIVED PARTS OF LONDON?

The talks followed a clear theme, describing the origins, implementation, developments and auditing of the Tavistock Primary care model, originally based in Hackney-the PCPCS (Primary Care Psychotherapy and Consultation service).

THE PRESENTATIONS WERE ENTITLED:

1. History of Psychotherapy in the NHS in the UK: Changing models, priorities, and practice
2. A new Primary Care Psychotherapy and Consultation Service (PCPCS): Philosophy, challenges, and practice.
3. The PCPCS in action-some case material consultations to GPs and clinical work with patients
4. The PCPCS in action-outcome monitoring and Health Economics research.

The fifth talk, reflecting my work for 17 years at a specialist Gastroenterology hospital (St Mark’s Hospital in Harrow, greater London) was entitled:

5. On working psychotherapeutically with medically symptomatic patients in a specialist gastroenterology setting
Each presentation was illustrated by clinical material, both case material of patients or families seen in the clinical setting and also video clips of patients, and general practitioners, describing what it was like receiving treatment, or the utility of the service to them as fellow professionals.

The presentations seemed to generate much interest. The South African context is obviously fundamentally different from that in the United Kingdom in almost every respect - to name but a few, the relative paucity of resources (in South Africa) both financial and professional, the receptivity or otherwise towards psychological treatments amongst the different populations (and sections of each population), the centrality of the general practitioner in the United Kingdom’s National Health Service compared with South Africa.

NOMETHLESS IT SEEMED TO ME AS THOUGH SOME OF THE PSYCHOLOGICAL THINKING UNDERPINNING THE WORK FROM THE TAVISTOCK, SOME OF THE WAYS OF THINKING ABOUT INDIVIDUAL PATIENTS, THEIR FAMILIES AND THEIR DEVELOPMENTAL TRAJECTORIES, AND THE IMPORTANCE OF ATTENDING TO THE NEEDS OF GENERAL PRACTITIONERS AND OTHER HEALTH CARE PROFESSIONALS ARE ALL ISSUES WHERE THERE ARE SUBSTANTIAL SIMILARITIES AND AREAS OF SYNERGY BETWEEN OUR WORK IN THE UNITED KINGDOM AND WHAT OUR SOUTH AFRICAN COLLEAGUES ARE GRAPPLING WITH.

This was highlighted for me by the 3 case presentations. The standard of clinical work, of case presentation and of thoughtfulness was exceptional, and I was delighted to be able to witness such excellence. It reinforced my belief in the quality of professional training and teaching in South Africa – at least amongst those who presented, and the many colleagues with whom I interacted during the 3 days. The first case was presented by Lauren Bock (a psychologist in the Department) She described her ongoing work with a complex woman, and amongst many issues raised were those to do with links between the body and mind, femininity and sexuality, and developmental challenges.

Rhodie Sapinoso (a registrar in the Department) then presented a fascinating case “A person divided”, about a patient where RS was not only the psychotherapist but also the ward registrar, and some of the `dilemmas in this work and in maintaining boundaries, and a place to think.

Finally a group of 5 mental health care professionals from Tara Hospital, working with Craig Bracken (consultant psychiatrist) presented a complicated, potentially tragic case of a young woman, emotionally unstable, prone to enactments, and her trajectory. All team members came across as extremely dedicated, intuitively in tune with the patient and appropriately professional. But I thought that part of the reason for presenting this case was something that the team was grappling with – how to work with this very demanding patient and be firm with her, without feeling excessively guilty about such firmness; how to create a therapeutic holding environment which combined both understanding, care and a sense of caring, with a firmness that could help her see the extent of her aggression and her propensity towards destructiveness.

The audience remained thoughtful and involved throughout the 3 days, and it was gratifying that by the 3rd day more and more of the trainees were contributing, rather than relying on the more senior staff in the front to ask and discuss. This is a worldwide phenomenon, I think – the initial reluctance of more junior staff to be prepared to speak, and question.
One of the subtexts of the visit, and one which I was able to discuss with Christopher Szabo towards the end of the workshop was the fact that Medical Psychotherapy is a recognized sub-speciality within UK psychiatry (unlike in South Africa).

Within the RCPsych, there is a Faculty of Medical Psychotherapy with its own 3 year training, equivalent to Forensic or Child, Old Age or Neuro-psychiatry; and the possibility of this being initiated in the South African College of Psychiatrists, with help from myself and other UK colleagues was discussed.

In addition, further links between our organizations and hospitals— for example research, educational opportunities, and other collaborations were tentatively explored.

But the main aim of the visit was to provide South African colleagues with some input from what I have learned in the United Kingdom, and to think about similarities, as well as differences.

SOUTH AFRICA IS A VERY DIFFERENT PLACE FROM WHEN I STUDIED MEDICINE IN THE 1980’S, MOST OBVIOUSLY EVIDENCED BY THE RACIAL MIX OF THE COLLEAGUES PRESENTING, AND ATTENDING THE WORKSHOP.

As I have stated above, I was delighted with the caliber of the clinical work, and the thoughtfulness of all the colleagues I had the pleasure of speaking with. I reiterate my heartfelt thanks to Christopher Szabo, to Ugas Subramaney and Cora Smith as well as Craig Bracken (and not forgetting Chantal Lambert for assistance with logistical matters), and to all who presented and attended the workshop. It was a real privilege to come and speak, listen and learn so much in my homeland.

SUGGESTED READING:


Julian Stern (FRCPsych) is a psychiatrist and currently Director of Adult and Forensic Services; and Consultant Psychiatrist in Psychotherapy Tavistock Centre, LONDON, UK. Correspondence: julianstern@hotmail.com
The congress, with the theme: Response / Ability, featured key speakers such as Professor Anthony Pillay (PsySSA president), Professor Sumaya Laher (PsySSA president elect), Professor Saths Cooper (President: International Union of Psychological Science) and Professor Juan Nelson (Past President PsySSA).

The congress explored perspectives on Psychology’s response and ability to meet individual and society’s needs. The congress offered 8 pre-congress workshops, a Plenary day during which the theme of response/ability was explored, “first from a discipline perspective and then through the lens of decolonisation” (Professor Laher). In addition, there were 176 oral presentations, 16 themed symposia, 13 roundtable discussions, 4 case presentations and 17 posters.

Professor Pillay provided a perspective on the 2016 theme, which defines moments not only in our discipline but in the history of our country. The focus shifted from beyond the different scopes of practice to include gender, trauma, sexuality and decolonisation. Professor Pillay further explored the role of the discipline in addressing psychosocial needs.

Professor Saths Cooper provided a viewpoint on Psychology’s responsibility to inform research and policy development and practice thereby allowing us to transform to a socially relevant discipline in training and practice. Psychologists were encouraged to think about the scope of the profession and not just focus on the “scope of practice”. There was debate around separate categories which can allow for structure and differentiation, however with differentiation sometimes being perceived as better. Overall the presentations and discussions addressed the discipline’s ethical responsibility to respond to societal issues and the needs affecting the nation. This led to questions such as “are we socially relevant as a discipline and are we being responsive to current issues?” In light of the above we (Barnwell, G & Noorbhai N) presented the work of a “fairly new service” being carried out at CHBAH. The presentation titled ‘Psychologists role in the gender affirming process of patients accessing public services for Gender Dysphoria’.

The presentation describes the services offered by CHBAH and the role of the psychologists and Psychiatrist in meeting some of the needs of the Transgender population. Included are the challenges and limitations faced by both Psychology and Psychiatry.

On a lighter note the congress provided an opportunity to network, meet colleagues and be informed of current issues. In 2017 PsySSA is proud to host its first joint congress with the Pan African Psychology Union (PAPU) embracing the theme ‘Psychology for Society’.

Najeebah Noorbhai is a Senior Clinical Psychologist at Chris Hani Baragwanath Academic Hospital (CHBAH) and is jointly appointed in the Department of Psychiatry at the University of the Witwatersrand, Johannesburg, South Africa.

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In support of World Mental Health Day on October 10, the KZN Mental Health Advocacy Group hosted the second annual Durban Mental Health Symposium, at the Nelson R Mandela School of Medicine at the University of KwaZulu-Natal.

After an overwhelmingly positive response at the inaugural event in 2015, hosted by King Dinuzulu Hospital Complex Departments of Psychology and Psychiatry, the need for such a symposium was well established.

A DIVERSE CROWD ATTENDED, INCLUDING 100 MENTAL HEALTH PROFESSIONALS, FROM NURSES, PSYCHOLOGISTS, PSYCHIATRISTS, OCCUPATIONAL THERAPISTS & ACADEMICS. OUR FEEDBACK SHOWS THAT BEYOND CONTINUING EDUCATION POINTS, PROFESSIONALS ARE CRAVING OPPORTUNITIES TO SHARE EXPERIENCES, COLLABORATE, NETWORK, LEARN, AND EVEN LAUGH TOGETHER. THE IDEA BEHIND THE ADVOCACY GROUP AND THE SYMPOSIUM IS TO CREATE SHARED SPACES THAT FOSTER A STRONGER CULTURE OF COLLABORATION, SO THAT PEOPLE DON’T WORK IN SILOS.

The keynote speaker was Professor Melvyn Freeman, the national director for non-communicable diseases at the Department of Health. He reflected on his personal journey in mental health policy and practice, as clinical psychologist and policy maker, sharing stories from the tumultuous 1980s when he was involved in doing psychological first aid under apartheid conditions. He foregrounded the impact of social determinants on health, leaving the audience with challenging questions about where our focus of intervention ought to be as mental health experts.

Dr. Hasleu reported her PhD study which explored the role of couples therapy in contemporary Zulu culture. Dr. Paruk explored the link between cannabis use and adolescent mental health, especially psychosis and the development of serious mental illnesses.
Professionals are craving opportunities to share experiences, collaborate, network, learn, and even laugh together. The idea behind the Advocacy Group and the Symposium is to create shared spaces that foster a stronger culture of collaboration, so that people don’t work in silos.

A new book, Talk Therapy Toolkit, was also launched at the symposium by the editors, Dr. Thirusha Naidu and Dr. Suvira Ramiall. The text, written by practitioners from KwaZulu-Natal, is an accessible introduction to the theory and practice of counselling and psychotherapy, foregrounding the South African context.

Suntosh R Pillay is a clinical psychologist at King Dinuzulu Hospital Complex, and honorary lecturer at UKZN’s Dept. of Psychiatry. He is also vice-chair of PsySSA’s Division for Community and Social Psychology. Correspondence: suntoshpillay@gmail.com
Talk therapy toolkit addresses the unique and diverse social and cultural characteristics of the South African milieu. This collaboration between psychology and psychiatry delivers a resource that reflects the reality faced by health care professionals in their working environment.

Through the development of increasingly complex human social groups, social and economic changes and challenges, industrialisation, technological advancement, global mobility and electronic communication, a significant gap of care has emerged. The erosion of the intimate social support systems that originally nurtured, protected and developed the human psyche, has necessitated the emergence of various talk therapies as alternative forms of psychosocial and emotional support. Talk therapy toolkit is a practical and accessible text aimed at introducing emergent practitioners to the theory, techniques and practice of counselling and psychotherapy.

Talk therapy toolkit may be used to apply counselling and psychotherapy tools to promote the development of people in various contexts, ranging from healthcare and coaching to the workplace and beyond. Features include illustrative composite case studies and examples from the South African context, learning objectives and practical suggestions on the application of core principles and practices. Chapters on spirituality and neuroscience in psychotherapy will appeal to advanced practitioners and offer beginners a comprehensive overview.

Contents include the following:
- Basic counselling skills
- Supportive psychotherapy
- Grief, trauma and crisis counselling
- Psychodynamic therapy
- Cognitive behavioural therapy
- Narrative therapy
- Motivational interviewing
- Group therapy

Talk therapy toolkit is aimed at beginner therapists, psychologists, psychiatrists, social workers, counsellors, coaches and nurses and health care professionals working in the South African context.

For more information, to request a review copy or to arrange an interview with the authors, please contact:

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The Psychiatry Department at King DinuZulu Hospital Complex celebrated World Mental Health Day by hosting a meeting for mental health care users and their families at the hospital on the 10 October 2016.

The theme of the meeting was based on the WHO theme of ‘Dignity in mental health: Psychological and mental first aid for all’. The theme was very pertinent in our resource challenged setting where improving mental health awareness and empowering the public and all health care professionals with basic mental health skills may help decrease psychological distress and stigma for mental health care users.

Dr Karim, a psychiatrist at the hospital, presented an informative talk on psychological first aid with a focus on simple techniques that families and staff could use to assist mental health care users. A mental health care user shared his mental health journey and explained that his greatest challenge was accepting the illness and overcoming the stigma.

This was followed by a forum discussion where patients and carers were able to engage with the multi-disciplinary team on concerns about mental health care.

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THE 5 A’S:
A CHECKLIST FOR MAKING MENTAL HEALTH MATTER

Suntosh R Pillay

Suntosh R Pillay suggests five As to help us all walk the talk for world mental health day on October 10.

It’s no secret that mental health has always been the Cinderella of the health system: locked up in a dark basement hoping never to be found. Or, when mental health does get a few good moments in the limelight, like Cinderella’s carriage it turns into a pumpkin at midnight and becomes old news by the morning. Unfortunately, even our fairy god mothers have failed to impress – neither the long awaited Mental Health Care Act in 2002 nor an impressive national policy framework and strategic plan that began in 2012, have resulted in significant change. The magic wands appear to be elusive. The National Health Insurance (NHI) is also thin on details about the implications for mental health.

AFTER ALL, THE NATIONAL DEPARTMENT OF HEALTH SPENDS ONLY ABOUT 4 PERCENT OF ITS BUDGET (R9.3 BILLION) ON MENTAL HEALTH.

As such, the dominant discourse in global mental health right now is a concept called task-shifting – which means shifting specialised tasks that psychiatrists and psychologists would do with patients and breaking them down into smaller, more manageable tasks that could be performed by lower level workers in the health system. Studies abound about the benefits of task-shifting – or task-sharing – and its reported success in low and middle income countries. It’s a realist, pragmatic approach to addressing the burden of mental illness on the public health care sector – after all, at our current training, graduation and public sector employment rates, we’re never going to have enough specialists to go around.

At a broader level, task-sharing also demands that all of us – the public included – become advocates and enablers in the promotion of positive mental health and prevention of mental illness. Along these lines, the global theme for 2016, set by the World Federation for Mental Health, is Psychological and Mental Health First Aid. This catchy concept of “mental health first aid” means that the public should be able to deal decisively in the case of a psychological emergency in the same way that in a medical emergency of someone choking or needing CPR you know what to do.

What do you do, for example, if a friend phones you to say that they are suicidal? Or if you find your teenager slitting her wrists? Or if your brother gets aggressive and dangerous at a party? Or if your son is threatening to run away from home? Or if a student in your class has a panic attack? Or if a colleague has a manic episode at work? What do you do? These are the kinds of scenarios that warrant all of us to be skilled in responding effectively and empathically to the person in need in the heat of the moment, before a professional person can intervene. In this way, mental health becomes everybody’s business (which in communal interdependent societies, like South Africa, ought to be the norm). It is culturally appropriate therefore, that communities take back their responsibilities to each other, because positive mental health is rooted in a sense of belonging to a larger social group.

In order for this to happen, there is an enormous amount of legwork required and is currently being done by research groups, universities, the public sector, and advocacy groups. To simplify the agenda, I suggest that we adopt a simple five point plan (the 5 As) as a checklist of our progress, focusing on ATTITUDE, AWARENESS, ASSETS, ACCESS, AND ACTION.

1. Attitude
Our attitudes to mental illness must change. Stop using words like psycho, crazy, mad, stupid, off your head, and other offensive and stigmatizing...
phrases that make it difficult for people with mental illness to be open and honest about what they are experiencing. Health professionals, too, need to destigmatize their own language and attitudes. Sometimes these myths operate more benignly, like believing that mental health conditions always require specialized or institutionalized intervention, rather than being treatable at a community or clinic level. Professionals also need broader and deeper access to mental health care training and skills development, especially communication and basic counselling skills.

2. Access
The public needs smooth and efficient access to health care facilities and information and access to life-changing medication and psychotherapies that can prevent symptoms from becoming disabling. The implementation of a United Nations-endorsed project to get 90% of the population tested for HIV, on treatment and virally suppressed is being expanded to include mental health in some provinces in South Africa, such as KwaZulu-Natal. This means setting a far more ambitious agenda for the number of people being screened and treated for mental illnesses.

3. Awareness
A long overdue national mental health awareness campaign is on the cards. People carry around astoundingly ignorant beliefs and misconceptions about what mental illness is; or are unaware of the different roles of psychologists, occupational therapists, social workers, psychiatrists, counsellors etc. or the usefulness of medication, psychotherapy, support groups, etc. There are creative examples to draw from, such as the use of art and drama at grassroots level, the development of a mental health app, the #DignityInMind Film Festival in Cape Town, or the newly formed KZN Mental Health Advocacy Group that I am involved in.

4. Assets
An overlooked component is an appreciation of the assets in communities. We need to strengthen what works, build on social capital especially in the absence of financial capital, drawing from the rich communal traditions that define Ubuntu in a South African context. Research shows over and over again that supportive and empathic relationships are the foundation to mental wellbeing. We need to start asking communities different types of questions in our research, such as ‘what works?’

5. Action
A lot of the right words have been written and spoken, but action is what’s needed. This includes – foremost – political will to create and fill vacant posts at all levels, to train and capacitate people to deal with mental health, and to fulfill the promises laid out in policy rhetoric. This also requires communities and individuals to take mental health into their own hands – such as the Bessie Makatini Foundation – and to help change attitudes, create awareness, strengthen assets, demand better access to services, and ultimately be action-oriented advocates for change.

CINDERELLA WAITS WITH HOPE FOR THE GLASS SLIPPERS THAT FINALLY FIT.

This article was first published on the PsySSA column of the Mail and Guardian blogging site, Thought Leader, for which there is no copyright on any of the articles.

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The annual Tara Mental Health Day was held on the 21st of October 2016 and attended by mental health practitioners from different disciplines and organisations within Gauteng. Sr Delray Jones and her committee worked very hard to ensure that the event was again one of the highlights of the Tara calendar.

As in previous years the theme was aligned with the World Mental Health Day theme for 2016. This year’s theme ‘Dignity in Mental Health: Psychological and Mental Health First Aid for All’ was again inspiring and thought provoking.

According to Professor Gabriel Ivbijaro, President of the WFMH (World Federation for Mental Health) and Chair of The World Dignity Project, “getting the right help in crisis remains an area that provides challenges for people with mental ill health and their families”. The aim of the WFMH is that every member of the general public should be a first aider and reach out to people in mental health crisis so that they feel less vulnerable, less fearful and more accepted by society. They want to address the stigma associated with mental ill-health so that dignity is promoted and respected. Furthermore, their aim is to empower people to take action to promote mental health and spread understanding of the equal importance of mental and physical health and their integration in care and treatment.

During registration the attendees could enjoy homemade rusks, specially prepared by the Tara Occupational Therapy team, with their tea or coffee. Each attendee also received a ‘First Aid’ bag to get them through the morning, which included bottled water sponsored by Lundbeck.

Tara CEO, Dr Florence Otieno, opened the event with an inspirational welcoming note and Sr Lorraine Kekana as a very dignified master of ceremonies ensured that the programme ran smoothly.

The first speaker was Dr Yvette Nel from Tara Hospital and she gave a brief history of dignity in mental health and an introduction to the concept of mental health first aid. This really gave an excellent foundation for the speakers who followed to build on as the audience had a much clearer understanding of the theme and the role of mental health practitioners in promoting dignity and improving outcomes for mental health care users.

Dr D du Plessis, a well-respected midwife and owner of Babywise (specializing in antenatal care) explored Maternal Perinatal Mental Health in a very engaging way. Following which, Safiya Bobat, an educational psychologist gave an introduction to the Ububele Home Visiting Project, a community-based, preventative mental health intervention. Khosi Sithole, a Home Visitor then gave a thoughtful case presentation which brought the work alive. Ububele is based in Kew and focuses its expertise and programmes on improving the emotional development of children under the age of 7 years. Most of the programmes are located in Alexandra.

The attendees were able to reflect on the first talks over a scrumptious tea sponsored by Janssen and Abbot Nutrition.
Adrie Vermeulen looked at First Aid for families living with Addiction. Adrie Vermeulen is a social worker with vast experience in the substance abuse field. She was a director at SANCA Phoenix House for over 21 years and is currently involved as a consultant for SANCA National. Adrie highlighted the importance of early intervention and the links between substance abuse and mental health well being.

Thereafter, Luke Lamprecht, the director of Fight with Insight and a longstanding advocate for child protection looked at Psychological First Aid (PFA) Basic Action Principles and assumptions as well as the requirements of a caring community. He ended by looking at the work done by the Children’s Memorial Institute as a mental health continuum of care and the application of PFA.

The morning ended with a delicious lunch sponsored by Adcock and prepared by Market Caterers. This was hopefully an opportunity for the attendees to get to know each other better and strengthen working relationships in a relaxed atmosphere. An event like this would not have been possible without the sponsorship of Janssen, Abbott Nutrition, Lundbeck, Adcock Ingram, the Saxon Hotel, PPS, Old Mutual and Fresenius Kabi.

Ronelle Price-Hughes is a sub specialist child and adolescent psychiatrist at Tara Hospital and jointly appointed in the Department of Psychiatry at the University of the Witwatersrand, Johannesburg, South Africa. Correspondence: Ronelle.Price-Hughes@gauteng.gov.za
had the privilege of being involved in the SASOP Board as a member since 2010, first as National Public Sector Convener (2010-2012), then as Honorary Secretary (2012-2014) and as President-Elect (2014-2016). During these terms of office, the SASOP’s identity, function and role was significantly developed and strengthened, by the continued strategic focus and foresight of recent subsequent presidents, namely Ian Westmore (2010-2012), Gerhard Grobler (2012-2014) and most recently Mvuyiso Talatala (2014-2016).

Ian was able to give particular structure and form to the changed context of SASOP as a registered non-profit company, by identifying specific strategic objectives and outcomes during his term of office. In particular with regard to the strengthening of the public sector component of SASOP with the aim to be on par with the already well managed private sector component.

Gerhard was able to build on these outcomes by further developing the strategic capacity and functioning of the SASOP of which contracting with Healthman - a healthcare consultancy company specializing in the management and administration of professional associations and other specialist healthcare networks, was not the least. During his term, the identity of a well-functioning company with effective governance systems and financial oversight was established.

During Mvuyiso’s term, a new phase of SASOP’s development was reached, in that the SASOP was required to be experienced, by its members and other stake holders, to play an effective role in the mental health care environment in which both private and public psychiatrists work.

The SASOP had to be further established as an important and respected role player in the affairs of practitioners and patients, giving credence to its identified core business of promoting, maintaining and protecting the honour and interest of psychiatrists, the discipline of Psychiatry as a medical speciality and to serve the community.

This was demonstrated in particular, by the extent of engagement by SASOP in liaison with other advocacy groups, in the issue and consequences of the closure of Life Esidimeni facilities in Gauteng. It was also in anticipation of the theme of social responsibility of the November 2016 World Psychiatric Association’s International Congress in Cape Town - which the SASOP co-hosted, that it was necessary during this period to revisit the question of how best a professional society should be used to achieve involvement in broader social issues and to effect favourable political outcomes.

During 2015, a consultative program was started with regards to psychiatrists’ relationship as a national group, with different stake holders in the clinical care process, such as: the SASOP’s own members, the users of services and advocacy groups; the media and public at large; public and private managers and funders of psychiatric services; medical and training institutions; as well as the different professional groups/societies in the area of mental health. This came to be referred to as “Psychiatry’s and psychiatrists’ social contract”.

The notion of a contract was obtained from Bhugra and Cruess who suggested that Medicine’s and Psychiatry’s relationship with society should be seen as a mutual agreement, a compact, and a (albeit unwritten) memorandum of agreement or understanding, in which the scope, principles, quality and outcome of such an agreement are specified.
THIS PROGRAM HAS THE PROMOTION OF PROFESSIONALISM AS ITS MAIN AIM, WITH SELF-AWARENESS AND ACTIVE SELF-REGULATION AT THE CORE OF ITS ACTIVITIES.

In terms of the proposed liaison with these different groups, the SASOP already had consultative meetings with a group of advocacy organizations, as well as with a group of professional societies involved in Psychiatry and mental health care, including the PsySSA (psychologists), SAMa (general practitioners and other specialists), DENOSA (nursing), OTASA (occupational therapists) and PHASA (public health practitioners). In other words, the professional bodies of all the professional groups involved in the multi-disciplinary team. This initiative will continue during the 2016-2018 term of office, including activities involving SASOP members in public and private practice, as well as the different medical and training institutions in Psychiatry and mental health (e.g. the Health Professions Council of SA, the College of Psychiatrists of SA (CPsychSA), and the academic departments of Psychiatry.

- **Advocacy groups** - The SASOP currently has active working relations with the SADAG, the SAFMH, the Rural Health Advocacy Project and the Rural Mental Health Campaign, as well as Section 27. This will continue and be further developed, while the same level of engagement that was recently achieved in mental health care issues in Gauteng, will also be pursued in all other regions. In particular, in lesser resourced provinces such as the Eastern Cape, Free State, Limpopo, Mpumalanga and North West.

- **Medical and academic institutions** - Consultation with all related professional societies and institutions (HPCSA, CMSA, universities) will be pursued on matters regarding the scope of practice, the arrangement of academic meetings and continued professional development, post graduate curriculum content and examination process, as well as appropriately representing SASOP’s associate membership, consisting mainly of psychiatric registrars affiliated to the eight South African departments of Psychiatry.

- **Media and public relations** - Ongoing media engagement will continue including proactive contact and preparation of information and educational material on identified topics. This will also require a robust and responsive communication capacity with regards to the response to the public and media’s questions, queries and complaints.

- **Pharmaceutical Industry** - An ongoing professional and ethical relationship will be pursued focusing on individual SASOP members’ engagement with Industry, as well as SASOP collectively. Refocused attention will be afforded to e.g. extended financing models for SASOP’s main and regional academic meetings.

- **Creative Arts Program** - Considering the WPA2016 congress theme of “Psychiatry: Integrated Care for the Community”, the Local Organising Committee’s Creative Arts Sub-Committee ensured that a significant creative arts component was integrated into the congress proceedings.
American Psychiatry

As much activity has been invested during the preceding two years in developing contact and platforms for psychiatry in Africa, it can be envisaged that such endeavors will continue during the current term of office, including active liaison with different psychiatric societies, but also with individual psychiatrists in countries with no formal society yet.

TO ACHIEVE THESE OBJECTIVES, THE SASOP’S COMMUNICATION STRUCTURES, ITS ACADEMIC JOURNAL (THE SAJP), WEBSITE, NEWSLETTER AND SOCIAL MEDIA VEHICLES WILL HAVE TO BE USED TO ITS FULL POTENTIAL.

When being nominated during 2014 as SASOP’s President-Elect, I noted at the time in my vision statement for the SASOP Presidency of 2016-2018, that it will be necessary to consider what has been achieved during the previous passed terms of office of Dr Westmore (2010-2012), Dr Grobler (2012-2014) and Dr Talatala (2014-2016). I realised then that the 2016-2018 term of office would have to be the time to operationalize already existing policy and position statements on different aspects and levels in a practical way, by e.g. implementing SASOP’s own social contract with the people of South Africa through various projects. Such projects, with allocated budgets, will have to focus on developments in the seven SASOP subgroup regions, of SASOP nationally, as well as in the WPA Eastern and Southern African region and perhaps further.

I therefore envisage that the 2016-2018 SASOP Presidency should further strengthen members and the profession of psychiatry in South Africa, mainly through continuous professional development facilitated by a high standard of local academic meetings, while also meeting the growing challenge of managing the SASOP NPC and its subsidiaries in the public and private sector, in an effective and creative way. This will hopefully, towards the end of the term, have ensured a further integrated fraternity and even a more well-run company with a strategic edge to eventually also hand over to another team during their subsequent term of office.

In conclusion, I allude to the SASOP crest incorporating the heraldic symbol of the butterfly for the psyche. This symbol was also included in the WPA2016 Congress logo, with the four free flying butterflies ultimately representing the integration of the five different tracks of the congress program: neuroscience, psychotherapy, social involvement, cultural-religious-spiritual contexts in which clinical problems present, as well as integrative care (i.e. systems and the networking required to provide different levels of services in a multi-sectoral environment). It appears that the 2016-2018 SASOP Presidency and term of office will be an opportunity to implement the different activities and agendas identified during the WPA2016 congress, through which to address the remaining unfinished business of reconciling, transforming and integrating aspects of our communities and of our clinical psychiatric practice.

I would consequently therefore, as below, like to include a notion of this symbol as an association with this term of office, but also as a reminder to myself and to SASOP members of the work required to achieve these set outcomes.

I am looking forward to undertaking the activities of the 2016-2018 term with the new SASOP Board: Dr Mvuyiso Talatala (Immediate Past-President); Prof Bonga Chiliza (President- Elect), Dr Indhrin Chetty (Honorary Treasurer), Dr Anusha Lachman (Honorary Secretary), Dr Sebo Seape (National Chair PsychMG), and Dr Lesley Robertson (National Convenor, Public Sector).
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PHARMACOLOGICAL CLASSIFICATION: 4.2.6.5 Central nervous system depressants. Miscellaneous structures.

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This information is intended for Healthcare Professional use only.
Speakers included Dr Renata Schoeman (the diagnosis of adult ADHD), Dr Kim Ragsdale (the treatment of adult ADHD), Dr Rykie Liebenberg (comorbidity and the treatment thereof), and Prof Willie Pienaar (ethical aspects of the use of stimulants in patients with and without ADHD).

Dr Schoeman, co-convenor of the SIG, discussed the core symptom triad (inattention, hyperactivity and impulsivity) and the associated behavioural, cognitive, emotional and social problems adults with ADHD experience. Although symptoms of ADHD often appear to decrease over time, adults are often more adept at managing symptoms and compensate for ADHD-related impairment through lifestyle and career choices. The DSM-5 (APA, 2013) has lowered the diagnostic threshold for diagnosis, with individuals older than 17 years needing to meet fewer criteria (5+ symptoms). However, symptom onset should be early (before age 12), pervasive across the lifespan and across different settings, and cause significant impairment in functioning. ADHD remains a clinical diagnosis (NICE, 2013). If an adult was diagnosed with ADHD during childhood (by a psychiatrist, or paediatric neurologist), general adult psychiatric services for the confirmation of the diagnosis and ongoing treatment will suffice.

However, it is recommended that adults with suspected ADHD without previous diagnosis during childhood, consult with a specialist psychiatrist with adequate training and experience in the assessments of adults with suspected ADHD for confirmation of diagnosis and treatment initiation.

Screening questionnaires have value (the best researched being the World Health Organization Adult ADHD Self-Report Scale (ASRS) Symptom Checklist (Kessler, Adler, Ames, Demler, et al, 2005) with a sensitivity of 68.7% and specificity of 99.5%). However, be warned that individuals have access to this (and other) questionnaires on the internet and often learn the symptoms by heart. A positive screen should always be followed by a full diagnostic evaluation. A thorough interview is needed, documenting present symptoms and functionality across all spheres of the patient’s life.

The use of a structured diagnostic interview such as the Diagnostic Interview for ADHD in adults (DIVA) (Kooij & Francken, 2010) may be considered. It is also very important to exclude differential diagnoses (e.g. a lack of effort, poor vocational match, or transient situational or environmental circumstances, and other psychiatric or medical diagnosis (and treatment thereof)) and to assess for the presence of comorbid disorders. Collateral information is invaluable. Special examinations are a significant cost-driver in the management of ADHD and should not be requested routinely. The purpose of special examination is two-fold: to exclude causative or comorbid medical disorders, and as a baseline safety assessment. At present, no neuropsychological test has sufficient sensitivity and specificity to serve as an individual diagnostic test for the diagnosis of adult ADHD. Computerised assessments (e.g. the Quantified Behavioural Test (QbTest), the MOXO c-CPT (Berger &
Goldzweig, 2010), and the Test of Variable of Attention (TOVA) have also not yet established utility and cost-effectiveness.

Dr Ragsdale followed with a discussion on the non-medical and medical treatment of ADHD. In her talk, she gave a brief overview on the role of nutrition and supplements, the importance of sleep, and the benefits thereof in ADHD. Coaching for ADHD is also very beneficial for skills development, but access to coaching is often problematic. Many good self-help books are available (e.g. More attention, less deficits: success strategies for adult ADHD (Tuckman, 2009)). Educational psychologists play a valuable role in assisting students with the development of memory aids and study skills, as well as assessments and applications for concessions.

Psychosocially, cognitive-behavioral therapy (CBT) should be considered.

Dr Ragsdale proceeded to discuss the pharmacological management of ADHD. Methylphenidate and atomoxetine are considered first-line agents in the treatment of adult ADHD. Methylphenidate, a noradrenergic/dopaminergic reuptake inhibitor, has a rapid onset of action, but also wears off suddenly. It has a potential for abuse, while atomoxetine, a noradrenergic reuptake inhibitor, has a slower onset of action and doesn’t have a wear-off effect. The goal of treatment is to find the “sweet spot”, i.e. correcting the NA/DA deficit, without causing a hyper-noradrenergic/dopaminergic state which in itself can cause distractibility, inflexibility, anxiety, and even psychosis. Methylphenidate and atomoxetine have similar, usually mild and transient, side-effects: loss of appetite, nausea, abdominal pain, constipation, a dry mouth, increased blood pressure and heart rate, palpitations, insomnia, irritability and edginess, and headache. However, methylphenidate is more prone to “wearing off dysphoria”, being socially subdued, being overly focussed and having difficulty in attentional shifts, and may aggravate tics and anxiety. Atomoxetine, on the contrary, may alleviate anxiety and cause sedation. Another potential, albeit rare, side-effect is hepatotoxicity. In choosing one of these agents, psychiatrists should consider the need for immediate results, the patient’s preference, the presence of comorbid disorders, previous experience, and the availability of products. In general: start low, go slow, and aim high: to maximise efficacy and tolerability. When both the first line agents are ineffective or poorly tolerated, off-label use of noradrenergic tricyclic medications, bupropion, and venlafaxine may be considered.

Dr Liebenberg, convenor of the SIG, highlighted that the majority of adults with ADHD have complicating and significant comorbid psychopathology – with more than 87% having more than one psychiatric disorder, while 57% have more than two comorbid disorders. The comorbid condition is often the presenting problem, and is a confounding factor in the diagnosis, with a negative impact on treatment decisions and response. A thorough assessment of comorbidity is important as it may determine outcome of treatment as much as the primary condition. The most challenging part of the assessment of adults with ADHD (and one of the reasons why specialist evaluation is recommended) is to identify the condition in the presence of other conditions, and also deciding whether treatment is appropriate in the presence of these other conditions. The incidence of comorbid disorders in adults with ADHD range from 19-37% for mood disorders, 25-50% for anxiety disorders, 32-53% for substance abuse disorders, and 10-20% for personality disorders. ADHD is comorbid in 20% of psychiatric patients! She suggested an “ultrashort” screening for adults for ADHD (Kooij, 2006):

1. Are you
usually restless? 2. Are you usually easily distracted or chaotic? 3. Do you usually do things before thinking? If 1 of 3 answers is yes: 4. Did you have this symptom all your life? If YES: further diagnostic assessment of ADHD, or referral. ADHD often mimics some aspects of anxiety, e.g. difficulty coping with social situations because they are unable to focus on conversations, difficulty travelling because they become irritable and require waiting in queues and their experience of forgetting things and high levels of disorganisation. An important distinction is to consider whether the symptoms have a similar onset and time course to ADHD or whether they arise episodically and in response to stressors, which is characteristic of anxiety. In general, treat anxiety first - but use clinical judgement regarding the primary problem. Stimulants (with or without SSRIs) or atomoxetine can be used. A volatile and irritable mood is frequently seen in adult ADHD and is not usually the consequence of comorbid depression or bipolar disorder. However, bipolar disorder is present in 10-20% of patients with ADHD, while ADHD are present in 15-18% of patients with bipolar disorder. A staged approach is beneficial: 1. Remove offending agents like stimulants and antidepressants, 2. Maximize mood stabilisers, 3. Reintroduction of ADHD medication and/or antidepressants, and 4. Try mood stabilizers that treat both mania and depression, or consider bupropion. It is crucial to first stabilize the mood prior to treating ADHD. In ADHD comorbid with depression, the more severe and disabling condition should be treated first - usually the depression.

This may result in improvement of some symptoms of frustration, anxiety and irritability. Some cognitive domains may also improve on antidepressant treatment. Choose antidepressants that have noradrenergic or dopaminergic effects for a better effect on cognition, or consider atomoxetine.

FINALLY, PATIENTS WITH SUBSTANCE USE DISORDERS (SUD), OFTEN PRESENT WITH MORE SEVERE SUD, AS SHOWN BY EARLY ONSET, EXTENDED DURATION OF SUD, GREATER IMPAIRMENT, AND SHORTER TRANSITION FROM SUBSTANCE USE TO DEPENDENCE. THE SUD CAN BE TREATED EITHER BEFORE OR SIMULTANEOUSLY WITH TREATMENT FOR ADHD – BUT CLOSE SUPERVISION IS INDICATED WHEN TREATING PATIENTS WITH STIMULANTS – AS DIVERSION AND ABUSE ARE A CONCERN. ATOMOXETINE MAY BE A BETTER TREATMENT OPTION.

The final presentation was a though- and debate-provoking discussion by Prof Pienaar. He emphasised that we have a duty as physicians to alleviate suffering and to always act only in the best interest of the patient. We need to keep up with the scientific research and clinical experience and should always keep in mind that what we do is within accepted norms and standards of our profession and the moral good action. He used as an example an article which was published in the Sunday Times on 29 May 2016 – labelling methylphenidate as “kiddies cocaine” and “milder form of Tik”, and also describing the non-medical use of MPH as a “smart-drug” and “gateway drug”. SASOP did respond to this article by releasing a position statement which emphasised their support of the treatment of ADHD in patients in which the diagnosis was established through a thorough and comprehensive diagnostic assessment.

**PSYCHIATRISTS HAVE A RESPONSIBILITY TO BETTER THEIR DIAGNOSTIC SKILLS, TO INFORM AND EDUCATE PATIENTS WITH REGARD TO TREATMENT OPTIONS AVAILABLE, TO RESPECT THE RIGHT OF THE INDIVIDUAL TO CHOOSE (THE PRINCIPLE OF AUTONOMY), AND TO ACT BENEVOLENTLY AND CAUSE NO HARM.**

Furthermore, the treatment of ADHD must benefit the community: we need to advocate for making treatment available for all - not just a privileged few. Neglecting the diagnosis and treatment of individuals may be considered maleficent – as we neglect our professional and moral duty to provide the best care available. In the second part of his talk, Prof Pienaar focussed on the use of stimulants by individuals without the diagnosis of ADHD. He discussed human enhancement and competition and emphasised that distributive justice is not a good argument against the use of stimulants. He highlighted that success follows dedication, hard work, resilience, perseverance, and sacrifice. He also mentioned that stimulants are considered safe, have little side-effects, and that the abuse potential is small. However, he warned against the traps of overdiagnosis, overtreatment, doctors becoming mere “agents” of patients, financial gains (commercialised medicine), practicing outside of “patient care”, and treating the “worried well” (not the suffering). Further problems with regard to the use of stimulants in the absence of ADHD are the lack of peer review, inflating medical scheme claims and costs (even distorting statistics through “manipulation” of diagnostic codes), and extending our scope of “needed service delivery” beyond our professional boundaries. Finally, always be aware of being opinionated without arguing true facts.

*Renata Schoeman* is a psychiatrist in private practice www.renataschoeman.co.za Correspondence: bibitica@mweb.co.za
The 2nd semester 2016 FC Psych Part II examinations were held in Cape Town and jointly convened by Stellenbosch University and UCT.

Twenty-two candidates sat the Part II. Of these, 13 were invited to the clinical examination, together with 4 others who were granted written exemptions from the 1st semester examination. Of the 17 candidates, 13 candidates passed (59% pass rate overall).

Pass rates for the other examinations were as follows: 40% (4 of 10 candidates) in the FC Psych Part I examination, 96% in the DMH (24 of 25 candidates passed) and 100% on the Certificate in Child and Adolescent Psychiatry examination (2 candidates).

The 1st semester 2017 examinations will be held in KZN.

Here are a few reflections from successful October FC Psych Part II candidates:

**DR. JOE STARKE**

My time as a registrar has been interesting and valuable, but also extremely challenging and tiring at times. Finally completing the part 2 exams was a welcome relief. The written papers in July were fair and covered a broad cross-section of knowledge. The 4 month gap until the clinical exam was very trying time, however, especially as we only found out our written paper results after a long delay. The clinical exams themselves went relatively smoothly, and were well organized both on the Stikland and Valkenberg side. Thanks to all those involved in getting this right, I am now looking forward to having some time to spend with friends and family.

**DR. RIAAN PRINSLOO**

**DR. CANDICE JACOBSON**

Thrilled to have my FC Psych Part II exams behind me and looking forward to the future! The journey to the point of writing was in fact more gruelling than the actual exams, especially with full time jobs and families in tow. However, I felt adequately prepared thanks to the supportive teaching programme provided by UCT. Good luck to all my colleagues with the road ahead.

**DR. MEHNA RAMNARAIN**

Please find below few sentences about my exam experience:

Although exams are stressful and draining, everything was well structured and went smoothly without any confusion. Examiners were very professional, patient, understanding and helpful. I would like to thank those additional supporting staff members and consultants who created such a friendly atmosphere on the OSCE day by guiding us and always being there to boost our moral and self-esteem. It was a “unique” experience.

**DR. GRAEME MICHIE**

No exam is ever a pleasurable experience, but I felt my registrar training and the support of my department helped me to prepare well for the Part II examination. The standard of the examination remains high, and I found my interaction with the College very professional.
It is necessary to have an assessment at the end of intense training. The written papers done on successive days (Monday, Tuesday and Wednesday) is quite heavy and difficult - it is a test of the ability to withstand pressure (strength) rather than a test of one’s knowledge. Spacing between papers is strongly recommended, bearing in mind that the scope for both general psych and special psych is very broad. The neuropsych paper was for all intent and purposes very fair. Having 3 examiners to separately mark the written papers will further improve objectivity in such exams for it has been shown that 3 examiners can mark the same paper (using the same memorandum) and come up with 3 different marks.

Eleven of the twelve OSCE questions were very practical and remain relevant. The 12th station was super-specialised and not specific - the scenario kept changing to further create traps that can only be rescued by one’s knowledge of much legislation - not entirely fair. The clinical case was fair but examiners should always keep in mind that candidates only have an hour with the patient (no collateral information) and one can only interpret the clinical signs and draw conclusions from the history given. Having 3 examiners is excellent. Some examiners are very difficult and insist on things that have no bearing in the ultimate diagnosis and management of the case.

I don’t feel that it would be possible to describe my experience of the exam in just a few sentences! However, I would like to say that I am extremely grateful to a whole host of people - consultants, lecturers, senior registrars, fellow registrars, doctors, administrative staff, secretaries, nursing staff, friends and family - who each played an important role in helping me to pass my examination.

“The FC Psych Part II examination is not only about cumulative knowledge gained during registrar time; it is also a journey of passion and perseverance. My sincerest thanks to my family and friends for their support and encouragement every step of the way.”

The Cape Town CMSA written and clinical examinations were well organised and efficiently run throughout. The organisers made themselves available on the respective days and eagerly addressed any queries the candidates had.

I really enjoyed the College exams for the following reason: The OSCE was relevant to everyday situations and was well run. People were friendly. The questions in the written exam were of a high standard (which I think is important to keep at that standard) and also relevant to Psychiatry.

It is not an overstatement to say the college examinations are a formidable mountain that requires all the physical, mental and spiritual strength and preparation. It is, however, equally important to remain calm and confident at all stages of the examination. I was touched by the team work, civility and conviviality that existed among all candidates from all academic institutions at the examinations in Cape Town regardless of the discipline. It felt like we were a very serious and select group destined to improve health outcomes in the country. The highlight indeed was the spontaneous messages of congratulations and goodwill that flowed from all; senior colleagues, peers, registrars, family and friends. It is indeed a warm and refreshing welcome to the realisation of a dream to be a psychiatrist.
GOLD MEDAL
BEST CANDIDATE

THE FCPSYCH II GOLD MEDAL FOR BEST CANDIDATE IN 2015 (AWARDED AT CMSA GRADUATION CEREMONY OCTOBER 2016)

The Gold Medal was awarded to Dr Tessa Roos.

Tessa Roos is a consultant psychiatrist at the University of Cape Town. She is based in the division of Consultation Liaison Psychiatry (CL) and is working towards an MPhil in this subspecialty. Her interest is in the interface between medical and psychiatric care, where liaison psychiatry is well positioned to influence the way mental illness is treated by all health professionals and to profoundly alter outcomes for medical patients.

SHE IS RESPONSIBLE FOR THE GROOTE SCHUUR EATING DISORDERS CLINIC AND ALSO WORKS IN MATERNAL MENTAL HEALTH, ADOLESCENT CL CLINICS AND THE INPATIENT CL SERVICE WITH FUTURE INVOLVEMENT IN THE PAIN, PSYCHO-ONCOLOGY, TRANSGENDER AND TRANSPLANT SERVICES. SHE IS AN ENTHUSIASTIC TEACHER, TRAINING MEDICAL STUDENTS AND COORDINATING UCT’S PSYCHIATRY REGISTRAR TEACHING PROGRAM.

Having obtained her medical degree at the University of Cape Town in 2007 she then completed her internship in East London during 2008-2009. This was followed by community service at Fort England Psychiatric hospital in Grahamstown in 2010, where she obtained the Diploma in Mental Health.

From 2011 to 2012 she travelled overseas, walking the Camino De Santiago, a 900km pilgrimage across the North of Spain and then worked at the Capio Nightingale, a private psychiatric hospital in London. Returning to South Africa, Tessa joined Stellenbosch University in 2012 as a registrar where she graduated with the MMed (Psych) degree in 2015. Her Masters research titled “Facial affect recognition and exit examination performance in medical students: a prospective exploratory study.” (Roos et al. 2014), was published in the BMC Medical Education, vol.14:245.

Other research involvement includes the bipolar mood monitoring study at Stikland Hospital, which she recently presented at the World Psychiatric Association Conference.

Tessa completed her FCpsych in May 2015 and was awarded the Novartis medal. In the same year she also became a member of the Royal College of Psychiatrists in the UK.
LUNDBECK AND ABILIFY

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Elaine Milne
Marketing Manager
Senior registrars and newly qualified psychiatrists attended the 4th annual Registrar Finishing School (RFS) in Gauteng in November 2016.

This interactive, collaborative learning and teaching experience introduces young psychiatrists to mentors in both the private and public sector. Originally based on the Registrar Finishing School developed and hosted by Lundbeck in Australia, it has evolved since 2012 to include a range of topics uniquely suited to the South African Mental Health service arena. The RFS forms part of an initiative by SASOP to establish a mentoring network for psychiatrists in South Africa.

The transition from registrar to consultant/private practitioner in psychiatry can be a difficult one. Medical knowledge and clinical skills are well covered by the end of training, but the running of a business and managing new relationships with various stakeholders like funders, private hospitals and the pharmaceutical industry often remain unexplored.

Unlike colleagues in the public sector who retain the mentorship and support of experienced consultants in departments, most young psychiatrists in private practice end up in solo practices with multiple challenges, few work-related support systems and high service demands.

The two-day seminar covered the organization of psychiatric services in South Africa; the management of the business side of full- and part-time private practice; managing professional relationships with colleagues, industry, the media and patients; time management and taking care of personal relationships; the challenges of medico-legal work and continued professional development and medical education. The presenters, experienced practitioners from both public and private sector and heads of academic departments, shared knowledge and experiences about the system-based competencies needed for a successful transition to the role of consultant psychiatrist. The event was co-sponsored by an educational grant from Lundbeck South Africa and Adcock Ingram.

The Lundbeck Institute

Hoepie Howell

Attained her medical degree and psychiatry specialization in Bloemfontein, South Africa. She has been practicing psychiatry since 1988 in both private and public sectors in South Africa, New Zealand and Canada. She was head of Department and Chief Specialist in Psychiatry, at 3 Military Hospital, Bloemfontein, for 7 years. From December 2009 until June 2013, she worked as Director of Scientific Education at The Lundbeck Institute in Denmark; designing, developing and presenting international, evidence-based education for specialists in CNS disorders. She currently works as private practitioner in the Western Cape. As private contractor, she continues to develop and present national and international educational events for the Lundbeck Institute. She enjoys collaborative and interactive teaching and has always been involved in formal and informal training of health care professionals.

Correspondence: hubihowl@gmail.com
REPORT

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From left to right: Mvuyiso Talatala, Christopher Szabo

From left to right: Vinola Poliah, Sthe Mingadi, Nadira Vahedia, Zen Tenea, Ani Anic, Corinne Johnson

From left to right: Ian Westmore, Lisa Nuss, Riaan Prinsloo, Raksha Singh, Matthews Banda, Mvuyiso Talatala, Christopher Szabo

From left to right: Michele Parker, Joe Starke, Robyn Akhurst

From left to right: Frans Korb, Anthony Townsend, Michelle Parker, Joe Starke, Robyn Akhurst, Lihle Mgwebe-Bewana, Juan Benvers

Tracy Feinstein (SADA(G)

Allan Sweidan (Akeso)

Katinka Botha

Ani Anic, Shaakira Moosa

Anthony Townsend

Tando Melapi

Pieter Cilliers

Mvuyiso Talatala

From left to right: Pieter Cilliers, Zuki Zingela, Solly Rataemane

From left to right: Mvuyiso Talatala, Ian Westmore
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References:
1. Efegen XR package insert, Ranbaxy (S.A.) Pty Ltd (July 2010)
2. Applicant: Ranbaxy (S.A.) (Pty) Ltd, a SUN PHARMA company; Ground Floor, Tugela House, Tlhabologa Office Park, 1390 Havel Avenue, Centurion, 0040. Tel: +27 12 640 2000; Fax: +27 12 640 3091. www.sunpharma.com
2017 Annual Psychiatric Conference

9th Annual Kenya Psychiatric Association Scientific Conference

The 2017 Annual Meeting of the African Association of Psychiatrists and Allied Professions

30th March - 1st April

Venue: Pride Inn Paradise Hotel - Shanzu, Mombasa

Theme: Implementation of Mental Health Research for Policy Development in Africa

Sub-Themes:
- Translating mental health research into policy
- Policy guidelines in management of mental disorders
- Integrating mental health care in NCD care
- Integrating mental health care in HIV/AIDS care

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- Students: KSH 4,000
- International Delegates: USD 150

Late Registration Fee:
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GOOD HEALTH CAN’T WAIT
I often contend that psychiatry rests at the confluence of the art and science of medicine: it’s a discipline rooted in science, but its practice is an art. A juxtaposition. While appositions such as ‘classic with a modern twist’ or ‘shack chic’ litter glossy decorating or design magazines, they’re uncommon in the wine world. But, then there’s Glenelly, on the road up to Rustenberg. Its logo reflects a classic 19th century illustration of an elegant French woman riding side saddle on a powerful South African rhinoceros – some juxtaposition! – a fragile glass balanced in her hand.

May de Lencquesaing’s father Edouard Mialhe was of French royal wine-broker lineage, and he acquired Chateau Pichon Longueville Comtesse de Lalande (‘Pichon-Lalande’) in Pauillac – the famed commune of Bordeaux – in 1925, the year May was born. She subsequently became owner and manager and, over some three decades, is credited with having modernized the château’s installations ‘in the truest respect for tradition’. ‘Her indefatigable passion elevated Pichon-Lalande to a level equalled only by its consistency all over the world,’ say Maisons Marques & Domaines. ‘The story of Pichon-Lalande (...) is also the story of Bordeaux,’ wrote Serena Sutcliffe MW.

So, when Madame de Lencquesaing acquired Glenelly, an old fruit orchard just off the R310 heading up the Helshoogte, with the intention of developing a wine farm, there was both surprise, and a frisson of excitement. Wine growing is a long-term business, she was 78, and this was at the birth of our new democracy in 1993... From the outset, Madame made it clear this would not be a French imposition on African soil, a sort-of ‘mini-me’ Bordeaux chateau at the foot of Africa. She developed local talent – Luke O’Cuinneagain is the winemaker, Heinrich Louw the viticulturalist – and planted vines best suited to the Stellenbosch soil. Her first Grand Vin was a Cabernet and Shiraz blend, hardly Bordelaise.

Now, fourteen years later and in her nineties, Madame is reshaping the property with two grandsons, 8th generation vintners Nicolas Bureau and Arthur de Lencquesaing. After closing for renovations for a year, the Glenelly offering is bigger and better, and includes a standout restaurant from French South African Chef Christophe Dehosse. The wine range has been rebranded and is better defined. The Glass Collection is a clutch of single varietal wines made for early enjoyment that are unpretentiously closed under screw-cap. The Estate Reserve duo incorporates previous Grand Vin labels and is comprised of a Chardonnay 2014 and Reserve Red 2011. Lady May, a single vineyard Cabernet, is the epitome of this endeavour: if you name a wine after yourself, it better be good. And so it is. The 2012 will be released mid-2017.
The new tasting room, on the top floor of the modern winery, overlooks the lower slopes of the Simonsberg Mountain. While the building itself is, well, utilitarian rather than easy on the eye, the elegant design, exquisite use of natural light, and uninterrupted views from this locale – recall, you are looking out, not in! – provide an agreeable setting to appreciate current and back vintages of the Glass Collection, Estate Reserve and Lady May wines.

May de Lencquesaing’s private glass collection has been redesigned for display in the underground of the winery; the room is charcoal grey to allow the beautifully illuminated glasses to take centre stage. It’s a journey through 2000 years of glassmaking, with the 160 items each telling a story. There are Roman pieces, XVIIth and XVIIIth century glasses, as well as Daum, Salvador Dalí and American and South African contemporary artists’ works.

But if there’s one reason not to miss the new Glenelly, it’s The Vine Bistro. Chef Christophe Dehosse is French-born but moved to Cape Town with his Stellenbosch-bred wife, Susan, in the early Nineties. I met him when advising on the wine-list at Au Jardin, the couple’s silver-service restaurant at The Vineyard Hotel, and we have been friends since. The press release is perfect: “The ideal chef to look after this exciting new venture: French, but very established in South Africa, mastering haute cuisine but cooking simple dishes, getting his inspiration from traditional bistros of his homeland while experimenting with African and Mediterranean ingredients.” What beautiful juxtaposition… The menu is classy bistro. Starters (R85-R105) include Duck Pistachio Galantine, Cool Red Pepper Soup with chorizo and octopus, and Porcini Provençal. There’s a Cape-style Bouillabaisse, pan-fried Veal Sweetbreads on a port reduction, Beef Fillet Sauce Diable and Dehosse’s signature Pork Cheeks braised in red wine with bacon, baby onion and mushrooms for mains (R170-R230). His classic Warm Melting Chocolate Biscuit with poached pear and yogurt Chantilly (R75) vies for attention with a plate of local artisanal cheeses (R80) to close the repast. Glenelly wines are available at the time of writing, with a full wine list in the wings once the paper work is done.

Art? Science? The new Glenelly is both a juxtaposition, and a pleasure.

David Swingler is a writer for Platter’s South African Wine Guide for eighteen editions to date, Dave Swingler has over the years consulted to restaurants, game lodges and convention centres, taught wine courses and contributed to radio, print and other media. A psychiatrist by day, he’s intrigued by language in general, and its application to wine in particular.

Correspondence: swingler@telkomsa.net
By the time that you will be reading this review, yet another new year will have kicked off. At the beginning of every year I choose a theme for myself that helps to carry me through the days and months of personal and professional ups and downs.


Played by Garrett Wareing, Stetson Tate, or ‘Stet’ as he is known, is an 11-year old boy from an impoverished background in a small Texas town. On the way back home one day after running away from school following a singing try-out arranged by the school’s headmaster, Ms. Steel (played by Debra Winger), he finds that his alcoholic mother has died in a car crash. This leaves Stet an instant orphan, and at his mother’s small funeral he meets his biological father, Gerard (played by Josh Lucas) who was contacted by Ms. Steel. She tells Stet’s biological father about the failed try-out as she believes Stets to have a unique gift for singing.

Gerard takes Stet all the way back East to the home of a prestigious and elite choir academy for boys – the very same one from which he had run away when they visited his school for the singing try-outs. On the journey there it becomes apparent to Stet that Gerard has a family life of his own and that his biological father’s family is not aware of his existence.

The academy’s choir master, Master Carvelle (played by Dustin Hoffman), refuses to accept Stet as a student, and it is only after Gerard makes out a cheque for a huge donation that the academy’s headmistress Justine (played by Kathy Bates) insists that Stet be accepted by Master Carvelle, and others, into the academy.

Stet struggles to find his way in a setting that is very much removed from the one he came from. He also struggles with his fellow students as they are most certainly not the kind of boys that he was used to while growing up back in Texas. As Master Carvelle pushes Stet more and more into finding his voice and using his unique talent to the fullest, Stet engages in acting-out behaviour – although not entirely unprovoked.

Devon (played by Joe West) is the lead soprano and a favourite of one of the academy’s trainers, Drake (played by Eddie Izzard), who happens to be Master Carvelle’s right-hand aide. As Stet’s performance grows at the academy, Devon becomes threatened about his position as lead soprano, and he sets out to humiliate Stet in any way he can. One notable attempt includes Devon removing Stet’s vocal score as he is about to sing a difficult aria from the 2nd movement to Handel’s Ode to the Birthday of Queen Anne, a piece of secular music composed by Handel for the queen’s birthday celebrations in February of 1713.

In addition to Stet’s difficult journey, the film also highlights some of the choir’s performances in which Stet has to not only learn to stand his ground against Devon and his mates, but also prove the worth of his talent to the academy. Shortly before one concert Stet’s biological father receives a pair of tickets sent
Franco Visser is a psychologist and lecturer in the Department of Psychology at UNISA, Pretoria, South Africa. He has a special interest in Forensic Psychology. Correspondence: Vissefp@unisa.ac.za

can sing the superb part. Now for those of you in the know, reaching a high D in the 6th octave is no mean feat, and the competition for this coveted part comes down to two students – Stet and Devon. What happens next, and how the film develops further, I will leave for you to discover.

BOYCHOIR BROUGHT BACK MANY WARM MEMORIES OF MY OWN YOUTH SPENT SINGING IN VARIOUS CHOIRS, AND IT IS A FILM THAT I WOULD READILY RECOMMEND YOU TO VIEW. THE ACTUAL CHOIR VOICES INCLUDED IN THE FILM ARE THOSE OF THE AMERICAN BOY CHOIR STUDENTS UPON WHICH THE FILM LOOSELY BASES ITSELF; THE MUSIC IS MAGICAL, AND THE GIFT OF HEAVENLY VOICES IS RATHER EXTRAORDINARY, ESPECIALLY IF ONE KEEPS IN MIND THAT A MALE SOPRANO AND DESCANT VOICE ONLY LASTS FOR A COUPLE OF YEARS IN ONE’S YOUTH, ONLY TO BE REPLACED BY A VOICE THAT CAN BE TENOR, COUNTER-TENOR, BASS, ALTO, FALSETTO OR EVEN SANDPAPER IN QUALITY.

For those of you who like choral works, getting a copy of the film’s soundtrack is also a must in addition to viewing the film. Writing this review has made me more resolute to stick with my chosen theme for 2017 – this year I will have music! How about you?

Franco Visser is a psychologist and lecturer in the Department of Psychology at UNISA, Pretoria, South Africa. He has a special interest in Forensic Psychology. Correspondence: Vissefp@unisa.ac.za
FROM THE EDITOR

I write today as 2016 winds down and we stand on the cusp of a new year, 2017. The past year has seen SASOP engaging in issues that affect members and their practice of the discipline of psychiatry at various levels. Subgroups have been engaging at a local level with provinces and local Dept’s of Health, whilst the SASOP Board of Directors has been taking care of issues on a national level, both in the public and the private sectors. No doubt, 2017 will be equally busy and challenging.

At the AGM held in November, the new SASOP Board of Directors (BOD) was elected. These officials will be in office for the next two years, until the next SASOP National Congress, to be held in 2018. In this Headline, you get to meet some of these colleagues. We wish them well in the work that lies ahead for them.

The successful WPA International Congress 2016, hosted by SASOP in Cape Town, was certainly a highlight in the history of South African Psychiatry. After three years of intensive planning, we were able to hold an international congress on our own shores, with a varied program and lively debate.

The theme, “Integrative Care for the Community” explored our discipline’s “Social Contract” with society on various levels and within multiple forums. The debate will now continue as Prof Bernard Janse van Rensburg, our new President, leads us into the next term. Word has it that planning for the 2018 congress, to be hosted by the Free State Subgroup, is already underway!

Dr. Ian Westmore (Editor)

MEET THE NEW SASOP BOARD OF DIRECTORS (BOD) (2016-2018)

The Editor asked members of the new SASOP BOD to introduce themselves to the SASOP membership by means of a short paragraph. Here goes… meet some of your new leaders:

PRESIDENT ELECT: PROF BONGA CHILIZA
Bonga Chiliza is an Associate Professor and Senior Psychiatrist in the Department of Psychiatry, Stellenbosch University and Tygerberg Hospital. His research interests include schizophrenia, consultation-liaison psychiatry, health services and medical education. Prof Chiliza has received a number of awards including the Hamilton Naki Clinical Research Fellowship and the CinP Rafaelsen Young Investigators Award. He has authored over 50 peer reviewed articles and book chapters. He has also served on a number of NGO Boards, including the SA YMCA, Life Choices and Harambee.

LIKES: “WATCHING SPORTS, PLAYING INDOOR SPORTS WHERE CHASING A BALL IS INVOLVED, READING, AND PLAYING SUDOKU”. DISLIKES: “LONG MEETINGS!”

What he hopes to achieve in the next two years: “To learn as much as I can from Bernard and Mvuyiso and then to bring much more focus on to the SASOP Board – focusing on just three things that we can do really well”.

Ian Westmore (Editor) is psychiatrist in private practice in Bloemfontein and is a Past President of SASOP (2010-2012). He is the current convenor of the SASOP Mentorship, Young Psychiatrists and Registrars Division and a member of the Local Organising Committee of the WPA International Congress to be held in Cape Town in November 2016. He has served on the SASOP Executive and National Council in various capacities since 2002. Correspondence: westmore@axxess.co.za
HON SECRETARY:
DR ANUSHA LACHMAN DEVCHAND

I am a Child & Adolescent Psychiatrist at the Department of Psychiatry (Stellenbosch). I am responsible for both the Adolescent Inpatient Unit and the paediatric consultation liaison service at Tygerberg Hospital. My research and academic interests include Adolescent neuropsychiatry and Infant Mental Health. I am interested in maternal and infant mental health service development, accessibility and improving the social commitment of psychiatrists in South Africa. I hope to work on strengthening cross-sectoral collaboration as a board member of SASOP and look forward to engaging and expanding the South African footprint across the continent and African diaspora.

HON TREASURER:
DR INDHRIN CHETTY

I am currently employed as a forensic psychiatrist in the Forensic Psychiatry Unit at Sterkfontein Hospital, Krugersdorp, Gauteng, and am also a joint appointee in the Department of Psychiatry, University of the Witwatersrand. Prior to commencing work in my current position in January 2015 I was in private practice in Umhlanga, KwaZulu Natal. My work in forensic psychiatry allows me to combine my interests in medicine and law. My other area of interest is animal rights and animal welfare, and I hope to educate myself more comprehensively in this area and contribute to a wider awareness. It is an honour to hold the position of treasurer in SASOP and I look forward to serving over the next two years.

PUBSEC REPRESENTATIVE:
DR LESLEY ROBERTSON

I am Lesley Robertson and am on the Board of Directors as the National Convenor for Public Sector Psychiatrists. I work as a District Psychiatrist in Southern Gauteng and am a joint appointee in the Department of Psychiatry at Wits University. My primary goal is to see a formal structure for Community Psychiatry developed within the mental health care system in South Africa, and I hope to establish a Community Psychiatry Unit in my district in the coming year. I really enjoy practicing a patient-centred recovery orientated psychiatry, but often feel frustrated with the limitations imposed by the health care system within which we work.

I DO NOT ENJOY THE SENSE OF FUTILITY THAT SO OFTEN ACCOMPANIES MY CLINICAL EFFORTS. AS TO PRACTICE EFFECTIVE PATIENT CARE REQUIRES AN EFFICIENT MENTAL HEALTH SYSTEM, WHICH IN TURN MUST ADDRESS THE PUBLIC MENTAL HEALTH NEEDS,

I will continue to engage with the Department of Health and NHI in order to work towards improved individual care for the next generation.

3. THE WPA/SASOP 2016 INTERNATIONAL CONGRESS

The Congress held in Cape Town in November was a combination of both an International WPA event, and a local National Congress. SASOP not only hosted the event, but also specifically sponsored an “Early Career Lounge” at the congress. There was also an opportunity for some of the Special Interest Groups to get together during the congress. On the Sunday evening, SASOP held its President’s Dinner, during which some awards were made.

a. The Early Career Track:
The WPA President, Prof Dinesh Bhugra, had specifically requested that an “Early Career Track” be developed for the Cape Town congress. The planning of this was done by the “Mentorship, Young Psychiatrists and Registrars” Division of SASOP in liaison with the Local Organizing Committee, and was mostly hosted in a designated “Early Career Lounge” at the Convention Centre.

It was an opportunity for local early career (EC) psychiatrists to network with their international colleagues – many new friends were made at the different meetings, including an EC networking evening.

The track consisted of:

- Tea time discussions in the lounge where some leaders in psychiatry were quizzed about “The most important lessons that I have learnt in my career as a psychiatrist”. Young psychiatrists were able to engage with these leaders in a relatively informal way and the talks were very inspirational! These included the WPA President Elect, Prof Helen Herrman; the WPA President, Prof Dinesh Bhugra; the President of the Royal College of Psychiatrists, Prof Sir Simon Wesseley; the President of the European Psychiatric Association, Prof Wolfgang Gaebel and the President of the American Psychiatric Association, Prof Maria Oquendo.
- Lunchtime “Meet the Expert” sessions. Here local EC psychiatrists interviewed experts Professors Vikram Patel, Norman Sartorius and Sean Hill respectively, and
facilitated questions from the floor while attendees enjoyed their lunch.
• Two Early Career Symposia held on the Monday of the congress, one on “Leadership and Mentorship in Psychiatry” and another on “Finance and Funding of Mental Health Care and Education”.
• Recorded interviews of prominent psychiatrists in the EC Lounge. Dr Franco Colin interviewed Prof Michael Berk from Australia and Prof Jair Mari from Brazil, whilst Dr Eugene Allers interviewed Dr Florence Baingana from Uganda.
• A most enjoyable EC Networking Evening where there were opportunities for EC psychiatrists to interact on a more social level. Dr Hussien Elkoly, Chair of the WPA Early Career Psychiatrists Section, gave some background to the activities of the section.
• Medical students from the two local universities met with the WPA President for a 90 minute informal discussion on the discipline of psychiatry. These students ranged from second to final year candidates from the Universities of Cape Town and Stellenbosch, and engaged with the President over tea - we were struck by their enthusiasm and insight into the challenges posed by working in psychiatry!

The RFS has become an important mentoring tool, and we hope that it can be developed into a more comprehensive mentorship program for South African psychiatrists as from 2017.

5. FROM THE SUBGROUPS

a. LIMPOPO
(DR MATSHELE KEWANA, CHAIRPERSON)
The subgroup hosted its very first SASOP organized symposium on 17th September 2016. This event went very well and we had Prof B Chiliza as our keynote speaker. We will be hosting our 2nd symposium in the 2nd half of 2017.

b. NORTHERN
( DR C KOTZÉ, CHAIRPERSON)
The northern subgroup of the South African Society of Psychiatrists held an annual general meeting in May 2015 where a new executive committee was to be elected. Unfortunately a quorum could not be established and the current executive committee was willing to continue: Dr Carla Kotzé (Chairperson and representative of the University of Pretoria and Weskoppies Hospital), Dr Robyn van Schoor (Treasurer), Dr Mia Rademeyer (Representative for Denmar Hospital and the private sector) and Dr Pierre Malherbe (Secretary).

ACTIVITIES OF THE SUBGROUP

The Subgroup hosted its annual symposium on 18 June 2016 at the CSIR convention centre in Pretoria. The event was well attended by 165 registrars from different universities who were given a “crash course” in being a consultant in the Public Sector, or a psychiatrist in private practice.

This year the workshop was sponsored dually by Lundbeck and Adcock. Dr Hoepie Howell was the facilitator, and there were presentations by psychiatrists in both the public and private sector, as well as from AKESO clinics, and a psychologist, Anthony Townsend spoke on the pitfalls encountered when becoming involved in custody issues.

5. FROM THE SUBGROUPS

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b. The President’s Dinner & Awards:

This event was held on the Sunday night of the congress and was well attended by local psychiatrists and members of the pharmaceutical industry. Invited guests included some WPA officials and presidents of National Associations of Psychiatry. At the dinner, the outgoing President, Dr Mvuyiso Talatala handed over the chain of office to the new President, Prof Bernard Janse van Rensburg. He also acknowledged all the previous presidents of SASOP. Two awards were made for excellence: one to Dr Renata Schoeman for her work in the media, and a community service award went to Cassey Chambers from the South African Depression and Anxiety Group (SADAG) which was collected on her behalf by the CEO, Zane Wilson. SASOP also conferred Honorary Membership on Prof Dinesh Bhugra, WPA President; and Dr Saul Levin, CEO of the APA, at the dinner.

4. THE REGISTRAR FINISHING SCHOOL

The fourth annual Registrar Finishing School (RFS) was held in Sandton, Johannesburg on 04 and 05 November 2016. This was attended by final year registrars from different universities who were given a “crash course” in being a consultant in the Public Sector, or a psychiatrist in private practice.

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delegates, including psychiatrists, registrars, general practitioners, psychologists, nursing personnel and other mental health care practitioners.

The theme for the event was Trauma and Mental Health. Six speakers including Prof U Subramaney, Prof P Joubert, Dr A Ladikos, Dr F Bale, Dr R Sykes and Dr C Kotzé made up the faculty.

FUTURE PLANNED ACTIVITIES OF THE SUBGROUP

Further events for 2016 were indefinitely postponed due to the WPA that took place in November and the activities for 2017 will be discussed at the next exco meeting.

CURRENT PROBLEMS THAT WE FACE

The executive committee finds it difficult to engage its members, the events are generally poorly attended and few members have made themselves available for election on the executive committee, leaving the subgroup with sub-optimal management. There still seems to be little clarity on the management of subgroup financial affairs. We as a subgroup have been managing finances on a local level, but would rather relinquish control to the central governance of SASOP.

c. WESTERN CAPE

(DR NEIL HORN, CHAIRPERSON
& DR KIRSTEN REID (UCT REP))

Our AGM did not go ahead as planned as too few members RSVP’d. It will be held in early 2017. We held another successful Registrar dinner in the second half of the year in September which was a great success. Registrars from both UCT and US attended and enjoyed getting to know each other and members of the subgroup committee outside of the usual working environment. In addition we had a very interesting talk on pharmacogenetics by Dr Hilmar Luckhoff.

We have found these dinners to be a good way of introducing registrars to SASOP and many join SASOP at the dinners as we take application forms along to facilitate the process!

SASOP ACKNOWLEDGEMENTS AND HONORARY MEMBERSHIP:

DR R SCHOEMAN
1 November 2016

NOMINATION OF DR RENATA SCHOEMAN FOR EXCELLENCE IN MEDIA WORK AWARD

Her academic achievements are many and her career is marked by many awards and achievements. Her latest degree is an MBA at Stellenbosch University Business School, where she finished as top student and was awarded the Director’s award. She now lectures at the business school, as well as running her private practice.

I have known Dr. Schoeman throughout her career but since 2014, we have worked more closely together. Our aim was to develop a special interest group in Adult Attention Deficit Disorder, under the auspices of the South African Society of Psychiatrists (SASOP). Dr Schoeman has done research and has had an interest in cognitive functioning and neuro-development for many years.

Adult ADHD has been underdiagnosed and poorly treated for many years, and has only recently been recognized as a valid concept in adults. Many adults have been denied treatment, and are still being denied treatment. We therefore initiated this Special Interest Group, with very clear objectives, to help create awareness, and improve access to resources for sufferers. Renata has been a strong motivating force in this process, and has done many hours of work towards creating a memorandum of incorporation for our group. Her enthusiasm and knowledge have been invaluable in enabling the start-up of our endeavour.

Her special task was to write formal guidelines for the treatment of adults with this disorder, in a local context. This has not only not been done locally, but is very scarce internationally. It enables us as a professional body to benchmark treatment for peer
review and unlocks resources for patients. This is a huge undertaking requiring up to date research and hours of hard work, and specialized medical writing. This task has now been completed, and the guidelines are awaiting approval by the professional bodies. The result was of outstanding quality.

The reality is that funders will not pay for treatment without these guidelines in place, and patients are left without any treatment. In the state sector, very few resources are available for sufferers of this condition, and the research and formalizing of treatment and diagnostic guidelines will also enable them to be recognized and treated. It will be life changing for many patients in years to come, both in the private and state sector.

She has spent months on this research, and is absolutely up to date and current in her research. Her writing and presenting skills are superb, and she has also been involved as a driving force in presenting at regional workshops on ADHD, arranging more workshops for specialists and GPs on this topic and arranging symposia for the forthcoming World Psychiatric Conference in Cape Town later this year. This is all done against the background of running her busy practice, and lecturing in the MBA course for Stellenbosch University Business School.

Her media presence, as a spokesperson for ADHD, psychiatry, and on the topic of burnout, has been prominent, and generated a huge amount of interest for ADHD. It has presented Psychiatry and Psychiatrists as scientific and professional, something we have been striving for throughout the years.

Her media presence in the last year:
• Guest editor of ADHD in Focus
• 4 articles (SAJP-accepted, ADHD in focus, SAP)
• One talk for Sanofi and PsychMg in Magaliesburg
• 6 radio talks: Power FM, SAFM, Islamic Broadcasting, CCFM, RSG, Cape Talk.
• TV: eNuus Kyknet, SABC 3 Afternoon Express, SABC 2 Focus.
• Online: News 24 YouTube clip
• Lilly Webinar series
• Finalist Business Woman of the Year Award, Science. (for work in ADHD and leadership development)
• Director’s award USB for MBA and thesis.

Dr. Schoeman has truly outstanding achievements as an academic and a researcher, and this is shown by her rich array of awards. She is a role model for any woman. She is a very talented individual, but also hardworking, conscientious and able to balance work with living life, as is shown by her interest in quilting, gardening, keeping physically fit, and spiritual wellbeing.

I can only endorse her nomination, as she is a unique woman, someone to admire and look up to as a professional and a person. She richly deserves an excellence award.

Rykie Liebenberg: Proposer

SASOP HONORARY MEMBERSHIPS:
DR S LEVIN – CURRENT CEO OF THE AMERICAN PSYCHIATRIC ASSOCIATION

PROF D BHUGRA – CURRENT PRESIDENT OF THE WORLD PSYCHIATRIC ASSOCIATION
PRESIDENT’S REPORT

It gives me great pleasure to write this report as it is an opportunity to give feedback to SASOP members on the work done by SASOP leadership in the term 2014-2016. I would like to thank SASOP for giving me the opportunity to lead this society. I wish to thank the support that I have received from the National Council and the Board of Directors of SASOP. This has been a term of presidency that demanded hard work and was full of challenges and opportunities.

At my inauguration as SASOP President in 2014, I committed that during my term I will focus on 3 key areas, namely, the unity within SASOP, African Psychiatry and the 2016 WPA International Congress. It has been a busy and eventful 2-year term of Presidency. We have seen a closer cooperation between Pubsec and PsychMg.

There has been improved interactions between SASOP and government especially at the level of the National Department of Health and Gauteng Department of Health. There are improved relations with other international societies especially the American Psychiatry Association and the Royal College of Psychiatry.

SASOP has taken on historic battles highlighted by the ongoing Life Esidimeni/Community Mental Health battle. Preparations for the 2016 WPAIC that will be held in November 2016 have had their own challenges.

We have continued with the project of strengthening SASOP. It is difficult to build and sustain institutions. For SASOP to be sustained there must be specific actions to develop membership and to have sound governance structures. A good communication strategy for internal and external communication is essential.

Dr Mvuyiso Talatala
President 2014-2016
INSTRUCTIONS TO 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

Feature articles will, as of the February 2017 issue, be sent for commentary to be published with the article. This will constitute a form of open peer review.

REPORTS
- Related to events e.g. conferences, symposia, workshops

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 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. Whilst references may be noted in text, they will not be published with content but noted as available from the author/designated author where there are multiple 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 ARTICLES
Such content will specifically comprise the literature review of the final version of a research report towards the MMed - or equivalent degree - as a 5000 word review article

- A 300 word abstract that succinctly summarizes the content will be required.
- Referencing 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)
- The submission should be accompanied by the University/Faculty letter noting successful completion of the research report.
  - This will constitute peer review given that the examination process involves 2 independent examiners, with any revisions generally having been undertaken to the satisfaction of both your supervisor and Head of Department.

All submitted content will be subject to review by the editor-in-chief, and where necessary the advisory board. All content should be forwarded to the editor-in-chief, Christopher P. Szabo - Christopher.szabo@wits.ac.za
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- An effective hypnotic
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- Unaltered REM sleep \(^1,3\)
- Rapid sleep onset and maintenance of sleep
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- Helps reduce anxiety symptoms associated with insomnia \(^4,5\)

- Caution should be exercised in patients suffering from anxiety accompanied by an underlying depressive disorder

References:


For full prescribing information refer to package insert approved by the medicines regulatory authority.