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SOUTH AFRICAN PSYCHIATRY

ABOUT the discipline FOR the discipline

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DISTRICT PSYCHIATRIC SERVICES

MENTAL HEALTH LEADERSHIP
A SOUTH AFRICAN INITIATIVE

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Features

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NOVEMBER 2014

COVER PHOTOGRAPH: CATHIE TYLER

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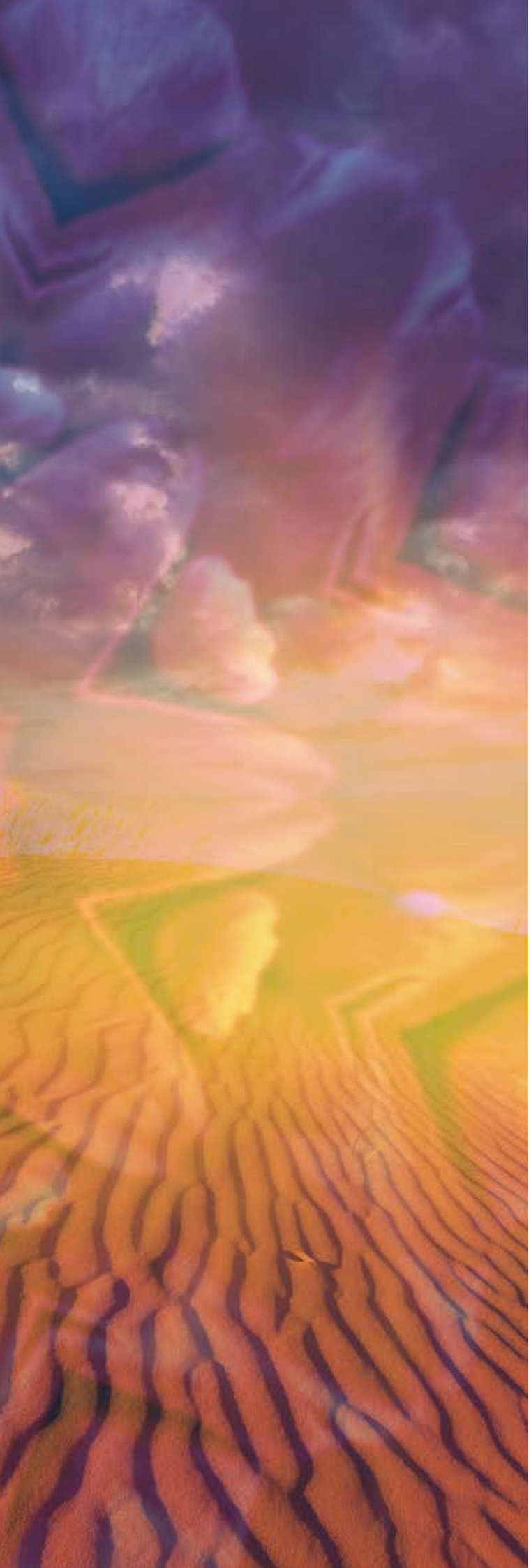

Dear Reader,

Welcome to the first issue of South African Psychiatry - a publication *about the discipline for the discipline.* Any new publication has to contend with two critical considerations, relevance and viability. The former will determine to what extent the publication is supported through contributions and readership and the latter to what extent it attracts commercial support – which may well be a function of relevance as well as financial considerations. I believe the first issue of South African Psychiatry is testament to both the relevance and viability. The contributions in this issue speak to a range of activities that constitute critical components of the richness that is South African Psychiatry. So many colleagues are involved in activities that deserve a platform, but related content would not be readily amenable to publication in scientific journals. South African Psychiatry is that platform. The commercial support that has contributed to the appearance of the first issue speaks to the perceived value of supporting a locally relevant publication. This cannot be overstated. The private health care sector is a major role player and contributor to South African Psychiatry. Beyond a commercial agenda in terms of product promotion, the publication affords opportunity to showcase their contributions too. Inclusiveness is a key guiding ethos. I would like to see South African Psychiatry connect psychiatrists (state and private), institutions (Academic Departments, the South African Society of Psychiatrists and the College of Psychiatrists) and all role players that both serve and contribute to the discipline - nationally. A cohesive discipline can only benefit all, especially our patients. This publication is about you and I invite each of you to consider contributing.

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A WORD ON OUR COVER

Cathie Tyler's Rose Image was chosen as the cover for our launch edition. It was chosen for its visual appeal, but behind the beauty is a story. It took some detective work to establish who owned the rights to the image. It turned out to be the artist's widower husband, **David Gwyther**, as Cathie had passed away. Upon being told of our intention to use the image he agreed to waive the fee for use of the image in lieu of our making a donation to a suitable charity. He also agreed to provide some insight into the artist. Accordingly we will be donating an amount to an approriate charity. Here is what David had to share...

Cathie would have loved to know she is being honored with your cover art. She was born in Bellevue, Washington, USA. Her father learned that her mother could not care for her when she was 18 months old. Her parents separated and her father hired twin childcare teenage women to help. He married one of them before her half brother was born two years later. Her stepmother raised Cathie in Fairbanks, Alaska from age five - without her family's help - to age 13. She left Alaska trying to find a better life in Seattle, but found only troubles. She ended up a foster child with very poor situations until she found a family that hired her for child care at 16. She loved helping raise their two young girls. Cathie graduated from High School, and learned photography and flower arranging.

Cathie moved to Portland, Oregon a year after graduation and moved into my apartment building where I saw a young 6"2" redhead. She worked in retail and managed a gift shop in a town hotel next to a major concert venue. Cathie's looks and personality led her to meet and befriend many famous musicians and other stars coming to the hotel. She developed a back problem, but without health insurance she could not get treatment until an abscess appeared. She spent two months in a hospital thanks to poor care. She was discharged with a back problem, a drug problem, no job, no home and no way to get back to stability. She spent five years homeless with all the related issues with police, other homeless people and no family help.

I FOUND HER, WE TALKED AND IN A FEW MONTHS I GOT HER TO STAY ON AN EMPTY COUCH IN MY FRONT ROOM, SHE DID NOT TRUST ANYONE. OVER THE NEXT TWO MONTHS SHE GOT IN TO DRUG TREATMENT AND STARTED BACK TO A NORMAL LIFE. I GAVE HER A SMALL CAMERA AND SHE USED MY OLD COMPUTER, SHE LEARNED FAST.

Our relationship grew and after several years we were in love. Neither of us had been married. I proposed in 2008 and we were married at the end of October in 2009 on the deck of a Federal Judge's chambers in Eugene, Oregon.

AT OUR WEDDING RECEPTION IN PORTLAND, CATHIE WAS WELCOMED BACK TO HER FAMILY. THE NEXT CHRISTMAS, SHE GOT THE CAMERA, WHICH SHE SUBSEQUENTLY USED TO TAKE ALL THE PHOTOS IN HER COLLECTION, FROM HER MOTHER'S FATHER. SHE GOT TO SEE HER GREAT-GRANDMOTHER THAT EVENT, THEY HAD BEEN CLOSE. WE WENT TO SEVERAL FAMILY REUNIONS. THE LARGEST WAS THE GREAT-GRANDMOTHER'S CELEBRATION OF LIFE WITH 104 BLOOD RELATIVES.

We wanted children but with no health insurance and both of our possible health problems it didn't make sense, I had serious problems first and she was diagnosed with an advanced stage cancer of the cervix and uterus in August 2013. She had not been to a doctor in 14 years. She did not trust doctors. Cathie only went to the ER of the medical school after she had an extended time with bowel problems, and I insisted. She had had cancer for years but did not know. Our medical system is getting better but Cathie was only covered after she was terminal. The money spent in the last nine months of Cathie's life could have given health care for hundreds of people for years but the USA doesn't understand these issues easily.

Cathie was a generous soul. Her life was a testament to overcoming adversities and seeing beauty in all. ■

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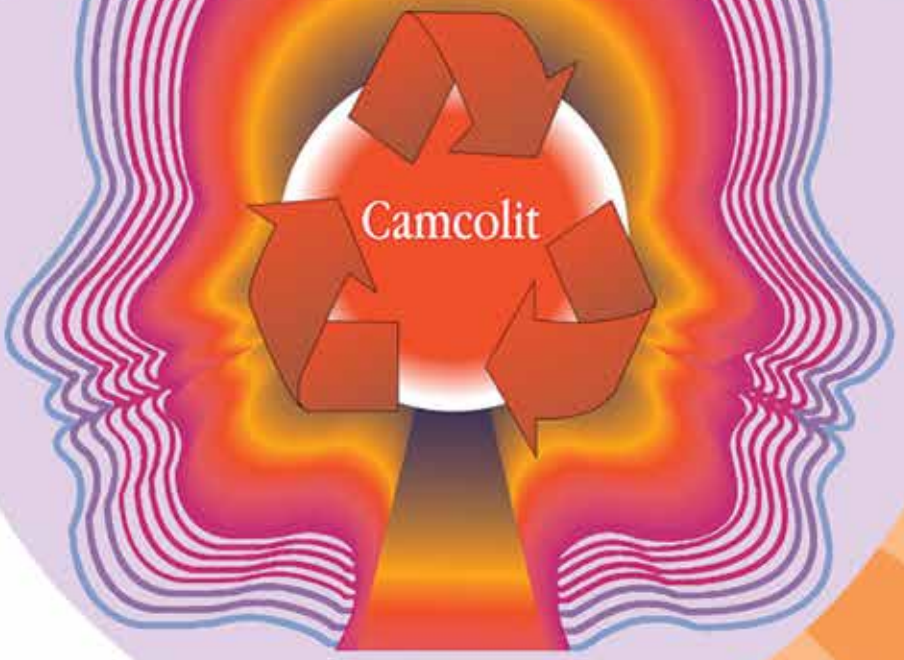

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DISTRICT

MENTAL HEALTH - IMPROVING SERVICE DELIVERY

South Africa has a population of 53 million. Whilst the country has hundreds of practicing psychiatrists of whom many are in the public sector, most psychiatrists prefer to live and practice in an urban setting for various personal reasons. So what happens to the mental health needs of the huge population of people living in the rural environment distant from any biomedical urban psychiatric service?

Lennart Eriksson

This is the question that confronted me eight years ago when I joined the Ugu North Region in Kwa Zulu Natal as a sessional consultant psychiatrist. The Ugu North Region, the northern half of Ugu District, has a population of 370 000. This population is served by a District Hospital – GJ Crookes Hospital – to which are attached 15 rural clinics and a Community Health Centre.

My appointment followed a courtesy visit to the CEO of the GJ Crookes Hospital, Mrs S Nyawo – a Psychiatric Professional Nurse – who requested I consider being available as a sessional consultant psychiatrist. In discussion with the medical manager he was of the opinion that a consultant sessional psychiatric service of five hours a week would be more than adequate for the needs of the hospital. The needs of both in-patients and members of far flung rural communities was never discussed. The consultant service would not be supported by a hospital based medical officer, but rather by a visiting general practitioner who would be available four hours per week. A registered psychiatric nurse and a resident Clinical Psychologist completed the team.

At that time the mental health clinic occupied a waiting area and two small examination rooms. I was soon to understand – as the waiting room filled to capacity – that the community's needs for a mental health service was far greater than could be provided for by five hours per week. The five hours was only for patients that had managed, with much effort and expense, to reach the district hospital.

The GJ Crookes Hospital Wednesday mental health clinic at 08:00.

WITHIN A MONTH A SERIES OF FUNDAMENTAL QUESTIONS DEMANDED AN ANSWER. IF THE DISTRICT HOSPITAL – SERVING A POPULATION OF 370 000 – HAD MANAGED TO "SCRAPE BY" WITH NO CONSULTANT PSYCHIATRIST FOR MANY YEARS WHY WOULD A CONSULTANT SERVICE NOW SUDDENLY BE A "MUST HAVE" ?

With the huge number of expectant faces filling the waiting room should I now make myself available to see as many patients as possible? Such a decision would mean moving away from providing a purely consultative service – for the select few - to providing an improved general mental health service. The prospect of taking on the responsibility and role of being an "over qualified" medical officer did not escape me! After some struggles defining my personal values (political, spiritual, philosophical), my own needs (financial, energy, time) and interests (neuropsychiatry) a decision was reached. I would embark on exploring the possibility of establishing an improved mental health service at a district hospital. If that decision required that I assume the daily tasks of a medical officer then "so be it". Armed with my decision I approached management to increase my sessional time from five to twenty hours per week.

Becoming a member of the hospital clinical team brought me in closer contact with the reality "on the ground". The incongruity twixt the needs of the community and the priorities of hospital management - no clear vision or mission statement with respect to mental health services – resulted in my perceived goals facing a structural void. The increasing demands of the "sessional" psychiatrist and the perceived priorities of management heralded a long period of raised tension. The need for a designated space to care for mentally ill males, in particular, was, in my opinion, an obvious priority. Only after a particularly unfortunate incident, involving a mentally ill male patient "housed" in the male medical ward, did the matter receive due attention. It was the medical matron who brought me to a disused building with the question – "Can you use this space?"

WITH A POUNDING HEART AT THE POSSIBILITY OF CREATING A SEPARATE SPACE FOR THE CARE OF THE MENTALLY ILL I SOON DREW UP PLANS FOR THE NEW "UNIT". AFTER RECEIVING LITTLE SUPPORT FROM THE REGIONAL HOSPITAL MENTAL HEALTH TEAM, ASSISTANCE AND APPROVAL WAS SOUGHT FROM THE THEN PROFESSOR OF PSYCHIATRY, NELSON MANDELA MEDICAL SCHOOL, PROF. DAN MKHIZE. AFTER A PERSUASIVE PRESENTATION PROF. MKHIZE AND HIS TEAM CONFIRMED THAT THE UNIT WOULD "HAPPEN". MUCH HOSPITAL MANAGEMENT SUPPORT IS REQUIRED TO ESTABLISH A FUNCTIONAL PSYCHIATRIC UNIT. ENERGY AND DEDICATED ENTHUSIASM WAS IN GOOD SUPPLY. THE UNIT, WITH TWO SECLUSION ROOMS OPENED ON 19 NOVEMBER, 2010. THIS SMALL 9 BED ENCLOSED UNIT, DESIGNED TO CARE FOR THE MENTALLY ILL, REMAINS THE FIRST UNIT OF ITS KIND IN A DISTRICT HOSPITAL.

The mental health MDT in Ethembeni

Whilst the Psychiatric Unit – named Ethembeni (Hope) by way of a naming competition - took shape, the medical matron again came to our rescue. The outpatient infrastructure had remained woefully minimalistic for many a year and was no longer able to meet the needs of either the patients or the staff. Matron TG Mkhize identified an ideal area vacated by the Gateway Clinic. The now expanded mental health team includes an allocated medical officer, two clinical psychologists, a community service clinical psychologist, a once a week sessional medical practitioner, a professional nurse and a nursing assistant completed the mental health team.

An improved district hospital mental health service is currently in place.

Opening of Ethembeni Ward 16 October 2014 01:11 PM - Prof L Mkhize, Mrs. L Mkhize, Dr L Eriksson and Mrs. S.P Nyawo, Hospital CEO cut the ribbon which leads to the ward

COMMENT

The Mental Health Care Act 2002 Chapter II, subsection 3 states - *The objects of this Act are to - (a),(i) regulate the mental health care in a manner that makes the best possible mental health care, treatment and rehabilitation services available to the population equitably, efficiently and in the best interests of the mental health care users within the limited resources; and (iii) integrates the mental health services into the general health services environment.*

This Chapter in the Act is possibly the most difficult – and most expensive - to enforce. The Mental Health Review Board (MHRB) has powers with respect to ensuring that the rights of the Mental Health Care User (MHCU) are adhered to "on paper" (MHCA 2002, Chapter III, subsection 19; Powers and functions of the Review Board). However the MHRB has no powers to enforce that the patient, at the facility or clinic level, will receive "the best possible mental health care, treatment and rehabilitation services....."

MAY WE AS CLINICIANS CONTINUE TO STRIVE TO ENSURE THAT PATIENTS PLACED IN OUR CARE WILL RECEIVE THE BEST POSSIBLE CARE "WITHIN THE LIMITED RESOURCES". THIS CAN ONLY BE ACHIEVED BY WAY OF A PERSONAL COMMITMENT: A PERSONAL COMMITMENT TO IMPROVE THE PHYSICAL INFRASTRUCTURE AND STANDARD OF CLINICAL SERVICES.

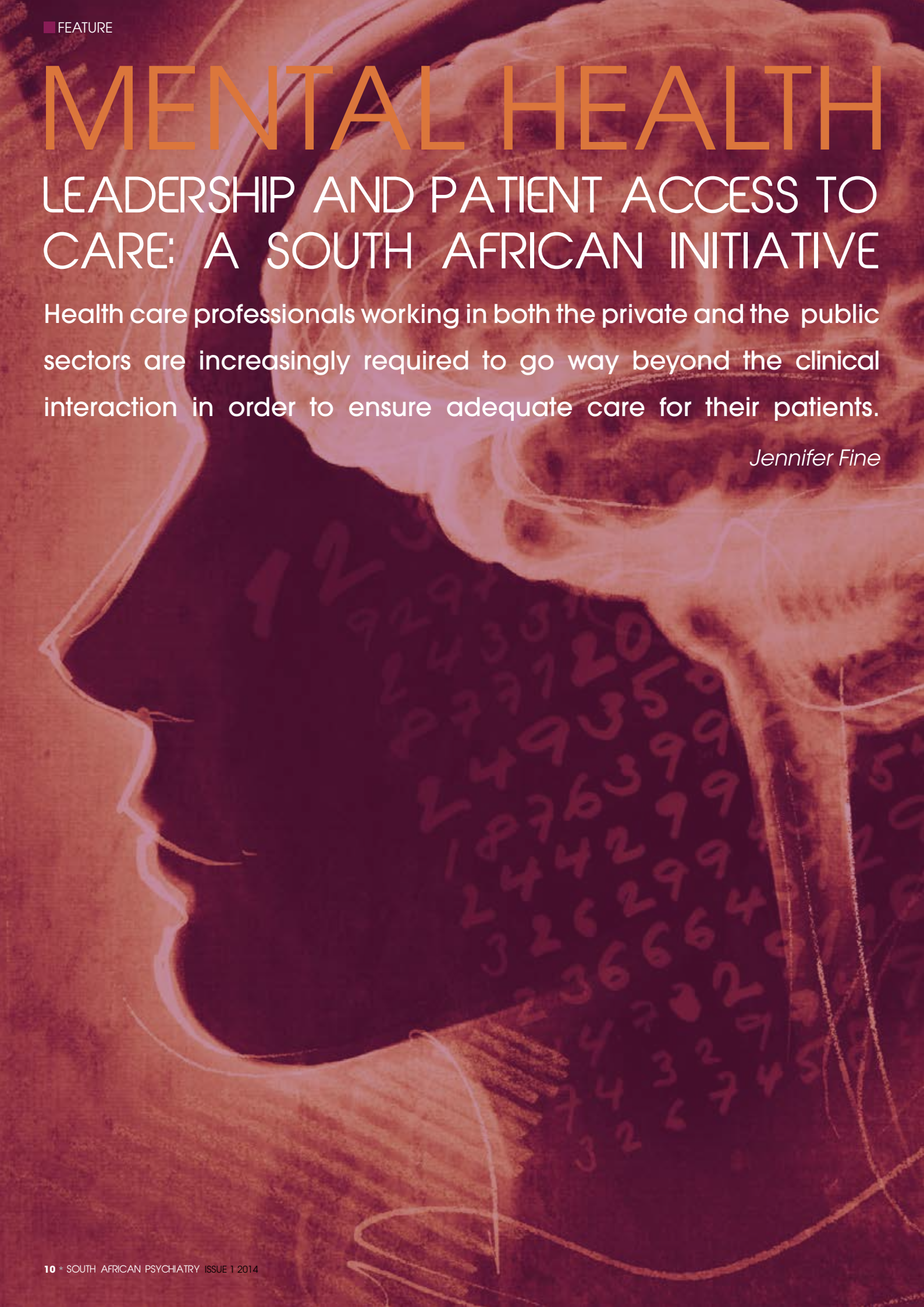
Lennart Eriksson is a psychiatrist, now retired from state practice. He was a consultant psychiatrist for the Ugu District and at GJ Crooks Hospital, Scottborough, KZN. He is currently the convenor of the Spirituality and Psychiatry Special Interest Group of the South African Society of Psychiatrists. **lennarte@iafrica.com**

MENTAL HEALTH

LEADERSHIP AND PATIENT ACCESS TO CARE: A SOUTH AFRICAN INITIATIVE

Health care professionals working in both the private and the public sectors are increasingly required to go way beyond the clinical interaction in order to ensure adequate care for their patients.

Jennifer Fine



Engaging with hospital administrators, government departments and funders has become an integral part of patient care, whether motivating for individuals or for entire sectors of the patient population. Yet in spite of this expectation, clinicians are generally not well equipped to take on an advocacy role. Nothing in our conventional medical education formally prepares us for professional leadership, whether it be as individuals or as members of professional bodies, whether engaging in service development, policy planning or building partnerships for action.

The need for advocacy is particularly pressing in the realm of mental health where stigma and prejudice persist, despite South Africa's progressive human rights law. People with psychosocial disabilities continue to be marginalized - socially, occupationally and in terms of government attention and development aid. The South African Department of Health itself has acknowledged that "for the majority of people with mental health problems there is just no care"(Kahn, T. "Most people with mental disorders not getting care they need." Business Day 13th June 2013. http://www.bdlive.co.za/national/health/2013/06/13/most-people-with-mental-disorders-not-getting-care-they-need). Similar treatment gaps have been noted in many other countries due to low prioritization, poor funding and inadequate human resources for mental health globally.

Jennifer Fine, Tuviah Zabow, Pat Myers, Christopher Szabo, Shan Naidoo

RECOGNIZING THE POTENTIAL FOR MENTAL HEALTH CARE PROFESSIONALS TO PROVIDE LEADERSHIP IN TRANSFORMING THE HEALTH CARE ENVIRONMENT AND ENSURE BETTER ACCESS TO CARE FOR THEIR PATIENTS, SANOFI SOUTH AFRICA HAS EMBARKED ON AN INNOVATIVE MENTAL HEALTH LEADERSHIP TRAINING PROGRAMME.

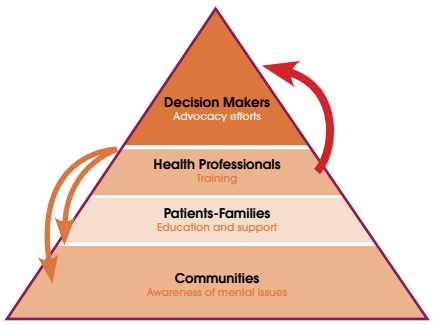
The idea evolved through innumerable discussions with colleagues, health authorities, academics and civil society over more than two years. Conceived as a pure corporate social responsibility initiative, divorced from any commercial incentive, the progamme seeks to build leadership capacity in the public mental health sector. The express aim is to equip health care professionals with the skills necessary to more effectively advocate for their patients.

Current participants include 15 mental health care professionals drawn from six public health care facilities nationally, representing a range of disciplines such as psychiatry, psychiatric nursing, occupational therapy and psychology. In addition to didactic teaching, the programme comprises a novel component in which participants are mentored over a period of two years, in pursuit of a practical long-term project related to an aspect of their daily work. Mentors and participants come together on a six-monthly basis to report on project progress, share successes and tackle challenges. The project component of the course adds a unique practical dimension in which skills and learnings can be applied, while tackling an aspect of daily professional work which negatively impacts on patient care.

It is hoped that this leadership programme can be integrated into a future public mental health component in specialist training, in association with the College of Psychiatrists within the Colleges of Medicine of South Africa. The concept has been adopted in principle by the Public Sector group within the South African Society of Psychiatrists (SASOP). Plans are in progress for a focused "public mental health forum" as part of registrar training as early as 2015.

Sanofi sincerely hopes that this initiative will provide a model for future training to develop a cadre of clinician advocates as potential drivers of change, and ultimately translate into better resources and enhanced services for patients.

SHIFTING THE FOCUS



Health care professionals (HCP) are generally focused on patient/family interactions, and recognize the value of community support organizations in patient care. The course aims to strengthen HCP leadership and managerial skills so that they are able to more effectively engage with decision makers in transforming the health care environment.

Jennifer Fine is a neurologist and the senior medical advisor at Sanofi South Africa, responsible for the CNS portfolio. Sanofi thanks Prof Christopher Szabo for his contribution to the conceptualization and design of this project, and his unwavering support and commitment. Thanks also to our three mentors, emeritus Prof Tuviah Zabow, Prof Shan Naidoo and Prof Pat Mayers, all experts in their fields, who have had the difficult task of maintaining participants' enthusiasm and motivation when the going has got tough. **jennifer.fine@sanofi.com**

MINDFULNESS
FOR BORDERLINE PERSONALITY DISORDER

Harvard Psychiatrist, Dr Blaise Aguirre speaks at Tara Specialized Psychiatric Hospital

Jow'hara Chundra

Mindfulness, as described by John Kabat-Zinn is: "paying attention in a particular way on purpose, in the present moment, and without judgment." And in an animated two-hour talk, Dr Aguirre certainly kept the audience from the Department of Psychiatry at Wits University mindfully alert and enlightened.

Dr Blaise Aguirre is Assistant Professor of Psychiatry at Harvard University and Medical Director at the Mclean Adolescent Dialectic Behaviour Therapy (DBT) unit. Located at Mclean Hospital and affiliated to Harvard University, the unit offers a unique, residential DBT program for young women exhibiting self-endangering behaviours and borderline personality traits. Dr Aguirre has been a staff psychiatrist at McLean since 2000 and is widely recognized for his extensive work in the treatment of mood and personality disorders in adolescents.

He has authored ***Borderline Personality Disorder in Adolescents: A Complete Guide to Understanding and Coping When Your Adolescent Has BPD and Depression (Biographies of Disease).*** He is also a co-author of ***Mindfulness for Borderline Personality Disorder: Relieve Your Suffering Using the Core Skill of Dialectical Behavior Therapy***; and ***Helping Your Troubled Teen: Learn to Recognize, Understand, and Address the Destructive Behavior of Today's Teens***. Dr Aguirre is an expert in child, adolescent and adult psychotherapy, including DBT, and psychopharmacology.

MINDFULNESS IS ONE OF THE FOUR MODULES IN DIALECTICAL BEHAVIOURAL THERAPY, AND AGUIRRE STRONGLY BELIEVES, THE MOST IMPORTANT ONE.

Dr Aguirre's interest in Mindfulness began rather stoically. Being interested in Borderline Personality Disorder (BPD) and noticing that many symptoms of this disorder occurred amongst the adolescent patients he was seeing, he asked his PA to book him a place on a training course with Marsha Linehan. Little did he realise, that instead of intensive DBT training with the originator of DBT and a world expert on BPD, he found himself with Dr Linehan and various others, on a prolonged silent retreat!

It was during this retreat that he began his own practice of Mindfulness, which continues. As he says to his patients, " How many psychiatrists are willing to take that which they prescribe?" thus urging the patient to join him in embracing this empirically supported psychotherapeutic treatment, and also setting the tone for collaborative work between patient and therapist, an important part of DBT.

Aguirre reminds us that mindfulness is not equal to meditation. Mindfulness is the act of consciously focusing the mind in the present moment without judgement or attachment. It can be done at any time, in any moment. Meditation is the formal practice of mindfulness while sitting, walking or standing quietly for a period of time. It is setting aside time, to formally practice mindfulness.

Aguirre alluded to the fact that in the USA, there was some concern with Mindfulness Practice having an Eastern influence. He hence stressed that meditative practices are parts of most religions, though different terms are used for them.

He briefly reviewed the evidence for Mindfulness in decreasing: anxiety; depression and rates of relapse; binge eating; numbing or avoidance in Post Traumatic Stress Disorder; chronic pain; symptoms of fibromyalgia; stress levels and high blood pressure. Mindfulness also improves self-regulation, attention, concentration, interpersonal functioning, the immune response in HIV, response to drug treatment and it even improves test results!

A large part of Dr Aguirre's talk was to give an overview, and some very practical information on the Mindfulness Module within Dialectical Behavioural Therapy. For the purpose of this article, I will review some of what he said, but also try to expand on some of the concepts, especially for those who are not familiar with DBT.

IN DIALECTICAL BEHAVIOURAL THERAPY, REFERENCE IS MADE TO THE THREE STATES OF MIND: THE REASONABLE MIND, THE EMOTIONAL MIND AND THE WISE MIND. IN OUR REASONABLE MINDS, WE PAY ATTENTION TO THE FACTS.

The plan is important, and logical steps are necessary. Sometimes, when in this state, emotions can be squashed down or ignored. In the emotional mind, our feelings dictate what we think and how we behave. We're in our emotional minds when we're in love, or when we're sad at a funeral. The wise mind is a state we try to reach where we can be aware of our thinking, our feelings and the impulse to act. When in the Wise Mind, we can manage the impulse to act, and can essentially be mindful of what is going on in the here and now.

SO, HOW CAN ONE BE MINDFUL? WHAT ONE NEEDS TO DO, IS TO OBSERVE, TO DESCRIBE AND TO PARTICIPATE. AND HOW? NON-JUDGEMENTALLY, ONE-MINDFULLY AND EFFECTIVELY - AGUIRRE ADDS NON-REACTIVELY. WE THUS TEACH OUR PATIENTS TO JUST NOTICE THEIR EXPERIENCE, TO OBSERVE THEIR THOUGHTS, FEELINGS AND SENSATIONS. TO NOTICE AND ATTEND WITH ALL SENSES, WITHOUT GETTING JUDGEMENTAL ABOUT WHAT THEY NOTICE. AGUIRRE JOKED ABOUT HOW DRIVEN WE ARE IN THIS DAY AND AGE TO MULTI-TASK. OUR MINDS ARE BUSY, WITH A MILLION THINGS TO DO, WE DRIVE, WE TEXT, WE EAT AND DRINK. WE HARDLY EVER DO ONE AND ONLY ONE THING IN THE MOMENT. MULTITASKING HAS BEEN PROVEN TO BE LESS EFFECTIVE AND LESS EFFICIENT. ANY TASK YOU CAN DO MINDLESSLY, YOU CAN DO MINDFULLY. BY GETTING PATIENTS TO PARTICIPATE FULLY IN ONE MOMENT, THEY MOVE AWAY FROM THE STRESSES OF THEIR LIVES AND RECOGNISE THAT THIS IS WHERE THEY ARE, AND THEY CAN BE OK RIGHT NOW.

One of the exercises given by Aguirre was to observe an itch. The audience had to sit for a few moments, and just notice an itch somewhere in their body. To pay attention to that itch and hold it in mind. And importantly, to manage the urge not to scratch the itch or wriggle. For some people the itch eased in intensity to the point that some slowly realised that they no longer had an itch. For others the intensity increased, and it was really difficult not to scratch. Another exercise was to focus on dramatically changing your body's position, as Aguirre clapped his hands. With each new clap, a new position was asked for. Initially feeling

Blaise Aguirre, Jow'hara Chundra

quite self-conscious, most people made small changes. But as the rhythm built up, as the maniacal robotic dance of others fell away from consciousness, one was able to truly participate in the exercise.

Towards the end of his talk, Aguirre spoke about the importance of practicing these skills, and the benefits of incorporating them into one's daily practice. He spoke of his own difficulties over the years, especially in setting up a unit that treated adolescents with Borderline Personality Disorder, when one can't make that diagnosis in adolescents; of how his own mindfulness practice made challenges easier to manage.

FOR MY TEAM AND I, WORKING ON A DBT-INFORMED PSYCHOTHERAPY UNIT AT TARA HOSPITAL, AGUIRRE REALLY HELPED CONSOLIDATE WHAT WE KNEW, AND WHAT WE HAD PUT INTO PRACTICE ON THE UNIT. USING AGUIRRE'S BOOK ON MINDFULNESS AS A GUIDE, WE HAD STARTED A DAILY MINDFULNESS MORNING GROUP THAT IS PROVING TO BE MOST BENEFICIAL FOR OUR PATIENTS. I BELIEVE HIS TALK ALSO HIGHLIGHTED A NEED FOR AN ADOLESCENT DBT-INFORMED UNIT IN JOHANNESBURG.

Mindfulness is not a cure-all for every difficulty. However, it helps us let go of unwanted attachment and suffering, helps our patients to do so. It allows us to choose where to focus our attention, and hence to take control of our minds.

Jow'hara Chundra is a psychiatrist and Head of the Psychotherapy Unit at Tara Hospital, affiliated to the Department of Psychiatry at the University of the Witwatersrand, Johannesburg. **jowhara.chundra@gauteng.gov.za**

Christopher P. Szabo The end of a triennium

- Reflections of the immediate past President of the College of Psychiatrists.

As the outgoing President of the College of Psychiatrists it has been, to say the least, an interesting three years. My previous experience of the College, before becoming President, had been somewhat remote comprising involvement with exams in various capacities over the years. However, at the level of leadership I found myself propelled from never being a member of Council to President of the College and de facto Chair of Council. To those who elected me, I trust that your faith in my ability was not misplaced. In this regard I have to acknowledge the Council I have had the privilege of working with for this triennium extending from November 2011 – November 2014. This has been a critical triennium.

Foremost in the work undertaken has been the need to review, revise and update regulations that provide the basis for operational aspects of all exams offered by the College i.e. fellowship (FCPsych), diploma (DMH) and subspecialist certificate (child and adolescent psychiatry currently). Of particular significance has been the appointment of the Colleges of Medicine of South Africa (CMSA), of which Psychiatry is but one College, as the body responsible for the single national exit exam for all specialist and sub specialist disciplines.

The University MMed higher degree that previously had been an option for specialist registration has now fallen away for that purpose. And yet, in many ways, the MMed is as important – if not more important than ever. This with specific reference to the research component. Research is a requirement for entry to the part II exams of the FCPsych, with the regulations having been revised to provide greater detail (**www.collegemedsa.ac.za**).

More specifically, it needs to be emphasised that specialist registration with the Health Professionals Council of South Africa (HPCSA) requires proof of research completion i.e. it is an imperative and in this regard the College's requirement serves to ensure that upon successful exam completion, registration will follow the conclusion of training time.

A national exit exam raises an important issue, ensuring that there is consistency of training across all academic institutions. In this sense the college has moved beyond simply acting as an examining body that provides an option for specialist registration – but is now needing to become directly involved in standards of training.

This leads to the next issue – syllabus development. Another significant activity of this triennium has been the need to create blueprints for each exam offered. INDEED, THIS ENCOMPASSED ALSO CREATING NEW REGULATIONS AND BLUEPRINTS FOR THE EMERGENCE OF A RANGE OF NEW SUB SPECIALIST CERTIFICATES I.E. NEUROPSYCHIATRY, FORENSIC PSYCHIATRY AND OLD AGE PSYCHIATRY WITH ADDICTION PSYCHIATRY AND CONSULTATION LIAISON PSYCHIATRY TO FOLLOW.

In time the certificates will be renamed as fellowships. This process has required clinicians to evolve into medical education "specialists" without any formal training or prior meaningful involvement in such pursuits.

TO THIS END THE OUTGOING COUNCIL ACHIEVED WHAT SEEMED AN IMPOSSIBLE TASK I.E. TO CREATE SYLLABI, TO REVISE THE FOCUS OF PAPERS ACCORDINGLY AS WELL AS RE ENGINEER THE APPROACH TO EXAMINING - MOVING TOWARDS A MORE OBJECTIVE APPROACH THAT IS DEFENSIBLE. HENCE THE SHIFT TOWARDS ELIMINATION OF ORAL EXAMS AS PART OF THE CLINICAL EXAMINATION, WITH AN INCREASE IN USE OF OBJECTIVE STRUCTURED CLINICAL EXAMINATIONS (OSCES).

The issue of "risk" is a legitimate concern - and no doubt part of the motivation for such a move - given that challenges to examination processes and outcomes are increasing, with the potential for legal consequences.

This triennium also saw a shift in expectations and standards with changes in the requirements to gain admission to the clinical exams following the written papers seeing a more stringent approach. And yet this amounted to a requirement for 50% overall, together with a minimum number of questions needed at 50%. This has resulted in fewer invites to the clinical exams but in general, a higher pass rate at those exams. There has been talk of moving away from the "long question" in the written paper.

I would prefer that this does not happen, after all – Psychiatrists should be competent wordsmiths. A wider range of examination approaches beyond the "single best answer" option – currently seen as the most objective approach - might serve the discipline better. During the past triennium we had to contend with DSM 5. A pragmatic approach was adopted, with a phasing in of the requirement to be fully conversant as of 2015.

THE ANNUAL REGISTRAR TRAINING WORKSHOP REMAINED A KEY ACTIVITY OUTSIDE OF THE BI ANNUAL EXAMS AND THE PARTICIPATION OF REGISTRARS NATIONALLY AS WELL AS SPEAKERS CONTRIBUTED TO THEIR SUCCESS, AS DID THE GENEROUS SPONSORSHIP OF SERVIER WHICH WILL CERTAINLY CONTINUE FOR 2015. A NEW COUNCIL WILL COMMENCE AS OF NOVEMBER 2014, WITH A NEW PRESIDENT.

Whilst not all Heads of Departments (HoDs) will be members of Council, it is I believe incumbent on HoDs to have awareness of Council and College matters either through members of their Departments on Council or through the President. I have no doubt that this will be the case. Whilst much has been achieved, the next triennium will be about successful implementation with ongoing development.

I wish the new Council and President all the success.

COUNCIL MEMBERS: 2011-2014
Back row: Jonathan Burns
Next row: Pete Milligan, Suvira Ramlall
Next row: John Joska, Orlando Betancourt, Soraya Seedat
Next row: Janus Pretorius, Louw Roos
Front row: Puleng Molepo-Mokoena, Christopher P.Szabo, Solly Rataemane
Absent: Sean Kaliski

Christopher Paul Szabo is Professor and the current Head of the Department of Psychiatry in the Faculty of Health Sciences at the University of the Witwatersrand, Johannesburg. He is Chief Specialist and Head of the Department of Psychiatry at Charlotte Maxeke, Johannesburg Academic Hospital, Johannesburg. **christopher.szabo@wits.ac.za**

THEME: BRAIN SCIENCES
- ADDRESSING RESEARCH NEEDS AND PRIORITIES IN AFRICA

SICK NOTES AND THE PSYCHIATRIST

Psychiatrists issue sick leave certificates every day. Do we however know what we are doing? How do we decide how long a patient should be booked off? What purpose would the sick leave serve?

Stoffel Grobbelaar

Could sick leave possibly be harmful? Will refusal to issue a sick leave certificate harm my relationship of trust with the patient? Are we even sure what a legal sick certificate should look like? These and other questions around sick leave are seldom discussed at conferences and certainly not during our training. This article will attempt to address some of the issues around sick leave.

To make informed decisions about a particular treatment modality, a physician has to carefully consider the risk-benefit profile of the modality. The problem with regard to sick leave is that there are many factors that are unknown to us for example the patient's job description and responsibilities at work, grievance procedures should they feel they are being unfairly treated and sick leave policies.

Once sick leave is granted, even more issues come into play like absenteeism policies, the role of the health risk managers, the insurance industry's processes and benefits and psychiatric impairment assessments and reports.

CAN SICK LEAVE BE HARMFUL?

Two of the pillars of the ethical practise of medicine are non-maleficence and beneficence. When it comes to the issuing of sick certificates these two pillars need to be considered more carefully as research has shown that there are instances where sick leave may be clearly harmful to our patients.

Work occupies a major place in many people's lives. The primary purpose of work may be to provide financial status and security, but work also defines the individual and his or her role in society. To a greater or lesser extent, work provides an income, an activity, an occupation, a structure of time, social interaction, and a sense of identity and purpose.

It is not surprising then that loss of work and unemployment can have a catastrophic effect on an individual. Whatever the cause, the effects of loss of work can include poverty, social deprivation and social isolation, poor physical and mental health, and increased mortality. There is a growing body of research that has shown that work absence is associated with a progressive deterioration in physical and psychological health, an increase in the rate of suicide, pressures on interpersonal relationships, the loss of identity and self worth, financial hardship and a general erosion of quality of life.

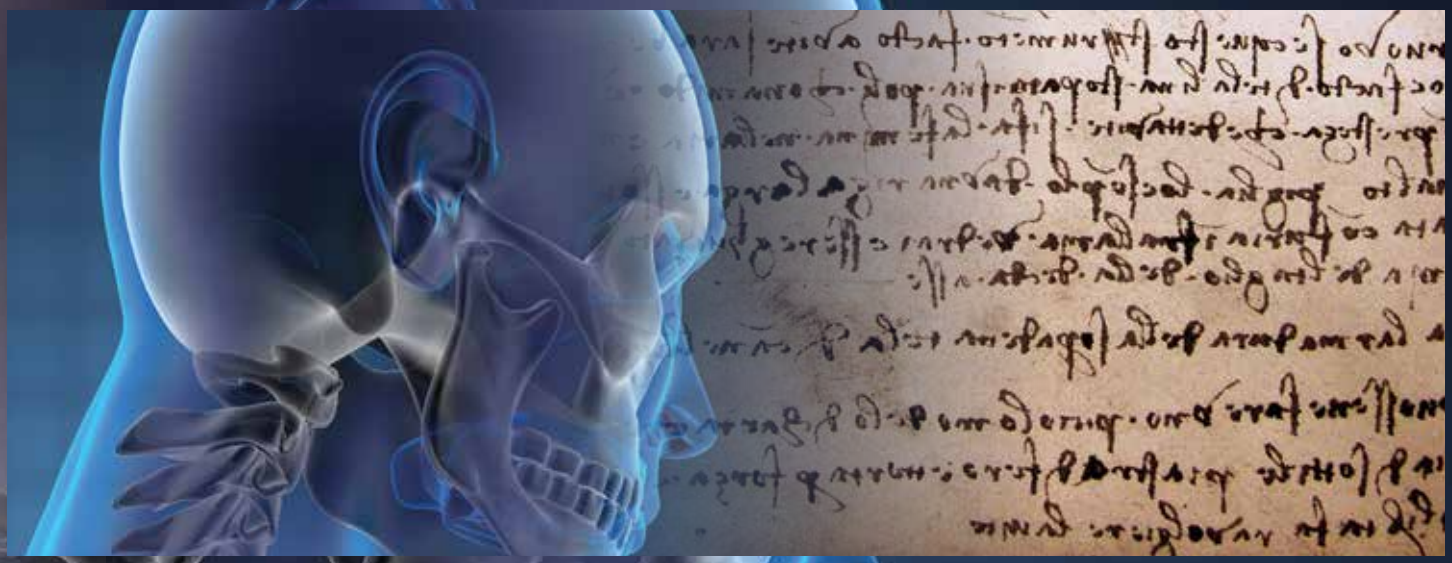
Stoffel Grobelaar

Work absence also tends to perpetuate itself: that is, the longer someone is off work, the less likely he or she is ever to return. If a person is off work for 20 days, the chance of ever getting back to work is 70%; 45 days, the chance of ever getting back to work is 50%; and 70 days, the chance of ever getting back to work is 35%.

At a societal level, the economic costs of work absence place a significant burden on national economies, and the condition is now considered to be a public health problem. In South Africa, the cost of sick leave runs into the billions every year. Absence due to sickness has increased sharply in South Africa over the past decade. In 2013, at a given point in time, 3.7% of workers were on sick leave; whereas a decade earlier, in 2001, 0.7% of workers were absent from work due to sickness. In 2013, the loss of output due to absenteeism totalled R4.29 billion in direct costs. According to the Adcorp Employment Index report of August 2013, 3.96 million workers were absent due to sickness during the year, compared to 700 000 in 2000. This represents an increase of 466%, despite the fact that the number of people employed was essentially the same over the decade.

THE FUNCTION AND SCOPE OF A SICKNESS CERTIFICATE

A sickness certificate creates a link between work and health. It functions as the entry and exit gate to health-related income support and basically provides access to financial benefits whilst off sick. Following a 'fitness for work' consultation and the production of a sickness certificate, a person can be exempted from work and normal responsibilities while they recover from the effects of illness or injury.



Income maintenance payments can be disincentives to resuming work. The availability of income replacement benefits may act as an incentive for workers with marginal disabilities to drop out of the work force and seek these benefits instead, particularly where there is relatively loose control of the gateway to such benefits. The receipt, or potential receipt, of disability benefits may act as a disincentive to rehabilitation as well.

Once the patient starts receiving income replacement benefits, it may act as a financial barrier to returning to work once better or finding part-time work which will increase his or her income but will result in the discontinuation of his or her income replacement benefits, leading to the so-called 'benefit trap'.

SICKNESS CERTIFICATES IN SOUTH AFRICA

The Health Professions Council of South Africa's Ethical and Professional Rules of the Medical and Dental Professions Board provides doctors with guidance to the writing of sickness certificates.

ACCORDING TO RULE 15.(1)(G) OF THE ETHICAL AND PROFESSIONAL RULES 'CERTIFICATES OF ILLNESS' SHOULD INCLUDE 'WHETHER THE PATIENT IS TOTALLY INDISPOSED FOR DUTY OR WHETHER THE PATIENT IS ABLE TO PERFORM LESS STRENUOUS DUTIES IN THE WORK SITUATION'.

Rule 16 states that:
"A practitioner shall grant a certificate of illness only if such certificate contains the following information: (a) the name, address and qualification of such practitioner; (b) the name of the patient; (c) the employment number of the patient (if applicable); (d) the date and time of the examination; (e) whether the certificate is being issued as a result of personal observations by such practitioner during an examination, or as a result of information which has been received from the patient and which is based on acceptable medical grounds; (f) a description of the illness, disorder or malady in layman's terminology with the informed consent of the patient: Provided that if such patient is not prepared to give such consent, the practitioner shall merely specify that, in his or her opinion based on an examination of such patient, such patient is unfit to work; (g) whether the patient is totally indisposed for duty or whether such patient is able to perform less strenuous duties in the work situation; (h) the exact period of recommended sick leave; (i) the date of issue of the certificate of illness; and (j) the initial and surname in block letters and the registration number of the practitioner who issued the certificate".

Furthermore, the rule states that the certificate of illness has to be signed by a practitioner next to his or her initials and surname printed in block letters. A practitioner may also issue a brief factual report to the patient upon the request of the patient.

The law considers sickness certificates as a legal document that 'enjoys the full and indisputable notion of truth'. In other words, the law assumes that the sickness certificate is limited to medical facts; is based on the practitioners' own questioning and examination; is produced by the practitioner who establishes the facts in person; is completely truthful; is guaranteed by the practitioners' conscientiousness and faithfulness; and is certified by a signature and identification.

SICKNESS CERTIFICATION TRENDS IN OTHER COUNTRIES

It is not only in South Africa that doctors are grappling with the thorny issue of sickness certificates. Sickness certification has been under the spotlight in a number of European countries, amongst them Norway, Sweden, and the United Kingdom, where regulations for the issuing of sick leave are being modified in order to make medical practitioners aware of the benefits of work and reverse the "sick note culture".

In Norway, sick leave fell by a formidable 20% after the Norwegian authorities launched their reform plans, which in essence involved increasing the amount of administrative work for doctors when issuing sickness certificates.

Sick notes and the Psychiatrist *Cont...*

Furthermore, in Australia, there was a 70% increase in requests for sickness certificates between 2000 and 2009, prompting the release of a position statement by the Australasian Faculty of Occupational and Environmental Medicine entitled 'Realizing the Health Benefits of Work'.

A QUESTION THAT MANY DOCTORS ASK, ESPECIALLY IN PSYCHIATRY, IS 'HOW DOES ONE DECIDE THE LENGTH OF TIME REQUIRED OFF WORK FOR OPTIMAL MANAGEMENT OF PSYCHIATRIC DISORDERS?' THE ANSWER IS NOT ALWAYS FORTHCOMING AND MOST CLINICIANS RELY ON THEIR CLINICAL JUDGEMENT AND EXPERIENCE WHEN DECIDING ON THE LENGTH OF TIME A PATIENT NEEDS TO BE OFF WORK IN ORDER TO RECUPERATE.

In Sweden, practitioners can get guidance with regard to the length of sickness certification of numerous medical conditions, ranging from bronchitis to tinnitus and including mental disorders, on the Swedish National Sickness Certification Guidelines website available at **http://www.socialstyrelsen.se/riktlinjerforsakringsmedicinsktbeslutsstod** and in the USA guidance is available for doctors on the US Department of Health and Human Services' website at **http://www.guideline.gov/content.aspx?id=47588&search=mental+illness+stress.**

SKILLS REQUIRED IN MANAGING THE "SICK-ROLE"

There appears to be a common naive belief that being away from work will in itself 'allow the medication to work and the patient to heal' in an atmosphere of reduced stress. The quality of the advice given to patients on their fitness for work, however, depends to a large degree on the skills of the doctor in managing these clinical areas and in addressing the relevant occupational factors.

STUDIES HAVE SHOWN THAT OLDER DOCTORS AND THOSE CONSULTING AT A HIGHER RATE PER HOUR ISSUE MORE CERTIFICATES, AND DOCTORS WITH A HIGH LEVEL OF POSTGRADUATE TRAINING ISSUE FEWER CERTIFICATES.

There are several factors psychiatrists should consider when advising patients on fitness for work. The factors together with the skills required are depicted in Table 1.

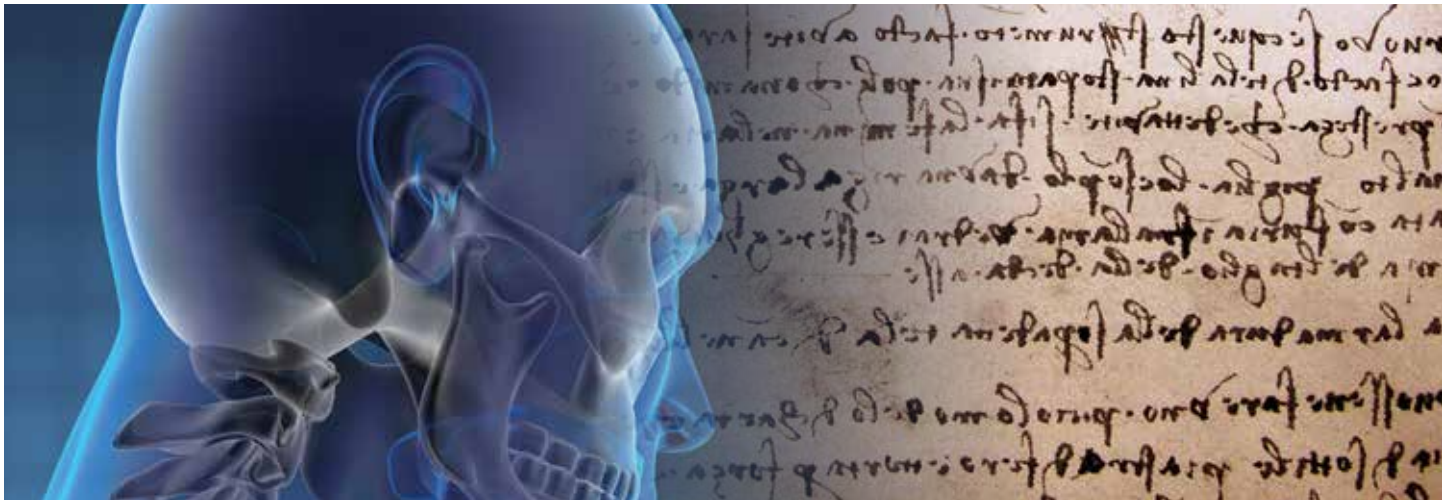


Table 1. Clinical knowledge and skills relevant to sickness certification

FACTORS TO CONSIDER	SKILLS REQUIRED
The nature of the patient's medical condition and how long the condition is expected to last.	Skills as a diagnostician and in accessing data about appropriate periods of incapacity for different conditions.
Functional limitations due to the condition, particularly in relation to the tasks the patient performs at work.	Skills in functional disability assessment, taking an occupational history and knowledge of the workplace.
Any reasonable adjustments that might enable the patient to continue working.	An understanding of the needs of employers and employees and relevant legislation including the Employment Equity Act and the employer's obligation towards 'reasonable accommodation'.
Clinical management of the condition which is in the patient's best interest regarding work fitness.	Skills in therapeutics and current best clinical practice and evidence-based treatment guidelines. Knowledge and understanding of the occupational therapist's role in functional assessment and vocational rehabilitation.
Managing any conflict of interest between the psychiatrist's advocacy role and the patient's need for economic support or compensation.	Knowledge of roles and responsibilities of the certifying doctor, the employer and the various other agencies involved. Skills in negotiation and managing confrontation.
Managing the patient's expectations in relation to his or her ability to continue working.	Skills in clinical consultation and eliciting any 'hidden agendas'.

BARRIERS TO RETURNING TO WORK

It is not uncommon for patients, after being booked off for some time, to be faced with obstacles to returning to work. These include:

- **Stigma and discrimination by employers and the public. Disabled people regularly put employers' negative attitudes high on their list of barriers to working. This is particularly the case for people with mental health problems.**

- **The benefits trap. Disabled people are understandably reluctant to risk a return to work and give up their benefits in case the job does not work out. Furthermore, disabled people report difficulty with accessing appropriate information about in-work benefits.**

- **Loss of motivation, confidence and skills. Maintaining motivation, self-confidence and self-belief is considered to be an important indicator of employability. In this context, the attitudes and expectations of relatives and friends are also very important.**

CONCLUSION

Throughout history, paradigm shifts in medicine have resulted in significant improvements to treatment, patient wellbeing and health outcomes. The best currently available evidence clearly states that another paradigm shift is required in relation to how we think about health and work. Long-term work absence and work disability may not seem like life and death matters but research shows that they are associated with a range of poor health outcomes including increased mortality rates. Issuing sick certificates not only has an immediate effect on the economy of the country but thoughtless re-issuing of sick certificates, repeatedly, without consideration of the medical reasons as to why inactivity is necessary, may in fact be outright harmful to a patient. Given the complex and challenging situation that psychiatrists involved in sickness certification find themselves in, it is vital that we show leadership on this issue.

The message is clear; work is generally good for people, and work absence is not. Sickness certificates should be issued with the same caution that applies to other treatments carrying significant health risks.

Stoffel Grobler is a psychiatrist and clinical head at Elizabeth Donkin Hospital in Port Elizabeth and an Associate Professor at the Walter Sisulu University medical school. He is also a part time lecturer at the Nelson Mandela Metropolitan University in the Department of Psychology as well as nursing. At present he is doing research in the areas of suicide and substance abuse and he has a special interest in psychiatric impairment assessment. **dr.stof@mweb.co.za**

THE OFF WORK CERTIFICATE

A recently published study by Australian researchers (http//www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0105430) found that "continuing to work while experiencing a depressive illness may offer employees certain health benefits, while depression-related absence from work offers no significant improvement in employee health outcomes or quality of life".

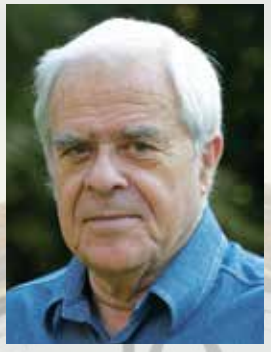
Mike Ewart Smith

The study, motivated by concern about the staggering costs to the economy of sick-leave, used complex socio-economic models with which few clinicians will be familiar or comfortable. There is virtually no reference to clinical features which normally play such an important part in determining whether a depressed employee should be granted absence from work. And, as is prominently acknowledged in the paper, most of the results of the actuarial calculations of societal costs could be due to the fact that patients who are more severely ill are more likely to be off work, and for longer, and to be treatment resistant.

However, the authors offer a persuasive and perhaps clinically relevant argument for immediate proactive workplace adaptations if a depressed employee, for whatever reason, decides to attend work rather than take time off: presenteeism rather than absenteeism. In practice we often press employers for such accommodations further down the line, when we are trying to get patients back to work who have been off for lengthy periods of time.

SHOULD WE MOTIVATE FOR GENERAL ACCEPTANCE THAT MANY CASES OF COMMON PSYCHIATRIC DISORDER WOULD BE BEST MANAGED FROM THE OUTSET, BY RELATIVELY SIMPLE FORMS OF WORKPLACE ACCOMMODATION, SUCH AS TRANSFER TO ANOTHER DEPARTMENT, REALIGNMENT OF THE WORK DEMANDS, ALLOWING CERTAIN PATIENTS TO ONLY WORK DAY SHIFTS, OR SHORTER WORKING HOURS ?

If the simplistic news media headlines and coverage which such findings inevitably precipitate, cause psychiatrists to sometimes pause for thought before issuing off work certificates, the study will have served a very important function. The number of working days lost due to psychiatric illness continues to increase dramatically, with by far the commonest diagnoses being mood and anxiety disorders. Some believe that these conditions have become more common, others that we have become more expert at recognising them. Or, it may be that we now include as disorders, conditions formerly regarded as at best subsyndromal syndromes, or even normal psychological and emotional responses to life's adversities.



Mike Ewart Smith

In any event, in clinical practice, a significant sub-set of patients perceive that their symptoms have been caused or made worse by some or other aspects of their work circumstances.

Their demands for off work certificates are pressing. Anti-stigma campaigns, which are of course good things, do unfortunately remove the inhibitions which might have prevented predisposed patients from using the easily obtainable psychiatric labels for various forms of secondary gain, including time off work.

It is little consolation to realise that this is increasingly recognised as a worldwide phenomenon and concern about it is not limited to South Africa. For example, the American College of Occupational and Environmental Medicine (ACOEM) warned in its 2006 Guidelines that job dissatisfaction is one of the strongest statistical predictors of "disability', associated with a lack of motivation to work, and then legitimised as medical illness by the sickness certificate and other supportive documents issued by treating physicians.

ACCORDING TO ACOEM WE MUST "STOP ASSUMING THAT ABSENCE FROM WORK IS MEDICALLY REQUIRED AND THAT ONLY CORRECT MEDICAL DIAGNOSIS AND TREATMENT CAN REDUCE DISABILITY".

It does seem that psychiatrists are less resistant to issuing long term off work certificates as part of the management of anxiety and mood disorders. To add to the problem, psychiatric off work certificates are increasingly issued by general practitioners, various grades of psychologists, and now also by traditional healers. It is acknowledged that

most composers of these documents are conscious of their important role as patient advocates, and believe that they are acting in the best interests of the patient. They do, however, seem strangely unsympathetic to the interests of other agents, including not only employers but also other workers, stressed by having to cover for their absent colleagues.

In any event, and most important, there are also persuasive clinical reasons to believe that excessive time off work is undesirable.

MULTIPLE STUDIES REVEAL THAT PATIENTS WHO ARE NOT WORKING ARE SUSCEPTIBLE TO A PROGRESSIVE DECLINE IN HEALTH, THAT THEY ARE AT INCREASED RISK OF SUICIDE, THAT INTERPERSONAL AND FAMILY RELATIONSHIPS DETERIORATE AND THAT FINANCIAL DIFFICULTIES ARE COMMON. LOSS OF, OR WORSENING OF, EXISTING FEELINGS OF SELF WORTH IS COMMON. IN GENERAL THERE IS LIKELY TO BE AN EROSION OF THE INDIVIDUAL'S QUALITY OF LIFE. AND THERE IS A PUBLIC HEALTH ASPECT ALSO, PERHAPS PUTTING US ALL AT RISK, BECAUSE SMOKING RATES APPARENTLY INCREASE IN PATIENTS OFF WORK.

How then should we decide on the length of time patients should be off work? There is no scientific evidence or data base on which to determine optimal time off work in the management of common psychiatric disorders. We do not even have robust epidemiological data on the length of time for which episodes of anxiety or depressive disorders persist, never mind how to predict this in individual patients.

Yet it is common for off work certificates on psychiatric grounds in South Africa to be issued for periods of 3 or 6 or even 12 months, to allow the patient "to recuperate" or to "work through issues in therapy". Often this is "escape therapy" and many patients enter disability mode. Overseas figures show that only a minority of patients off work for longer than 6 months will ever return to work.

Surely the emphasis during any such period of extended leave should be on using the time to prepare the patient for returning to the open labour market, even if it is not to exactly the same position held before the episode of illness. Who will pay for the rehabilitation programmes? Until economists persuade the powers that be that long term benefits outweigh sort term costs, a change in attitude to the management of individual patients could improve the management of patients with phobic aversion to their perceived noxious workplace. Reassessment of how medical aid benefits are utilised, perhaps managing to save a bit on costs of medication, perhaps reviewing some aspects of expensive, current hospital admission practices, perhaps a rethink about the focus of, and conceptualisation of, some psychotherapy programmes.

According to Rule 16 of the Ethical and Professional Rules of the HPCSA (2008), Paragraph 1(g), an off work certificate should state "whether the patient is totally indisposed for duty or whether such patient is able to perform less strenuous duties in the work situation". Do you sometimes forget about that part? If so, I assure you that you are not alone.

If there is a date left, not yet taken by some good cause, I motivate for it to be assigned as "Think Before You Sign The Off Work Certificate Day".

References and relevant background information can be obtained directly from the author.

Mike Ewart Smith is the former principal psychiatrist at Sterkfontein Hospital. He is an honorary consultant in the Department of Psychiatry at the University of the Witwatersrand. He is in private practise and actively involved in disability assessments. **drmike@ewartsmith..co.za**

Lavinia Lumu Workload indicators in staffing needs

A critical review

The Workload indicators in staffing needs (WISN) is a tool developed to measure human resource capacity. The World Health Organisation (WHO) developed WISN in the late 1990s to address the issue of human resources in the health sector. The WISN tool has been utilised for many years in the business sector and has now been adapted for the health sector.

Other methods of determining human resource requirements such as the population-to-staff ratios were previously utilised but have a number of pitfalls. This method does not address the nature of the work done by the health professional and the time taken to carry out a specific work activity.

THE WISN TOOL DETERMINES HOW THE HEALTH PROFESSIONAL SPENDS THEIR TIME IN A SPECIFIED WORKING PERIOD AND ALSO WHAT IS DONE DURING HOURS OF PRODUCTIVITY. STANDARDISED STAFFING NORMS ARE REQUIRED TO DETERMINE WHAT A HEALTH PROFESSIONAL DOES IN AN AVERAGE WORKING DAY, AND IS REFERRED TO AS AN ACTIVITY STANDARD. THE ACTIVITY STANDARD FOCUSES ON SPECIFICS E.G. THE AVERAGE PSYCHIATRIST IS ABLE TO ASSESS EIGHT NEW PATIENTS IN AN EIGHT HOUR WORKING DAY.

The WISN tool then calculates that in a given patient-population, a certain number of health professionals are required to ensure that the service provided is efficient. The tool aims to address important issues in health such as long waiting times experienced by many patients, especially in the public health sector.

The WISN tool also aims to determine areas where there is an imbalance in staffing of health professionals. In keeping with the WHO, the WISN tool aims to ensure equal distribution of health professionals and equal access to efficient health services for the specified patient-population. Some areas may be over-staffed, and based on the model, health professionals may be redeployed to areas where there is a greater need.

The WISN tool is heavily reliant on accurate statistical capturing of the capacity of health professionals and their Standard Activity and also quantifying the patients seen over a specified period.

The National Health Insurance is imminent and aims to provide equal access of health-care for all people irrespective of socio-economic background. In South Africa, the gap between rich and poor has widened. The majority of the population is highly reliant on the public health sector, which is heavily under-resourced. This has resulted in an inefficient and ineffective functioning health sector. The minority of the population has access to the private health sector, which is well resourced with adequate staffing and in some instances overstaffing of health professionals, thus resulting in a highly efficient and effectively functioning private sector.

The WISN tool is important as it may assist the Department of Health in determining how severe the shortage of health professionals is and which areas of the country have the greatest need. It is unclear though, whether this tool will be applied to the public health sector alone or both the private and public health sectors.

So far the first phase of implementation of the WISN tool has taken place where health professionals from different specialities at all levels have been consulted to determine Standard Activity norms. In other words, the first phase has included trying to quantify what for e.g. the average specialist psychiatrist or registrar does in a forty-hour week at a specified centre e.g. a tertiary hospital.

The drawbacks of the consultation process are attempting to determine what the average specialist does in a day, as this may vary from person to person. Some doctors may be highly efficient, being able to see a large volume of patients in a specified period of time and others may be deemed as less efficient if they are not able to see as many patients in a specified period of time (according to Standard Activity norms).

THERE ARE FACTORS THAT NEED TO BE ANALYSED THAT THE WISN TOOL FAILS TO INCORPORATE INTO CALCULATING STANDARD ACTIVITY. HUMAN RESOURCE FACTORS THAT MAY IMPACT ON EFFICIENCY INCLUDE INEXPERIENCE, WHICH MAY SLOW DOWN PRODUCTIVITY AND THE NATURAL PACE OF THE SPECIFIC HEALTH PROFESSIONAL, AS SOME HEALTH PROFESSIONALS MAY BE NATURALLY SLOWER THAN OTHERS.

Patient factors also have an impact on the efficiency of a service provided. Patients may present with multiple problems and may be highly complicated resulting in more time being spent on them compared to a patient who may present with a simple problem that could be sorted out quickly.

In the discipline of Psychiatry, patients may be variable. Some patients may be more difficult than others with a range of complexity to their presentations. Other factors that need to be taken into account that indirectly affect the patient include liaising with families and allied health professionals. In some instances this is time consuming but essential in improving patient outcomes.

THE DIFFICULTY IS DETERMINING EFFICIENCY AND EFFICACY.

The WISN tool can easily quantify efficiency for e.g. the average vehicle manufacturing factory worker may be able to assemble eight vehicles in an eight hour working day and may be deemed as efficient. On the other hand, another factory worker who assembles less than the expected eight cars in an eight hour working day may be deemed as inefficient.

EFFICACY IN THIS INSTANCE WOULD FOCUS ON IMPROVED OUTCOMES AND THE QUALITY OF THE WORK. IN THE SAME EXAMPLE, THE FACTORY WORKER MAY BE DEEMED AS HIGHLY EFFICIENT BY BEING ABLE TO ASSEMBLE EIGHT CARS IN AN EIGHT HOUR DAY BUT THE CARS ASSEMBLED MAY HAVE FAULTS AND ERRORS. THIS MAY THEN DEEM THE FACTORY WORKER AS INEFFICACIOUS.

The WISN tool would work well with this crude example but the difficulty is how one determines the efficiency and the efficacy of the services provided by health professionals. It is difficult to quantify the efficiency and the efficacy of health professionals because of the multiple variables that may interfere with service delivery. Issues such as human resource shortages, a lack of adequate tools and infrastructure can all prevent health professionals from delivering an efficient and efficacious service to the population at large.

Despite the pitfalls of the WISN tool, it is a human resource tool that will be implemented to enable government to measure and quantify staffing needs. This is a first step in making a diagnosis of the ills of health in South Africa so that solutions can be brainstormed in an effort to deliver equal quality health care to all. However, for this process to yield a meaningful return, in the mental health domain, accuracy of input information based on understanding the specific discipline related factors is essential. The latter will require involvement of all likely to be affected.

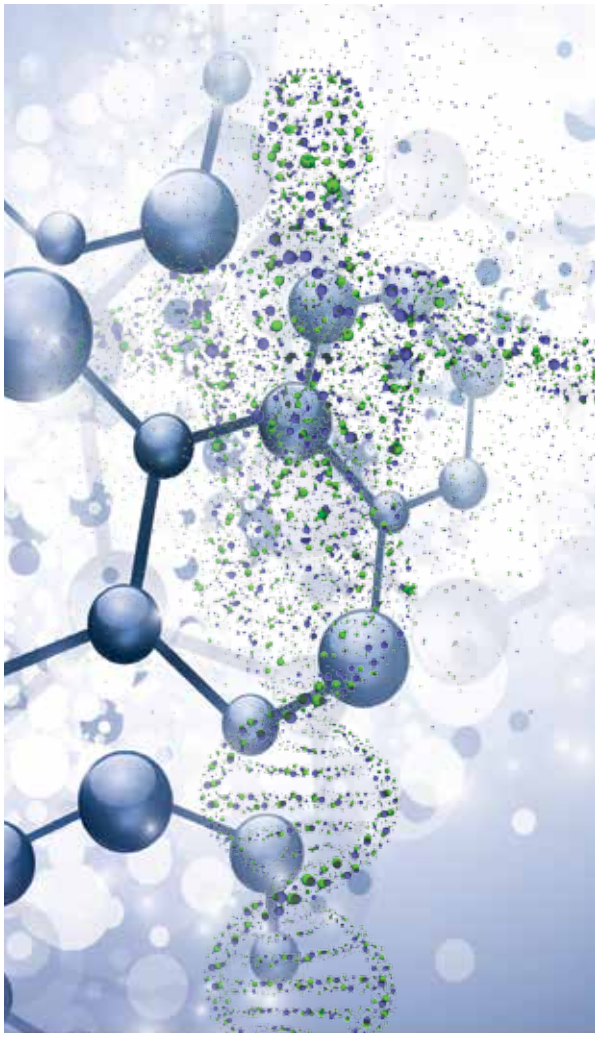
Lavinia Lumu is a psychiatrist in the Department of Psychiatry at the Charlotte Maxeke Johannesburg Academic hospital, Johannesburg with a joint appointment in the Department of Psychiatry at the University of the Witwatersrand, Johannesburg. Her areas of interest include biological and child psychiatry.
ldlumu@yahoo.com

THE POLYPHARMACY DITTY
HOW MANY IS TOO MUCH?

A few months ago, Steven Stahl, the renowned psychopharmacology guru, visited. His talks were interspersed with karaoke-like videos of ditties about drugs, with coloured smarties dancing above the words for the audience to sing along.

Sean Kaliski

One of the songs extolled the virtues of just adding more drugs to regimens for bipolar disorder, even up to 7 or more drugs. He readily muttered that there was no science underlying this, but, hey, aren't we all working in the real world and are not our patients' well-being our primary concern? The more you prescribe the more you care. He then asked the audience to give him examples of novel combinations they had tried, followed by whether anyone in the room had used agomelatine (whose manufacturer had sponsored his visit) in any interesting combinations. Leaving aside the obvious consideration that agomelatine deserves to be examined and used on its own merits the horror of the evening (apart from the novel experience of having a speaker sing for our supper) was that most of our colleagues seemed to bask in the invitation to indulge in some good old fashioned alchemy. Up went the hands, and the well worn "I had a patient....". In other words my anecdotal experience is your scientific proof.

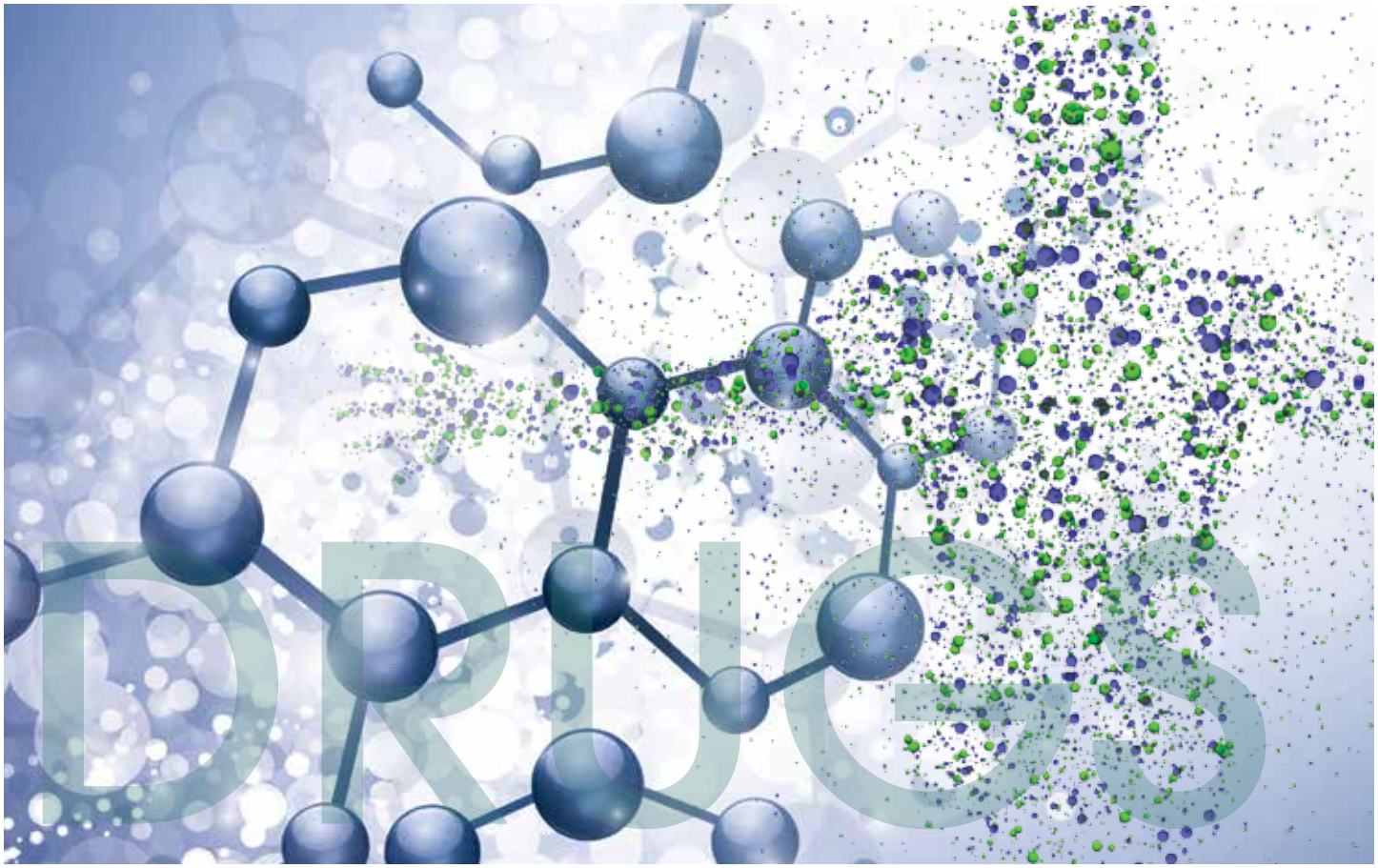


Psychiatry was almost rescued from being another quasi-scientific but religious sect under the sway of charismatic prophets by the promise that the evidence provided by biological explanations and treatments for mental illness (for maybe there is after all only one disorder) would convince our medical colleagues of our rightful place in the pantheon of sciences. Despite the euphoria that greeted the introduction of the so-called first generation drugs 60 years ago by the 1970's only about 3.3% of bipolar patients were treated with combinations of drugs. Then as the spigots opened and the cornucopia of second generation drugs gushed into our practices the prevalence of polypharmacy increased to 9% in the early 1980's, 34% in the late 1980's, 43% in the 1990's and about 60% by 2005. Nowadays a patient will rarely leave a first consultation with a prescription with less than 3 drugs, namely, an antidepressant (at least), hypnotic, and an anxiolytic. If the now ubiquitous diagnosis of bipolar type 2 is also uncovered then expect dollops of a 'mood stabiliser' to be added to the brew.

Sean Kaliski

THE MOST ASTONISHING SCRIPT I HAVE SEEN CONTAINED A LIST OF 12 PSYCHOTROPIC DRUGS TO TREAT A DEPRESSED ALCOHOLIC. YES, TWELVE DRUGS, WHICH MUST HAVE COST THE EQUIVALENT OF THE MONTHLY RENT IN AN UPMARKET PENTHOUSE. I ASSESSED THE PATIENT BECAUSE HE INSISTED THAT HE COULD NOT WORK AS HE SPENT MOST OF THE DAY SLEEPING AND LYING AROUND! HAVE PATIENTS BECOME SICKER, OR HAS THE EFFECTIVENESS OF OUR DRUGS DWINDLED?

The really depressing part is that there is almost no science underlying the practice of polypharmacy. How can there be, when there are unresolved methodological problems, such as subject selection, disagreement as to which drugs to use in combination and how many drugs to use, and for how long should such trials persist etc? And which pharmaceutical firms would rush to sponsor studies



that test their products as part of some heady brew? All we have to guide us are the opinions of experts, who invariably justify the use of combinations of drugs by resorting to theoretical considerations of their purported actions and therefore interactions. Clinicians accept their plausible explanations and opinions as accepted science, when in fact they are actually just hypotheses in search of real empirical evidence. So we do not really know for sure that large cocktails of drugs are actually beneficial. More importantly, we do not know the effects of using such cocktails over many years. What we do seem to know is that patients treated with polypharmacy may relapse readily when medication is discontinued or reduced to monotherapy. It is as if we have created a large cohort of legal drug addicts.

THIS MUCH WE DO KNOW: SOME OF THE DATA USED TO REGISTER MANY ICONIC DRUGS WERE FALSIFIED, AND MANY NEGATIVE TRIALS WERE SUPPRESSED. INCREASING EXPERIENCE HAS INFORMED US THAT THE SECOND GENERATION DRUGS, WHICH ARE MUCH MORE EXPENSIVE, ARE PROBABLY NOT MORE EFFECTIVE THAN THE FIRST GENERATION DRUGS (WHICH WERE PRESCRIBED IN MUCH TOO HIGH DOSES ANYWAY), AND THEY ALSO HAVE HORRENDOUS SIDE EFFECTS.

The bogey of extrapyramidal side effects has now been superseded by the more unpleasant metabolic syndrome (what would you rather have, a fluttering tongue or diabetes with atherosclerosis?). The acceptance that these drugs may not be terribly effective on their own does not permit the assumption that they work better when part of a cluster of similarly poorly effective drugs. There are also studies that suggest that polypharmacy is associated with cardiovascular problems, and that patients on multiple antipsychotics may be associated with an increased risk of mortality, especially older patients.

AND OF COURSE, WHATEVER HAPPENED TO THE OLD ADAGE THAT PSYCHIATRISTS SHOULD TALK TO THEIR PATIENTS AND HELP THEM OVERCOME THEIR REAL PROBLEMS, WHETHER THOSE RESIDE WITHIN THEIR OWN PERSONALITIES OR ENVIRONMENT?

We can accept that combination treatments have become the mainstay of psychiatric practice. But when does acceptable combination therapy transmute into unacceptable polypharmacy? We do not really know. This is a much needed area for research. But surely prescribing more than 4 drugs, especially in combinations that are likely to increase the risk of adverse effects ought to be avoided. In the absence of good empirical evidence psychopharmacology is dominated by eminent prophets and not scientists. Then we may as well resurrect all the old psychoanalysts and revert to our magical past.

References are available from the author.

Sean Kaliski is a Forensic Psychiatrist and Principal Specialist at Valkenberg/Lentegeur Hospitals in Cape Town. He is an Associate Professor in the Department of Psychiatry and Mental Health at the University of Cape Town. **sean.kaliski@uct.ac.za**

Bernard Janse van Rensburg South African participation at the 16th World Psychiatric Congress of the WPA in Madrid, 14th - 18th September 2014

The 16th World Psychiatric Congress of the World Psychiatric Association (WPA) was held recently in Madrid from 14th - 18th September 2014. A provisionally estimated number of 6700 psychiatrists across the world attended this meeting, including several South African psychiatrists who participated in committee activities and presented symposia and oral presentations.

These included:
Prof. Jonathan Burns (Department of Psychiatry, University of Kwazulu-Natal) who is also the Secretary of the WPA Section on Public Policy and Psychiatry, Prof. Dan Stein (Department of Psychiatry and Mental Health, UCT), Prof. Werdie van Staden (Department of Psychiatry, University of Pretoria), Prof. Solly Rataemane (Department of Psychiatry, University of Limpopo) - the outgoing WPA Zonal Representative for Eastern and Southern Africa after completing two three-year terms and chair of the WPA Section on Conflict Resolution and Management, as well as Prof. Bernard Janse van Rensburg (Department of Psychiatry, University of the Witwatersrand) who has been elected as Secretary of the WPA Section on Religion, Spirituality and Psychiatry. Dan Stein, who celebrated his birthday during the congress, delivered one of the invited key-note lectures of the congress on "Anxiety Disorders: an integrated approach".

John Cox, Werdie Van Staden, Bernard Janse van Rensburg, Peter Verhagen

SEVERAL SYMPOSIA WERE ORGANISED BY THE LOCAL PARTICIPANTS, INCLUDING:

- South African symposium on diagnostic systems and local psychiatry: Christopher Szabo (Head of the Department of Psychiatry, University of the Witwatersrand), Gerhard Grobler (Department of Psychiatry, University of Pretoria), Mvuyiso Talatala (private practice at Lesedi Clinic, Soweto) and Bernard Janse van Rensburg (Department of Psychiatry, University of the Witwatersrand)

Tarek Okasha, Dan Stein

- Symposium on "Global Mental Health Priorities" organised by Solly Rataemane, with speakers including Dr Saul Levin (CEO and Medical Director of the APA), Prof. Jack McIntyre, Michelle Riba, Elliot Sorel (USA) and Prof. Paul Summergrad, current APA President as discussant.

- An intersectoral symposium arranged by Bernard Janse van Rensburg between the three Sections on Philosophy in Psychiatry, Religion, Spirituality and Psychiatry, and Conflict Resolution, entitled "Philosophical and practical aproaches to the management and resolution of conflicts." Participants included Prof. John. Cox (UK and WPA Section on Religion, Spirituality and Psychiatry), Dr. Peter Verhagen (Netherlands, outgoing Chair WPA Section on Religion, Spirituality and Psychiatry), Werdie van Staden and Bernard Janse van Rensburg.

WPA ELECTION 2014 - 2017

During the recent 16th World Psychiatric Association Congress in Madrid (14th - 18th September 2014), the following officials were elected to office in the Executive Committee (EC) of the World Psychiatric Association (WPA) for the next triennium **(www.wpanet.org)**:

PRESIDENT
– PROF. DINESH BHUGRA (UK)
PRESIDENT-ELECT
– PROF. HELEN HERRMAN (AUSTRALIA)
SECRETARY GENERAL
– PROF. ROY KALLIVAYALIL (INDIA)
SECRETARY FOR FINANCES
– PROF. ARMEN SOGHOYAN (ARMENIA)
SECRETARY FOR SCIENTIFIC MEETINGS
– PROF. MASATOSHI TAKEDA (JAPAN)
SECRETARY FOR EDUCATION
– PROF. EDGARD BELFORT (VENEZUELA)
SECRETARY FOR PUBLICATIONS
– PROF. MICHELLE RIBA (USA)
SECRETARY FOR SECTIONS
– DR AFZAL JAVED (PAKISTAN)

In addition to the Executive committee, new representatives for the 18 WPA Zones across the world were also elected during this meeting whom with the EC, will be constituting the new WPA Board.

Bernard Janse van Rensburg

Relevance of diagnostic criteria in Psychiatry: A South African Perspective

A symposium organized and presented at the recent World Psychiatric Association Congress in Madrid , September, 2014

A South African symposium on diagnostic systems and local psychiatry was recently presented during the 16th World Psychiatric Congress held in Madrid from 14-18 September 2014. This symposium was chaired by Solly Rataemane, Head of the Department of Psychiatry, University of Limpopo, and Bernard Janse van Rensburg. The four speakers were Christopher Szabo (Head of the Department of Psychiatry, University of the Witwatersrand), Gerhard Grobler (Department of Psychiatry, University of Pretoria), Mvuyiso Talatala (private practice at Lesedi Clinic, Soweto) and Bernard Janse van Rensburg.

THE SYMPOSIUM ADDRESSED A RANGE OF ISSUES, INCLUDING THE IMPLICATIONS OF DIAGNOSTIC CRITERIA FOR SERVICE PROVISION IN TERMS OF THE PROPOSED NATIONAL HEALTH INSURANCE SYSTEM AS WELL AS FOR POST GRADUATE TRAINING, CONTINUOUS MEDICAL EDUCATION AND RESEARCH.

Although the International Classification of Disease (ICD) system has generally been used in South Africa for many years, the American Diagnostic and Statistical Manual (DSM) classification has also been adopted for decades by South African Psychiatry as a common conceptual basis for the description of psychiatric conditions and making diagnoses. In practice, this dual system has therefore existed for an extended period of time, whereby the ICD system is used for health statistics and resource allocation in the public sector, as well as for the billing of private health care funders, whilst DSM criteria are used to define the scope of psychiatric disorders and motivating care options. South Africa has therefore also been sharing in the periods of transition from previous editions to newer ones, e.g. in the 1990's to DSMIV-TR and again, recently, from DSMIV-TR to DSM-5. In recent years there has been local discussion about the limitations of the use of "Western" diagnostic systems in non-Western communities. While some viewed the current period of transition as an opportunity to reconsider the need to use both systems, the South African Society of Psychiatrists convened a task team towards the end of 2013, consisting of local academic heads and representatives from the public and private sector, to make recommendations.

Christopher Szabo addressed the controversies regarding the use of DSM-5 criteria in a South African context and the implications for post graduate psychiatric training. He noted that the publication of the 5th edition of the DSM in 2013 was preceded by much controversy, related as much to content as politics. Whilst a product of the American Psychiatric Association - and of direct relevance to psychiatrists in the United States of America - the DSM has, with its unique focus on Psychiatry, during the course of its various iterations established itself as a reflection of psychiatric nomenclature internationally. However, this has not been without controversy, not least of all because it stands in contrast to the World Health Organization's

Gerhard Grobler, Mvuyiso Talatala, Bernard Jane van Rensburg, Solly Rataemane, Christopher P.Szabo

ICD where Psychiatry constitutes only one component. While the ICD is currently in its 10th revision with the 11th anticipated, academic psychiatry continues to use the DSM as the basis for formal teaching of undergraduate medical students and post graduate specialist trainees, as well as for research.

Gerhard Grobler compared the DSM and ICD systems and examined its application in both the South African public and private sectors in the context of an integrated health care system. He alluded to the position statement that the South African Society of Psychiatrists (SASOP) published in November 2013, as advised by its Classifications Task Team, on the local use of both these two classification systems (see below).

Mvuyiso Talatala's presentation addressed the implications that diagnostic formulation has for specialists' coding and remuneration in South African private practice. He noted that although psychiatrists in South Africa are trained in terms of the DSM they are required by health funders to document diagnoses using the ICD classification for billing purposes. This implies that this ICD coding of disorders may not always be a true reflection of patients' actual (DSM) diagnoses. He concluded that the two diagnostic systems are most likely to remain in use in South Africa in both private and public sector, especially as South Africa moves towards a universal health insurance system.

Bernard Janse van Rensburg referred to cultural perspectives on the diagnostic systems and criteria used in a South African context, and reviewed its implications for the diagnosing of psychiatric disorders. He noted that the previous DSM IV-TR already formally introduced a cultural formulation to be added to the assessment of patients, as well as a glossary of culture-bound syndromes. Subsequently, discussion also followed in the literature about the overlapping dimensions of culture, religion and spirituality, emphasizing the need for clear definitions of terms and a critical review of available measures for research purposes. More recent developments include, for example: (1) DSM-5 continuing on this track by extending its content to include the Cultural Formulation Interview (CFI) to achieve a cultural formulation; and (2) locally, the current review of the South African College of Psychiatrists' syllabus for postgraduate training in Psychiatry.

These developments, amongst others, require for example specific recommendations regarding the adoption and integration of the CFI as an expected clinical competency, in terms of practicing and training psychiatry in South Africa. Consensus is required from licencing and examination authorities, as well as academic institutions on knowledge and skills requirements in order to assess candidates' cultural competence to practice in a local context. The importance of appropriately considering the cultural context in which psychiatric problems present and in terms of which it should be assessed can't be emphasized too strongly when working in the multi-cultural, multi-religious and spiritually diverse South African population.

SASOP POSITION STATEMENT ON PSYCHIATRIC CLASSIFICATION SYSTEMS

SASOP recognizes that there has long been a hybrid system using both DSM and ICD systems in the practice and teaching of Psychiatry in South Africa. SASOP takes note of the recent American Psychiatric Association's publication of the DSM-5 and the forthcoming publication of the World Health Organization's ICD-11. Acknowledging the complexities of psychiatric diagnosis and the global efforts in this area, SASOP is taking the position that there needs to be a transition from the current DSM-IV TR/ICD-10 to DSM-5/ICD-11 systems. The timing of this transition will vary according to the different contexts and requirements of the SASOP members involved in the practice and teaching of Psychiatry in South Africa. Members are encouraged to participate in discussions in this regard in the various sectors, e.g. private (PsychMG and SASOP Private Sector Group), public (SASOP Public Sector Group) and academic sector (College of Psychiatrists, academic departments of Psychiatry). November 2013

Bernard Janse van Rensburg, is a consultant psychiatrist at Helen Joseph Hospital and an Associate Professor in the Department of Psychiatry, University of the Witwatersrand, Johannesburg. References can be obtained from the author **Albert.Jansevanrensburg@wits.ac.za**

PRIORITIES,

PRINCIPLES, POTENTIAL: BACK TO BASICS

The 18Th National Congress Of The South African Society Of Psychiatrists, Durban, 3rd – 7th September 2014

BERNARD JANSE VAN RENSBURG

The 18th National SASOP Congress was held recently at the Southern Sun Elangeni and Maharani Hotel, Durban from 3rd - 7th September 2014, with the theme "Priorities, Principles, Potential: Back to Basics". The convenor of the congress was Dr. Shaquir Salduker, assisted by the rest of the organizing committee Drs. Agambaram, Barrett, Bodasing, Chetty, Govender, Mashapu, Nowbath, Pillay, Porter and Singh.

FOUR PRE CONGRESS WORKSHOPS WERE PRESENTED ON WOMEN'S ISSUES, SUBSTANCE USE RELAPSE PREVENTION, YOUNG PSYCHIATRISTS' ISSUES AND THE MOLECULAR GENETICS OF SCHIZOPHRENIA. PLENARY AND PARALLEL SESSIONS COVERED PSYCHOSIS AND DEPRESSION, GLOBAL MENTAL HEALTH, FORENSIC PSYCHIATRY, COGNITION, MEDICINE AND PSYCHIATRY, TRAUMA, ETHICS AND RIGHTS, SCHIZOPHRENIA, ADDICTIONS, AND HIV AND PSYCHIATRY.

The congress was attended by more than 500 delegates, including those from countries like Namibia, Australia, New Zealand, Ethiopia and Kenya.

Attending the Dr. Reddy's Laboratories beach dinner party at the Beach Bums Restaurant included Dr. Johann Fourie, Dr Johan Olivier and Dr. Christo Du Plessis.

Ms. Ferial Haffajee, Editor-in-Chief of City Press, delivered an inspiring opening key-note address, while international key-note speakers included: Prof. Pierre Blier (Canada) who spoke on the treatment of major depressive disorder; Dr. Jonathan Campion (UK) on public mental health; Dr. Rakesh Jain (USA) on the neurobiology of exercise and meditation in treating depression; Prof. Jose Maldanado (USA) on the management of delirium and alcohol withdrawal; and the eminent Sir Robin McGregor Murray (UK) on the management of schizophrenia. Prof. Seggane Musisi (Uganda) addressed sexual and gender-based violence in Africa. Dr. Angela Ofori-Atti (Ghana) presented on a new cadre of community workers, Dr. Stephen Suomi (USA) on epigenetics and Prof. Doug Zatzick (USA) on PTSD. Local invited speakers included Profs. Jonathan Burns, Robin Emsley, Solly Rataemane, Louw Roos, Soraya Seedat, Dan Stein and Christopher Szabo.

Dr. Gerhard Grobler, Prof. Jose Moldonado and Dr. Hemant Nowbath attending the Dr. Reddy's Laboratories beach dinner party at Beach Bums Restaurant, Tongaat

The two social events included the beach dinner party at Beach Bums Restaurant at Tongaat sponsored by Dr Reddy's Laboratories and the elegant congress dinner on the Saturday evening held in the Great Ilanga at the congress venue. Other sponsors of the congress included Accord Healthcare, Akeso Clinics, Adcock Ingram, Aspen Pharmacare, Cipla Medpro, Dr, Reddy's Laboratories, Eli Lilly, Equity Pharma, Janssen, Life Healthcare, Litha Pharma, Logans Booskshop, Lundbeck, Mylan, Norgine, Novartis, Pfizer, Pharma Dynamics, Reckitt Benckiser, Riverview Manor, Sandoz, Sanofi, Servier, Wavemed and Zentiva.

Priorities, Principles, Potential

SASOP 2014

Back to basics

SASOP 2014

18th National Congress of the South African Society of Psychiatrists

SASOP ELECTION 2014 - 2016

The South African Society of Psychiatrists (SASOP) is pleased to announce that, following the recent election during the 18th National SASOP Congress in Durban (3rd - 7th September 2014), the following colleagues were elected as office bearers to the SASOP Board of Directors for the next two-year term of office:

PRESIDENT
– DR. MVUYISO TATATALA (PRIVATE PRACTICE, JOHANNESBURG)

PRESIDENT-ELECT
– PROF. BERNARD JANSE VAN RENSBURG (WITS)

PAST-PRESIDENT
– DR GERHARD GROBLER (UNIVERSITY OF PRETORIA)

HONORARY SECRETARY
– PROF. LIEZL KOEN (UNIVERSITY OF STELLENBOSCH)

HONORARY TREASURER
– DR BONGA CHILIZA (UNIVERSITY OF STELLENBOSCH)

NATIONAL CONVENER PUBLIC SECTOR GROUP
– DR. ROBIN ALLEN (UNIVERSITY OF CAPE TOWN)

NATIONAL CONVENER PRIVATE SECTOR GROUP
– DR. SEBO SEAPE (PRIVATE PRACTICE, JOHANNESBURG)

Please also refer to the SASOP website **(www.sasop.co.za)** for information on the SASOP memorandum of incorporation and the recently adopted SASOP Company Rules.

C/O HEALTHMAN, Unit 16 Northcliff Office Park;
203 Beyers Naude Drive, Northcliff;
P O Box 2127, Cresta, 2118;
email: sasop@healthman.co.za

EXERCISING
A NEW APPROACH TO DEPRESSION

It's time for psychiatrists to begin prescribing exercise and meditation, not just medication, to prevent depression returning, says a leading US neurobiologist.

Glynis Horning

By Current pharmaceutical treatment options for depression are "all very good," says Dr Rakesh Jain, clinical professor of psychiatry at Texas Tech University School of Medicine in the US. "But the sad thing – in fact, the thing that scares the living daylights out of me - is that we don't do well with remission rates, and have high rates of relapse from disorders," he told a packed plenary session at this year's SA Society of Psychiatrists Congress in Durban.

The good news is that Jain believes there is a solution in two inexpensive and scientifically proven solutions – exercise, and more controversially, meditation. "I look Indian because I am, but I didn't come to meditation just because of that," he says. "I came to it the hard way – because the data is so good."

Numerous studies in recent years have shown that exercise and meditation are interventions "equally or more effective" than medication in preventing the return of depression - and he believes the time has now come for them to be prescribed along with it. It's no small recommendation, coming from someone who is also the director of psychiatric drug research for the R/D Clinical Research Centre at Lake Jackson, Texas.

"THE EFFECTS OF EXERCISE ARE AS PROFOUND ABOVE THE NECK AS BELOW," JAIN SAYS. HE CITES STUDIES IN WHICH EXERCISE HAS BEEN SHOWN TO INCREASE THE GENERATION OF NEW CELLS IN THE HIPPOCAMPUS REGION OF THE BRAIN (WHICH SHRINKS WITH EXPOSURE TO STRESS AND DEPRESSION), MODULATE INFLAMMATORY CYTOKINES (CHEMICAL MESSENGERS WHICH HAVE BEEN LINKED WITH DEPRESSION), IMPROVE IMMUNE FUNCTIONING, AND ALTER MOOD-ENHANCING NEUROTRANSMITTERS, NOT JUST DISPELLING NEGATIVE MOOD, BUT DEVELOPING POSITIVE MOOD. BRAIN SCANS HAVE SHOWN A REDUCTION IN OPIOID RECEPTOR AVAILABILITY AFTER EXERCISE, SO YOU FEEL LESS PAIN, AND FEEL HAPPY AND EUPHORIC, JAIN SAYS: "RUNNER'S HIGH IS A TRUE BIOLOGICAL INTERVENTION."

Exercise is effective for all ages, he adds, and has been shown in studies of young and old mice to "positively impact BDNF" - brain-derived neurotrophic factor, a protein which promotes neuron growth and produces antidepressant effects.

Dr Rakesh Jain, clinical professor of psychiatry at Texas Tech University School of Medicine

In a Cochrane Database meta-analysis of 25 studies comparing the effects of exercise and antidepressants, the results for exercise were "slightly better" than for antidepressants, Jain reports, "but evidence suggested that exercise probably needed to be continued in the longer-term for benefits to be maintained".

Aerobic exercise is good, but resistance training is even better, and the most effective exercise is a combination of the two, he says. Frequency, intensity and duration matter, and studies show that in order to benefit, it is necessary to do 20 to 30 minutes of exercise a day (at once, or in several short sessions), at least five times a week, at a moderate intensity "that makes it difficult to speak normally while doing it".

MEDITATION AS MEDICATION

Scientific data on the benefits of meditation in treating depression are even better than for exercise, Jain says. "If you think meditation is something done by removing your clothes and sitting in the lotus position, you need to change that. It's you and me, doing it in suits."

OF THE DIFFERENT FORMS OF MEDITATION, FROM TRANSCENDENTAL TO COMPASSION, LOVING KINDNESS AND HEART RHYTHM MEDITATION, THE BEST DATA ARE FOR MINDFULNESS MEDITATION.

He defines mindfulness as "paying attention in a

particular way: on purpose, in the present moment, and non-judgmentally," in the words of Dr Jon Kabat-zinn of the University of Massachusetts Medical Centre.

Numerous clinical studies in the past few years have shown that among other benefits, after just eight weeks of meditating for an hour a day, the amygdala (a part of the brain which becomes over-active in depressed patients) and the hippocampus change volume, he says. Inflammation is also reduced.

The best results have been from a combination of meditation with cognitive behavioural therapy (CBT) – a "promising new therapy" known as mindfulness-based cognitive therapy (MBCT), Jain explains. It has been shown to work for patients with anxiety, depression, panic disorder, even binge-eating and in one case, schizophrenia. And as with exercise, the beneficial effects continue for hours afterwards.

He advocates two hours of meditation a day and daily homework using CDs. "A large study has shown that MBCT has the same power to prevent relapse as a pharmaceutical intervention."

Psychiatrists should prescribe exercise and meditation to patients just as they do medication, Jain says, explaining the benefits to them and checking for compliance. To help with this they should ask patients to keep written logs, and encourage them to use smartphone apps and CDs.

"PSYCHIATRISTS SAY THEY ARE TOO BUSY TO TALK PATIENTS THROUGH MEDITATION, BUT THEY CAN REFER THEM TO ONLINE TRAINING, WHICH HAS BEEN SHOWN TO BE EFFECTIVE," HE SAYS. "MEDITATION IS NOT JUST A 'FEEL GOOD' INTERVENTION, IT'S SUPPORTED BY STRONG NEUROBIOLOGICAL FINDINGS. AND IT'S EASY TO INCORPORATE INTO A BUSY CLINICAL PRACTICE USING A VARIETY OF DIFFERENT RESOURCES. MEDITATION IS A POWERFUL CLINICAL INTERVENTION LEADING TO BETTER OUTCOMES."

HOW TO MOTIVATE PATIENTS TO EXERCISE FOR DEPRESSION

Analysis has shown dropout rates for exercise treatment are similar to those found in psycho-therapeutic and drug interventions, says Dr Rakesh Jain.

- Don't simply tell your patients to exercise and to see you in six weeks.
- Educate them about the neurobiological benefits.
- Ask them to begin with just five minutes three times a day.
- Suggest they start by exercising in water, with a cycle or by walking.
- Encourage them to aim for at least 30 minutes of moderate exercise (such as brisk walking) a day, at least five days a week.
- Monitor them: follow up every couple of weeks
- Ask them to log their exercise: provide a simple form where they fill in date, activity, duration, and indicate their mood before and after on a scale from 1 (not depressed) to 10 (very depressed).
- Ask them to write down their exercise goals to help entrench these.
- Suggest they use cellphone apps such as MyFitnessPal (which is free)...
- Expect pushback: patients will often ask if you can't give them a pill, rather than ask them to exercise.

HOW TO MOTIVATE PATIENTS TO MEDITATE TO TREAT DEPRESSION

- Begin a dialogue with them about meditation.
- Educate them about the neurobiological benefits.
- Provide handouts on these benefits.
- Begin your own meditation practice or refer them to clinicians who specialise in meditation.
- Provide them with a list of resources such as the book Mindfulness-Based Cognitive Therapy for Depression by Zindel Segal, Mark Williams and John Teasdale (available through Kalahari.com), which includes audio downloads of guided meditations.
- Encourage them to use one of the many meditation apps available free online.

Glynis Horning is an award-winning Durban freelance writer. Today she is a senior contributing writer for Associated Media titles Cosmopolitan, Good Housekeeping and House & Leisure, and writes for numerous other publications. Her special interest is health and mental health.
asmags@mweb.co.za

Lisa Selwood Psychosis and cannabis - A report from SASOP 2014

International invited faculty: Sir Robin Murray

Sir Robin Murray, a psychiatrist from Scotland, and professor of Psychiatric Research at the Institute of Psychiatry, Kings College in London, has been ranked as one of the most influential researchers in psychiatry. This is namely for his work in the Psychosis Research Group, which looks at methods to improve and treat psychotic illnesses, specifically schizophrenia. Murray and colleagues were among the first to demonstrate that prolonged, heavy use of cannabis can contribute to the onset of psychosis. He has written numerous articles and book chapters, has presented at many local and international conferences and is the second most cited psychiatrist outside of the USA. He was knighted in 2011 for his services to medicine.

It was therefore an honour to have a speaker of this caliber attend the local South African Society of Pyschiatrists (SASOP) Congress (held in Durban, 3rd - 7th September 2014) as part of the invited international faculty.

Prof Murray gave three lectures during his time at the congress. The first, bright and early at 7am on day 1 of the congress, was at a Janssen sponsored breakfast symposium, with a talk entitled 'What have we learned about schizophrenia from drug induced psychosis?' The second, examined the standards of care provided to people with psychosis, and offered a comparative viewpoint between the United Kingdom and South Africa. Finally, in a plenary session Murray discussed 'Now that we know the causes of schizophrenia…'

At the breakfast symposium, which was attended by approximately 140 delegates, Murray left the audience with the following take home points:

- **The more cannabis one uses, the greater the risk of developing schizophrenia**
- **The more often one uses cannabis, the greater the risk.**
- **The earlier one starts using cannabis, the greater the risk because the adolescent brain is still developing.**
- **The higher the levels of THC in the cannabis, and hence the greater the potency, the greater the risk.**

Interestingly, the strains Murray and his team are most concerned about in the UK, contain between 9 – 16% THC, whereas locally, the potent 'Durban poison' variety contains approximately 20 - 25% THC, signifying that there is even more of a risk in SA for local users. THC is responsible for impairment in attention, memory and learning, causes hallucinations and paranoid ideas and can induce transient psychotic symptoms. In addition, some people

Sir Robin Murray

are more sensitive or susceptible to the effects of cannabis and certain genetic vulnerabilities can make one more susceptible to a drug induced psychosis. Cannabis users are 5 times more likely to develop schizophrenia than the general population. Patients who continue to use cannabis after diagnosis, tend to be on a higher dose of antipsychotics.

AS IS OFTEN THE CASE IN PSYCHIATRY, THERE WERE MORE QUESTIONS THAN ANSWERS, MANY OF WHICH WILL ONLY BE ABLE TO BE ANSWERED AFTER EXTENSIVE RESEARCH INTO THIS AREA. WHEN DOES THE DIAGNOSIS CHANGE FROM 'SUBSTANCE INDUCED PSYCHOSIS' TO 'SCHIZOPHRENIA'? CAN SYNAPSES EVER RECOVER? HOW DO WE TREAT THESE PATIENTS? IS THE TREATMENT DIFFERENT TO SCHIZOPHRENIC PATIENTS WHO DO NOT USE CANNABIS? HOW LONG SHOULD TREATMENT CONTINUE FOR A DRUG INDUCED PSYCHOTIC EPISODE?

Prof. Murray was a delightful speaker, thoroughly knowledgeable about the topic at hand, and often had the audience in laughter. In particular, this talk was particularly relevant in the South African context, as there is a move to potentially decriminalize cannabis in the latter part of 2014.

Lisa Selwood is a pharmacist. Her current position at Janssen is Medical Scientific Liaison for the psychiatry portfolio. Lisa spent several years as a counsellor with the South African Depression and Anxiety Group (SADAG), and regularly contributes articles with psychiatric themes to local journals. **lselwood@its.jnj.com**

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Ian Westmore The Annual PsychMG Scientific and Business Weekend 2014

The PsychMG Scientific and Business weekend is always popular with members of the Psychiatry Management Group (PsychMG) as it provides a unique forum for psychiatrists in private practice to engage with one another and to learn from others in the field. This year was no exception and the 2014 meeting, held at the Mount Grace Hotel in the Magaliesberg was enthusiastically attended by psychiatrists from across the country. This event was made possible by unrestricted educational grants received from Aspen, Servier Laboratories and a generous sponsorship from PsychMG. The weekend meeting kicked off on Friday evening and ended at lunchtime on Sunday.

The Saturday program started with Mr Casper Venter from HealthMan highlighting some of the significant challenges facing private practice medicine in South Africa at present. He alluded to the White Paper on National Health Insurance (NHI) which has not been forthcoming; the many ways in which government is seeking to "interfere" with private healthcare and regulate it further; and provided an update on changes in the medical schemes environment. The topical issue of the re-emergence of the "Certificate of Need" and the (as yet failed) efforts by government to have it operational by April 2016 were also discussed.

THE TALK BY ANNEMIE HUMAN ON "SLEEPWALKING TO RETIREMENT" PROVIDED A MUCH-NEEDED JOLT FOR PSYCHIATRISTS WHO EARNESTLY NEED TO CONSIDER THEIR FINANCIAL PLANNING FOR RETIREMENT.

It was sobering to realize that 51% of pensioners cannot make ends meet, and that only 12% can retire comfortably. As doctors are notoriously poor financial planners, this talk surely inspired many to reconsider their investments. Dr Carol Hlela from the University of Cape Town gave a comprehensive overview of Psycho-dermatology, providing a clear guide to the interface between psychiatry and dermatology. She made particular reference to psycho-physiologic conditions, primary and secondary psychiatric causes of skin disorders and then skin conditions as a result of medicine adverse reactions.

Prof Alex van den Heever from WITS was the invited speaker on the background to the Competition Commission Enquiry into Private Healthcare in South Africa and the problems surrounding the process. As the enquiry is in its early stages, he set the stage for what will undoubtedly be a controversial process, with various political agendas. The afternoon session started with an informative talk by Verine Etsebeth on the Protection of Personal Information (POPI) Act and the Consumer Protection Act, with specific reference to the ways in which they impact treatment in psychiatric practice. There was lively debate afterwards regarding "explicit consent" and the content of the multitude of authorization forms that cross psychiatrist's desks daily, as well as requirements for the retention of patient records.

During the day, Steve Speller from Servier, and Stavros Nicolaou from Aspen, gave feedback on developments within their respective companies and plans for future development on not only the global stage, but also the local market. The final presentation in the afternoon was by Craig Getz from Care-Gauge on actuarial models developed for profiling and peer review, which will be particularly useful when considering so-called "alternative reimbursement models"

in future. Dr Mvuyiso Talatala chaired the Annual General Meeting of PsychMG in the late afternoon during which he was re-elected as chairperson and Dr Sebolelo Seape was nominated to be the private practice representative on the SASOP Board of Directors. The following directors were elected to the board: Franco Colin, Rykie Liebenberg, Thabo Rangaka, Shaquir Salduker, Paul Strong and Ian Westmore. Colleagues then had an opportunity to network and catch up over a "black and white" themed dinner, with live entertainment following a short presentation by Prof Bernard van Rensburg on the WPA International Congress in Cape Town planned for 2016.

On the Sunday morning there was an opportunity for a panel discussion, facilitated by Eugene Allers, Gerhard Grobler and Mvuyiso Talaltala. During this interactive session, pertinent issues were raised, discussed, clarified and resolved. These included:

- Feedback on engagement with medical schemes,
- The 2015 PsychMG Coding Guide
- Best practice for group therapy sessions in private hospitals
- Prescribed Minimum Benefits and Designated Service Providers agreements
- Billing by Child and Adolescent Psychiatrists
- Legislation regarding the admission of children and adolescents to private psychiatric hospitals and
- Alternative Reimbursement Models.

The PsychMG board of directors was delighted by the positive response received from members. As delegates prepared to leave, consensus was that this annual business and scientific meeting of PsychMG has become an indispensable part of the calendar in Psychiatry in South Africa – particularly given the complexities and challenges that psychiatrists in private practice face. We look forward to meeting in 2015!

Ian Westmore is a psychiatrist in private practice in Bloemfontein. He is a past president of SASOP with a current involvement with PsychMG.
westmore@axxess.co.za

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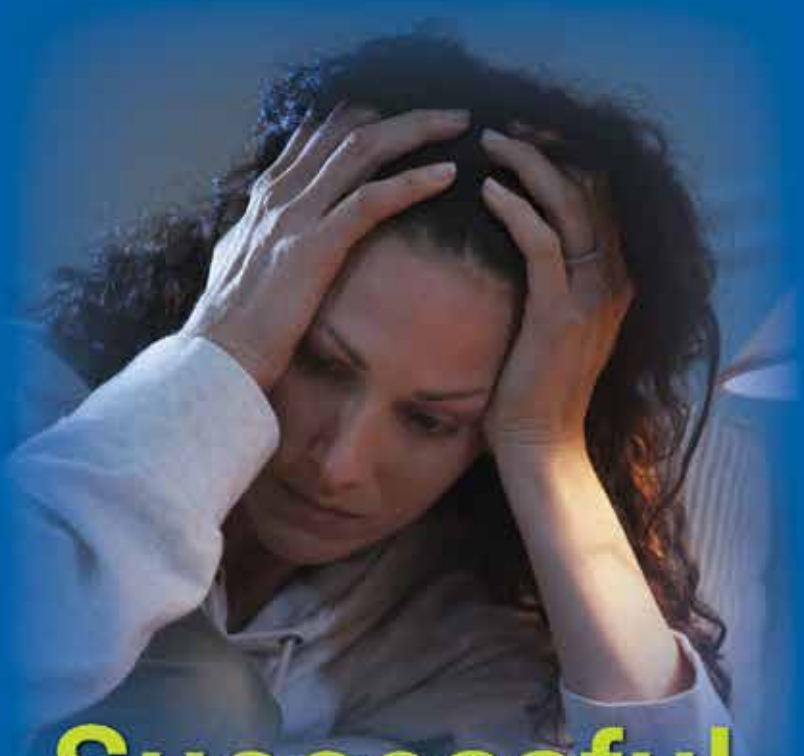

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COLLEGIUM INTERNATIONALE

NEURO-PSYCHOPHARMACOLOGICUM WORKSHOP 2014

This year's Collegium Internationale Neuro-Psychopharmacologicum (CINP) workshop was held on the 4th and 5th of October 2014 at the Sandton Hilton hotel with 95 Psychiatrists (both state employed and private sector) from across South Africa in attendance. This popular event on the CPD calendar is in its 5th year running and has accommodated now close to 500 attendees.

The meeting was originally modeled on similar CINP run workshops in Ireland, convened here in South Africa by Prof Robin Emsley and supported via an unrestricted educational grant by Servier.

Over the years various CINP international trainers along with local expert speakers have covered a wide variety of clinical topics. Profs Brian Leonard, David Baldwin and others have joined the academic faculty of the meeting.

THE RELEVANCE OF THIS TYPE OF MEETING WAS DESCRIBED DURING THE ORIENTATION SESSION: IN VIEW OF THE FACT THAT A SIGNIFICANT PROPORTION OF OUR DAYS ARE SPENT PRESCRIBING MEDICATIONS, WE NEED TO BE COMPLETELY CONFIDENT IN OUR KNOWLEDGE OF HOW AND WHERE THEY WORK AND THEIR RELATIVE INTERACTIONS AND SIDE EFFECTS. THE REALITY IS THAT PATIENTS IN THE REAL WORLD DON'T ALWAYS RESPOND AND THERE ARE SO MANY VARIABLES AND CONFOUNDERS OUT THERE… SO FOR US AS PSYCHIATRISTS THERE IS A NEED TO CONTINUOUSLY UP SKILL OURSELVES IN PSYCHOPHARMACOLOGY.

Robin Emsley, Peter Haddad, Marius Steyn, Bonginkosi Chiliza, Biagio Longano

Therefore this meeting provides a forum for high level information sharing and discussion in psychopharmacology with an emphasis on clinical relevance. This year the focus was on various aspects relating to the treatment of Bipolar disorder and Schizophrenia and prescribing of anti psychotic medications and psychosocial interventions. The organisers were pleased to welcome Dr Peter Haddad from the UK who shared his expertise in this field during 3 of the 7 sessions. Prof ChristopherSzabo (University of the Witwatersrand), Prof Jonathan Burns (University of Kwa Zulu Natal) and Dr Bonga Chiliza (University of Stellenbosch) completed the line-up of speakers chaired by Prof Emsley.

Peter Haddad, Robin Emsley, Christopher Szabo

The complex and challenging field of prescribing psychopharmacological agents for these conditions provided cause for stimulating debate as did the issue of ascribing certain benefits, side effects and safety issues to classes versus considering the specific differences between molecules within classes which was a recurring theme through the different sessions. Key areas covered included Pharmacological Management of Acute Mania; Pharmacological Management of Acute Bipolar Depression; Long Term Pharmacological Treatment of Bipolar; Psychosocial Interventions in Schizophrenia; Managing the Side-Effects of Antipsychotic Medication and Ethics of Prescribing Antipsychotics Workshop sessions were lively and interactive and delegate feedback clearly reflected the value gained from these experts and from the discussion and experience sharing. Content and speakers for future meetings are based on the feedback received.

In 2015 the CINP course will return to Cape Town in October.

Robin Emsley is a Professor in the Department of Psychiatry, Faculty of Medicine and Health Sciences, University of Stellenbosch, He has a Doctor of Science for studies in the psychopathology, neurobiology and psychopharmacology of schizophrenia. His main area of interest is in the neurobiology and psychopharmacology of schizophrenia – with his group having published extensively in this field. He serves on the Editorial Board of several journals, including Schizophrenia Research and Early Intervention in Psychiatry. He is Editor of the recently established Elsevier Schizophrenia Research Resource Centre website. **rae@sun.ac.za**

POST NATAL DEPRESSION

The Post Natal Depression Support Association (PNDSA), comprised of volunteers, who work towards addressing problems associated with perinatal depression. A recent workshop was presented by the PNDSA at Akeso Crescent Clinic in Johannesburg.

Carina Marsay

Depression is a common complication of the perinatal period and has devastating consequences for mother and child, as well as partner and other family members. Women who experience depression in pregnancy are more likely to have obstetric complications such as preterm births and low birth weight infants. Mothers suffering from depression have a negative impact on attachment, which can have damaging effects on both infant brain morphology and physiology, causing long-term neurobehavioral problems. Therefore, perinatal depression is a significant public health problem as biological, social and psychological factors affect the expression of disease across the lifespan of the unborn child.

Improving maternal and child health are global priorities. The United Nations Millennium Development Goals list child health and maternal health as two of the eight development goals (http://www.un.org/millenniumgoals/) The South African National Department of Health has also identified maternal and child health as one of four priority areas requiring urgent attention **(http://www.doh.gov.za/)** High level commitment to prevention and treatment are critical in an attempt to diminish the effect of perinatal depression on women and their families.

ALTHOUGH PERINATAL DEPRESSION CAN BE EFFECTIVELY TREATED LESS THAN HALF OF ALL CASES ARE IDENTIFIED. WOMEN IN THE PERINATAL PERIOD ARE IN AN IDEAL POSITION TO UNDERGO ROUTINE SCREENING, AS THEY HAVE REGULAR CONTACT WITH HEALTH CARE PROVIDERS. STRONG PREDICTORS FOR PERINATAL DEPRESSION INCLUDE A PREVIOUS HISTORY OF DEPRESSION, BEING A SINGLE MOTHER, AN UNWANTED PREGNANCY AND BEING HIV POSITIVE.

Estimates of the prevalence of major and minor perinatal depression range from 5%-25%.The high prevalence of perinatal depression has led to the recent recommendations for routine screening. The American College of Obstetricians and Gynaecologists (ACOG) in the US and the National Collaborating Centre for Mental Health in the UK have established national recommendations for perinatal health care providers to be aware of perinatal depression and identify cases for referral as needed. Routine screening is particularly important in South Africa where the rate of perinatal depression is 34 - 47%, which is much higher than accepted international rates, making it a significant public health problem.

PNDSA (Post Natal Depression Support Association), a non-profit organization is funded by donations from the private sector and membership fees. PNDSA was started by women who have recovered from Postnatal Depression and is staffed by volunteers. The association is dedicated to supporting women who may suffer from depression, making it easier for them to find help. While many mothers, do, in fact, experience the birth of a baby as a happy event; PNDSA is concerned with the parents, for whom this is not true.

PNDSA'S FUNDAMENTAL MESSAGE TO MOTHERS IS: YOU ARE NOT ALONE; YOU ARE NOT TOO BLAME; YOU ARE ENTITLED TO HELP; YOU WILL RECOVER. PNDSA STRIVES TO DE-STIGMATIZE PERINATAL DEPRESSION AND ANXIETY AND OFFER SUPPORT TO THOSE EXPERIENCING THESE SYMPTOMS DURING PREGNANCY AND AFTER BIRTH.

PNDSA is committed to increasing public awareness and educating health professionals to identify and treat ante- and post natal depression. It is the policy of PNDSA, not only to target the general public, but also to collaborate with existing health and community services, and to help train health care professionals to identify, refer and manage women with perinatal depression.

Thousands of women receive help from PNDSA each year, via telephone and face-to-face counseling, support groups, hospital visits, information packs and referrals to the mental health care professionals. PNDSA organize lectures and training workshops for support volunteers and professionals as well as commercial companies who employ a large number of women of childbearing age. A resource library is available for members. Volunteers regularly visit maternity hospitals to inform new mothers about services offered by the association.

A workshop held on 19th September 2014 at Akeso Crescent Clinic, was aimed at nurses, midwives, social workers, doulas and clinic sisters and included psychologists and psychiatrists who have a special interest in perinatal depression. The morning started off with registration and getting to know each other over coffee and rusks.

The introductory talk was given by Sally Baker, a social worker in private practice, who specialises in supporting families through pregnancy, birth and post partum experiences and transition. In her talk, Sally read excerpts from a children's book about perinatal depression. The book was entitled "A monster ate my Mum" by Jen Faulkner, describes perinatal depression from a child's point of view, which emphasized how perinatal depression is a systemic problem. After the introductory talk the audience was divided into 4 groups and rotated through 4 sessions on topics including screening, management, medication and feeding and attachment.

THE IMPORTANCE OF SCREENING FOR PERINATAL DEPRESSION WAS DISCUSSED BY DR CARINA MARSAY, WHO IS A PSYCHIATRIST WORKING IN A STATE HOSPITAL AND AN HONORARY APPOINTEE AT THE DEPARTMENT OF PSYCHIATRY AT THE UNIVERSITY OF THE WITWATERSRAND.

She is a member of the International Marcé Society, an organisation dedicated to perinatal mental health. Dr Marsay's talk emphasized how perinatal depression is a major public health issue, and screening at primary health care level is vital for the effective management and prevention of perinatal depression and its complications.

Dr Arbee, a psychiatrist in private practice at Akeso Clinic in Parktown, with a keen interest in women's mental health and the promotion of social awareness and destigmatization of mental illness, gave an informative talk aimed at destigmatising the use of medication in pregnant and breastfeeding women. Tamara Zanella, a HPCSA Registered Counselling Psychologist in private practice,

Tamara Zanella, Ana Frawley, Rica Gibson, Kirsten Miller, Feroza Arbee, Carina Marsay, Sally Baker. All committee members of PNDSA Gauteng.

focused her talk on the psychological management of perinatal depression. Most mothers in fact do well with short-term cognitive behavioural therapy, psychoeducation and peer support groups.

Ana Frawley is a registered midwife. She is passionate about helping and empowering mothers, fathers and their newborn babies. She runs the 20 hour MBFHI (Mother & Baby Friendly Hospital Initiative) course, to help nurses render the most effective nursing care for mothers and their newborn babies. Ana discussed feeding and attachment and gave practical advice on how to facilitate breastfeeding and bonding in mothers and babies.

The strength of the workshop lay in the breadth of knowledge and skill within a multi disciplinary team that spanned both state and private health care. No individual member is more important than another. Everyone has a vital role to play in the well being of our new mothers, their infants and their families.

PNDSA is a valuable resource that has the potential to work hand in hand with Government, The Department of Health as well as Private Medical Schemes to ensure better health care resources for the women of our country. If you would like to get involved in any way visit www.pndsa.org.za to find out more about this organization.

References are available from the author.

Carina Marsay is a specialist psychiatrist, affiliated to Sterkfontein Hospital and with an honorary appointment in the Department of Psychiatry at theUniversity of the Witwatersrand, Johannesburg. **carinamarsay@gmail.com**

Dr Saul Levin Psyched-up about mental health

Deborah Minors

Dr Saul Levin tells me he couldn't reply to my first email in October 2013 because he was in Russia. Although he'd been appointed Chief Executive and Medical Director of the American Psychiatric Association (APA) in July, he'd anticipated this holiday for a while and knew another was unlikely in future.

"My father's family is originally from Russia and I've always had a fascination with the country – even in high school at Damelin in the 1970s, when Russia was synonymous with communism," explains Levin over lunch at the Wits Club in August 2014.

He speaks fondly of his high school history teacher, Izaak Kriel, who visited Russia when Levin was a teenager. On his return, the kids bombarded their teacher with questions about Communist Russia. Levin recalls his teacher describing Swan Lake and how, when the velvet curtains lifted, there on stage was an actual lake upon which glided live swans. "And we had the Pretoria State Theatre…" says Levin ruefully, "So perceptions can change with additional information."

The Swan Lake-in-Russia story contextualises the "internationalisation" of psychiatry that Levin envisages as CEO of the APA the largest professional, Science-based association in the world, boasting around 35,000 US and international members. It's also the oldest in America, dating from 1844 when it was called the Association of Medical Superintendents of American Institutions for the Insane.

The APA is technically a 501(c) (6) not-for-profit organisation, sometimes called a trade association. Its subsidiary, the American Psychiatric Foundation, is a 501(c) (3) institution a charity responsible for handling the APA's social investment initiatives.

"FOR EXAMPLE, THE FOUNDATION BEGAN ITS TYPICAL OR TROUBLE PROGRAMME AFTER THE SPATE OF HIGH SCHOOL SHOOTINGS IN THE US," SAYS LEVIN. "TEACHERS, COACHES AND OTHERS ARE TAUGHT HOW TO IDENTIFY IF TEENAGERS ACTING UP THEIR CLASSROOMS ARE JUST BEHAVING LIKE 'TYPICAL' TEENAGERS, OR IF THERE WERE SIGNS OF TROUBLE THAT COULD ESCALATE WITH POTENTIALLY FATAL CONSEQUENCES."

One of the APA's mandates is to transfer knowledge between the US and the rest of the world. It's moving towards enabling open source knowledge that can benefit patients and their psychiatrists; for example, making academic journal articles freely available to clinicians in times of crisis, such as the tsunami in Haiti, or the earthquake in New Zealand. Similarly US patients can benefit from an exchange of ideas with other countries.

Bernard Janse van Rensburg, Deborah Minors, Saul Levin

The APA successfully lobbied the US Congress in 2008 to change mental health laws to ensure that fees for mental health and primary care are covered under insurance equally. It's this kind of "watch-dog role" that the APA hopes inspires others in global psychiatry to continue to fight for the profession.

Dr Saul Marc Levin, 57, (MBBCh 1982) is the first non-American to lead the APA. He was appointed for five years after an exhaustive country-wide search. Levin suggests it's that he recognised the role of all players in the psychiatric community, the need for integration with solo practitioners, and that the US health system is changing, that gave him the edge in landing the job.

"THERE'S A MOVE TOWARDS INTEGRATED HEALTHCARE IN THE US, WHERE CLINICIANS, GOVERNMENT AND STAKEHOLDERS COLLABORATE AND INTEGRATE TO PATIENTS' BENEFIT," SAYS LEVIN. HE ADDS THAT THE HANDS-ON MEDICAL TRAINING HE RECEIVED AT WITS ALSO CONTRIBUTED IN PART TO HIS LANDING THE APA JOB.

"In the US, medicine is very text-book, very learned," he says, compared to the much more visceral "hands-on" training healthcare professionals are exposed to in South Africa and at Wits in particular. The Wits Medical School uses the philosophical approach "see one, do one, teach one" to healthcare. For example, medical students see one baby delivered, then they, with observers, deliver a baby themselves, and then they teach someone else how to deliver a baby. "I remember in fifth year at Wits, in Obs and Gynae (obstetrics and gynaecology) we had to deliver 40 babies to qualify."

Levin emigrated in 1984 and his career since then has included appointments in the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services. He earned a Master's in Public Administration from Harvard University before establishing and leading a healthcare consulting company for a decade. He then became President and CEO of MESAB (Medical Education of South African Blacks), which provided scholarships to black South Africans. There he worked with Wits alumni Stan Bergman, Chairman of the Wits Fund Inc., Sowetan activist Dr Nthato Motlana, and MESAB's first Chairman, Professor Phillip V. Tobias. Levin was Vice-President of the American Medical Association for Science, Medicine and Public Health before joining APA.

Levin's job as APA Chief Executive and Medical Director is a full-time job, salaried and funded by the APA – not government. This independence is what gives the APA the teeth to tackle the big issues in psychiatry, both in the US and globally, and that enables Levin to fulfil his mandate without fear or favour. It's partly why he's in South Africa this August – for a whirlwind trip to see how the US and SA psychiatric communities can cooperate to mutual benefit.

The issue of clinicians' independence is a little more complicated in South Africa. Professor Bernard Janse Van Rensburg representing the South African Society of Psychiatrists (SASOP) and an Associate Professor in the Department of Psychiatry at Wits University. Janse Van Rensburg suggests that state sector/academic psychiatrists in South Africa have to strike a precarious balance between patient care and politics. They wield double-edged swords of being both employed and paid by the State, but having to engage constantly with a bureaucracy that institutes money-motivated policies with potentially far reaching consequences for patient care.

Head of the department of psychiatry at Wits, professor Christopher Szabo agrees: "Many of these patients are poor. With such an incredible demand for mental health resources – professionals, medicine, skills – our real challenge in South Africa is how we make the services and medicines accessible and available to all those who need them.

At the same time, we need to be mindful of Government financial constraints. While Government pays clinician salaries there is still an onus on clinicians to contest policy if deemed necessary. At times, we're employees as adversaries," says Szabo. He's clearly passionate about the topic.

The day we meet, Szabo is preparing for a meeting with representatives from the Gauteng Province and National Department of Health the next day. He and colleagues must discuss the implications of the impending removal of certain medications from the Essential Medicines List – because patients may relapse, return to hospital (thereby costing the State more) and leave their families in disarray. It's in matters of this nature that Szabo envisages Levin's APA assisting with a lobbying role, and bringing its considerable weight and credibility to bear on critical medical matters about which politicos might not be aware.

Szabo also wants to elevate the status of psychiatry in South Africa, and the APA's vision of electing Distinguished Fellows among its members may play a role in improving perceptions of psychiatry by government and other stakeholders in South Africa.

Levin explains that the APA's International Distinguished Fellowship programme is still in its infancy. The idea is that psychiatrists worldwide will be able to apply to become a Fellow – at a cost – and their election as Fellows will be decided by peer review against specified criteria. The benefits of APA International Distinguished Fellowship for South African psychiatrists in particular (aside from a certificate and the APA-associated prestige, credibility and reputation) are that Distinguished Fellows will be eligible for discounts on global conferences. This is important because attendance at these conferences generates CPD (Continuing Professional Development) points, which all healthcare professionals need to collect in order to continue practicing. Janse Van Rensburg points out that psychiatrists in South Africa already pay R3000 per annum towards membership of SASOP, so Szabo reckons that, "Discounts for conferences would be the real value-add and benefit to South African psychiatrists of becoming an APA Distinguished Fellow."

Further benefits to SA psychiatrists of APA membership are that it represents professionalism to patients, it's a guarantee of ethical adherence, and there is the prospect of the Distinguished Fellows' mentorship programme that Levin envisages.

Deborah Minors is the Senior Communications Officer for Alumni Relations at the University of the Witwatersrand, Johannesburg.
Deborah.minors@wits.ac.za

Mvuyiso Talatala
South African Society Of Psychiatrists (SASOP): 2014-2016

It is an honour for me to be the President of the South African Society of Psychiatrists (SASOP). I was inaugurated during the Biennial Congress of SASOP that was held at the Elangeni Maharani Hotel in Durban from the 4th to the 7th of September 2014. This presidency has a two year term that will end in November 2016. SASOP has taken upon itself to host the 2016 World Psychiatric Association (WPA) International Congress which will be held in Cape Town in November 2016. This will be one of the biggest events ever hosted by South African Psychiatry. We expect between 3000 and 5000 delegates to attend this prestigious congress.

The theme of this congress is "Psychiatry: Integrative Care for the Community". During my term as president, and as we build up to the 2016 congress, I challenge all SASOP members and mental health workers at large, to engage with this congress and its theme. SASOP members must think beyond their current practice in order to fully engage with this theme and make this congress a success. We need to ask ourselves: What is integrative care? Who is the 'community' and what is the relationship between psychiatry and the community? Is there a contract between psychiatry and the community it serves? Does psychiatry know the community that it intends contracting with or that it is already contracted with? My attempt at describing the community that South African psychiatry should contract with or is contracted to is: a divided nation that is in the process of healing with a huge burden of unfinished business. At times the community chooses to turn a blind eye to the divisions and the unfinished business. Psychiatry itself is part of that community. Psychiatry has divisions and unfinished business.

THE TOPIC OF SOCIAL CONTRACTING BETWEEN MEDICINE AND THE COMMUNITY SHOULD BE UNPACKED IN SOUTH AFRICA AND BE IMPLEMENTED AS WE GO FORWARD. FOR PSYCHIATRY, THE HOSTING OF THE 2016 WPA INTERNATIONAL CONGRESS WILL BE A MILESTONE THAT WILL PLAY A SIGNIFICANT ROLE AND BE AN IMPORTANT CATALYST IN THE SOCIAL CONTRACTING BETWEEN PSYCHIATRY AND ITS COMMUNITY.

The hosting of this 2016 WPA International Congress is one of the key objectives of my presidency. For the congress to succeed we require the active participation and contribution by all SASOP members and the active involvement of all mental health workers and important stakeholders such as the government, the pharmaceutical industry, the non-governmental organisations, and the mental health care users, to mention a few.

Unity within SASOP is a key goal for this term of presidency and for the future of SASOP particularly in view of the challenges ahead, including the 2016 Congress.

SOUTH AFRICAN PSYCHIATRY WILL NEVER ACHIEVE ITS GOALS IF IT REMAINS ISOLATED AND DOES NOT CONTRIBUTE TO AFRICAN PSYCHIATRY. AFRICAN PSYCHIATRY MUST BE STRENGTHENED TO BE A LEADER IN WORLD PSYCHIATRY.

THE AFRICAN ASSOCIATION OF PSYCHIATRY AND ALLIED PROFESSIONALS (AAPAP) IS THE ORGANISATION THAT CONTINUES TO PLAY A LEADING ROLE IN AFRICAN PSYCHIATRY IN ADDITION TO THE WPA ZONES.

South Africa is a member of Zone 14 of the WPA. Other countries in Zone 14 include Kenya, Uganda and Mozambique. Prof David Ndetei from Kenya was elected as the Zone 14 representative during the WPA general assembly that was held in Madrid, Spain, on Tuesday 16th of September 2014.

In February 2014, Prof Solly Rataemane from MEDUNSA was elected as the President of the AAPAP. SASOP will be working closely with the AAPAP and WPA Zones in Africa as we continue to build African Psychiatry. Many countries in the SADC region do not have professional societies for psychiatrists. However, the number of qualified psychiatrists in these regions is increasing. I envisage that SASOP will assist these countries in either forming their own societies or offering psychiatrists in these countries international membership to SASOP. (Within SASOP, international membership has always been available and we have had Namibian psychiatrists as members).

WHILST THE 2016 WPA INTERNATIONAL CONGRESS, UNITY WITHIN SASOP AND THE STRENGTHENING OF AFRICAN PSYCHIATRY ARE THE KEY GOALS OF MY TERM AS PRESIDENT THERE ARE ONGOING CHALLENGES IN SOUTH AFRICAN PSYCHIATRY AND THERE IS THE ONGOING BUSINESS OF SASOP.

The board of directors of SASOP under my leadership should strive to achieve the goals that are set out in the strategic document of SASOP and maintain the momentum of keeping this document a living document.

This should entail the continuous review of the strategic document, communication, marketing, mentorship, transformation of the subgroups and special interest groups into subsidiaries, and the maintenance of good relations with pharmaceutical companies while we strive for financial independence.

The Board of Directors of SASOP is composed of seven directors who are:

Dr Mvuyiso Talatala *(President),*
Dr Gerhard Grobler *(Past President),*
Prof Bernard Janse van Rensburg *(President Elect),*
Prof Liezl Koen *(Honorary Secretary),*
Dr Bonga Chiliza *(Honorary Treasurer),*
Dr Sebolelo Seape *(Representative of the Private Sector Vocational Group),*
and Dr Rob Allen *(Representative of the State Sector Vocational Group).*

Dr Talatala, Prof Janse van Rensburg and Dr Seape are based in Johannesburg. Dr Grobler is based in Pretoria and Prof Koen, Dr Chiliza and Dr Allen are based in Cape Town. SASOP has a nationwide representation through its Subgroups and Special Interest Groups. The Board of Directors of SASOP, the Subgroups and the Special Interest Groups are the team that will make the goals of the 2014-2016 term of presidency a success and this is the team that is available to all stakeholders in mental health for any kind of interaction. With this team I am very optimistic that we will be able to take our 62 year old society to even greater heights.

Mvuysio Talatala is a psychiatrist in private practice and the current Presdent of SASOP. **mvuysio@talatala.co.za**

Bernard Janse van Rensburg
World Psychiatric Association International Congress in Cape Town 2016

The South African Society of Psychiatrists (SASOP) has been awarded the hosting of a World Psychiatric Association (WPA) International Congress during November 2016 in Cape Town. The congress will be held at the Cape Town International Convention Centre (CTICC) from the 18th to 22th November 2016. **www.wpacapetown2014.org.za.** The congress presidents will be the WPA's President, Prof. Dinesh Bhugra, and the President of the SASOP, Dr. Mvuyiso Talatala.

"IT IS A GREAT HONOUR AND PLEASURE TO WELCOME YOU TO CAPE TOWN FOR THE WPA INTERNATIONAL CONGRESS WITH THE THEME "PSYCHIATRY: INTEGRATIVE CARE FOR THE COMMUNITY" HOSTED BY THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS. IT IS THE FIRST TIME THAT A WPA INTERNATIONAL CONGRESS IS BEING HELD IN SOUTH AFRICA."
(DINESH BHUGRA)

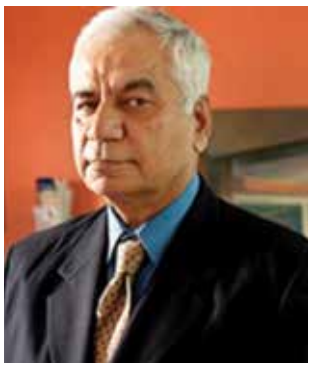
"ON BEHALF OF THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS, IT IS MY GREATEST HONOUR TO INVITE YOU TO THE WORLD PSYCHIATRY ASSOCIATION INTERNATIONAL CONGRESS THAT IS TO BE HELD IN CAPE TOWN, SOUTH AFRICA, FROM 18 TO 20 NOVEMBER 2016."
(MVUYISO TALATALA)

Mvuyiso Talatala,

With the recent death of Nelson Mandela in December 2013, there was a fairly general realization in South Africa, and elsewhere, that reconciliation, transformation and integration of our communities and of our clinical practice, have not been completed or, in some instances, not even undertaken yet. The theme of this congress will therefore be "Psychiatry: Integrative Care for the Community" and will explore concepts, controversies and consequences of Psychiatry's responsibility and accountability to society in terms of its scope of practice and of what can be considered as Psychiatry's social contract. As noted by Nelson Mandela in his State of the Nation Address to the SA Parliament on the 10th February 1999, "Transformation also includes reconciliation and creating a nation united in the rich diversity of communities previously forced apart." This is echoed by Mvuyiso Talatala in relation to the forthcoming Congress,

"TIME HAS COME FOR PSYCHIATRY TO ENGAGE IN A SOCIAL CONTRACT WITH THE PEOPLE OF SOUTH AFRICA, AS WELL AS WITH PEOPLE IN COUNTRIES ACROSS THE WORLD IN LINE WITH THE THEME OF THE 2016 CONGRESS, WHICH IS "PSYCHIATRY: INTEGRATIVE CARE FOR THE COMMUNITY".

The congress will consider how to integrate the developing scope of current psychiatric practice with emphasis on illness prevention, health promotion, clinical care, as well as rehabilitative interventions over the course of people's life time. The congress will deliberate on the expanding systems required for all four dimensions of care to be integrated, including: Psychiatry's core neuroscience content and evidence-base for clinical care (biological); established psychotherapeutic process (psychological) and active social involvement (social); undertaken within particular cultural, religious and spiritual contexts (spiritual).



Dinesh Bhugra

"MANY COUNTRIES IN AFRICA ARE PROVIDING INNOVATIVE SERVICES IN SPITE OF LIMITED RESOURCES AND WE NEED TO LEARN FROM EACH OTHER AND SHARE EXPERIENCES, SUCCESSES AND FAILURES. MANY TRADITIONAL HEALTH CARE MODELS ALREADY SEE PHYSICAL AND MENTAL HEALTH INTEGRATED AND WE NEED TO BE OPEN-MINDED ABOUT HOW WE LEARN FROM OTHER SCHOOLS OF MEDICINE. AS WE PROGRESS THROUGH THE 21ST CENTURY, THE RECENT ECONOMIC DOWNTURN HAS MADE IT EVEN MORE CHALLENGING TO DELIVER SERVICES FOR WHICH DEMAND IS INCREASING."
(DINESH BHUGRA)

In the process, the question of what aspects of psychiatric care and practice require further integration will be posed

to member associations and delegates from the 18 different WPA Zones, as well as to the more than 65 different Sections focusing on different interests within the WPA.

"THIS CONGRESS IS A MAJOR STEP FORWARD IN HELPING TO DEVELOP PSYCHIATRIC SERVICES AS WELL AS THE TRAINING OF MENTAL HEALTH PROFESSIONALS IN A MORE INTEGRATED MANNER, AND IT PROVIDES A SERIOUS PLATFORM FOR DISCUSSION AND DEBATE TO DEVELOP SERVICES WHICH OUR PATIENTS WILL BE WILLING TO USE. WORLD PSYCHIATRIC ASSOCIATION IS COMMITTED TO IMPROVING THE HEALTH CARE OF PSYCHIATRIC PATIENTS THROUGH RAISING STANDARDS OF TRAINING, EDUCATION AS WELL AS CLINICAL PRACTICE. THIS CONGRESS PROVIDES AN EXCELLENT OPPORTUNITY TO SHARE ACADEMIC KNOWLEDGE, INCREASE SOCIAL INTERACTIONS AND SUPPORT EACH OTHER." *(DINESH BHUGRA)*

During the next two and a half years, interactive discussions amongst members and delegates on related congress topics will be pursued and encouraged through the use of available social media and electronic communication. Key contributions and regular updates to the process will be made available on the congress website **(www.wpacapetown2016.org.za).**

On behalf of the SASOP and the WPA, you are cordially invited to reserve this date on the 2016 calendar, to actively participate in the process, and to prepare for your attendance and presentation on your specific local practice, or area of interest.

"I HOPE THAT, IN 2016, YOU WILL ALSO EXPERIENCE CAPE TOWN AS THE REFRESHMENT STATION THAT IT HAS BEEN, AS YOU CONTINUE IN YOUR ENDEAVOURS TO ENGAGE WITH AND EXPRESS PSYCHIATRY'S RESPONSIBILITY AND ACCOUNTABILITY IN YOUR COMMUNITIES." (MVUYISO TALATALA)

Bernard Janse van Rensburg is the Chair Local Organizing Committee WPA International Congress in Cape Town 2016 and President-Elect South African Society of Psychiatrists (SASOP) 2014-2016 **bernard.sasop@mweb.co.za**

ST. ANTHONY'S HOME – CATERING FOR CHRONIC BPD AND SCHIZOPHRENIA PATIENTS.

"If only we'd known about you before" is often what psychiatrists, parents, trustees, curators and others say when they finally hear about St Anthony's Home in Little Mowbray, Cape Town. St Anthony's caters primarily for the long term residential care of the chronic BPD and Schizophrenia sufferer. These are the "lucky ones" for whom their parents or trusts can afford to put their child or ward into a homely environment. In this environment they will be treated as adult members of a large family. The minimum entry age is 30 years old and maximum is 50. Residents stay long after 50 if their physical health warrants it – i.e St Anthony's does not cater for old age and frail care.
At St Anthony's the resident will be treated with both dignity and compassion.
We have a staff complement of 25. St Anthony's is fully licenced as a "Community Mental Health Facility" by the Western Cape Government. We have rigorous annual inspections from the Department. They are welcomed !

Our residents come from as far afield as Zimbabwe, Johannesburg and Durban. Local psychiatrists as well as Valkenberg Mental Hospital support us. Each resident has his or her own Government or Private psychiatrist. We have a Nursing Manager(ess) and she and the nursing staff ensure compliance with medication, personal hygiene and all matters medical. We are not a lock down facility. We also aren't a rehabilitation facility.

Our residents are part of a caring family comprising their fellow residents as well as professional carers.
It works! Basically we could be viewed as a long term residential hotel catering for a very specific clientele.

For more information please view our website (www.stanthonyshome.co.za) or the Nursing Manageress Sr. Harmse at sister@stanthonyshome.co.za 021 689 1665 or contact the owner directly – Michael Edwards – michaeledwardsza@gmail.com, phone 072 909 1599.

CURRENT DEBATE

DECLARATION ON MENTAL HEALTH IN AFRICA: MOVING TO IMPLEMENTATION

Abdallah S. Daar[1]*, Marian Jacobs[2], Stig Wall[3], Johann Groenewald[4], Julian Eaton[5], Vikram Patel[6,7], Palmira dos Santos[8], Ashraf Kagee[9], Anik Gevers[10,11], Charlene Sunkel[12], Gail Andrews[13], Ingrid Daniels[14] and David Ndetei[15,16]

[1]Dalla Lana School of Public Health and Department of Surgery, University of Toronto and Grand Challenges Canada, Toronto, Canada; [2]Faculty of Health Sciences, University of Cape Town, Cape Town, South Africa; [3] Department of Public Health and Clinical Medicine, Umea° University, Umea , Sweden; [4]Strategic Initiatives, Stellenbosch Institute for Advanced Study, Stellenbosch, South Africa; [5]CBM International, West Africa Regional Office, Lome´, Togo; [6]Centre for Global Mental Health, London School of Hygiene and Tropical Medicine, London, UK; [7]Sangath Centre, Provorim, Goa, India; [8]Mental Health Department, Center for Applied Psychology and Psychometric Tests, Ministry of Health, Mozambique; [9]Department of Psychology, Stellenbosch University, Stellenbosch, South Africa; [10]Gender & Health Research Unit, South African Medical Research Council, Pretoria, South Africa; [11]Department of Psychiatry & Mental Health, University of Cape Town, Cape Town, South Africa; [12]Awareness, Advocacy & Communications Officer, Central Gauteng Mental Health Society, Johannesburg, South Africa; [13]Office of the Director General, National Department of Health, Pretoria, South Africa; [14]Cape Mental Health, Observatory, South Africa; [15]Department of Psychiatry, University of Nairobi, Nairobi, Kenya; [16]Africa Mental Health Foundation, Montreal, Canada

Urgent action is needed to address mental health issues globally. In Africa, where mental health disorders account for a huge burden of disease and disability, and where in general less than 1% of the already small health budgets are spent on these disorders, the need for action is acute and urgent. Members of the World Health Organization, including African countries, have adopted a Comprehensive Mental Health Action Plan. Africa now has an historic opportunity to improve the mental health and wellbeing of its citizens, beginning with provision of basic mental health services and development of national mental health strategic plans (roadmaps). There is need to integrate mental health into primary health care and address stigma and violations of human rights. We advocate for inclusion of mental health into the post-2015 Sustainable Development Goals, and for the convening of a special UN General Assembly High Level Meeting on Mental Health within three years.

Keywords: *Africa; mental health; WHO action plan; roadmap; basic services; policy; implementation; stigma; human rights; post-2015 Agenda; UN General Assembly*
Responsible Editor: Peter Byass, Umea° University, Sweden.
***Correspondence to:** Abdallah S. Daar, Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada, Email: a.daar@utoronto.ca
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On behalf of:

List of Signatories

Firstname lastname	Organization
Atalay Alem	College of Health Sciences, Addis Ababa University, Ethiopia
Astrid Berg	Department of Child Psychiatry, University of Cape Town, South Africa
Yomi Esan	Department of Psychiatry, University of Ibadan, Nigeria
Hendrik Geyer	Director, Stellenbosch Institute for Advanced Study (STIAS), South Africa
Abdullah S.Daar et al.	

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Firstname lastname	Organization
Oye Gureje	Department of Psychiatry, UCH, University of Ibadan, Nigeria
Karen Hofman	Director, Priority Cost Effective Lessons for Systems Strengthening, University of Witwatersrand, School of Public Health, South Africa
Lars Jacobsson	Department of Psychiatry, Umea° University, Sweden
Lotta Jernstro¨m	Department of Health and Social Care, SKL, Sweden
Sylvia Kaaya	Department of Psychiatry, Muhimbili University, Tanzania
Lou-Marie Kruger	Department of Psychology, Stellenbosch University, South Africa
Bernard Lategan	Former Director, STIAS
Ingrid le Roux	Philani Child Health & Nutrition Project, Cape Town, South Africa
Nasser Loza	Behman Psychiatric Hospital, Cairo, Egypt
Crick Lund	Centre for Public Mental Health, University of Cape Town, South Africa
Sandra Marais	Researcher, South African Medical Research Council
Keymanthri Moodley	Department of Psychiatry, Stellenbosch University, South Africa
Bronwyn Myers	South African Medical Research Council
Maud Olofsson	Former Deputy Prime Minister of Sweden
Inge Petersen	PRIME South Africa & Department of Psychology, University of Kwazulu-Natal, South Africa
Soraya Seedat	Department of Psychiatry, Stellenbosch University, South Africa
Dan Stein	Department of Psychiatry & Mental Health. University of Cape Town, South Africa
Leslie Swartz	Department of Psychology, Stellenbosch University, South Africa
Stephen Tollman	Agincourt, School of Public Health, University of Witwatersrand, South Africa
Mark Tomlinson	Department of Psychology, Stellenbosch University, South Africa
Lize Weich	Department of Psychiatry, Stellenbosch University, South Africa

On 24 and 25 February 2014, a group of people with a common interest in mental health met at the Stellenbosch Institute for Advanced Study (STIAS) in South Africa at a roundtable meeting to address the topic: *Mental Health Challenges in Sub-Saharan Africa: Moving to Implementation.*

Participants included representatives of groups of interest such as persons with psychosocial disabilities, NGOs, policymakers, academics, research funders, service providers, and others from East, West, South, and North Africa, as well as colleagues from Sweden, Canada, theUS, Germany, and the World Health Organization (WHO).[1] Together with others who participated in planning and at a previous workshop at STIAS, we recognized that in spite of mental, neurological, and substance use disorders constituting a very high burden of disease globally, and that depression is the leading cause of disability throughout the world, these disorders have not been given sufficient attention. In Africa, where mental disorders also account for a huge proportion of burden of disease, in general less than 1% of the already minimal national health budgets are spent on these disorders. In communities in which persons with psychosocial disabilities live, and even in the health care system, the affected persons, their families, and caregivers are frequently stigmatized and experience social exclusion and discrimination; and it is often assumed that little can be done to address their circumstances. However, a growing body of scientific evidence shows that much can be done for treatment, at moderate additional costs, and with significant economic benefits to countries, while at the same time reducing suffering and improving, and often saving, the lives of those who are affected.

At a global level, the 194 member states of the WHO (including those from Africa) have adopted the Comprehensive Mental Health Action Plan (MHAP) with the objectives of advancing the mental health agenda in the world. This plan is supported by technical tools like the mhGAP Intervention Guide fornon-specialist health settings, to assist in scaling up services. In Africa, these provide important opportunities for country-led intervention.

We believe that action is urgently needed not just by governments and other groups as set out below but also by international donors who contribute to health budgets and influence health policy, the mental health professional community, medical and public health schools, research institutions, and research funding bodies. Recognizing that there is no health without mental health, that widespread poverty results in greater vulnerability to mental illness, and that mental health therefore deserves particular attention on the African continent, we believe that:

1. Africa has an historic opportunity now to improve the mental health and wellbeing of its citizens.
2. There is an urgent need for political vision, commitment, and leadership at the highest level to encourage national dialogue on mental health. Governments should take the lead, while working with and supporting an inclusive, cross-sectoral, multi-stakeholder approach that has been found to be critical for dealing effectively with mental conditions and in addressing the social circumstances that create disability associated with these.
3. While supportive legislation and access to mental health services are crucial, there is an urgent need to address stigma, social exclusion and discrimination as dealing with these greatly contributes to improving the quality of life. Communities that include service users, their families, and other stakeholder groups must play a major role in bringing about these positive changes.
4. There is an opportunity for every African government to build on the MHAP to develop a National Mental Health Strategy and Plan (Roadmap). We support the evidence and experience that indicate that such a plan must:

1We sincerely thank WHO's Dr. Shekhar Saxena for his many valuable contributions.

DECLARATION
ON MENTAL HEALTH IN AFRICA: MOVING TO IMPLEMENTATION *Cont...*

i. Encompass the principle of parity in providing resources for mental and physical health alike;
ii. Integrate mental health care services at all levels of the health system, with a focus on integration into primary health care;
iii. Include provision of resources for training, supervising, and supporting different cadres of health and other personnel with an emphasis on task-sharing;
iv. Take a life-course approach, recognizing that there are different needs at different stages in life such as pregnancy, infancy, childhood and older age, and that investment in early intervention can reduce later disability;
v. Allow for targeting of actions to address the specific needs of groups such as women, the very poor, the homeless, and so on, many of whom have been historically neglected. Such specific focus is necessary because these groups may have different risk factors, disease prevalence, and help-seeking behaviors;
vi. Be person-centered and holistic, providing psychological and social care as well as improving access to biomedical services;
vii. Specifically respond to the mental health needs that arise as a consequence of violence in society, especially against women and children;
viii. Include provision of care that is evidence-based and culturally appropriate; and
ix. Pay particular attention to the link between mental health and other health and development priorities like HIV/AIDS and Maternal and Child Health. Integrating mental health into other health and development initiatives provides an opportunity to improve outcomes in other sectors (1, 2), while allowing efficient investment in mental health through these other programs.

We noted the experience of some countries like South Africa and Ethiopia who have progressed in developing national mental health policy frameworks and strategic plans. Together with the WHO Comprehensive Mental Health Action Plan, such examples are a useful template to be modified appropriately by other African countries. These and other relevant plans can be accessed for reference through the WHO MiNDbank resource: http://www.who.int/entity/mental_health/mind bank/en/index.html.

Furthermore, acknowledging that governments have a moral and legal obligation to safeguard the human rights of all their citizens, including those who suffer from mental conditions, we also recommend that:

5. In parallel with developing a national strategic plan, governments must ensure availability of all essential medications and basic services for mental health care for all their citizens; and

6. It is necessary for governments to have a robust legislative response to counter inhumane practices against those who are suffering, such as institutionalization, imprisonment, isolation, discrimination in access to public goods, and other violations of their human rights.

We also recognize that African governments and civil society organizations have the immediate opportunity to join the leadership of those advocating for the inclusion of mental health in the UN post-2015 Sustainable Development Goals.

Furthermore, we urge African governments, civil society organizations, and others to advocate strongly for the convening of a special UN General Assembly High Level Meeting on Mental Health within 3 years.

In providing an evidence base for such advocacy, we recommend that African governments should foster implementation research that focuses on sustainability and scaling-up of services at affordable cost; support research on mental health integration into primary care; and facilitate gathering of high-quality epidemiological data on mental disorders, including better integration of mental health in routine national health management information systems. In this regard, sharing of knowledge, experience, and best practices among African countries could be very valuable, especially if done on a subregional level.

In conclusion and in pursuit of these interventions, we recommend engagement through Africa-wide mental health networks made up of various stakeholder groups, Declaration on mental health in Africa: moving to implementation including communities of persons with psychosocial disabilities, their families, and their caregivers.

Acknowledgements

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MAKING MENTAL HEALTH MATTER

Mental illness and the stigma surrounding it is a critical issue in South Africa, with 1 in 3 people suffering from a mental illness in their lifetime.

ACCORDING TO THE WHO, BY 2020 MENTAL ILLNESS WILL BE THE MAIN BURDEN OF DISEASE WORLDWIDE.

The South African Depression and Anxiety Group (SADAG) are at the forefront of patient advocacy, education and destigmatisation of mental illness in the country.

SADAG IN PARTNERSHIP WITH DISCOVERY HEALTH PRESENTED A WORKSHOP "COGNITIVE BEHAVIOURAL THERAPY: FROM SCIENCE TO PRACTICE" WITH INTERNATIONAL GUEST SPEAKER AND ONE OF THE WORLD'S LEADING EXPERTS IN THIS FIELD; PROF STEFAN HOFMANN, FROM BOSTON UNIVERSITY. THIS WORKSHOP WAS HELD ON THE 3 NOVEMBER 2014 AT THE DISCOVERY HEAD OFFICE IN SANDTON AND WAS OPEN TO HEALTH PROFESSIONALS WHO WANTED TO TAKE THE OPPORTUNITY TO LEARN MORE ABOUT CBT FROM A LEADING EXPERT.

Prof. Hofmann is a world renowned CBT specialist with numerous accolades accredited to him. His research focuses on the mechanism of treatment change, translating discoveries from neuroscience into clinical applications, emotions, and cultural expressions of psychopathology.

He is the past President of The Association for Behavioural and Cognitive Therapies, and the International Association for Cognitive Psychotherapy. He is also Editor-in-Chief of Cognitive Therapy and Research in addition to being an Associate Editor of Journal of Consulting and Clinical Psychology. Of his most recent books include "An Introduction to Modern CBT."

Prof. Hoffman spoke on how Cognitive Behavioural Therapy (CBT) can be used effectively in the treatment of illnesses such as obsessive compulsive disorder, social phobia, depression and anxiety.

Participants became familiar with modern Cognitive Behavioural Therapy (CBT), which effectively targets virtually all DSM disorders. Content included:

- Why psychological treatments, such as cognitive behavioural therapy, are effective for anxiety and mood disorders.
- How we can translate knowledge from basic neuroscience into practical clinical techniques.
- Latest CBT treatment for social anxiety
- How psychological treatments can be made more culturally sensitive in order to enhance their efficacy, dissemination and acceptability.

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SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP ADHD Helpline

ADHD Day 14th September New Line Launched

If you or a loved one finds it difficult to focus on something without being distracted, have difficulty controlling what you do or say, are less able to control your restlessness when other people seems to be, and are more impulsive then others – it may be ADHD. Attention Deficit Hyperactivity Disorder is a serious psychiatric illness that affects almost 10% of children and 5% of adults worldwide.

SADAG IS LAUNCHING A NEW TOLL-FREE ADHD LINE - THE SADAG ADHD HELPLINE - MADE POSSIBLE BY AN EDUCATION GRANT BY JANSSEN. ACCORDING TO THE MOST RECENT DATA, UP TO 10% OF SOUTH AFRICANS HAVE ADHD. IT COULD BE PRESENT FROM BIRTH OR EARLY CHILDHOOD AND USUALLY PERSISTS THROUGHOUT A PERSON'S LIFETIME, BUT IS OFTEN NOT RECOGNISED OR DIAGNOSED. THIS TOLL-FREE LINE - 0800 55 44 33 –WILL BE OPEN 7 DAYS A WEEK FROM 8AM TO 8PM FOR EDUCATION, ADVICE, REFERRAL AND INFORMATION ON ADHD.

Driven by their commitment to patients, and the fact that they recognize the impact of serious conditions on people's lives, they aim to empower people through disease awareness, education and access to quality care. Janssen has a long-standing history in making a meaningful difference in global public health, dating back to Dr. Paul Janssen's pioneering work in mental health and pain medication. Inspired by his legacy, Janssen aims to help more people in more places have access to sustainable, effective healthcare solutions.

With health care professionals, the media, and society calling it so many things – overactive, inattentive, attention deficit, attention deficit hyperactivity disorder, hyperkinetic disorder, hyperactivity – getting a firm understanding on what ADHD is and how to live with it can be a challenge in itself. "Misinformation about ADHD frequently blames those in need of treatment which may discourage people from seeking appropriate care", says Cassey Chambers, Operations Director of SADAG.

SHE SAYS THAT PARENTS MAY AVOID PROFESSIONAL HELP BECAUSE THEY FEAR BEING LABELLED AS POOR PARENTS, OR BEING ACCUSED OF SEEKING TO MEDICATE OVERLY PLAYFUL, NON-COMPLIANT OR MILDLY DISRUPTIVE CHILDREN.

"Receiving an accurate and appropriate diagnosis can bring a sense of relief and correct treatment helps adults and children suffering with and affected by ADHD to deal with the issues more effectively", says Chambers. This is why this new SADAG ADHD Helpline is so critical. Education, awareness, support and appropriate referral are crucial – in all health conditions and ADHD is no different.

AN ADHD DIAGNOSIS CAN ONLY BE MADE BY A MENTAL HEALTH PROFESSIONAL WHO SPECIALISES IN THE FIELD AND AFTER PHYSICAL EXAMINATION AND CASE HISTORIES HAVE BEEN TAKEN. "DIAGNOSING ADHD IS NOT A SIMPLE PROCESS AND IT IS VERY IMPORTANT THAT POTENTIAL PHYSICAL ISSUES ARE DISCOUNTED AND THAT TIME IS SPENT TAKING COMPLETE HISTORIES TO PROPERLY ASSESS BEHAVIOUR", SAYS DR FRANS KORB.

While barriers to treatment have been reduced in recent years, there is still much stigma, misunderstanding and an environment of blame-and-shame that discourages people from seeking help for mental health disorders, including ADHD. The disabling consequences of untreated ADHD are often due not to lack of effective treatment but rather limited access to expert knowledge, accurate information, and specialist care.

THE SADAG ADHD HELPLINE

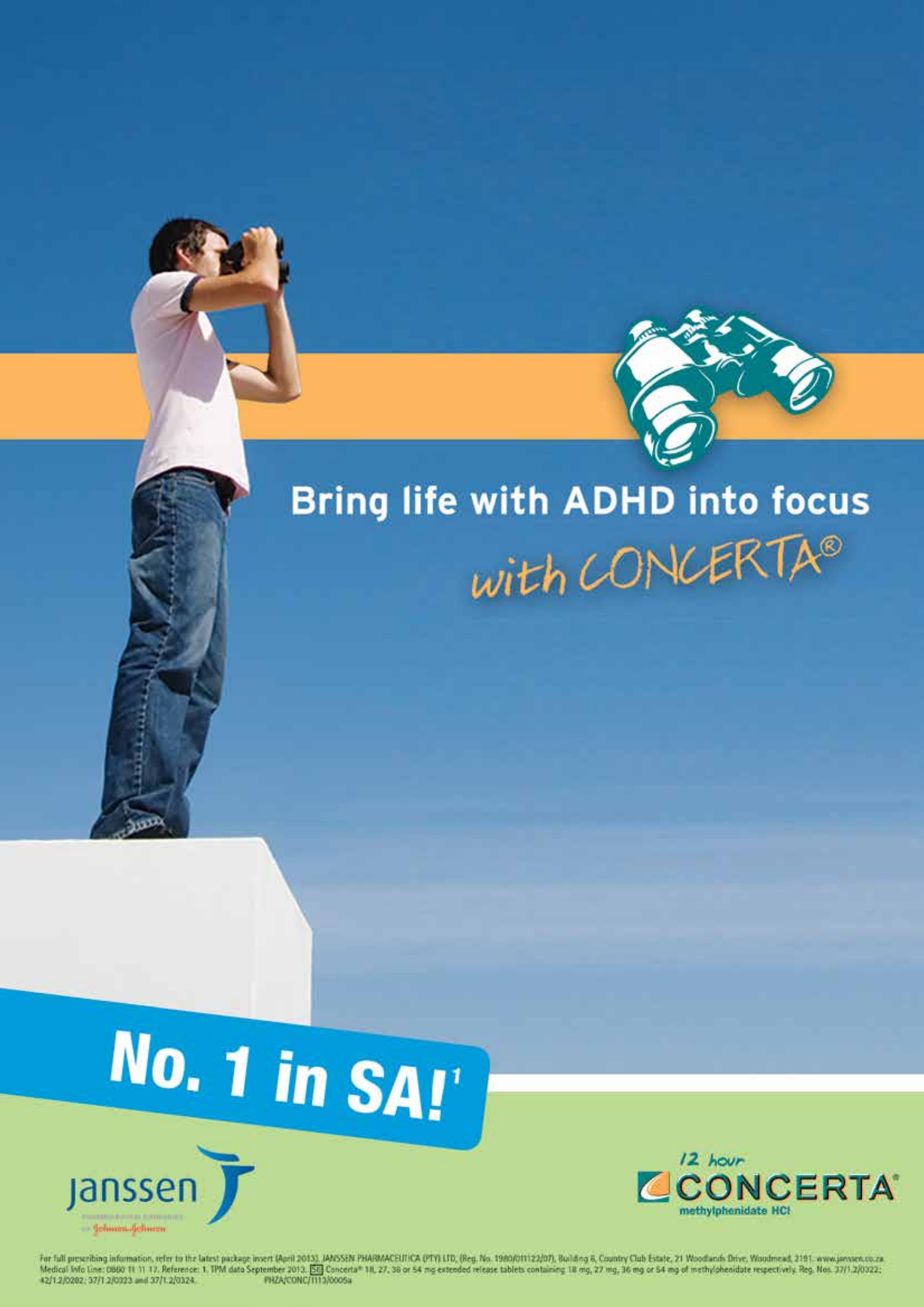
(0800 55 44 33),

Made Possible Through An Education Grant By Janssen, Will Give All South Africans Accessto These Resources.

Not sure if you may suffer from ADHD?

Go to www.sadag.org and fill in questionnaire to see if you may have symptoms of ADHD.

On the website, you'll also find brochures, handouts, self-help tips, online resources for child and adult ADHD



Duncan Rodseth Lundbeck FOCUS Meeting

274 Psychiatrists and Consultants from all over South Africa gathered at The Maslow Hotel in Sandton on 1st and 2nd August 2014.

The occasion was an educational event, "The Lundbeck FOCUS Meeting", hosted by Lundbeck South Africa, at which international speakers presented the latest information on future directions of research into depression, new treatments and the disability associated with the illness.

"We are so excited to have had such a fantastic response from Psychiatrists," said Wendy Cupido, Group Product Manager with Lundbeck South Africa.

"WE COULD NOT HAVE HOPED FOR A MORE SUCCESSFUL SYMPOSIUM" ECHOED ELAINE MILNE, MARKETING MANAGER AT LUNDBECK.

The Master of Ceremonies for the evening was the doctor-turned-comedian Riaad Moosa who introduced the speakers and had the audience shrieking with laughter at his inimitable brand of humour.

Mr Ben Christen, Managing Director of Lundbeck South Africa, welcomed the guests on behalf of the company and spoke about some of the significant milestones for Lundbeck, including the launch of Cipramil in 1994 and Cipralex in 2004. He affirmed Lundbeck's commitment to psychiatry and mentioned that Lundbeck is celebrating 30 years in South Africa. He also spoke about exciting new products that Lundbeck expects to launch starting within the next few months.

Professor Roger McIntyre from Canada began the academic presentations on Friday night. He is currently a professor of Psychiatry at the University of Toronto and Head of the Mood Disorders Psychopharmacology Unit at the University Health Network, Toronto, Canada.

Roger McIntyre

In his talk 'Is MDD a disconnection syndrome?' Professor Mcintyre explored the frontiers of research into depression from the stand-point that brain disorders have their origins in brain development and are progressive cognitive disorders. New conceptualizations of depression and new directions of research are likely to lead to the development of novel and innovative treatments for depression.

Bjarke Ebert

On Saturday morning the first of 3 presentations was entitled 'Food, Music and Rats – understanding multimodality". Dr Bjarke Ebert, the Senior Medical Advisor at H.Lundbeck in Copenhagen, entranced the audience, using M & Ms and Jelly Beans to elucidate the complexity of serotonin receptors, GABA, Glutamate and other neurotransmitters modulated by a multimodal antidepressant.

PROF ROGER MCINTYRE RETURNED TO THE STAGE WITH A FASCINATING PRESENTATION ENTITLED 'THE COGNITIVE DOMAIN AND DEPRESSION: IMPLICATIONS FOR DIAGNOSIS, DISEASE PATHOGENESIS, MEASUREMENT AND TREATMENT'. HE GUIDED THE AUDIENCE THROUGH THE NEWEST THINKING AND RESEARCH ABOUT THE IMPORTANT LINKS BETWEEN COGNITION AND DEPRESSION.

The final talk was presented by Mr. Peter Strasheim. Mr Strasheim is a legal advisor and management consultant specializing in the fields of disability & incapacity, employee benefits, mental health law and pensions law. The title of his talk was 'When They Don't Know that They Don't, Treating the Dunning Kruger Effect'.

This presentation covered the difficult area of mental health law and its impact on employers, an area in which Psychiatrists often have to present opinions. He gave very useful practical advice and tips for writing reports and he was surrounded by members of the audience, after the meeting, who wanted to ask further questions.

Peter Strasheim

The delegates departed at midday after a rewarding symposium. There was an air of excitement about the new developments in a field that is central to the practice of Psychiatry.

Duncan Rodseth is a psychiatrist in private practise in Johannseburg and a consultant to Lundbeck South Africa. **drodseth@icon.co.za**

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