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SOUTH AFRICAN PSYCHIATRY

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Features

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NOVEMBER 2015

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Dear Reader,

Dear Reader, by the time you read this the end of the year will be looming large. As I reflect on *South African Psychiatry* I have to ask myself, where was all this material before? The advent of the publication opened up a unique space, one that is now filled with content that before might have either remained, at best, very local in terms of awareness or at worst – lost. South African Psychiatry is rich, despite the challenging circumstances. There is activity, striving and progress. *South African Psychiatry* has positioned itself to promote that richness and I believe that with this our 5th issue – another jam packed one at that – we continue to grow and evolve. (We've gone from 58 pages for the November 2014 issue to 88 pages for the November 2015 issue). A sincere word of thanks to all of the contributors, both clinicians and industry.

I recently had occasion to view criteria for Department of Higher Education and Training (DoHET) criteria for inclusion as an accredited publication – I believe we are 2 years away from an application, given that one of the criteria is 3 years of continuous publication. This may sound like a long time but a year has passed so quickly that preparation for this time is necessary. Bar some minor adjustments, and subject to current accreditation criteria remaining operational, I am confident that this will happen. Although we took an initial decision not to publish references or to have a peer review process – this will likely change in the years ahead, specifically for the Feature articles. Whilst the publication has not been characterized as one that publishes hard science in the form of data driven research, if one considers the Feature content published to date – it certainly is scientifically based albeit presented in a less formal and structured format. In essence, the articles are not hard science but certainly inform the "scientific" community (which is not a descriptor confined to those in academia) - with a more personal touch. All clinicians by virtue of the nature of clinical work are scientists, albeit not necessarily researchers in the formal sense. The bottom line is that *South African Psychiatry* is a scientific publication, albeit not a journal per se, with a look and feel that is intentionally non-conformist and with an emphasis on accessibility and utility of content. DoHET accreditation is on our agenda.

The current issue sees the inclusion of dedicated content from the South African Society of Psychiatrists (SASOP), related to the business of the Society, with mention of this association on our cover. This is essentially the rebirth of the former SASOP publication *Headline* (welcome back!). Ian Westmore is the editor of this section and he has done a sterling job for this issue's content. We are delighted with this development which I believe will serve both parties and is entirely in keeping with the stated intention of *South African Psychiatry* i.e. about the discipline, for the discipline. Finally I would like to welcome some old friends writing about movies and wine…all work and no play…

I trust you will enjoy the issue and that your end of year will be peaceful, with best wishes for 2016.

In the August 2015 issue it was mentioned in the Dear Reader piece that the report by Lisa Selwood was for the ECNP Congress. It was in fact the EPA Congress.

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THE UCLA/SOUTH AFRICAN TRAUMA RESEARCH TRAINING PROGRAMME (PHODISO)

The University of California (UCLA) /South African Trauma Research training programme (PHODISO or "healing" in Northern Sotho) has been funded by the National Institute of Mental Health (NIMH) in the USA to prepare future investigators to conduct research in trauma and injury prevention as a result of personal, interpersonal and community level violence.

Ugash Subramaney

The focus of the research programme is to minimize health and mental health effects, specifically depression and Post Traumatic Stress Disorder (PTSD) in South Africa (SA).

THE SPECIFIC AIMS ARE:

1) To develop a multidisciplinary training programme for research into trauma, injury, and effects on health and mental health,
2) To train fellows in trauma, injury, and the effects on health and mental health.
3) For mentors and instructors to evaluate the research training programme and the research of the PHODISO fellows,
4) To assess the training programmes sustainability and integration into academic, private and government supported agencies.

TRAUMA AND INJURY ARE WIDE SPREAD IN SOUTH AFRICA. APPROXIMATELY 1 MILLION TRAUMA CASES ARE REPORTED ANNUALLY TO HOSPITALS, WITH THE INCIDENCE OF VIOLENCE ACCOUNTING FOR MORE THAN HALF OF THE TRAUMA CASE LOAD. [1] TRAUMATIC EXPERIENCES INVOLVING PERSONAL, INTERPERSONAL, AND COMMUNITY LEVEL VIOLENCE AND ABUSE CAN HAVE LASTING EFFECTS ON MENTAL AND PHYSICAL HEALTH. [2]

Trauma can also alter physiological regulatory systems associated with cardiovascular functioning, as well as contribute towards atherosclerosis and glucose metabolism –related disease and other disorders of the Hypothalamic-Pituitary-Adrenal axis (HPA).[3, 4, 5] The effects of the histories of personal, interpersonal and community level violence warrant further research and investigation.

The PHODISO post doctoral fellowship programme was initiated in 2006, with early collaborations with the University of Limpopo (UL).

Ugash Subramaney

It has since expanded to include Northwest University, the University of Cape Town, the Health Science Research Council (HSRC) and the Medical Research Council (MRC). The aim is to train and support South African professionals in traumatic stress and mental health research. The scholars are faculty members at various South African institutes such as UNISA, the University of the Witwatersrand (WITS), the University of KwaZulu-Natal, as well as Monash University and the MRC.

The conceptual organisation for the PHODISO programme includes the ecological and social learning theories. In particular, Bronfrenbrenner's ecological perspective on the study of human development guides the training model, guiding researchers to be cognisant of the various Microsystems, exosystems and Macrosystems that may be involved in a conceptual model for trauma.[6] Each year, applications are invited for recruitment and fellows are selected for the programme on the basis of commitment to the continued research into traumatic stress studies as well as academic distinction. A research proposal in keeping with the vision and mission of the PHODISO programme is presented to the selection committee. Once accepted onto the programme, the proposal is then developed whilst at UCLA, with assistance and mentorship regarding ethics clearance and data collection. The candidate is fully funded for the duration of their programme with UCLA.

Upon joining the programme, fellows are expected to be mentors and role models as they train to conduct research. Annual meetings take place in SA (hosted at various centres, 2015 was held in Cape Town) where interactive discussions take place with regard to progress in the programme, presentations

of research to date and face to face mentorship with regards to future leadership in research. New fellows are also selected at separate interviews each year. To date research has been encouraged in many diverse fields in trauma related research such as cultural aspects of trauma in SA, gender based violence (including intimate partner violence), youth suicide, xenophobia, trauma and emergency medical personnel, policemen and trauma and HIV and AIDS. Whilst at UCLA, every effort is made by the core faculty members to put a scholar in touch with experts in their chosen field of research.

I am extremely privileged to be part of the PHODISO family, and was the 2nd cohort of fellows chosen in 2007 together with Professor Renier Steyn of UNISA. (I did my PhD thesis on the biological and psychological attributes of PTSD in SA metro policemen). The programme entailed 3 months spent at UCLA, working very closely with mentors in the field of trauma (notably Professors Gail Wyatt and John Williams). During this time I attended classes at UCLA, including a course in statistics and trauma studies, the latter of which is compulsory. I completed my post doctoral research on the impact of resilience in women who undergo first trimester termination of Pregnancy (TOP) and am currently finalizing the last paper for publication, under the supervision of Professor Gail Wyatt, who is the principal researcher and director for the centre for Culture, Trauma and Mental health disparities, as well as the director of the UCLA Sexual Health programme, and Associate director of the UCLA AIDS Institute.

Spending 3 months at UCLA, rated amongst the top 5 "Ivy League" universities in the USA at that time, was a like a dream come true for an academic interested in broadening horizons in the traumatic stress research field. Working at the Semel Institute for Neuroscience and Human Behaviour at the Department of Psychiatry and Bio behavioural sciences, a Department where a culture of research is valued so strongly made me acutely aware of my deficits as a South African researcher. I was near completion with my PhD, and now had the gruelling task of commencing a second project in the field of traumatic stress. Having said that, I do believe that having the all round skills of academia, teaching and clinical acumen helped me enormously in juggling the various classes as well as the actual project I was tasked with. I recall Gail and John noting with surprise the numerous roles we as South African public health workers with joint appointments had to play. It's no wonder that research often takes a back seat; or that we have to grab whatever opportunity we can to establish ourselves as researchers. It is with this sentiment in mind that I encourage all researchers in the behavioural sciences to consider doctoral and postdoctoral fellowships in their chosen fields.

My involvement with PHODISO has encouraged the way I think in terms of research and academia; I have mentored and assisted many others in their research endeavours, whether related to traumatic stress or not. It has also opened up many other opportunities for the development of trauma research in SA. For instance, ongoing collaborations with the programme include the TIRISANO Project, a project aimed at mentoring and developing masters' students and their research. To this end, a Webinar was held on the 11th June 2015, on the funding Opportunities for Trauma, Global Mental Health and Drug Abuse Research, run by LeShawndra Price (PhD) who is Chief of the Research Scientist Development Program in the Office for Research on Disparities and Global Mental Health at the National Institute of Mental Health, National Institutes of Health (USA). There is also assistance with grant writing, specifically for social sciences.

Apart from the scholarly work, a PHODISO fellow has the opportunity to do various other things on the west coast of the USA. Many enjoy trips to Las Vegas and San Francisco, as well as spotting famous actors and actresses in Hollywood. For me one of the greatest highlights of my trip to the USA (apart from the extremely supportive research environment I found myself in of course) was the opportunity to engage with literary giants at the annual UCLA /Los Angeles Times Literary fair; hosted on the grounds of the university. What a treat for a bibliophile like me!

Ugash Subramaney is an Adjunct Professor in the Department of Psychiatry, University of the Witwatersrand, Johannesburg, South Africa. She is also a subspecialist Forensic Psychiatrist and the Clinical Head at Sterkfontein Hospital. References are available from the author. **Correspondence: Ugasvaree.Subramaney@wits.ac.za**

PUBLIC MENTAL HEALTH FORUM

David Webb

The first Public Mental Health Forum for psychiatry registrars was held at the Sunnyside Park Hotel in Johannesburg on the 10th October 2015. Organised by the Department of Psychiatry in the Faculty of Health Sciences at the University of the Witwatersrand (WITS), the meeting aimed to take the first steps to assist new psychiatrists in developing a fuller understanding of the social context and social environment in which they work and in which their patients live. Registrars from Departments nationally were invited to attend. *Professor Christopher P. Szabo*, Head of the Department of Psychiatry in the Faculty of Health Sciences at WITS, opened the Forum.

HE EXPLAINED THAT THE PURPOSE OF THE FORUM, WHICH IS HOPED TO BECOME AN ANNUAL EVENT, WAS TO ASSIST IN DEVELOPING A MORE "COMPLETE" PSYCHIATRIST. SPECIALISTS SHOULD HAVE THE KNOWLEDGE AND SKILLS, NOT ONLY TO TREAT THEIR PATIENTS, BUT ALSO TO INFLUENCE POLICY AND SOCIAL CHANGE REQUIRED TO INTEGRATE THEM BACK INTO SOCIETY, AS FAR AS IS POSSIBLE, AS PARTICIPATING AND CONTRIBUTING INDIVIDUALS.

He gratefully acknowledged the sponsorship by Sanofi, which made the meeting possible. He specifically noted Daniel Gerard and Dr Jennifer Fine. In that context, Professor Szabo welcomed and introduced Greg Sinovich, the Zentiva (a Sanofi company) district sales manager (National State) for CNS and CVS portfolios to give a brief overview of the company and its approach to providing solutions for healthcare in South Africa.

Appropriately, the day of the Public Mental Health Forum meeting corresponded with the World Health Organization's (WHO) World Mental Health Day (http://www.who.int/mental_health/world-mental-health-day/2015/en/), whose theme for 2015 was "Dignity in Mental Health". *Associate Professor Bernard Janse van Rensburg* (Department of Psychiatry, WITS University) President Elect of SASOP, explained that the intention of the WHO campaign was to raise awareness "of what can be done to ensure that people with mental health conditions can continue to live with dignity, through human rights oriented policy and law, training of health professionals, respect for informed consent to treatment, inclusion in decision-making processes, and public information campaigns." In line with that theme, he explained that people with mental illness are generally deprived of mental health rights, stigmatised by society and frequently exposed to mental and physical abuse; problems which are often compounded by poor quality of healthcare. He reiterated Professor Szabo's introduction, saying that the Public Mental Health Forum was a step towards educating psychiatrists to assist and empower their patients and to facilitate change in society for better care and social integration.

David Webb

The first formal speaker of the day was *Professor Laetitia Rispel*, Head of the School of Public Health at WITS. In line with the definition of public health, Professor Rispel defined public mental health as the science and art of preventing mental disease, prolonging life and promoting mental health and quality of life through the organised efforts of society. Public mental health intends to engender equitable improvement of mental health and well-being of the community. She explained that public health is a core competency for psychiatrists that requires close relationships with the communities in which they work, so that required resources and necessary social reforms can be identified and linked to reforms in healthcare.

Professor Soraya Seedat, Head of the Department of Psychiatry at Stellenbosch University, spoke about the importance of epidemiological studies in informing public mental health policies.

STUDIES SHOW THAT MENTAL HEALTH DISORDERS ARE HIGHLY PREVALENT, AND EVEN MORE SO WHEN ONE CONSIDERS THE CONSIDERABLE PROPORTION OF PEOPLE WITH SYMPTOMS THAT ARE SUBTHRESHOLD FOR DIAGNOSIS.

MENTAL ILLNESS OFTEN BEGINS IN EARLY LIFE, HAS A PROTRACTED COURSE AND IS, MORE OFTEN THAN NOT, COMORBID. IMPORTANT SOCIETAL RISK FACTORS INCLUDE TRAUMA, PARTNER VIOLENCE, ALCOHOL AND SUBSTANCE ABUSE, AND POOR EDUCATION. BECAUSE OF THESE SOCIAL ISSUES AND STIGMATISATION ASSOCIATED WITH THESE DISORDERS, THEY ARE UNDERDIAGNOSED AND UNDERTREATED. THE LIFETIME PREVALENCE OF MENTAL ILLNESS IS ESTIMATED AT 30%, WITH ONLY ONE IN THREE INDIVIDUALS WHO NEED IT RECEIVING TREATMENT. WHEN THEY ARE TREATED, THERE IS COMMONLY A SUBSTANTIAL DELAY BETWEEN FIRST APPEARANCE OF SYMPTOMS, DIAGNOSIS AND TREATMENT. EPIDEMIOLOGICAL STUDIES ARE IMPORTANT TO HELP IDENTIFY THESE PATTERNS, TO IDENTIFY OPPORTUNITIES FOR PREVENTATIVE MEASURES AND TO ADDRESS TIMELY, ACCURATE DIAGNOSIS, AND MANAGEMENT.

Professor Jonathan Burns, Head of the Department of Psychiatry at the University of Kwa Zulu Natal, discussed mental health policy and service organisation. He explained that mental disorders are a considerable source of disability, especially in low to middle income countries.

Challenges to the South African mental health system are numerous and include, among others, lack of skills, capacity, referral systems, access to healthcare resources, follow-up and treatment adherence, collection of statistics & data, loss of community mental health teams, making partnerships with community-based organisations, and community-based resources for people to go back to after leaving hospital (step-down care centers).

In order to address these issues, the South African National Health Policy was drafted to set down a system of principles to guide decisions and inform the development of an action plan. Key principles in the national policy framework include a pyramid of care, where mental health is available to all, from primary healthcare upwards, with encouragement of self-care. Expensive specialised care is limited to those who need it. Deinstitutionalisation with community-based care in collaboration with other governmental departments (e.g., education, housing, security) and stakeholders in the wider community (e.g. faith-based organisation, traditional healers) is encouraged, informed by appropriate research and monitoring activities. Mental health should be actively promoted alongside measures to prevent mental illness. Advocacy of human rights is emphasised to reduce discrimination and stigma, and promote equality, respect, privacy and dignity.

Associate Professor Crick Lund, Director, Alan J Flisher Centre for Public Mental Health, Department of Psychiatry and Mental Health, University of Cape Town, explained why consideration of social determinants of mental health is so important. These determinants include socioeconomic factors (including poverty, employment and education), negative life events, population group, globalisation, social capital and inequality. They provide information on aetiology, opportunities for preventative interventions, and what to consider when planning service provision and agendas for social and economic policies.

The issue of advocacy was expanded further by *Dr John Parker*, Clinical Head of Outpatient Services at Lentegeur Hospital. Through promoting awareness, education, training and mutual help, advocacy is essential to champion the rights of people with mental health disorders and to reduce the stigma and discrimination that they face in their communities.

Dr Parker said that patient management needs to focus on psychosocial rehabilitation, where restoration of functional activity and patient empowerment is linked to acceptance back into the community. In order to achieve this successfully, accessible community support services are required. Opportunities for employment of patients once they return to the community need to be fostered, especially in the informal sector. Residential support (day hospitals, crisis homes and home treatment teams) is required to provide alternatives for hospitalisation.

HE ENCOURAGED THE DELEGATES TO CONSIDER THE RECOVERY PHILOSOPHY, WHICH BRINGS THESE ASPECTS OF COMMUNITY MANAGEMENT TOGETHER. THIS PHILOSOPHY PROMOTES POSITIVE ATTITUDES, VALUES, SKILLS, ROLES AND GOALS TO IMPROVE SELF-WORTH AND FEELINGS OF VALUE, MEANING AND CONTRIBUTION IN THE COMMUNITY. BY ADDRESSING THE EXPERIENCE OF MENTAL HEALTH, THE SOCIETY IN WHICH THE PATIENT LIVES, EMPLOYMENT AND SOCIAL SUPPORT, THIS APPROACH ENCOURAGES PATIENTS TO CONTINUE TO GROW AS A HUMAN BEING WITH THEIR MENTAL ILLNESS, EVEN IF THEY STILL HAVE SYMPTOMS.

The next speaker, Associate *Professor Stoffel Grobler* (Walter Sisulu University) highlighted the importance of helping and encouraging patients with impairment due to mental health disorders to continue working. Studies show that the longer a person is off work, the less likely it becomes that they will ever return. In fact, among people off work for 6 months or more, 85% will never return!

IMPAIRMENT CAN AND MUST BE ASSESSED FOR INDIVIDUALS WHO ARE UNABLE TO CONTINUE WITH THEIR JOB DUE TO MENTAL ILLNESS AND CAN BE EXPRESSED AS A PERCENTAGE THAT WILL INFORM NECESSARY CHANGES TO WORKING CONDITIONS TO KEEP THE INDIVIDUAL AT WORK. PROFESSOR GROBLER EXPLAINED THAT EMPLOYERS HAVE A DUTY TO MAKE REASONABLE ACCOMMODATION FOR AN IMPAIRED WORKER. EARLY CONSULTATION WITH THE EMPLOYER AND AN OCCUPATIONAL THERAPIST IS ESSENTIAL TO FACILITATE THESE DECISIONS AND TO MINIMISE TIME OFF WORK.

The last speaker was *Adjunct Professor Shan Naidoo* who is Head of the Department of Community Health in the School of Public Health at WITS University. In his entertaining and humorous presentation he eloquently differentiated between the characteristics that define a good leader

IN COMPARISON TO MERELY BEING A MANAGER. HE ADVISED THE DELEGATES THAT THEY NEED TO DEVELOP THE COMPLIMENTARY CHARACTERISTICS REQUIRED OF BOTH A LEADER AND A MANAGER. IN ADDITION TO THE SKILLS NECESSARY FOR PLANNING, ORGANISING, IMPLEMENTING, MONITORING AND EVALUATION, HE EMPHASISED THAT IT IS IMPORTANT TO BE ABLE TO INSPIRE AND ACKNOWLEDGE OTHERS, TO SHOW APPRECIATION AND ENGENDER TRUST AND HONESTY WITHIN A TEAM WORKING TOWARDS A COMMON GOAL.

The meeting was closed by A*ssociate Professor Janse van Rensburg and Professor Szabo.* They encouraged the delegates to develop an interest in public mental health and to implement the principles that had been discussed at the Forum during the course of their professional activities. Examples of questions from recent fellowship examinations relating to public mental health were shown and discussed.

Detailed summaries of individual presentations will be published early in 2016 in *South African Psychiatry.*

David Webb is a medical writer. He qualified as a medical doctor from the University of the Witwatersrand in 1992. In addition to clinical practice, he has worked in the pharmaceutical and advertising industries. **Correspondence: dawebb@mweb.co.za**

SANOFI MENTAL HEALTH LEADERSHIP INITIATIVE CHOSEN AS FINALIST IN BHF ANNUAL TITANIUM AWARDS

The Sanofi Mental Health Leadership Initiative, prominently featured in previous issues of this publication (November 2014;May 2015; August 2015), was recently publically recognized by the Board of Healthcare Funders (BHF) by being shortlisted for the Annual Titanium Award for Excellence in Healthcare Delivery in South Africa.

Jennifer Fine and Christopher Paul Szabo

The initiative was placed third in the Excellence in Corporate Social Investment category at the Board's annual gala evening held on Monday 27th July at the Cape Town International Convention Centre. The event was part of the 16th Annual BHF Southern African Conference.

The Initiative seeks to build leadership capacity in the public mental health sector in South Africa. The express aim is to equip health care professionals with the requisite skills to more effectively advocate for their patients. Health care professionals are increasingly required to go way beyond the clinical interaction, engaging with hospital administrators, government departments, and funders as an integral part of patient care. Nowhere is this more true than in the care of the mentally ill where stigmatization and marginalization remain pressing challenges worldwide. Yet healthcare professionals are ill-equipped to adopt this leadership role, their formal training focusing primarily on disease management and patient care.

The Titanium award was granted on the basis of submission of a comprehensive report attesting to the Initiative's achievements, sustainability and contribution to social and economic development in South Africa. Our report was supported by letters of commendation from international leaders in the field of mental healthcare, including past and present office bearers of the World Association of Social Psychiatry (WASP) and the World Psychiatric Association (WPA).

As the Sanofi leadership initiative has gained momentum with public recognition increasingly

Jennifer Fine (Left) & Christopher Paul Szabo (Second from Right) together with Tuviah Zabow, Pat Mayers and Shan Naidoo – Mental Health Leadership Initiative mentors

forthcoming, public mental health, leadership and management skills have been incorporated into the formal curriculum of the national specialist psychiatry qualification (FCPsych (SA)). As part of this inclusion, a national Public Mental Health Forum – funded by Sanofi - was held on World Mental Health Day (10th October 2015) where leading experts from around the country provided lectures on related content (see report in current issue).

This was a direct outcome of the Sanofi Mental Health Leadership Initiative. The planning process for the next Forum has commenced with involvement of both the South African Society of Psychiatrists and the College of Psychiatrists (Colleges of Medicine of South Africa)

The Sanofi Mental Health Initiative has acted as a catalyst for training of mental healthcare professionals in public health advocacy. Graduates will be better equipped to drive change in the mental health sector, with enhanced services and better resource allocation for the vast numbers of patients with mental illness in South Africa.

Jennifer Fine, at the time of writing was the Senior Medical Advisor, Sanofi, South Africa. She has subsequently taken up a position as Senior Medical Director,Medical Intelligence and Patient Perspective, Sanofi Global R&D. **Correspondence: Jennifer.Fine@sanofi.com** *Christopher Paul Szabo* is Professor and Academic Head of the Department of Psychiatry at the University of the Witwatersrand, Johannesburg, South Africa and Head of Clinical Department, Psychiatry, at the Charlotte Maxeke Johannesburg Academic Hospital.

PSYCHIATRIC SERVICES A WORLD APART

From Gällivare, Sweden (Pop. 18 231, Lat. 67) To Manguzi/Kwa-Ngwanase (Pop. 5 534, Lat. -27). Travel Notes Of A Rent-A-Shrink.

Christer Allgulander

Gällivare is a mining town in Sweden, north of the arctic circle. Reindeer graze in the midnight sun near the town center. The main human leisure activity is skiing or walking mountain trails. Young doctors come here to learn their trade and to ski - cross-country and downhill. There is no disco.

The 2nd hand bumpy propeller plane took me due north from Stockholm in 2.5 hours. I asked my taxi driver if she worked full time. Blond, blue-eyed and 23, she laughed and said no, her main occupation was drilling for iron ore at 1,2 km below. She stopped at the emergency room for me to pick up the key my accommodation. Then she brought me there, at minus 22°C and 3 feet of snow. I was going to work for a week in outpatient care, and learn about the one and only Swedish implementation of telepsychiatry. Kiruna and Jokkmokk, the nearest towns, are 125 and 95 km away through marsh land and pine forest. An internet-mediated communication system must save a lot of time and CO2.

The next morning I was given more keys, a smart card, and access to VAS, the electronic health record system of Norrbotten County. 5 outpatients a day were scheduled; one per hour. Four administrative women organized us 3 docs. Some patients did not show up because of the distance or for other reasons. To read up on each patient and then to feed VAS 'the dragon', issue electronic prescriptions (98% of prescriptions in Sweden are electronic), order lab tests, and dictate notes took about half of that time. Patients here have a lot of patience and are used to a high turn-over of doctors.

> "THE USE OF TRAVELLING IS TO REGULATE IMAGINATION BY REALITY, AND INSTEAD OF THINKING HOW THINGS MAY BE, TO SEE THEM AS THEY ARE."
> *SAMUEL JOHNSON (1709 -1784).*

ABOUT THE CATCHMENT AREA POPULATION

Women reach a mean age of 84 years, and men 77. The Sami population across northern Norway, Sweden, Finland and the Russian Kola

Gällivare Reindeer downtown

Peninsula is an ethnic partly nomad group, herding reindeer up and down the mountains or fishing (**www.barentsinfo.org**), *(Lotta O, Mikael S. 2015)*. Some refugees from Syria, Afghanistan and Africa that afford to pay smugglers for the Mediterranean crossing find shelter here. Some seek asylum because they are HBTQ *(Homosexual, Bisexual, Transsexual, Queer–the accepted Swedish acronym)* and would be killed in their native countries. There is no HIV/AIDS, and only a very occasional tic or dagga smoker. The unemployment rate is 2.5%.

There is no Nkandla scandal. The annual community reports proudly pronounce pure dedication by the public servants. Sweden's economy relies on progressive income tax and a 25% sales tax that redistributes wealth based on a strong egalitarian ethos. This ethos is strained now by the pressure of migration flow that is staggering when it comes to integration into society.

THE COSTS

My presence, organized by a manpower company, deducted ZAR 85 000 per week from the county budget, which translates into ZAR 4000 per actual patient visit (not kidding). There are potentially substantial savings with telepsychiatry and increased continuity of care.

Gällivare Outpatient waiting area

23% OF EARNED INCOME IS TAXED BY THE COMMUNITY FOR DAYCARE, SCHOOLS, SEWAGE, WATER, OLD AGE CARE, THE ENVIRONMENT, SKI-LIFTS, TRACKS FOR SKIS AND SNOW-MOBILES, RECYCLING, ROADS, BUSES AND CULTURE, AND ADMINISTRATION. THE HEALTH CARE TAX IS 10%.

Gällivare Snow mobiles at the hospital

I chatted with the young and dedicated doctors at coffee breaks and at lunch. We organized a daily Happy hour so they could bring their difficult cases for guidance.

Out of curiosity, I barged into the one ward with 16 beds to check out the patients. A huge miner had used his axe on the neighbours' houses and had been taken in by sturdy cops.

A woman with schizophrenia walked around bent over without being aware; a rare case of camptocormia, perhaps induced by dopaminergic meds.

A man had relapsed after ECT believing he was dead, a case of Cotard delusion. His wife was fed up.

Another psychotic woman was admitted because she could not cope with her Alzheimer-sick husband.

A young woman born in Afghanistan and raised in Teheran had come as a refugee via Greece (homeless there for a year) and was home-caring for elderly. She had OCD since early childhood, not diagnosed because of overriding somatizing presentation (cystoscopy and gastroscopy with no findings) and language difficulties. Her obsessions with contamination interfered with her work. There were 10 families from Afghanistan seeking asylum so she was well connected.

ABOUT MANGUZI HOSPITAL

Manguzi is the last town before the crossing into Mozambique. The hospital opened in 1948. Cliff Allwood (former Head of Department of Psychiatry at Wits) was the superintendent from 1970-1976. ARVs were first distributed in July 2004.

In November 2013 I travelled to Manguzi. Hannes de Kock, the psychologist in charge of the hospital's mental health services met me at his house on the hospital grounds. Hannes had written to me that

"MANGUZI HOSPITAL IS AN EXTREMELY RURAL HOSPITAL WITH 280 BEDS, 11 RESIDENTIAL CLINICS AND 3 MOBILE TEAMS VISITING 35 POINTS. OUR HOSPITAL VEHICLES ARE 4X4 IN ORDER TO GET TO THE CLINICS AND PATIENTS' HOMES…"

On the first day I got stuck, so Hannes deflated my tires for the maze of thick sand roads. No reindeer to break for, but goats. The 2nd morning I got lost on the dunes. The 3rd morning the hospital guard welcomed me with a grin of familiarity. Africa is anything but boring.

MANGUZI

There was an impressive team of 30 young dedicated South African, British, Swiss, Belgian and Dutch doctors residing and socializing in villas on the hospital grounds, providing all imaginable medical services 24/7. We had a braai at Hannes' residence and a pleasant evening out at Kozi Forest Lodge.

MARK BLAYLOCK, THE CHIEF MEDICAL OFFICER AND AN EXCELLENT SURGEON, HOSTED MY TALK ABOUT NEUROAIDS. IN 2008, MARK WAS SUSPENDED FOR A MONTH FOR THROWING A PICTURE OF THE MEC OF HEALTH NKONYENI INTO A DUSTBIN. SHE STATED AT A HOSPITAL VISIT THAT ARVS WERE TOXIC.

Hannes saw in- and outpatients and I trailed along. A girl came with her stepmother with the typical features of FAS. Her biological mother had been drinking.

A terminal patient with AIDS was lonely and depressed and we organized for his next-of-kin to travel to sit with him.

A young, very anxious girl came in unable to speak after moving away from her home in the Eastern Cape. We checked on a man with resistant TB (MDR-TB) who had had a psychotic reaction to the meds.

A woman in her 50's had been on meds for a long time over a marital conflict, so we decided to stop that.

A woman with NeuroAIDS exhibited paranoid ideation and we dealt with that.

Manguzi doctors: dinner

Manguzi: Christer Allgulander and Hannes de Kock

PERHAPS YOU THE READER HAVE SOME REFLECTIONS AT THIS POINT. WHAT STRIKES ME IS THE SIGNIFICANCE OF YOUNG, BRIGHT AND DEDICATED DOCTORS WHO ARE CAPABLE OF ADAPTING TO ALL KINDS OF ENVIRONMENTS; DIGITAL, HOT, COLD, RURAL, LOAD-SHEDDING, BUREAUCRATIC, AND MORE. AS A CLINICAL RESEARCHER I SEE THE CHALLENGES OF SUBSTANCE USE, VIRUSES, POVERTY, VIOLENCE, LONELINESS AND HOW TO MAKE PRACTICAL SENSE OUT OF IT. SO MUCH REMAINS AN UNMEASURED MYSTERY THAT WE MUST DEAL WITH BASED ON OUR MEDICAL TRAINING AND 'CONVENTIONAL WISDOM'.

Thanks to Lennart Eriksson and Hannes de Kock for commenting.

Christer Allgulander is a psychiatrist and wild life enthusiast. He is an Associate Professor, Karolinska Institutet, Department of Clinical Neuroscience, Stockholm, Sweden and Honorary Professor, Department of Psychiatry and Mental Health, University of Cape Town, Cape Town, South Africa. Reference available from author. **Correspondence: christer.allgulander@ki.se**

SANOFI PSYCHIATRY DEVELOPMENT AWARD

Sanofi has been sponsoring the "SANOFI PSYCHIATRY DEVELOPMENT AWARD" for three consecutive years. The sponsorship is in partnership with the Heads of academic Departments of Psychiatry at the Universities of Cape Town, Free State, KwaZulu Natal, Sefako Makgatho Health Sciences University, Pretoria, Stellenbosch, the Witwatersrand and the Walter Sisulu University

THE AWARD (R50 000, IN PART OR FULL AMOUNT) IS OPEN TO ALL REGISTRARS AT ANY OF THE AFOREMENTIONED INSTITUTIONS AND TO JUNIOR CONSULTANTS WITHIN 3 YEARS OF SPECIALIST REGISTRATION. THE PURPOSE IS TO SUPPORT RESEARCH AND RESEARCH-RELATED ACTIVITIES. THE BASIS OF FINANCIAL SUPPORT INCLUDES COMPLETION OF HIGHER DEGREE RESEARCH PROJECTS, ATTENDANCE AT CONFERENCES TO PRESENT SUCH RESEARCH, OR PARTICIPATION IN WORKSHOPS TO FACILITATE SKILLS ACQUISITION RELEVANT TO THE RESEARCH.

Applications are submitted annually to Sanofi, and thereafter distributed to the Heads of Departments for adjudication. Their decision is final. The award may be made in full to one applicant or in part to a range of applicants. On completion of the project recipients are required to submit a full report to Sanofi and to the Heads of Departments.

APPLICATIONS ARE OPEN FROM 1st JULY 2015 AND CLOSE ON 30th JUNE 2016.

For further details contact: Greg Sinovich, 082 449 9844
Greg.Sinovich@sanofi.com

SANOFI

SA Federation for Mental Health

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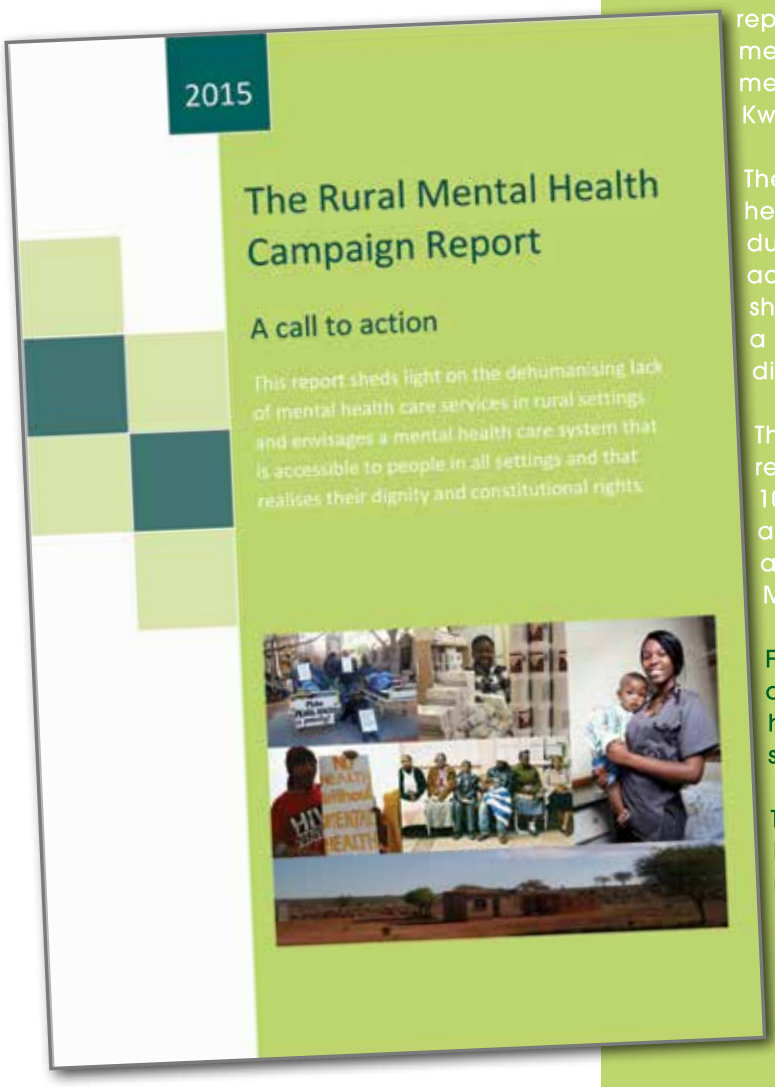

PACASA

Rural Health Advocacy Project

The Rural Mental Health Campaign Report

Dear Partners in Mental Health

The Rural Mental Health Campaign is pleased to announce that we have completed a report on the state of rural mental health care services. The report highlights the challenges that exist in rural mental health care through the testimonies of mental health care users in the Eastern Cape, KwaZulu-Natal, Limpopo and the North West.

The findings of the report reflect that rural mental health care services are still largely inadequate due to the lack of service availability and accessibility, budgetary constraints, drugs shortages, insufficient human resource capacity, a lack of integrated care, as well as stigma and discrimination.

The Rural Mental Health Campaign released the report publicly on World Mental Health day the 10 October 2015. Since the release of the report an interview has been done with SABC radio and an article was published in the Daily Maverick today.

Follow the link to the article http://www.dailymaverick.co.za/article/2015-10-12-health-e-news-mental-health-the-poor-crazy-stepchild/#.VhtUs8vB1UN.

To access a copy of the Rural Mental Health Factsheet go to http://www.rhap.org.za/rural-mental-health-factsheet/

Please share the report and follow the campaign and World Mental Health Month events on #DignityInMind and #WMHD2015. I will be sharing an update soon with the events that will follow the release of the report this month.

The report may be finished but this is really only the beginning!

I look forward to hearing your thoughts and feedback as we develop the Campaign.

Kind Regards
Shannon Morgan
Chairperson
The Rural Mental Health Campaign

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SOUTHERN GAUTENG YOUNG PSYCHIATRISTS' FINANCIAL LITERACY WORKSHOP

Tando Melapi

On the 29th of August 2015, the Southern Gauteng subgroup of the South African Society of Psychiatrists (SASOP) in association with Sanlam and uHambo, held a financial literacy workshop in Midrand. The target group for this workshop was registrars and newly qualified psychiatrists. Most of the newly qualified psychiatrists are starting off in private practice on a full time or part time basis.

This workshop was prompted for a number of reasons. Firstly, my observation and indeed personal experience is that registrar time is one that is, among other things, financially difficult. The Department of Health's policy allows staff who are employed on contract basis, like many registrars are, to choose between a retirement funding income, meaning that they structure your package to allow for medical aid, risk cover and pension, and non-retirement funding income meaning that you get your cost to company less tax paid to you. As a result of cash flow difficulties, many registrars opt for the latter. In turn, the marginally higher net payment they receive is used to help with their cash flow difficulties and goes towards living expenses.

ONCE THEY QUALIFY, THERE IS A NEED TO REVISIT THEIR PERSONAL FINANCES, ESPECIALLY THEIR EXPOSURE TO RISK. THIS INCLUDES PROTECTION OF INCOME AND FAMILY OBLIGATIONS IN EVENT OF DEATH, DISABILITY, BEING DIAGNOSED WITH A DREAD DISEASE AND ACCIDENTAL INJURIES, AS WELL AS SAVINGS I.E. EMERGENCY ACCOUNTS FOR FAMILY FUNERALS / HOLIDAYS / SETTING UP OF PRIVATE PRACTICE, AS WELL AS LONG TERM RETIREMENT PLANNING

With more financial pressures like weddings, children's education, retirement planning and needs or wishes for other lifestyle-related expenses that were largely ignored during the training period (holidays, bigger houses, cars etc), many newly qualified specialists find it difficult starting a private practice, even if only part time.

Many specialists who start in private practice report that they soon realise they are not trained or prepared for private practice. Although registrar time prepares one to assess, diagnose and treat psychiatric disorders, one is not prepared on how to deal with the financial side of running a business. Personal finances, tax matters, staff employment and other similar issues are just a few examples of challenges that await those who start private practice. Often specialists in private practice also find difficulty in knowing how to best invest the profits of the business or how to create an emergency account for their business. All these matters lead to a need for financial literacy for the continued professional development of registrars and specialists in psychiatry and possibly various other fields. It is for these reasons that the SASOP Southern Gauteng subgroup saw a need to have a workshop of this nature and many thanks go to both uHambo and Sanlam for sharing this vision and assisting in making this workshop happen.

Tando Melapi

Delegates: Mpho Tsikoane, Sibongile Nkahle and Nonhlanhla Chuene

This workshop took place at a golf estate in Midrand. Professor Matthew Lester and Ms Odette Ward were the two main speakers. Professor Lester heads the business school at Rhodes University, lectures on tax and related matters and writes a column on tax matters for one of South Africa's most widely read weekly newspapers. He spoke on various aspects of financial planning, starting with a clear and easily explained background of current local and global economic environment, to personal financial planning and ended with business finance, including advantages and disadvantages of different business models.

Ms Ward was the second speaker at this event. She is the owner of a boutique styled financial services company called uHambo.

Ian Westmore, Gcina Mhlophe, (poet, scriptwriter, storyteller), Odette Ward, Tando Melapi

She is a senior financial planner who has been partnering with Sanlam for over fifteen years. Ms Ward gave a broad overview of financial planning and what it entails. She emphasized the importance of building a relationship with a financial planner that would empower you in financial matters and the impact of this both personally and professionally. She went on to explain that her practise does not operate as a sales company, but rather a relationship of empowerment in financial matters, explaining some of the services that her company offers, the relationship between Sanlam and uHambo and how her business relationships with clients work.

It is hoped that those in attendance were stimulated and informed enough about various aspects of their personal and, where applicable, business finance. With many worries about the world economy, possible recession, interest hikes, job insecurities and many other financial uncertainties, SASOP Southern Gauteng hopes to assist its members to be better prepared for any financial storms encountered that may impact on them and their families, dependants, as well as how to improve financial security.

This, in some way can help the health care professionals be more focused on applying their skills and doing what they are trained to do and passionate about; and that is to render their services to the Gauteng and indeed South African community to better their mental health and help alleviate mental illnesses.

THE LAST SPEAKER OF THE DAY WAS GCINA MHLOPHE. MS MHLOPHE IS A WELL KNOWN SOUTH AFRICAN FREEDOM FIGHTER, ACTIVIST, ACTRESS, STORYTELLER, POET, PLAYWRIGHT, DIRECTOR AND AUTHOR. IT IS DIFFICULT TO DO JUSTICE TO HER PERFORMANCE AND SPEECH. SHE PERFORMED SONGS, TOLD STORIES AND OVERALL MOTIVATED THOSE IN ATTENDANCE ABOUT MANY ASPECTS OF LIFE, REMINDING MANY OF US OF THE PAST THAT THE COUNTRY COMES FROM. MS MHLOPHE SPOKE ABOUT DETERMINATION IN SPITE OF ADVERSITIES AND THE NEED FOR SELF-DEVELOPMENT. SHE ALSO TOUCHED ON THE IMPORTANCE OF MENTORSHIP IN ONE'S LIFE JOURNEY.

Tando Melapi is a consultant psychiatrist at Sterkfontein Hospital, a lecturer in the Department of Psychiatry at the University of the Witwatersrand (Johannesburg, South Africa) and the convener of the Young Psychiatrists section of the Southern Gauteng Sub group of the South African Society of Psychiatrists. **Correspondence: tasmelapi@gmail.com**

FINANCIAL PLANNING FOR YOUNG GRADUATES DON'T STUFF UP LIKE DAD

Most financial planning campaigns are directed at the 'Baby Boomer' generation (born between 1945 and 1963) and Generation X (born between 1964 and 1980).

Matthew Lester

These will be the first generations that will retire without receiving guaranteed benefits from their employers. And it is generally accepted that most will have insufficient private savings to make up the shortfall.

The Baby Boomer generation and Generation X are getting the message and many are making desperate attempts to catch up the shortfalls in their retirement savings.

BUT THE MESSAGE DOES NOT SEEM TO HAVE FILTERED DOWN TO GENERATION Y, BORN BETWEEN 1980 AND 2000, THE CHILDREN OF THE BABY BOOMER GENERATION AND GENERATION X. WHEN CONFRONTED WITH THE FINANCIAL PLANNING PLIGHT OF THEIR PARENTS THE GENERAL REACTION IS, 'THERE BUT FOR THE GRACE OF GOD GO I.'

Almost 20% of South Africa's taxes are ploughed into education. Yet it is quite fascinating that universities and colleges seem to offer little or nothing in the form of general life skills courses to alert students to the fundamental mistakes they will make with their personal finances within the first five years after graduation. Some mistakes will haunt them for decades to come.

There have also been changes in lifestyle trends in Generation Y that impact on the finances to the Baby Boomer generation and Generation X. In particular Generation Y is remaining financially dependent on their parents for far longer.

GONE ARE THE DAYS OF DAD'S FAMOUS WORDS AT HIS SON'S 18TH BIRTHDAY PARTY: 'GO TO THE MILITARY, GO TO UNIVERSITY, OR GO AND GET A JOB. BUT THE IMPORTANT WORD IS "GO."'

OFF TO A BAD START

Matthew Lester

Prior to the global credit crunch most people had easy access to credit. Today this is restricted by the requirements of the National Credit Act. However, easy access to credit remains a reality for young graduates. Within months of graduation, former students are issued with gold and platinum credit cards before they have even experienced the reality of daily costs of living outside of the student environment. This often results in a hopeless debt trap within the short term. And it takes many years for some young graduates to recover from the experience. Unless of course they receive a financial bailout from friends or relatives (usually within the Baby Boomer or Generation X categories).

Added to the credit problem is immediate access to cellphone contracts, clothing accounts and vehicle finance. Thus graduates land up owning an iPhone and an iPad before they even own an iRon!

JUST 10 YEARS AGO IT WOULD HAVE BEEN A REASONABLE FINANCIAL PLAN FOR A GRADUATE TO 'BUY A HOUSE AS SOON AS POSSIBLE AND PAY IT OFF BY AGE 35-40. THERE WILL BE PLENTY OF TIME TO CONCENTRATE ON A RETIREMENT PLAN THEREAFTER'.

It is quite amazing that, in spite of the obvious difficulties within the residential property market since 2008, there is still a perceived urgency for graduates to enter the residential property market. Few realise that in many respects residential property has turned from asset to liability as holding costs have sky rocketed. Most would be far better off if

they remained in rented accommodation for the short to medium term.

OTHER RISKS

Today, many graduates are initially employed on limited duration contracts. Some employment benefits (medical aid, group life and permanent health insurance schemes, and retirement funds) are either not provided or participation is voluntary. Graduates actually prefer such packages as they increase disposable income in the first years of employment.

The standard rules of medical aids are usually that a student may remain on the parents' medical aid, even after age 21. However separate arrangements have to be made after graduation. If the dependent wishes to remain on the parent's medical aid, a full member's rate will be charged.

The absence of group life cover for a new graduate is by no means the greatest risk to a family. But the absence of disability, permanent health and income protection insurance poses a substantial risk to the entire family. A health problem or accident of any family member has the potential to ruin the financial planning efforts of the parent as most parents would attempt almost anything to keep away from South Africa's current health care system.

SOME ARGUE THAT GENERATION Y WILL BENEFIT FROM THE GOVERNMENT'S PLANS FOR IMPLEMENTATION OF A NATIONAL HEALTH INSURANCE (NHI) SYSTEM WITHIN THE MEDIUM TERM. THIS PROJECT REMAINS IN ITS INFANCY AND IT WILL BE MANY YEARS BEFORE SOUTH AFRICA WILL BE ABLE TO AFFORD A COMPREHENSIVE NHI SYSTEM. MANY PREDICT THAT EVEN IF NHI IS IMPLEMENTED, THOSE WHO CAN AFFORD PRIVATE HEALTH CARE WILL REMAIN ON PRIVATE MEDICAL AID.

There can be no doubt that today's graduates are subject to substantial unavoidable risks when living in the new South Africa.

THE GOOD NEWS IS THAT GRADUATES REPRESENT AN EXTREMELY LOW RISK TO INSURANCE COMPANIES.

Over the years financial institutions have developed specific products to cover the risks of graduates. Thus, the costs of disability, permanent health and income protection insurance cover for graduates represent a fraction of the cost to the general public. These products are as much for the protection of the insured as they are for the insured's family.

Some prudent parents even go so far as to facilitate medical aid, permanent health insurance and disability cover for their adult children, just to protect themselves. The cost of the premiums is a fraction of the damage to the parents' financial plan should something go horribly wrong. There is no doubting the wisdom of this action.

RETIREMENT PLANNING FOR GENERATION Y

Generation Y can understand the attraction of the concept of making tax-deductible contributions to retirement funds. But it is extremely difficult to sell the prospect of tying up Generation Y's investments in retirement funds until aged at least 55. In the past this was not of major concern as nearly every employer enforced some form of retirement fund contribution for all employees. Thus some form of retirement saving started from commencement of employment.

Previous generations may have received a substantial boost to their financial planning efforts through an inheritance from parents and family. However the increased life expectancy of the Baby Boomer generation and Generation X make this a distant prospect for most of Generation Y.

Today the world has moved away from the defined benefit pension fund towards provident and retirement annuity funds. And it has become all too

DON'T STUFF UP LIKE DAD

easy for employers to allow employees to contribute on a voluntary basis until permanently employed or attaining the age of 30. This potentially loses the initial five years of retirement fund contributions. At first this would appear insignificant when seen in the context of a 40-year career.

However, Generation Y do not stop to consider the prospect that if they retire at 65 they may have to live in retirement for 30 – 40 years. Furthermore, the prospect of South Africa implementing a national comprehensive retirement plan is an even more distant goal than National Health Insurance.

TAKING A RETIREMENT CONTRIBUTION OF R1 000 PER MONTH, RETURN RATE 10%, AND INFLATION RATE 6%, THE FUND VALUE AFTER 40 YEARS, IN TODAY'S TERMS, WOULD BE +/- R852 000. OVER 35 YEARS THE FUND VALUE WOULD BE +/-R688 000. AND OVER 30 YEARS IT WOULD BE +/-R544 000.

There can be no doubt that the need for retirement planning for Generation Y is as important as for the Baby Boomer generation and Generation X.

The National Treasury discussion papers released over the past two years have hinted at the prospect of enforced retirement saving requirements for all employees. This would obviously be a severe measure and it would be very surprising if such proposals are ever be implemented. But there is no denying that the need exists.

CONCLUSION

Many parents devote much time and effort to their financial planning without assessing the risk posed by their children. The stark reality remains that the social security systems of South Africa will be of little comfort or help should a disaster happen.

In as much as investment planning for retirement is essential for every employed South African, it is also of vital importance to assess the financial risks of the entire family. Fortunately the costs of insuring against the risks of younger family members, particularly graduates, are highly attractive.

This article originally appeared in Have we left the door open? Financial planning for Generation Y in glacier by Sanlam, The {Inside} Story and the Rhodes Business School website, www.criticalthought.co.za and biznews.com

Matthew Lester is a Rhodes Business School professor, tax and financial planning specialist and now Biznews.com contributor.

Correspondence: profmatthewlester@gmail.com

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PART 1

POSTGRADUATE PSYCHIATRIC EDUCATION IN SOUTH AFRICA
IDEAS, IDEALS & IDEOLOGIÉS...(& PYRAMIDS!)

Each year we churn out a few dozen new graduates in psychiatry. A few leave the country, fewer remain in the public sector, and even fewer choose to practice within academic centres.

Suvira Ramlall

While the Colleges of Medicine of South Africa (CMSA) is tasked with the final exit examination, universities are challenged to train our graduates in collaboration with Departments of Health. Over the last decade especially, significant shifts have occurred within the CMSA towards refining examination methods, procedures etc. While this has in part been due to the creeping in of a culture of litigation by candidates, the upside has been a critical review of how training and examinations are conducted which in turn have shone the spotlight on not just what is taught but how it is taught.

WHERE ONCE IT SUFFICED TO BE A MEDICAL SPECIALIST WITH AN INTEREST IN TEACHING, THE CURRENT CLIMATE IS INCREASINGLY REQUIRING MEDICAL SPECIALISTS TO HAVE MORE THAN BASIC COMPETENCE IN TEACHING AND LEARNING; KNOWLEDGE OF PEDAGOGICAL PRINCIPLES AND PRACTICE WILL BE NECESSARY TO EFFECT A PARADIGM SHIFT IN POSTGRADUATE EDUCATION.

But is this one hat too many for the 'mad hatters'? This article explores a few current dialogues that are likely to impact on the future of postgraduate psychiatric education.

CONTEXT

The median treatment gap for mental disorders remain unacceptably low especially in developing countries, ranging from 32.2% to 78.1% across 37 countries. "The role of psychiatrists in reducing the burden of mental illness is quite apparent. Psychiatrists have to play multiple roles if this treatment gap is to be corrected-as clinicians and mental experts within multidisciplinary teams, as teachers imparting knowledge and skills to students and other staff, as researchers to increase the repertoire of knowledge of mental health, as public health specialists in developing the infrastructure for mental health services and as advocates to increase awareness and needs around mental health issues. These multiple roles require comprehensive as well as continuing training of psychiatrists." (WHO Psychiatric Training Atlas 2005)

Suvira Ramlall

Psychiatric training has undergone major developments over the last few decades with scientific developments in the fields of molecular biology, neurobiology, genetics, cognitive neurosciences, neuroimaging, psychopharmacology, psychiatric epidemiology and many other related fields contributing to the growth of psychiatry as a medical discipline. With the exponential increase in knowledge and corresponding impact on curriculum content, educators and learners are challenged to accommodate this expansion within the confines of the 4 year training period. While the temptation exists to extend the registrar training period, one needs to question the wisdom of such a move? Can we ever catch that moving train? Is the goal of training to exhaustively cover content? Is it possible to know everything when 'everything' is ever expanding? Should we be working harder to keep abreast of latest developments ..... or should we be working smarter?

MATCHING CURRICULUM CONTENT WITH MENTAL HEALTH NEEDS

In order to unpack some of the demands on and requirements of postgraduate education and training, a pragmatic approach would be to measure this against the public mental health needs. In the context of severe resource constraints regarding mental health professionals and public

health funding, specialists should after all be custom made to meet the need on the ground.

In order to address the treatment gap in psychiatry, the obvious solution would appear to be to mass produce psychiatrists and mental health practitioners …..but the voices in the head suggest that this is a naïve and short-sighted approach. While the number of psychiatrists has increased exponentially over the last decade, the quality of mental health services and the mental health of society have not enjoyed a commensurate boost. Admittedly, a vast array of socio-political factors can be cited as determinants of mental health, factors over which we have limited control. But, are we taking responsibility for those factors that we potentially can influence?

The WHO (2003) defined the optimal mix of psychiatric services (Figure 1) as one that recognizes the frequency of need in relation to the costs associated with meeting those needs.

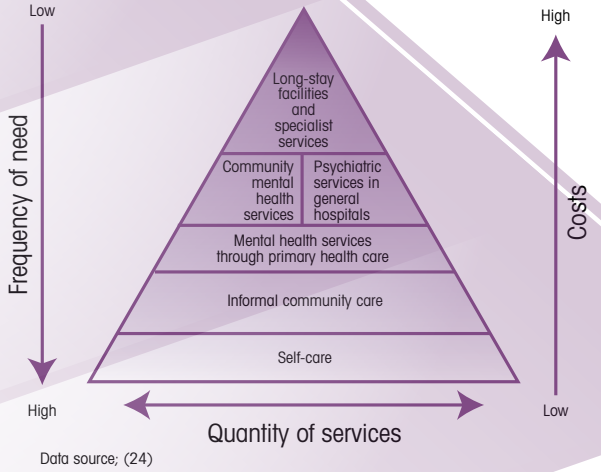

Figure 1: Optimal mix of services for mental health (WHO, 2003)

Our graduates are largely concentrated at hospital level practice. While this is not necessarily wrong, what makes our work 'hard' and not 'smart' is the relative lack of investment at the 'high frequency of need/low cost/greatest quantity of need' level of care. It makes good business sense to have a steady and continuous flow of patients but, as specialists, who occupy the honour of being one of a very small, select and privileged pool of professionals, I believe that our mandate extends beyond the treatment of existing problems. We have a professional and moral responsibility to utilize our positions of privilege to promote mental wellness, and implement preventative strategies that can impact the growing burden of mental illness. Where socio-economic factors impact on mental wellness, as experts in the field, we are morally obliged and ideally placed to work with policy makers to create a platform that focuses on investment in self-care and community-level health consciousness. Psychiatry has always prided itself on its multi-disciplinary team approach in clinical settings; is it not time to evolve the concept and redefine that team within a health-systems framework?

The WHO made the following key recommendations to countries regarding mental health service organization:

1. Limit mental hospitals
2. Build community mental services
3. Develop mental health services in general hospitals
4. Integrate mental health services into primary care
5. Build informal community mental health services
6. Promote self-care

While the promulgation of the MHCA 17 of 2002 did much to promote mental health services in general hospitals, the remaining recommendations are variably implemented around the country and indeed, the current graduate competencies pay scant attention to the knowledge and application of a community-orientated service or one that promotes self-care in those that are well. Over the last few years the CMSA had all Colleges embark on the exercise of blueprinting their curricula. This was driven by academic, quality and litigation issues but served as a useful exercise to interrogate what exactly our graduates are expected to accomplish (at a minimum), both in terms of knowledge and competencies. The usual approach to defining curricula content is to scan the academic and scientific literature globally to ensure that candidates are in- the- know about all the cutting edge developments in the field across the world, admittedly, largely influenced by European and American publications…..yet we are meant to be training professionals to address the health care needs of the local population. Indeed, we certainly need to be cognisant of global trends, but my view is that unless and until our graduates can speak to issues of the men, women and children in the remote villages of our diverse country, and address their needs in a culturally-appropriate and cost-efficient manner, we are deluding ourselves that training more psychiatrists will make a difference to the burden of mental illness in our country.

Thomas R Frieden describes in his 5-tier pyramid (Figure 2) the impact of different types of public health interventions as a framework to improve health. Population wide interventions clearly have the greatest impact, with clinical interventions, counselling and education being both the least effective and requiring the most effort. Interventions at the top tiers, where most of our graduates gravitate to, are designed to help individuals and have limited public health impact because they depend on long-term individual behaviour change. If we are intent on increasing the likelihood of success in reducing the burden of mental illness, graduates need to be adept at not

only clinical interventions but competencies that equip them to provide expert input into helping to make individuals' default decisions healthy ones and implementing long lasting protective interventions. To achieve this we need to shift the current focus from informative learning to transformative learning.

Optimal mix of mental health services

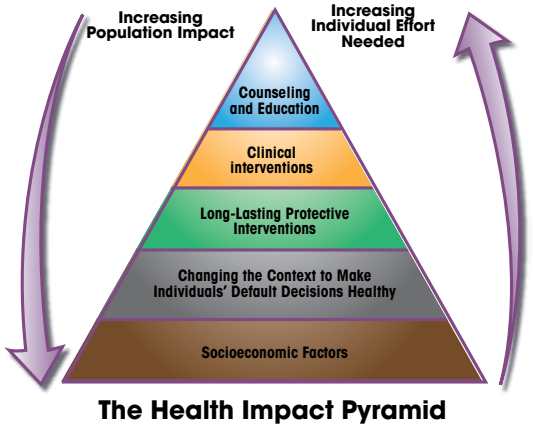

Figure 2: The health impact pyramid (Frieden, 2010)

An illuminating read for all academics and clinicians is the Lancet's Global Independent Commission on Education of Health Professionals for the 21st Century (2010). The following brief discussion focuses on the key issues highlighted in the comprehensive document.

During the past century, three generations of medical educational reforms took place. At the beginning of the 20th century, a science-based curriculum was taught, mid-century saw the introduction of problem-based instructional innovations. The commission recommended that a third generation of reform was now needed that should be systems based to improve the performance of health systems by adapting core professional competencies to specific contexts, while drawing on global knowledge. It outlines its vision for such a model:

" ALL HEALTH PROFESSIONALS IN ALL COUNTRIES SHOULD BE EDUCATED TO MOBILISE KNOWLEDGE AND TO ENGAGE IN CRITICAL REASONING AND ETHICAL CONDUCT SO THAT THEY ARE COMPETENT TO PARTICIPATE IN PATIENT AND POPULATION-CENTRED HEALTH SYSTEMS AS MEMBERS OF LOCALLY RESPONSIVE AND GLOBALLY CONNECTED TEAMS. THE ULTIMATE PURPOSE IS TO ASSURE UNIVERSAL COVERAGE OF THE HIGH-QUALITY COMPREHENSIVE SERVICES THAT ARE ESSENTIAL TO ADVANCE OPPORTUNITY FOR HEALTH EQUITY WITHIN AND BETWEEN COUNTRIES."

REALISATION OF THIS VISION SHOULD BE GUIDED BY INSTRUCTIONAL AND INSTITUTIONAL REFORMS GUIDED BY TWO OUTCOMES:

1. **Transformative learning** is the highest of three success levels starting with informative learning which is about acquiring knowledge and skills and whose purpose is to produce experts; this level is followed by formative learning which concerns itself with socialising students around values and which aims to produce professionals. Transformative learning is about developing leadership qualities and producing enlightened change agents. Effective education builds each level on the previous one. It requires three fundamental shifts:
   - **a.** From memorising facts to searching, analysis and synthesis of information for decision making
   - **b.** From seeking professional credentials to achieving core competencies for effective teamwork in health systems
   - **c.** From non-critical adoption of educational models to creative adaptation of global resources to address local priorities.

Transformative learning requires instructional reforms.

2. **Interdependence in education** is characterised by a systems approach and also involves three fundamental shifts:
   - **a.** From isolated to harmonised education and health systems
   - **b.** From stand-alone institutions to networks, alliances and consortia
   - **c.** From inward-looking institutional pre-occupations to harnessing global flows of educational content, teaching resources and innovations.

Interdependence in education requires institutional reforms.

The commission observes that even though health professionals have made enormous contributions to health and development over the past century, complacency will only perpetuate the ineffective application of 20th century educational strategies that are unfit for 21st century challenges.

The 1910 Flexner report about health professional education, initiated ground-breaking reforms that saw the integration of modern science into curricula at university-based schools which ultimately contributed knowledge that resulted in the doubling of the human life span during the 20th century.

In the 21st century gaps and inequities in health exist within and between countries and the new challenges of infectious, environmental and behavioural risks exist together with rapid demographic and epidemiological transitions that threaten health security globally. Professionals

encounter more socially diverse clinical populations who are more proactive and assertive in their health-seeking behaviour; they have to integrate the 'explosive' increase in knowledge and technology with increasing roles and responsibilities while there is increasing professional differentiation. Professional education has not kept pace with these changes and challenges largely because of fragmented, outdated and static curricula that produce ill-equipped graduates. A 'slow-burning crisis' is emerging.

The problems are systemic:

- Mismatch of competencies to patient and population needs
- Poor teamwork
- Persistent gender stratification of professional status
- Narrow technical focus without broader contextual understanding
- Episodic encounters rather than continuous care
- Predominant hospital orientation at the expense of primary care
- Quantitative and qualitative imbalances in the professional labour market
- Weak leadership to improve health system performance.

Professional tribalism has undermined attempts to address these deficiencies. Redesign of professional health education is necessary and timely in view of the opportunities for mutual learning and joint solutions offered by global interdependence which are facilitated by accelerated flows of knowledge, improved technologies, financing across borders, and the migration of both professionals and patients.

What is clearly needed is a thorough and authoritative re-examination of health professional education, matching the ambitious work of a century ago. The traditional model where a curriculum informs educational objectives and assessment needs to be replaced with a competency based education model where health needs and systems inform the competencies and outcomes required of graduates; it is these competencies and outcomes that should determine the curriculum and the appropriate assessment of graduates (Figure 3).

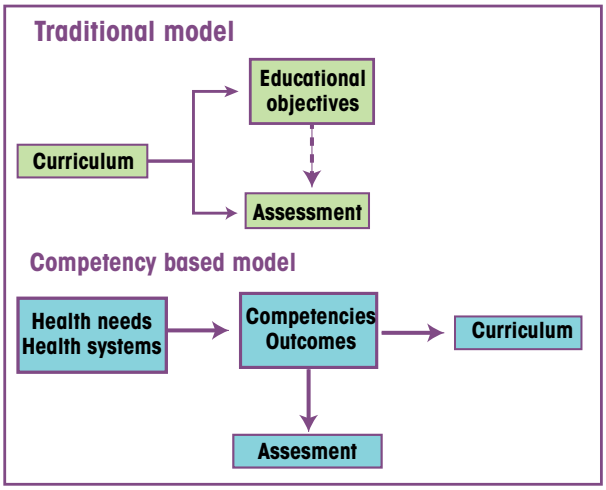

Figure 3: Past and future models of medical education
(Lancet, 2010. Vol 376: p1943)

"A RENAISSANCE TO A NEW PROFESSIONALISM—PATIENT-CENTRED AND TEAM-BASED—HAS BEEN MUCH DISCUSSED BUT IT HAS LACKED THE LEADERSHIP, INCENTIVES, AND POWER TO DELIVER ON ITS PROMISE." AN APPROPRIATELY REFOCUSED GRADUATE PROGRAMME HAS THE POTENTIAL TO INITIATE SUCH A RENAISSANCE IN MENTAL HEALTH BY PRODUCING GRADUATES WHO HAVE THE VISION AND SKILLS TO TRANSFORM MENTAL HEALTH.

Having explored what should be taught, the other important questions that arise are how it should be taught and assessed?

Part 2 of the article will be published in the February 2016 issue of South African Psychiatry.

Suvira Ramlall is Bio-clinical Head of Psychiatry-King Dinuzulu Hospital Complex; Lecturer-Department of Psychiatry, UKZN; Secretary- Council, College of Psychiatrists; Member of KZN mental health advisory committee. References are available from the author. **Correspondence: Ramlalls4@ukzn.ac.za**

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Thirusha Naidu & Suvira Ramlall (Editors)
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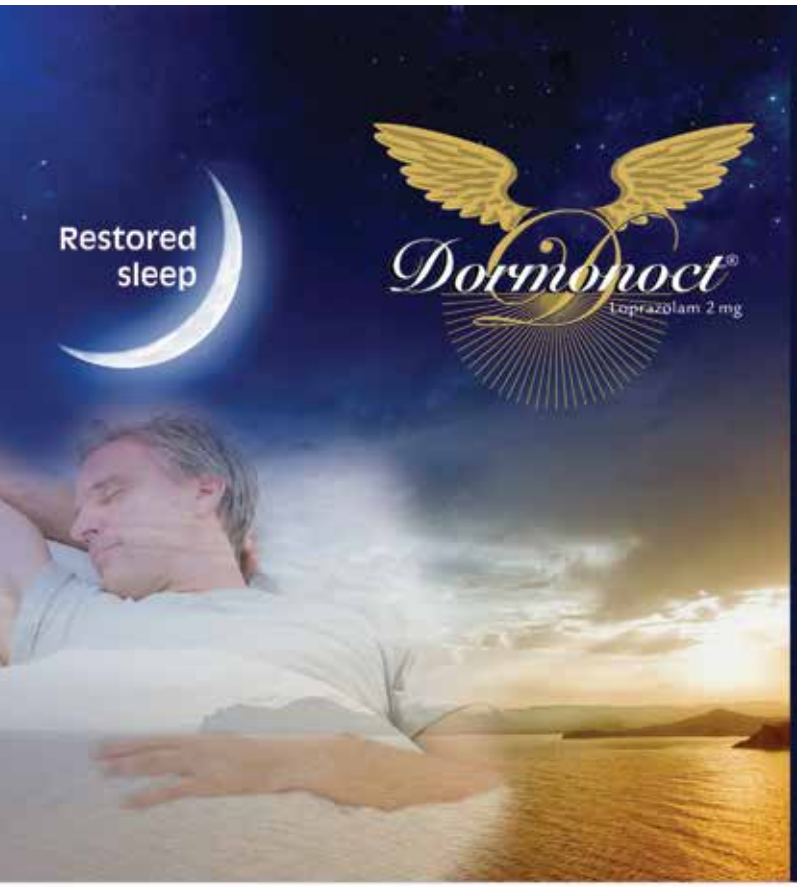

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EDUCATIONAL SEMINAR ON PSYCHIATRIC TRAINING DURING THE 2015 APA MEETING IN TORONTO, CANADA

Bernard J van Rensburg, Solomon Rataemane, Mvuyiso Talatala

Participants in this seminar on psychiatric training, which took place on the 18th May 2015, at the Fairmont Royal York Hotel during the American Psychiatric Association's 168th annual meeting in Toronto, included: the **Royal College of Psychiatrists** (RCPsych), the **American Psychiatric Association** (APA), the **Canadian Psychiatric Association** (CPA), the **Royal Australian and New Zealand College of Psychiatrists** (RANZCP), as well as the S**outh African College of Psychiatrists** (SACPsych) and S**outh African Society of Psychiatrists** (SASOP).

The SACPsych and SASOP received this invitation in follow-up of discussions between the RCPsych and SASOP during June 2014. *Mvuyiso Talatala* (SASOP President), *Solly Rataemane* (Head Department of Psychiatry, Sefako Makgapo University and SACPsych Councillor) and *Bernard Janse van Rensburg* (SASOP President-Elect and SACPsych Councillor) represented SASOP and SACPsych. The aims of the meeting were to:

- DEVELOP AN UNDERSTANDING OF THE TRAINING STRUCTURE IN PSYCHIATRY IN EACH COUNTRY; - DEVELOP AN UNDERSTANDING OF THE ASSESSMENT STRUCTURE IN PSYCHIATRIC TRAINING IN EACH COUNTRY; -

develop an understanding of the regulatory structure in each country; - explore the ways in which we can share good practice; and - explore possibilities of trainees receiving part of their training in another of these countries.

APA – Dr Tristan Gorrindo gave an overview of the route to qualify as a psychiatrist in the USA, including: four years of medical school (often increased to five years to accommodate a year in research), including four to six weeks' rotation in psychiatry, after which graduates are matched with vacant residency posts.

THE US MEDICAL LICENSING EXAMINATION, A THREE-PART EXAM, IS CARRIED OUT DURING AND AFTER MEDICAL SCHOOL, REQUIRING CANDIDATES TO PASS PARTS 1 AND 2 TO BE A PRACTICING DOCTOR IN THE USA, WHILE PART 3 IS GENERALLY UNDERTAKEN AFTER ONE YEAR IN A RESIDENCY POST.

About 20% of American medical doctors continue to take a Fellowship in Psychiatry for an additional one, or two, years. Assessments during training involve 22 psychiatry competencies or "milestones" that are acquired over four years of residency. Residents are assessed by their resident director. Subsequent maintenance of the certification process is currently optional, based on a ten-year cycle. The APA is currently working towards making this a lifelong process.

CPA - Dr Susan Abbey presented on Psychiatry training and revalidation in Canada. Medical training is organized around the CanMeds model of the medical expert (communicator, collaborator, manager, health advocate, scholar, professional) involving four years of medical school (or three years of longer teaching time), which involves three or four rotations. Specialist training in Psychiatry is mandated by Royal College of Physicians and Surgeons of Canada's (RCPSC) Psychiatry Specialty Committee. It occurs over five years, including rotations in inpatient and outpatient care, child and adolescence psychiatry and old age psychiatry. Residents have the opportunity to train out of country for six months.

THE EXIT EXAM IN CANADA TAKES PLACE IN THE FIFTH YEAR OF TRAINING AND INCLUDES A PAPER MCQ EXAM AND A PRACTICAL EXAMINATION. Maintenance of certification is also mandated by the RCPSC, consisting of a five-year cycle working as a credit cycle. In July 2017 training will move to a competency based training program.

RANZCP - Dr Margaret Aimer and Ms Elaine Halley summarized training, revalidation and recruitment in Australia and New Zealand. All medical school students and junior doctors receive psychiatry training. While medical school psychiatry training can

Back row: Dr Susan Abbey (CPA), Ms Kristin Kroeger Ptakowski (Chief Policy, Programs, Partnerships APA), Mr. Glenn Brimacombe (CEO CPA), Dr Peter Bowie (Chief Examiner, RCPsych) Mrs Vanessa Cameron (CEO RCPsych), Prof Bernard J/van Rensburg (SASOP/SACPsych), Dr Andrew Brittlebank (Specialist Curriculum Advisor, RCPsych)
Front row: Ms Elaine Halley (GM RANZCP), Dr Margaret Aimer (Chair Education Committee RANZCP), Dr Tristan Gorrindo (Director Education APA), Prof Solly Rataemane (SACPsych), Dr Wendy Burn (Dean RCPsych), Dr Mvuyiso Talatala (SASOP)

vary from university to university, the RANZCP set the training programmes for psychiatrists and continuing professional development after qualification.

PSYCHIATRY TRAINING CONTINUES FOR FIVE YEARS AND IS MADE UP OF ROTATIONS OF SIX MONTHS. WHILE THE FRAMEWORK FOR JUNIOR DOCTORS PROVIDES EXPERIENCE OF ASSESSMENT AND MANAGEMENT OF COMMON PSYCHIATRIC CONDITIONS, SPECIALIST TRAINING INVOLVES FELLOWSHIP PROGRAMMES.

This includes Workplace Based Assessments (WBAs) which are used as formative elements rather than pass/fail tests. Specialist training also involves Entrustable Professional Activity (EPAs) that look at important tasks. Supervisors must be confident that the trainee can demonstrate their ability to perform activities competently and independently, with passing or failing of a candidate is being informed by the EPAs and WBAs. Post training, the RANZCP runs CPD programmes which are compulsory for psychiatrists, in Australia based on a credit system and in New Zealand based on hours.

RCPsych - Dr Andrew Brittlebank, Dr Peter Bowie and **Dr Wendy Burn** presented an overview of training and revalidation in the UK:

- Undergraduate education at medical school takes five years, followed by two years of Foundation Training. Doctors should be exposed to psychiatry during their foundation years but this varies.
- Doctors subsequently chose a specialty and enter Core Training for three years (CT 1, 2 and 3), followed by Specialty Training (ST 4, 5 and 6).
- The RCPsych does the assessment of trainees via the MRCPsych examination, as well as in training assessments (e.g. WBAs).
- Revalidation after qualification is done in five year cycles and guided by specific guidelines, with a 90% participation rate.
- RCPsych sets the curriculum for training, which is also based on the CanMeds model's competencies, is outcome oriented and has constructive alignment.
- The MRCPsych examination consists of Paper A and Paper B, and a clinical exam. Paper A is on theory and on the basic sciences and candidates don't need to be in Psychiatry training to sit for it. To take Paper B and the clinical exam trainees have to have undertaken psychiatry training.
- The RCPsych have established a new online learning resource for trainees, namely "TrOn", which is aligned with the MRCPsych syllabus and was launched in 2014. The TrOn provides learning modules to help trainees gain knowledge for practice, and not just to pass exams.

- There are also ways for trainees from outside the UK/EU to join training in the UK; via the GMC PLAB route which tests candidates and for shorter term via the RCPsych MTI scheme (2 years maximum).

SACPsych/SASOP - Prof Solomon Rataemane and **Dr Mvuyiso Talatala** gave a presentation on recruitment, training and revalidation in South Africa:

- Undergraduates receive eight weeks of training in psychiatry and family medicine, with many psychiatry trainees moving over to family medicine.
- There are about 550 psychiatrists in South Africa for a population of about 50 million. A number of South African psychiatrists currently work in the UK, Canada and Australia, while there is an increase in doctors coming to South Africa from other African Countries to do their training.
- Individual universities set their own psychiatric training programmes, with three provinces still without a psychiatry training programme.
- Posts are provided and funded by the government, with a downturn in the economy resulting in unfunded posts.
- Psychiatry training involves a 4 year supervised training programme and includes a six month rotation in child and adolescent psychiatry and a long psychotherapy case over a year. This case can be supervised by a psychotherapist or a suitably trained psychiatrist.
- There are mental health courses being offered to non-specialists e.g. a diploma in mental health.
- To become a psychiatrist, trainees need to take two exams to obtain Fellowship of the College of Psychiatrists. There are also two sub specialty training certificates, including a Certificate of Child and Adolescent psychiatry. From 2016 there will also be certificates in Geriatric Psychiatry, Forensic Psychiatry and Neuropsychiatry.
- The examination has two components, with the first part consisting of three written papers and the second part including written and clinical components. Trainees can sit Part 2 if they have passed Part 1 or taken a university administered (MMED) Part 1 exam.

CONCLUSIONS AND NEXT STEPS

(1) Practice guidelines exist in all countries and while in many respects are universal, there will be cultural differences.

(2) Common competencies in these curricula could be implemented, which is e.g. being planned in Europe through the Union of European Medical Specialties (UEMS).

(3) Reciprocity might be a future goal, although countries could already share assessors or moderators.

Bernard Janse van Rensburg is an Associate Professor in the Department of Psychiatry, University of the Witwatersrand and a consultant psychiatrist at the Helen Joseph Hospital. He is President Elect of the South African Society of Psychiatrists.
Correspondence: Albert.JanseVanRensburg@wits.ac.za
Solomon Rataemane is Professor and Head, Department of Psychiatry, Sefako Makgatho Health Sciences University and current President of the African Association of Psychiatrists and Allied Professions (AAPAP).
Mvuyiso Talatala is a psychiatrist in private practice and current President of the South African Society of Psychiatrists.

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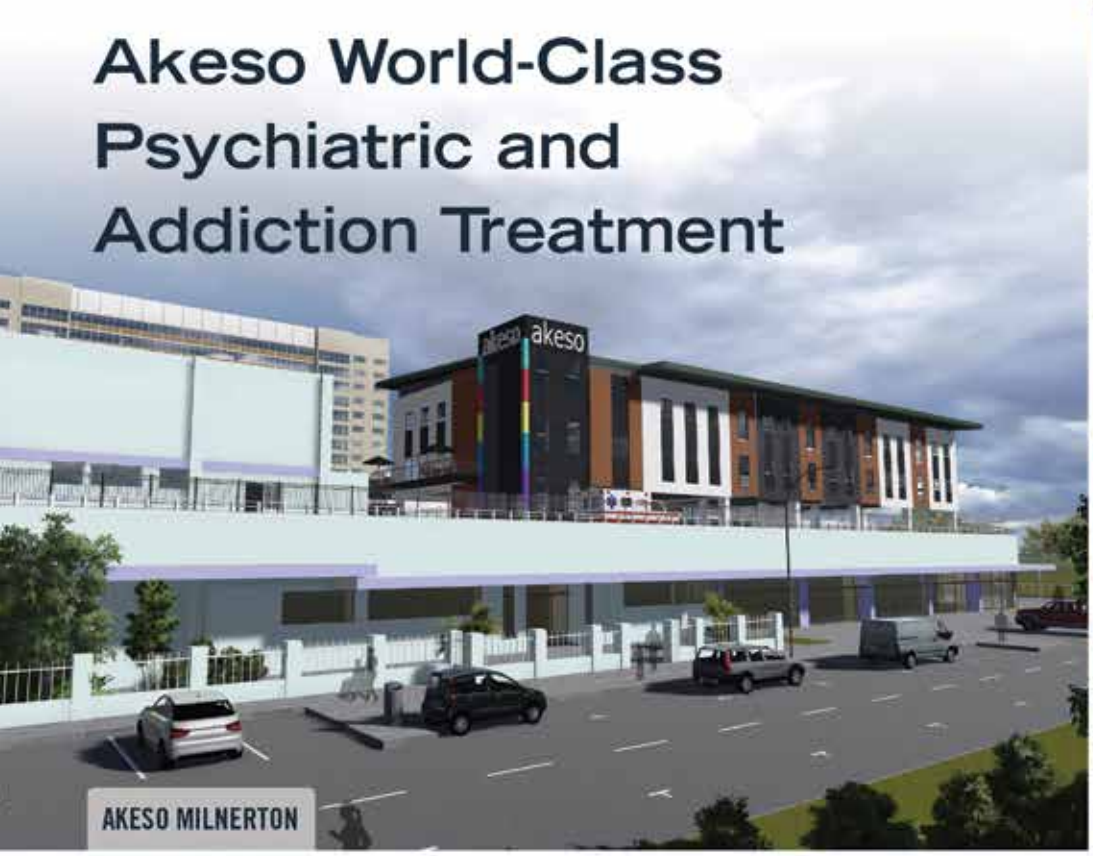

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EVOLUTION AND THE MOLECULAR BASIS OF PSYCHIATRIC ILLNESS

Uncovering the molecular pathology and biochemistry of mental health disease is currently one of the major challenges of modern medicine. There are fundamental differences in the practice of psychiatry and other branches of medicine.

Pierre M. Durand and Zané Lombard

For the primary psychotic, mood and anxiety disorders there are no diagnostic pathology tests. An understanding of the pathophysiology is often rudimentary and the molecular pathology largely unknown.

There are many reasons for this but perhaps the most significant is that mental health illnesses do not lend themselves to enquiry in the same way as other disorders. The reductionist molecular biology approach has resulted in significant advances and in some ways psychiatry is a victim of this success.

THE ASSUMPTION IS THAT BY FOLLOWING THE SAME APPROACH THAT HAS UNTIL NOW WORKED WELL IN OTHER DISCIPLINES THE PATHOPHYSIOLOGY OF MENTAL ILLNESSES WILL BE EXPLAINED.

Of course molecular biology will help, but on its own is unlikely to yield the quantum advances that characterise so many other fields in medicine. In this essay we will substantiate these statements and argue that significant progress depends on adopting a more systems biology-type approach and developing corresponding research tools. At the outset; however, the consideration is more ontological.

WHY DO PSYCHIATRIC ILLNESSES EXIST AT ALL?

Broadly speaking, when considering the origin and maintenance of any derived trait evolutionary biologists think in terms of adaptive and non-adaptive processes. For the adaptationist the challenge is to understand the fitness advantage (if any) conferred by psychosis or a primary mood or anxiety disorder. At the individual level, and certainly in the modern world a fitness advantage seems unlikely; severe psychiatric illness usually come with costs to reproduction, viability or both. However, in early hominid and ancient human populations the selective pressures may have been different.

Pierre Durand

It is unknown what role a symptom like psychosis may have had in sexual selection, kin selection or whether the fitness benefit may have applied to another level of sociality (tribes, clans etc). Given the uncertainties, arguments for psychosis as a group level adaptation have often been proposed without much thought. They are; however, largely speculative. Furthermore, it would be almost impractical to obtain clinical, field or empirical data to support the adaptive hypotheses and most explanations invoking mental health illnesses as adaptations in early hominid populations fall into the "just so story" category so derided by biologists. Evolutionary psychology is notoriously vulnerable to this. Arguments are conjured up to explain how almost any behaviour may have provided a fitness advantage. To make matters worse, adaptationist explanations are often untestable and proponents are emboldened by a lack of mechanistic knowledge. Non-adaptive and maladaptive explanations are also limited by the gap in knowledge concerning psychiatric disease pathophysiology. Nevertheless, it is quite conceivable and perhaps even more likely that psychiatric illnesses exist because of pleiotropic effects or simply because the phenotype is under weak selection. Providing support; however, will again be assisted by a more detailed understanding of the mechanisms involved.

To appreciate the complexities of the problem and for in depth discussion the reader is referred to the works of local academics Jonathan Burns, Dan Stein and others. While the underlying mechanisms remain elusive the debate concerning the evolutionary origins and maintenance of mental illness will surely continue. Significant progress is likely to materialise only once the basics of the molecular genetics and pathophysiology have been illuminated.

THE MOLECULAR BIOLOGY AND BIOCHEMISTRY OF PSYCHIATRIC ILLNESS

Contrasting the pathophysiologies of mental health disorders with other disease phenotypes reveals the enormity of the problem faced by researchers. At one end of the spectrum there are monogenic disorders like sickle cell disease. While the biochemistry and thermodynamics of protein folding is certainly complicated the chain of events leading to the disease trait is not. A point mutation in the 6th codon of the beta globin gene causes a glutamic acid to valine substitution, protein folding is impacted, erythrocyte morphology is abnormal and so on, eventually giving the disease phenotype. For more complex polygenic diseases for example diabetes mellitus, hypertension and others, disentangling the mechanistic processes is more challenging. At the other end of the spectrum are the psychiatric illnesses. These are the most complex of all; the term complexity is used here to describe the systems and levels of biological organization involved in generating the phenotype. The reductionist approach, while providing an entry into examining the molecular pathology, can only take one so far. There is still no identifiable causal relationship between a single gene that is either necessary or sufficient for a particular psychiatric disease phenotype.

There are many examples illustrating the biocomplexity of psychiatric disease. Prof H. Sive (MIT), in a recent seminar (August 2015, Sydney Brenner Institute for Molecular Biosciences, Wits University) described 25 genes at locus 16p11.2 that are associated with mental health and other disorders (including psychotic and anxiety disorders), collectively called the "16p syndrome". At least two or more genetic variants were required for a particular symptom.

Molecular pathology research in psychiatry often takes a more comprehensive approach and Genome Wide Association Studies (GWAS, see Box 1) are the order of the day. Data published by the Schizophrenia Working Group of the Psychiatric Genomics Consortium described "Biological insights from 108 schizophrenia-associated genetic loci" (Nature, 2014, Vol 511, p 421-427.). While there is undoubtedly an inherited genetic component, variations at any single locus, or even combinations of loci, are insufficient to explain the psychiatric symptoms. The complexities of mental health phenotypes are not being captured by traditional genetics. The question then arises, with the acquisition of more and more genetic and genomic data is it ever going to be possible to explain psychiatric conditions in terms of molecular networks of genes or proteins? This is a fundamental question that extends beyond psychiatry and medicine to all biology disciplines.

THE GENOTYPE-PHENOTYPE MAP

In some cases, such as the sickle cell example above, the genotype-phenotype map is clear. However, as the number of molecular components and the interactions between them increases the mechanistic basis for a disease phenotype becomes exponentially more complex. In addition, there are levels of information organisation that can potentially be impacted. Starting at the simple gene level, there are variations (mutations, insertions, deletions, copy number) at a particular locus. These can be impacted at a genomic level by regulatory regions, chromatin folding and transcriptional control all of which themselves vary. RNA variants arise because of differences in transcription rates, epigenetic changes, secondary molecular structures, alternate splice sites and copy number, all of which may affect translation, post-translational modifications and protein folding. Another level of information can be found in the enormous number of potential protein-protein interactions, which are the engine behind cellular functions. The potential for variation and stochasticity at a sub-cellular level is immense and occurs prior to any cellular communication or connectivity is played out.

THE NEURONAL NETWORK IS ITSELF MUTABLE, PLASTIC AND CAPABLE OF A STAGGERING NUMBER OF POTENTIAL CELLULAR INTERACTIONS. WITH THESE LAYERS OF INFORMATION AND INHERENT VARIATIONS IN THE MOLECULAR, SUB-CELLULAR AND INTERCELLULAR SYSTEMS IT IS HARDLY SURPRISING THAT THE CAUSAL CHAIN OF EVENTS BETWEEN START AND END POINTS (THE GENOTYPE AND PHENOTYPE) IS UNCLEAR.

The conventional biochemistry and molecular biology approaches while helpful in directing researchers are unlikely to disentangle all the parameters. In simple traits reductionism has worked well. In complex pathologies a more innovative approach is required.

EMERGENT PROPERTIES AND THE SYSTEMS BIOLOGY OF CONSCIOUSNESS

Systems biology as the name implies is tasked with examining the interactions between component parts as well as the properties of the biological system itself. These include the functional control of molecular pathways (via transcription factors or other regulatory proteins), protein-protein interactions (proteome and interactome), and nutrient exchange between cells, intercellular communication and many other levels of connectivity between a system's components. In addition the system's properties can be investigated

in terms of their robustness, plasticity, complexity, capacitance and the emergence of novel phenotypes. This is a major challenge. Of course to some degree reductionist thinking is informative but there are a number of points worth highlighting.

While there has been considerable progress, systems biology is very much in the early stages and the tools and methodologies are continually developing. For an overview of the field and how it relates to human disease readers are referred to the Institute for Systems Biology website (www.systemsbiology.org). One of the overall aims is to obtain systems level data and develop appropriate investigative tools. Data measurements are integrated to formulate mathematical models that recapitulate all prior observations. Examples of systems level measurements are transcriptome or proteome data associated with a particular phenotype. These are then used to develop diagnostic and predictive models. In psychiatry one of the most exciting developments is the Human Connectome Project (www.humanconnectome.org), which aims to document the neural network in the brain. The expectation is that once the data have been collected, mathematical and computational models of variations in the intercellular connections may be used to establish causal links between brain function and psychiatric phenotypes.

An intriguing feature of some systems, and which may be particularly relevant to psychiatry, is the concept of emergent properties. An emergent property exists only because of the interactions between the component parts in the system. Remove one of the component parts to investigate it in isolation and the property of interest disappears. The phenomenon is common to physics, chemistry and biology. Using water as an example, fluid dynamic properties exist in collections of water molecules in the fluid state. Remove a single water molecule to study it in isolation and the fluidic property no longer exists. And so it is with phenotypes in psychiatry. Properties like cognition, consciousness, imagination, and perception depend almost exclusively on the interactions between component parts.

CONCLUDING REMARKS

Biochemistry and molecular biology methodologies have yielded tremendous insights and progress. In this essay, we argue that while this will alert researchers to essential mechanisms in psychiatric disease, significant advances are likely to occur when a systems level approach is adopted and the appropriate tools for investigating them are developed. The philosophy that schizophrenia is primarily a "disorder of the functional and structural connectivity of the social brain network" (see J. Burns, "The social brain hypothesis of schizophrenia" World Psychiatry. 2006, Vol 5, p 77–81) captures the challenge faced by future researchers.

BOX 1: GENOME WIDE ASSOCIATION STUDIES

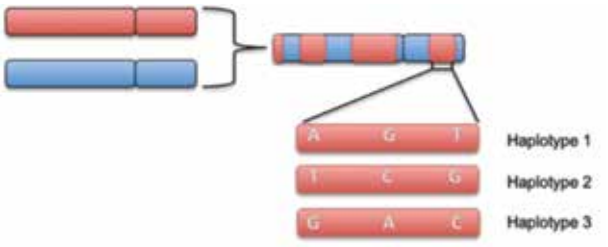
Understanding the role genetic variation plays in human disease susceptibility is an important focus of biomedical research. Historically, families with multiple affected individuals were studied using a technique called linkage analysis – the weakness of this technique is its poor resolution, as it is only possible to correlate a relatively large chromosomal region with a disease diagnosis. As our understanding of the human genome has expanded, new techniques have arisen, and it is now possible to hone in on the actual DNA polymorphism that could be disease causing.

The most common technique used today to study the role of genetics in disease, is the genome-wide association study (GWAS), typically involving several affected individuals (cases) and an unrelated, healthy cohort (controls). This approach is popular as it gives the researcher the ability to search for a disease association across the whole genome, without having to look at each variation individually. This is an important consideration as an average human genome is expected to harbour at least 3 million single nucleotide polymorphisms (SNPs) – having to test each one individually would be a very costly and time-consuming exercise.

GWAS is based on the premise of linkage disequilibrium – that is, the observation that sections of the genome are more likely to be inherited together, and knowing which combination of SNPs occur together in these stretches of DNA (called haplotypes) (Figure 1). This phenomenon is implemented in GWAS where only SNPs that act as proxies for a haplotype are genotyped (instead of all genetic variants). This enables researchers to survey the whole genome effectively by typing as little as a few hundred thousand SNPs.

GWAS methods have been helpful in detecting a number of robust genetic associations for dozens of common diseases – including many psychiatric disorders. One of the caveats of the GWAS approach is that one needs very large sets of cases and controls (several thousands) to effectively detect genetic associations. This weakness is now being addressed through large consortia of researchers that are combining their clinical and genotype data to add more power to their GWAS by doing meta-analyses. The Psychiatric GWAS Consortium (http://www.med.unc.edu/pgc/) consists of more than 100 researchers from over 54 institutions, who are currently undertaking GWAS meta-analyses for schizophrenia, bipolar disorder, major depressive disorder, autism and attention deficit hyperactivity disorder.

African populations have been utterly underrepresented in GWAS to date, especially in psychiatric GWAS. African genomes and the unique genetic structure of African populations can help shed light on disease etiology, and should be a priority in genomic research in future.



The principle of genome-wide association studies. Parental chromosomes recombine to produce the offspring's unique chromosome. Stretches of the genome are left intact after recombination, and remain intact after several generations (due to linkage disequilibrium). Genetic variants that occur together on the same stretch of DNA are inherited together (called a haplotype). The implication of this is that one variant can act as a proxy (called a tagSNP) for other variants - in this example, testing site one, and finding it is variant A, can tell us that it belongs to Haplotype 1. Without having to directly test the second and third site, we now know that the variants there are a "G" and "T", respectively.

Pierre Durand is a Consultant pathologist for Vermaak and Partners Pathologists and Pathlink Laboratories, South Africa as well as working for the Evolutionary Medicine Laboratory, Department of Molecular Medicine, Faculty of Health Sciences, and Sydney Brenner Institute for Molecular Bioscience, University of the Witwatersrand, South Africa; Department of Biodiversity and Conservation Biology, University of the Western Cape, South Africa; Department of Ecology and Evolutionary Biology, University of Arizona, United States of America. References are available from the author. **Correspondence: Pierre.Durand@wits.ac.za**
Zané Lombard is a member of the Department of Human Genetics, School of Pathology, Faculty of Health Sciences, University of the Witwatersrand and also works at National Health Laboratory Service, South Africa

DEPARTMENTS OF PSYCHIATRY

UNIVERSITY OF THE WITWATERSRAND

POST GRADUATE DIPLOMA IN HEALTH SCIENCES EDUCATION

WITS Postgraduate Diploma in Health Science Education 2014 & 2015

Craig Bracken

Diplomates with Dr Bracken – back row, last on the right.

I started the WITS Postgraduate Diploma in Health Science Education in 2014 when it was first offered at WITS and completed the final module in October 2015.The four modules can now be done as "full time study" in one year or "part time" over two years. The modules include, in the order I did them, teaching and learning theory, teaching methodology, curriculum development and essentials of assessment. My interest arises directly from my involvement with teaching and the realisation that I would benefit from an academic perspective.

While medicine is fundamentally based on a science; medical education is fundamentally based on teaching and learning theory, which is not entirely new territory for a psychiatrist. Still the introduction to teaching and learning theory is the biggest of the conceptual leaps. So for example teaching methods, assessment and research all are all linked or evaluated by how they relate to the underlying teaching and learning theories.

Like medicine and psychiatry there is an art to education practice, meaning that having access to a standard textbook (for any of these fields) provides few answers since decisions require weighing up of the advantages of particular choices based on a specific knowledge base balanced by experience and reflection. Some things are simple and some things not in both psychiatry and in education.

My interest is in the teaching and support of the development of clinical competency. How to improve the teaching program in the face of the increased undergraduate student numbers through programmatic design? How for postgraduates (with the introduction of the OSCE) to facilitate the learning of clinical competency in the workplace? The OSCE now adds to the exam a higher level (by demonstration) of clinical competence assessment and so raises the question of how best to use supervision and workplace assessments to bridge the gap between the workplace and final high stakes clinical competency assessments.

Overall I have thoughts, but no final easy answers; this is the way the process works. In short, to pose questions and implement solutions to programmatic assessment and improvement is a field in its own right and requires a theoretical underpinning linked to teaching and learning theory. I recommend this, or similar courses that are offered, to all psychiatry teachers who think about their teaching and assessment.

Correspondence: Craig.Bracken@wits.ac.za

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS – BIOLOGICAL CONGRESS 2015 : 24 – 27 SEPTEMBER 2015

Ugash Subramanney

Ugash Subramaney (Adjunct Professor) was awarded a certificate of excellence for her oral presentation (senior) entitled "Womb Raiders - Women Referred for Observation in Terms of the Criminal Procedures Act Charged with Foetal Abduction and Murder."

Kim Laxton

Kim Laxton (registrar) shared the prize for best poster for "Perceptions about Adolescent Body Image and Eating Behaviour" .

TEACHING ADVANCEMENT AT UNIVERSITY FELLOWSHIPS PROGRAMME

Over 12th to 16th July, Prof Ugash Subramaney (Department of Psychiatry) and Prof Ian Couper (Centre for Rural Health) were privileged to attend the first contact session of the inaugural Teaching Advancement at University (TAU) Fellowships programme, initiated under the auspices of the Higher Education Learning and Teaching Association of Southern Africa (Heltasa) and funded by the Department of Higher Education and Training (DHET). They joined 50 other pioneer TAU fellows from 22 universities, and 12 advisors from 7 universities, under the leadership of Professor Brenda Leibowitz from the University of Johannesburg.

After receiving nominations from home institutions, the TAU management committee selected 1 to 3 representatives from each University, representing together a wide spectrum of disciplines, from fine arts to law, accountancy to computer science, and physics to entrepreneurship. The session was considered to be the first unit in a year-long programme, which includes another two contact sessions. The participants had something important in common - a commitment to teaching and learning in higher education, based on experience.

The intense 4 days of input was structured around needs of the participants as elicited in a preceding survey, as well as introducing them to key ideas in higher education. The focus of most sessions was table discussions with 5-6 colleagues, enabling them both to draw on the wisdom and experience of the group, and to get to know each other. Some highlights of the week included sessions on engaging with transformation in Higher Education in SA, supporting academic staff development, the issue of language in higher education, enhancing student learning and success, and a presentation on burning issues in SA Higher Education by Prof Ihron Rensburg, Vice Chancellor of the University of Johannesburg.

One of the requirements of the Fellowship is for each participant to undertake an individual project. After submitting proposals, everyone was divided into enquiry groups with members' having projects along a similar theme; each enquiry group, supported by a faculty advisor, will assist its members to complete their project and will deliver a joint poster on their theme at the closing session in July next year. Prof Subramaney's project will be looking at resilience training and curriculum development, and Prof Couper's will focus on the most effective ways to develop self-directed learning amongst health science students

The long-term vision, if funding is secured, is for a regular intake into the TAU programme, with some of the current fellows becoming advisors in the future.

This content first appeared in the August 2015 issue of the Health Sciences Review, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa and is published with permission.

RWS CHEETHAM AWARD

Bernard Janse van Rensburg,

Bernard Janse van Rensburg, Associate Professor, has been awarded the RWS Cheetham award for 2015, for the best cross-culturally relevant manuscript/s in psychiatry (published in 2014).

The articles comprised:

Janse van Rensburg ABR, Poggenpoel M, Szabo CP, Myburgh CPH. Referral and collaboration between South African psychiatrists and religious or spiritual advisers: views from some psychiatrists. South African Journal of Psychiatry. July 2014; 20(2) 40-45. DOI:10.7196/SAJP.533. IF 0.273 (2012/13)

Janse van Rensburg, A.B.R. South African Society of Psychiatrists guidelines for the integration of spirituality in the approach to psychiatric practice. South Journal of Psychiatry. November 2014; 20(4): 133-139. DOI:10.7196/SAJP.593. IF 0.273 (2012/13)

Janse van Rensburg, A.B.R. Integrating spirituality in the approach to psychiatric practice. Invited editorial. South African Journal of Psychiatry. November 2014; 20(4): 131. DOI:10.7196/SAJP.594. IF 0.273 (2012/13)

UNIVERSITY OF CAPE TOWN

NATIONAL SCIENCE AND TECHNOLOGY FORUM (NSTF) AWARDS

At the 2014/2015 National Science and Technology Forum (NSTF) Awards , the TW Kambule Award for research and its outputs over the last 5-10 years by an individual was made to Dan Stein (Professor and Head, Department of Psychiatry and Mental Health; Director: Brain Behaviour Initiative, University of Cape Town; and Director: SU/UCT MRC Unit on Anxiety and Stress Disorders). It was noted that Prof Stein is one of the most highly published and cited clinician-scientists on the African continent. His focus is on neuropsychiatric disorders, which are the 3rd largest contributor to South Africa's burden of disease. His work aims to move from the bench to the bedside (translating basic neuroscience into clinical investigations), and from the bedside to the community (addressing public health issues in order to implement and scale up treatments).

Dan Stein

He has played a particularly important role in bringing attention to obsessive-compulsive and related disorders; he was Chair of both the DSM-5 and the ICD-11 workgroups on these conditions.

UNIVERSITY OF PRETORIA

AWARD OF DOCTORAL DEGREE

MANFRED WILHELM BÖHMER

Manfred Wilhelm Böhmer

THE THERAPEUTIC RELATIONSHIP AS REFLECTED IN THE EXPERIENCES OF HOSPITALISED PSYCHIATRIC PATIENTS: AN EXPLORATIVE-DESCRIPTIVE STUDY

OBJECTIVE

There has been a shift towards biological explanations and treatment of mental illness. Therapeutic relationships, which can improve outcomes of treatment, are neglected. This study was undertaken to explore experiences and therapeutic relationships of patients at Weskoppies Hospital, the main psychiatric training hospital for the University of Pretoria, South Africa, and to comment on registrar training.

METHODS

An explorative-descriptive qualitative collective instrumental case study was done. Thirty in-depth semi-structured interviews were conducted with 15 inpatients. Purposive sampling was used to ensure maximum variation and richness of information. Transcribed recordings were organised using the computer programme ATLAS.ti. Grounded theory methods were used for the data analysis.

RESULTS

The distress of psychiatric patients and need for relationships was highlighted. However, only a minority of patients developed good therapeutic relationships with their registrars, who mostly follow a symptom-based, biological approach. Most patients found support in relationships to fellow patients. The majority of patients had spent lengthy periods in closed wards and some had been victims of unacceptable incidents or practises. None of the patients who described good relationships with their registrars had been subjected to any coercive methods.

The findings point to a need for better containment. Therefore, a model of therapeutic relationships in a psychiatric hospital was developed in which the concept of a personal form of containment was placed at the centre. This needs to be embedded in a containing environment, since whatever happens in a hospital has to be seen from a systems point of view.

CONCLUSION

Registrars are overburdened and often seem to show limited interest in the personal life of the patient, as well as an anxiety to get involved on a personal level with patients. There is, however, an underlying interest and ability that can be kindled. Therapeutic relationships need to be fostered; the value of a personal form of containment is often not understood.

Such changes to psychiatric training should contribute to halting unacceptable practices, although better rules and more structured programmes are also needed in closed wards.

SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY

APPOINTMENT TO SERVE ON THE PROFESSIONAL BOARD OF THE HEALTH PROFFESSIONALS COUNCIL OF SOUTH AFRICA (HPCSA)

Prof. S Rataemane (Head, Department of Psychiatry) has been appointed to the Medical and Dental Professions Board (HPCSA) for a 5 year term of office from the 1st July 2015 – 30th June 2020. The Professional Boards were inaugurated on the 28th September 2015.

Prof. S Rataemane

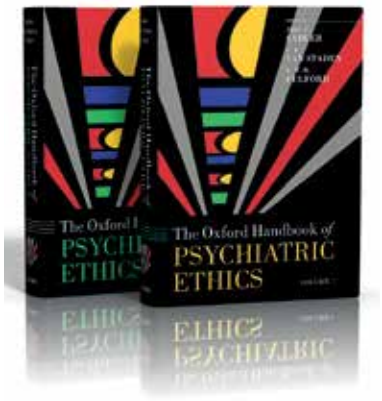
A LANDMARK BOOK ON PSYCHIATRIC ETHICS

The Oxford Handbook of Psychiatric Ethics edited by Prof John Sadler (University of Texas), Prof Werdie van Staden (University of Pretoria) and Prof Bill Fulford (University of Oxford) was recently launched at an event hosted jointly by St. Hilda's College, Oxford University Press and The Oxford Research Centre in the Humanities (TORCH).

Werdie van Staden

The book is extra-ordinary in several respects: It consists of 94 chapters written by 140 authors amounting to about 2 000 pages. It is by far the most comprehensive treatment of the field in history, with many chapters and even full sections breaking new ground.

The two-volume book examines ethical issues in twenty-first-century psychiatry and sets them in their social and political contexts. The changing contexts for which the book accounts are the impressive advances in neuroscience; the rapid expansion of electronic communications that invoke new demands on, for example, confidentiality, clinical boundaries, and privacy; multiculturalism and its associated diversity of values; new models of service delivery; new technologies; more oversight within stronger standards-based regulatory frameworks; and developing sophistication in practical ethics. The book covers the whole gamut from philosophy of ethics; traditional bio-ethics; religious and other values; perspectives of both patients and psychiatrists; and the multiple roles of the psychiatrist including being a citizen, a leader, an agent for society and the law, a researcher, a diagnostician, and a therapist.



The first chapter can be downloaded gratis at http://fdslive.oup.com/www.oup.com/academic/pdf/13/9780199663880_chapter1.pdf.

This chapter and three more (on respectively unique ethical challenges in psychiatry; what troubles psychiatrists; and tensions between individuals and society) constitute the first of 10 sections. Section 2 titled "People come first" gives a voice to service users/patients, some of whom are both experts-by-experience and experts-by-training. This section underscores that the people whom psychiatry serves are individuals embedded in multiple communities with intermingled identities and various values, purposes and vulnerabilities. Section 3 addresses specific populations: children; adolescents; older patients; the intellectually disabled; pregnant women; intersex patients; lesbian, gay, bisexual, and transgender patients; dangerous patients; patient peers; etc. Section 4 is on philosophy and psychiatric ethics including pre-modern ethics; justice and fairness; diversity of values; autonomy; identity and agency; rationality; principlism; virtues; pragmatism; feminism; utilitarianism; and values-based ethics. Section five describes the respective perspectives of seven major religions on psychiatric ethics.

Werdie van Staden

The societal focus of Section 6 speaks to abuses of psychiatry; advocacy; commissioning of services; public mental health; contagion; conflicts of interest; and genetic counselling. Section 7 considers psychiatric citizenship; leadership; communication with mass media; impaired health practitioners; the forensic psychiatrist's loyalties; criminal offenders; secure settings; and involuntary seclusion. Sections eight, nine and ten are respectively about research, diagnosis and treatments in psychiatry. Topics include the ethics of consent; capacity; using animals in psychiatric research; diagnostic classification; clinical assessments; brain imaging; professional boundaries; psychopharmacology; neuro-enhancement; team work; tele-psychiatry; recovery, and various kinds of psychotherapies.

South African colleagues who contributed to the book are Prof Sean Kalisky with his chapter titled "The Professional Role of the Forensic Psychiatrist: A tale of two (or more) loyalties", and the chapter on the ethics of psychopharmacology by Prof Dan Stein and Prof Anton van Niekerk.

More details of the book are available at the webpage of Oxford University Press (www.oup.com/uk/medicine) and individual chapters are available at Oxford Handbooks Online (www.oxfordhandbooks.com)

Werdie (C.W.) van Staden is a Professor of Philosophy and Psychiatry, and Director of the Centre for Ethics and Philosophy of Health Sciences at the University of Pretoria, with a clinical attachment as honorary psychiatrist at Weskoppies Hospital. He is the editor-in-chief of the South African Journal of Psychiatry, senior editor of the Johns Hopkins Press journal Philosophy Psychiatry & Psychology, regional editor of International Journal of Person-Centered Medicine, and managing editor of Philosophy, Ethics & Humanities in Medicine. He is honorary secretary to World Psychiatric Association's Section for Classification, Diagnostic Assessment and Nomenclature and on the steering committee of the International Network for Philosophy & Psychiatry. He serves on various executive committees at the University of Pretoria including being the Chairperson of the Research Ethics Committee of the Faculty of Health Sciences. **Correspondence: cwvanstaden@icon.co.za**

SANDOZ EXPERTS CONNECT

Lizl Bergh

Across various disciplines, be it Psychiatry, Cardiology, Gastroenterology or Internal medicine, we often hear the comment" If they only knew how their prescriptions affect my treatment regime…"

That is why, on 4-6 September 2015, Sandoz hosted 40 specialists from various disciplines at a Masterclass weekend to create an opportunity for these experts to connect with each other and gain insight into how different disease entities and their treatments affect each other.

Speakers like Dr Frans Korb, Dr Eugene Allers, Prof Helgard Meyer, Prof James Kerr Jnr and Dr Johan Smuts, presented interactive talks ranging from how depression relates to other diseases, biosimilars, new trial testing methods , medical –legal updates and the evolution of Pain.

Dr Frans Korb and delegates

Delegates went away having acquired new knowledge and new friends, with a promise to reconnect at next year's Sandoz Masterclass.

Lizl Bergh Product Manager: Cardiovascular/Diabetes, Sandoz South Africa (Pty) Ltd. **Correspondence: lizl.bergh@sandoz.com**

THE SOUTH AFRICA/UNITED STATES OF AMERICA (SAUSA) CHILD AND ADOLESCENT MENTAL HEALTH ALLIANCE

Rene Nassen, Desmond Kaplan, Tamara Maresky, Nkokone Tema

The South Africa / United States of America (SAUSA) Child and Adolescent Mental Health Alliance was established in 2014, as an initiative to forge ties between local clinicians working with children and CAMH clinicians abroad. The aim is to facilitate collaborations in a manner, which achieves bidirectional benefit to having differently resourced clinical settings collaborating and sharing best practices. This report describes the inaugural educational initiatives, aimed at both specialist and primary care clinicians practicing child mental health in South Africa.

CHILD MENTAL HEALTH CARE IN A PUBLIC HEALTH CONTEXT

In South Africa the resources allocated to mental health care is not equivalent to funding for other health programs within the primary care platform. Children and adolescents fail to access mental health care equal to adult users and the lag to presentation impacts negatively on mental health outcomes. This increases the cost of treatment at a later age and the socioeconomic burden of untreated mental illness. In 2006 Kleintjies et al reported on the findings of an expert working group, which estimated that 17% of children and adolescents suffer from a mental disorder (1) . In 2008 the SA Youth Risk behaviour Survey of 10 270 learners (from public schools in all nine provinces), revealed that 23.6% of learners had felt hopeless or sad during the past six months, 20,7% had considered attempting suicide and 16.8% of learners had planned a suicide attempt during the past six months. 21.4% had attempted suicide on one or more occasions in the prior six months (2). A systematic review conducted in 2012 by Cortina et al revealed that in Sub –Saharan Africa, 1 in 7 children and adolescents have significant difficulties, with 1 in 10 having a specific psychiatric disorder(3)

In South Africa, there are currently 21 child and adolescent psychiatrists in public sector posts and 25 practicing in the private sector. Mid-year population estimates during 2014 reveal that 39.6% (n=21,4 million) of the total population (54 million) are under 19 years old, representing 1 child psychiatrist per 500 000 of the population (4). However, most children requiring mental health services are likely to be potential users of services within the public sector. A more realistic estimate therefore would be close to 1 child psychiatrist to just under 1 million children. Child and adolescent mental health (CAMH) staffing needs for minimum coverage are estimated to be 5.8 in primary healthcare facilities, 6 in general hospital outpatient departments (OPDs), 1 in general hospital inpatient facilities, 1.1 in specialist CAMH OPDs, 6 in specialist CAMH inpatient facilities, 5 in specialist CAMH day services, and 0 .8 in regional CAMH teams (5). Current CAMH service provision in South Africa continues to fall far short of estimated minimum coverage. *References available from Rene Nassen.*

THE KHAYELITSHA CHILD AND ADOLESCENT MENTAL HEALTH FORUM (CAMH-F)

The Child and Adolescent Mental Health Forum (CAMH-F) stemmed out of a broader mental health (MH) Project, which was initiated in 2012 and focused initially on Khayelitsha, a low resourced area with both formal and informal settlements on the outskirts of Cape Town.

The CAMH-F was one of the most successful initiatives of the Khayelitsha MH Project and came about through the collaborative efforts of two child psychiatrists, Dr Rene Nassen, located at a tertiary academic child and adolescent mental health (CAMH) service and Dr Tamara Maresky, located at the district based Khayelitsha Eastern Substructure (KESS). The forum focuses on networking the existing resources across levels of care, between disciplines and across sectors (e.g. police, social services, education, justice). It also focuses on skills transfer and advocacy. It is the only forum of its kind in South Africa and was presented as a model of care for resource poor environments at the IACAPAP (International Academy of Child and Adolescent Psychiatry and Allied Professions) conference in 2014.

SAUSA COLLABORATION AND ESTABLISHMENT OF TRAINING MODULES

In August 2014, a SAUSA child and adolescent mental health alliance was established among CAMH clinicians from the Western Cape Department of Health and the Sheppard Pratt Hospital (in Baltimore), under the auspices of the CAMH-F. These clinicians and academics are affiliated to Stellenbosch University, University of Cape Town, Columbia

University and The University of Maryland. We wanted to develop a process where local clinicians and experts in the local context could work with foreign experts in a manner, which facilitated a bi-directional benefit to having differently resourced areas collaborating. From the start, the process behind the organization of the project was very important i.e. regular communications with the overseas coordinator and presenters provided a contextual framework, which ensured that the presentations were relevant and applicable to the local context.

AIMS AND OBJECTIVES OF THE SAUSA TRAINING COLLABORATION

- Differently resourced areas with bidirectional learning
- Long term relationships - driven
- Inclusive (academic and health institutions, CAMHS, interdisciplinary, private and public, utilizing creative art modalities in healing process)
- Clinical and academic focus
- Different levels of complexity to suit diverse audience
- Programme designed to allow clinicians to attend for shorter periods because no allocated educational leave typically
- CAMH-F community to drive content and format, NPO participation,
- Telemedicine to coordinate multi- site participation
- High quality knowledge and research to the people who are doing work (broad base)
- Marketing via a logo, social media (Wysetalk), CAMH-F newsletter

REPORT OF THE CAPE TOWN EVENT

The SAUSA alliance's inaugural project was a five-day child and adolescent mental health conference that took place in Cape Town, March 2015. Ten child mental health specialists from the USA collaborated with 18 local South African clinicians and experts to co-present across a wide range of topics. The conference was free and open to all health and allied professionals. It hosted 300 delegates per day from across the nation. An outcome from this initiative was the replication of the conference on a smaller scale in Johannesburg in September 2015.

BRIEF SYNOPSIS OF PRESENTATIONS

The Cape Town programme was divided across five days with a parallel programme of four separate one-day workshops. The main programme covered five main topics (Suicide, ADHD, Substance Abuse, Trauma and Public Mental Health) and was divided into foundation level information, innovative approaches to management and application to the South African context. There was ample time allocated to discussion. Four workshops covering infant mental health, creative arts, mental health of children in the educational setting, leadership in nursing was presented by local and USA speakers. The event was very well attended by a wide range of attendees from across the healthcare and education sectors. The event was offered free of charge in order to expose as wide a range of clinicians to excellent content and exposure to world experts from abroad. There was an extended programme that included visits to the Vera School for Autism and Lentegeur Elsen School (Mark Rappaport), and to the Khayelitsha District Hospital (USA team). Professor Christina Hoven and Alan Apter presented talks at the academic departments of Stellenbosch University and the University of Cape Town.

Attendees at the day covering Trauma and PTSD

Some of the presenters at the inaugural SAUSA meeting starting from the back, Left to right: Dr Tamara Maresky (Khayelitsha Eastern Substructure, Western Cape), Prof David Pruit (University of Maryland, Baltimore), Dr. Desmond Kaplan (Sheppard Pratt Hospital, Baltimore), Cheryl Blankenberg (Lentegeur Hospital, Western Cape), Dr. Rene' Nassen (Lentegeur Hospital, Western Cape), Eunice Dube (Sheppard Pratt Hospital, Baltimore), Naomi Botha. (Lentegeur Hospital, Western Cape), Anbrenthia Moos (Lentegeur Hospital, Western Cape), Dr. Bulelwa Mpinda (Lentegeur Hospital, Western Cape), Patti Prugh (Sheppard Pratt Hospital, Baltimore

COMMENTS FROM USA SPEAKERS

Mark Rappaport *"(It) was a chance to bring knowledge someplace where they were willing to hear what we have to say and in the end, it was very beneficial for us and the participants." "The relationships…as much as I think we gave, we were*

able to receive. It was not a one-way process. The need to go back and do more is an other take away."

Desmond Kaplan: *"The issues in inner city Baltimore are not that different from what goes on in the (townships) with drugs, alcoholism and poverty." "Telemedicine has allowed us to expand our reach on a local, national and international level. For the purposes of this project we used our telemedicine equipment to video conference with those in South Africa, which opened the lines of communication and understand the needs of their community before we even arrived." "There is an enormous amount of work to be done" "The world is getting smaller through technology "*

David Pruit: *" The public health thinking was actually more sophisticated than ours here in the US, because they have to look at the whole and find the issues that they want to intervene on. But there is a large gap between the private, public and academic centers; they much more siloed there because of the lack of resources."*
"I really did feel that I learned more than I taught which is remarkable. Because of those relationships, I think it is sustainable."

Comments from Attendees

"Excellent, thorough AND realistic…. acknowledges SA context! Sobering perspective, thought provoking, innovative thinking!." ***Educator at school for autism***

"Yes, the years of experience and expertise gained in the specialized fields were evident. Please continue with to host such workshops. I am amazed. I certainly look forward to the next conference. Certainly worth it ito value, content and relevance. Well done and congratulations" ***Psychologist public service***

"Try and combine all disciplines to demonstrate cohesion and integratedness" ***Anonymous***

REPORT OF THE JOHANNESBURG EVENT

Tara Hospital hosted the second SAUSA Collaboration seminar on the 3 – 4, September 2015. The invitations were sent out to the Gauteng child and adolescent psychiatry services (Johannesburg and Tshwane). There was also representation from the Gauteng Mental Health Directorate. Peacocks were also out in their numbers to show off and welcome the visitors with their colours and disturbing shrieks. The event hosted 70 – 90 delegates each day.

Peacock

The delegates were treated to a series of presentations from the 12 invited speakers. The largest part of the conference was dedicated to promoting tele-psychiatry in the country. Key leaders in telehealth (Prof Jennifer Chipps and the president of the South African Society of Tele-health Prof Maurice Mars) presented the history, challenges, and opportunities of this innovation in our local context. Dr Kaplan from Sheppard Pratt in Baltimore USA, shared his experience of Telepsychiatry, demonstrating how it has improved access to services and has been running for over ten years. He also gave a brief overview of their autism research programme and some of their publications. Drs Nassen, Maresky and Mpinda presented the formation, various teams and the activities involved in their Child and Adolescent Mental Health Forum that was established in 2013.

Orrganizers: Vuledzani Munzhelele (Clinical Secretary at Tara, H Moross; Dr Nkokone Tema (Tara, H Moross Hospital, Johannesburg), Celiwe Ntandathu

THEY SHOWCASED A MODEL OF HOW SERVICES COULD BE ORGANIZED TO MEET THE NEEDS OF A COMMUNITY IN A RESOURCE CONSTRAINED ENVIRONMENT AND EFFICIENCY OF INTERSECTORAL COLLABORATION. PATTI PRUGH PRESENTED AND ACTIVELY PROMOTED ART THERAPY AS A SIGNIFICANT MODE OF INTERVENTION IN MENTAL HEALTH CARE.

Prof Cora Smith (University of the Witwatersrand, Johannesburg) and Patti Prugh

Left to right: Dr. Desmond Kaplan (Sheppard Pratt Hospital, Baltimore), Dr. Lynda Albertyn-Cross (University of the Witwatersrand, Johannesburg), Dr. Nkokone Tema (Tara, The H Moross Hospital, Johannesburg), Patti Prugh (Sheppard Pratt Hospital, Baltimore), Dr. Rene' Nassen (Lentegeur Hospital, Western Cape), Dr. Bulelwa Mpinda (Lentegeur Hospital, Western Cape), Anbrenthia Moos (Lentegeur Hospital, Western Cape), Garth Newman (Lentegeur Hospital, Western Cape), Prof. Maurice Mars (University of Kwa-Zulu Natal, Kwa-Zulu Natal), Sis Tembi Gxabela (Lentegeur Hospital, Western Cape), Nombulelo Badela (Lentegeur Hospital, Western Cape), Brigitte Swarts (Lentegeur Hospital, Western Cape)

The dynamic CAMH team from Lentegeur Hospital in Cape Town presented their innovative adolescent lifeskills programme that has yielded good results and have managed to shorten length of hospital stay dramatically. Their programme also included the creative therapies focusing on group based drumming, art and music therapy. They topped this by presenting a case that demonstrated the role of the multidisciplinary team in youth mental health care. Roundtable discussion included a brief telephonic presentation from the Sheppard Pratt Hospital director of the adolescent day programme followed by a local experience by the Lentegeur hospital team. There was also discussion on how to take Tele-psychiatry forward through the training institution.

Prof Cora Smith was also there to represent Johannesburg with her "colourful" Black and White

GUIDING PRINCIPLES OF CAMH-F (including SAUSA collaboration)

- Umbrella body
- Connected by common interest and not geography
- Bottom-up
- Action orientated
- Agents of change
- Innovative,
- Pool resources
- Use technology
- Collaborative Relationships
- Leadership and mentoring to build human resources
- Bidirectional learning
- Process focus vs outcomes
- Advocacy for children's mental health by uniting forces

DISCUSSION

The vision for a CAMH-F is that it can function as an umbrella organization with no specific geographic and institutional affiliation, where people are united by their common interest in serving children, adolescents and families. The focus would not only be about innovative deliberation but on tangible, action-oriented implementation of viable, sustainable, and excellent clinical programmes within the public health sector.

THE GOAL IS TO BE AGENTS OF CHANGE (ADVOCATE) AND DEVELOPMENT WHERE WE UNIFY TO CHALLENGE SYSTEMS THAT ARE QUAGMIRED BY INEFFICIENT BUREAUCRACY. WE WOULD LIKE TO PRESENT INNOVATIVE AND ALTERNATIVE MODELS OF CARE AS ALTERNATIVES TO STUCK, RIGID, TOP-DOWN HEALTH CARE PROGRAMMING.

Utilizing a bottom - up approach, where initiatives are collaboratively determined from the outset may achieve buy-in and entrench new ways of working.

CONCLUSION

The CAMH-F plans to make such conferences an annual training event that networks differently resourced areas, builds strong collaborative relationships and reminds us all that we are working in a "global village". We hope to pool our scarce resources, support, and access the broadest possible public, see the event move to different areas within SA and even within the African continent and utilize

Rene Nassen Child and adolescent psychiatrist Lentegeur Hospital; Department of Psychiatry, Stellenbosch University, Western Cape, South Africa. References and contact details of presenters are available from the author. **Correspondence: rnassen@sun.ac.za** *Desmond Kaplan* Child and Adolescent Psychiatrist, Sheppard Pratt, Baltimore, USA. *Tamara Maresky* Child and adolescent psychiatrist, Khayelitsha Eastern Substructure, Western Cape, South Africa. *Nkokone Tema* Child and Adolescent Psychiatrist, Tara, H Moross Hospital, Johannesburg; Department of Psychiatry, University of the Witwatersrand, Johannesburg, South Africa.

It has been an exciting two months here at the PMHP. Our staff are working hard to prepare for World Mental Health Month (#DignityInMind), we featured in the MHTF blog series, published a new Issue Brief and released our 2015 Mid-Year Report.

Thank you to our incredible supporters and collaborators for making these things possible!

Insurers make a difference

Thank you to Gauteng Women in Insurance and AIG who donated the proceeds of one of their breakfast meetings to the PMHP.

We are most grateful for this support!

Find out how you can make a difference in a women's life here or make a donation on our website here.

Make a difference!

Making More Health

Simone Honikman, the PMHP director, is an Ashoka fellow and featured in this short video, supported by Boehringer Ingelheim. This video outlines the need for maternal mental health intervention and what the PMHP is doing to address the problem of maternal distress in South Africa.
Watch the video on our YouTube channel here.

PMHP video clips

New PMHP Publication

An exciting study conducted by the PMHP found that women using alcohol and drugs in pregnancy are often influenced by other difficulties in their lives. Identification and support for these related factors can assist in addressing their substance use.

Read the Issue Brief Alcohol and other drug use in pregnancy here.

PMHP resources

Assist us in the evaluation!

If you study the book, we invite you to take part in an evaluation of the effectiveness of this learning programme.

Your input will help us to improve this book. If you agree to participate in the evaluation, click here to find out more.

Read this and other newsletters on http://pmhp.za.org/about-us/newsletter/

SELF-HARM AND SUICIDE SYMPOSIUM

Graeme Hendricks

The Division of Psychotherapy within the University of Cape Town's Department of Psychiatry and Mental Health hosted a full day symposium on self -harm and suicide on the 5 August 2015 at the River Club, Observatory, Cape Town. Self- harm and suicide remains an area that is fraught with anxiety for the practicing clinician irrespective of the field of practice, and the importance of this issue was highlighted by the robust attendance at the symposium of 182 delegates including psychiatrists, general practitioners, psychologists, occupational therapists, nurses, social workers and other counsellors.

THIS SYMPOSIUM COVERED ETHICAL AND LEGAL MATTERS AND SUGGESTED PHARMACOLOGICAL AND PSYCHOLOGICAL INTERVENTIONS AS WELL AS ALERTING PRACTITIONERS TO POSSIBLE INTERVENTIONS THAT THEY MIGHT CONSIDER FOR FURTHER TRAINING. LASTLY, AVAILABLE REFERRAL PATHWAYS FOR AT RISK CLIENTS WERE ALSO PRESENTED.

The ethical and medico-legal context relating to self-harm and suicidal phenomena was presented by UCT Emeritus Professor Tuviah Zabow and Professor David Benatar from the Department of Philosophy at UCT. Professor Zabow spoke about the requirements of the law, the assessment of mental competency, the limits of confidentiality and considerations for professionals in preventing litigation. Professor Benatar provided a thought provoking look at arguments for and against suicide non- prevention.

Emeritus Pofessor Tuviah Zabow

Dr Jason Bantjes is a lecturer in the Psychology Department at Stellenbosch University and current recipient of an MRC research care award. He is currently involved in a research project with members of the Department of Psychiatry and Mental Health at UCT to investigate self- harm and attempted suicide at Groote Schuur Hospital. Dr Bantjes offered several presentations throughout the day focussing on the meanings and epidemiology of suicidal phenomena, assessment of patients, risk factors, risk assessments and the significance of the therapeutic alliance.

Dr Kerry Louw and Dr Jason Bantjes

He encouraged participants to see suicidal behaviour as a focus of attention in its own right and not just as a symptom of psychiatric illness. He pointed out to participants the limited utility of the epidemiological statistics and risk-factor models as well as the different definitions used to describe the phenomena in this area.

Dr Bantjes introduced participants to the theoretical constructs and theories that underpin suicide risk assessment, noting in particular the utility of the American Psychiatric Association framework, the Kagitabasi's 2005 construct of autonomy/ relatedness, Joiner's theory of suicidal behaviour as well as O' Connor's Integrated Motivational-Volitional model. He addressed protective factors when dealing with suicidal clients. He discussed evidence based brief cognitive interventions, the low efficacy of 'no harm' contracts and recommended replacing them with safety plans based on a hierarchy of co-constructed coping strategies.

SELF-HARM & SUICIDE

PHARMACOLOGICAL INTERVENTIONS AIMED AT SELF-HARM AND SUICIDE ATTEMPTERS WERE ADDRESSED BY DR KERRY LOUW A CONSULTANT LIAISON PSYCHIATRIST IN THE DEPARTMENT OF PSYCHIATRY AND MENTAL HEALTH.

The final session focussed on evidence-based psychological interventions and practitioner issues in the management of self-harm and suicidal phenomena. Ms Hayley Julius, a senior psychologist at Valkenberg Hospital with a special interest in personality disorders, presented on the use of Dialectical Behavioural Therapy within an inpatient treatment programme. Her co-presenter, Mrs Nadia Jacobs, a service user, provided insights from a lived experience perspective on the utility of this approach for her personal recovery, and its impact on her ability to conduct advocacy and peer support work following her treatment. Ms Lameze Abrahams, principal psychologist at Lentegeur psychiatric hospital in Mitchells Plain looked at the evidence for using Mindfulness interventions in the management of suicidal behaviour, experiential avoidance and ruminations. Ms Ereshia Benjamin, a senior psychologist at Groote Schuur hospital (GSH), and Ms Louise Frenkel, principal psychologist at GSH presented on practitioner issues relating to self- harm and suicide. They discussed technical and emotional difficulties experienced by practitioners in the assessment and containment of self-harm and suicidal behaviour and outlined essential supports to practitioners managing these phenomena in their practice.

THE DAY LONG SYMPOSIUM ENDED WITH TWO INPUTS ABOUT REFERRAL ROUTES, THE FIRST BY THE SOUTH AFRICA DEPRESSION AND ANXIETY GROUP (SADAG) WHOSE REPRESENTATIVE RYAN EDMONDS INFORMED THE PARTICIPANTS OF THE MORE THAN 400 SUPPORT GROUPS, THEIR 24 HOUR CALL CENTRE AND THE TRAINING WHICH SADAG PROVIDES TO DIFFERENT TARGET GROUPS. DR PETER MILLIGAN, CLINICAL HEAD OF PSYCHIATRY AT VALKENBERG HOSPITAL CONCLUDED THE MEETING WITH AN OVERVIEW OF THE MENTAL HEALTH ACT ADMISSIONS CRITERIA AND PROCESS AND AVAILABLE PATHWAYS FOR AT RISK CLIENTS.

Graeme Hendricks is a clinical psychologist in the Department of Psychiatry and Mental Health University of Cape Town.
Correspondence: graeme.hendricks@uct.ac.za

APAGMHPC
Newsletter
Issue I, Volume I
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Global Mental Health & Psychiatry Caucus

of the American Psychiatric Association

Eliot Sorel, MD
Editor-in-Chief

Dear Colleagues & Friends,

Greetings from Washington, DC…!

Welcome to the first issue of the ***Global Mental Health & Psychiatry Caucus Newsletter.***

We are grateful to our young colleagues, Doctors Philip Murray, Urooj Saeed, Rajeev Sharma, Veronica Slootsky, Mona Thapa and Milangel Concepcion-Zayas who inspired by their first international scientific experience at the WPA 2013 Bucharest Congress initiated, in the spring of 2013, the action paper to establish the **Global Mental Health and Psychiatry Caucus (GMHPC)** of the **American Psychiatric Association**, now a reality. The Caucus is a component of the APA Council of International Psychiatry.

As the first elected Chair of the GMHPC and the Editor-in-Chief of our Newsletter, I am pleased to present to you our editorial team. They are:

Zonal Editors
Africa: Prof. David M. Ndetei, Kenya and Prof. Solomon Rataemane, South Africa

Asia/Pacific: Prof. Yueqin Huang, China and Prof. Roy Kallivayalil, India

Americas: Prof. Fernando Lolas, Chile and Prof. Vincenzo Di Nicola, Canada

Europe: Prof. Gabriel Ivbijaro, United Kingdom and Dr. Mariana Pinto da Costa, Portugal

Associate Editors
Doctors Miguel Alampay, Rajeev Sharma, Veronica Slootsky, Mona Thapa, Milangel Concepcion-Zayas, Layan Zhang, all members of the **Career, Leadership & Mentorship** program of the **Washington Psychiatric Society**. We thank Anirban Chakraborty and all the Associate editors for their enthusiasm and the creative Newsletter logo design. We hope to involve other young psychiatrists as Associate Editors as we develop the Newsletter.

The GMHPC Newsletter will be published three times a year. The first issue is published this September 2015. The following two issues will be published in January and May 2016. We welcome global mental health news from throughout the world coordinated by our Zonal Editors and assisted by our Associate Editors. The news may include sharing of research, education and training programs, scientific events, advocacy and health policy initiatives and opinions.

We thank Congressman Patrick Kennedy and former APA Presidents, Doctors Jeffrey Lieberman, Dilip Jeste and Michellle Riba and the dedicated APA staff for their support of our Caucus.

MENTAL HEALTH ACTIVITIES IN SUB-SAHARA AFRICA

by Professor Solomon Rataemane

Africa deals with all sorts of mental health problems including sequelae of migration and disasters. The known mental illnesses such as schizophrenia and bipolar mood disorders are further compounded by head injuries, HIV/AIDS and substance abuse. It is in this context that the African Association of Psychiatrists and Allied Professions(AAPAP), collaborates with National Associations of mental health to host annual meetings in which further trends in mental health, particularly in Sub-Saharan Africa are reviewed with recommendations on how to work together to reduce the morbidity associated with severe mental illness and co-occurring disorders. The 2015 annual meeting of AAPAP will be hosted in collaboration with Ghana Psychiatric Association and Ghana Psychological Association at the University of Ghana 15 – 17 October in Accra, Ghana.

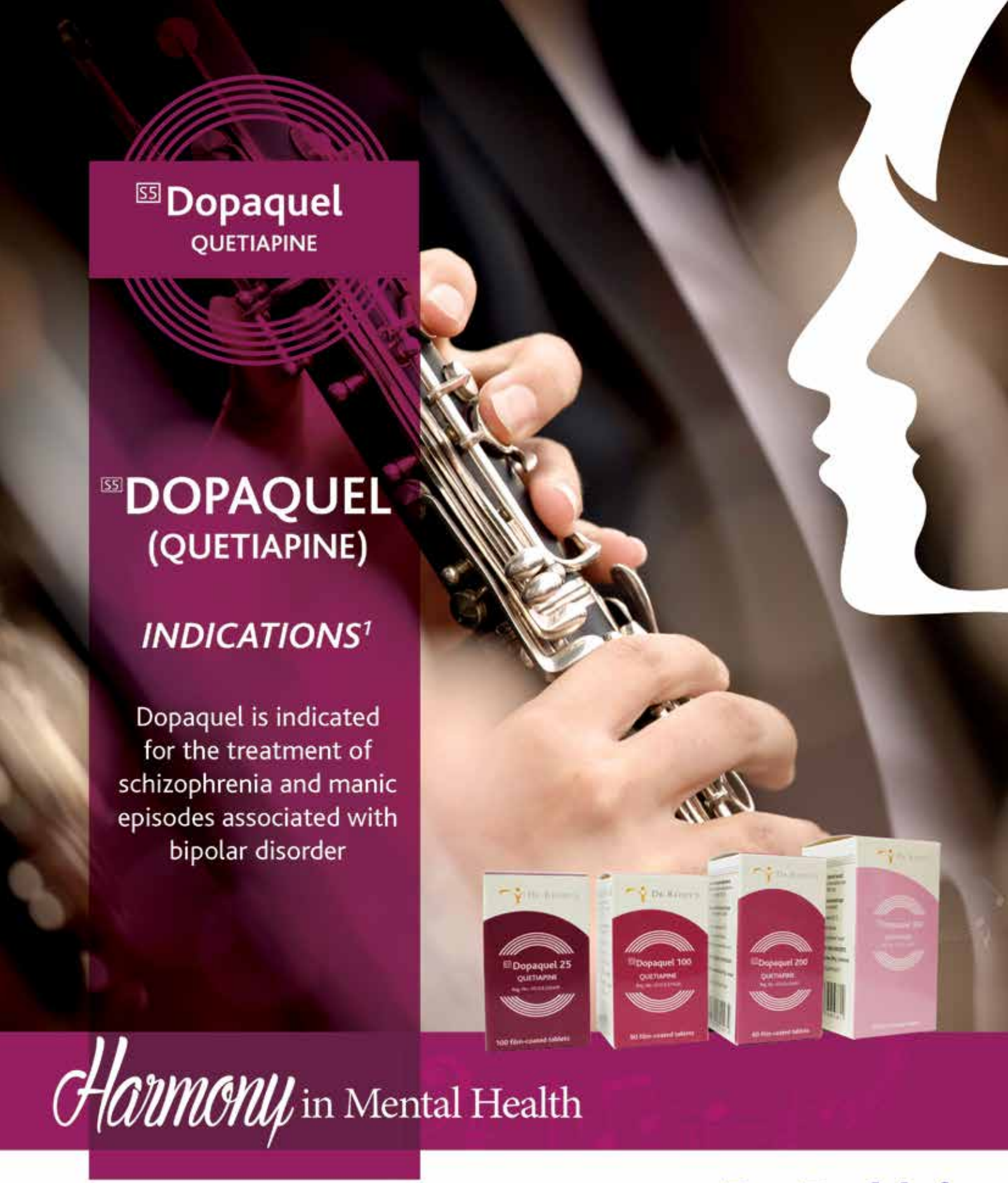
THEME: "Mental Health in Africa: Prospects and Challenges"

This theme will address various aspects of mental health including

- Neuropsychiatric aspects of mental health
- Mental health in the workplace
- Consolidation of mental health research in Africa
- Principles of psychosocial rehabilitation in mental health
- Challenges in the assessment of children
- Scaling up mental health services in Africa
- In-group/out-group issues in multicultural societies
- Attitudinal challenges in African development
- Effects of disaster, displacement and trauma in Africa
- Advocacy for mental health

These sub-themes focus on issues relevant to mental health in Africa. The presenters will also showcase ongoing research in various centers despite limited financial resources. This was clearly demonstrated at a conference in Nairobi, Kenya 13 - 16 July 2015, with the theme of **"Trauma through the Life Cycle."** The conference was sponsored by the Peter C Alderman Foundation; University of Nairobi and the Mental Health Research Foundation based in Nairobi. It addressed triggers and expressions of psychological trauma from the womb to the tomb, with specific emphasis on assessment and management in the primary health care settings. Finally in the Southern tip of Africa, The South African Society of Psychiatrists (SASOP) will host the International Congress of the World Psychiatric Association (WPA) in Cape Town, 18 - 22 November 2016 (**www.wpacapetown2016.org.za**). The theme of this congress is ***"Psychiatry: Integrative Care for the Community."*** This congress will be attended by opinion leaders in Global Mental Health to address several aspects of this theme, with emphasis on Integration of Mental Health in Primary Care settings including assessment, management and advocacy.

Professor Solomon Rataemane
International Fellow of the APA
Chairperson of WPA Section on Conflict Management and Conflict Resolution
Chairperson of International Relations Division of SASOP
Chief Psychiatrist: Sefako Makgatho Health Sciences University (SMU), South Africa



S5 Dopaquel
QUETIAPINE

S5 DOPAQUEL (QUETIAPINE)

INDICATIONS[1]

Dopaquel is indicated for the treatment of schizophrenia and manic episodes associated with bipolar disorder

Harmony in Mental Health

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Sophie Scott: Why we Laugh

A BIOLOGICAL PSYCHIATRY CONGRESS 2015 SATELLITE SYMPOSIUM

LAUGHTER

LAUGHTER AND THE SOUND PEOPLE MAKE WHEN LAUGHING, IS PRIMITIVE. IT'S MUCH MORE LIKE AN ANIMAL CALL THAN IT IS LIKE SPEECH.

To understand laughter, it is necessary to look at the ribcage. The ribcage is used all the time: for breathing and laughing. The intercostal muscles between the ribs bring air in and out of the lungs. As soon as a person starts talking, very fine movements of the ribcage squeeze the air out. Laughter uses these same muscles and the muscles start to contract very regularly. The contractions run together, creating spasms.

Nietzsche thought humans were the only animals that laughed, but this is not so. Laughter is found throughout the mammals and has been observed in primates.

Laughter is also associated with play. Wherever laughter is found, it is associated with (social) interactions.

ROBERT PROVINE POINTS OUT THAT PEOPLE ARE 30 TIMES MORE LIKELY TO LAUGH WITH SOMEBODY ELSE, THAN ON THEIR OWN.

People laugh to show others that they are understood, agreed with, liked, are part of the group and might even love them. Laughter does a lot of emotional communication for people. Robert Provine pointed out the reason someone laughs when somebody else is laughing, is that it has an enormously behavioural, contagious effect. Laughter is "caught" from somebody else, and this is more likely to happen if the person is known to them. Laughter is modulated by this social context.

There are two kinds of laughter. It seems possible that the neurobiology for helpless, involuntary laughter has a different basis than some of the more polite social laughter encountered – this isn't horrible laughter, but it's a behaviour of someone's communicative act to another, part of their interaction with that person.

In our evolution, people have developed two different ways of vocalising. Involuntary vocalisations are part of an older system than the more voluntary vocalisations.

IN OUR STUDIES, WE FOUND THAT PEOPLE ARE GOOD AT TELLING THE DIFFERENCE BETWEEN REAL AND POSED LAUGHTER. THERE APPEAR TO BE TWO DIFFERENT KINDS OF LAUGHTER. THEY'RE ACOUSTICALLY VERY DIFFERENT. THE REAL LAUGHS ARE LONGER.

They're higher in pitch. Laughter squeezes air out from the lungs under much higher pressure than could ever produce voluntarily. Contractions and weird, whistling sounds are emitted, all of which mean that real laugher is extremely easy, or feels easy to identify.

In contrast, posed laughter, sounds fake. Actually, it's not fake. It's an important social cue which is used when choosing to laugh in a particular situation. Posed laughter sounds nasal 'ha ha ha ha' – a sound not made if laughing voluntarily.

In a study to scan the brain's reaction to real and posed laughter, the brain responded significantly differently to each of the two laughters.

The auditory cortex of the brain responded to the real laughs. It responded to the involuntary laughing, hearing sounds one never hears in any other context.

In contrast, when posed laughter is heard, the brain processes the sounds in areas associated with mentalising, thinking about what someone else is thinking.

Laughter is always meaningful and people are always trying to understand it in context. Even if it has nothing to do with them, they still want to know why those people are laughing.

In another study with the Royal Society, people across the age spectrum were asked two questions:

1. Firstly, did these laughs sound real or posed? It found that despite a rapid onset, as people got older they got better and better at spotting real laughter. Laughter is not fully understood in puberty, nor by the time a person's brain has reached maturity at the end of the teen years. Laughter is learnt throughout the person's entire early adult life.
2. Secondly they were asked how much does this laughter make you want to laugh. The younger they are, the more people want to join in when they hear laughter. Everybody, young and old, finds real laughter more contagious than the posed laughs, but with age, it becomes less contagious.

There's even more to laughter than its important social emotion. People are phenomenally nuanced in terms of how they use laughter.

Robert Levenson is doing a longitudinal study with married couples. In response to the questions "tell me something your wife does that irritates you", Levenson found that the couples who manage their feelings of stress with laughter (a positive emotion), not only became immediately less stressed, they feel better physically because they are dealing with this unpleasant situation together and report high levels of satisfaction in the relationship.

WHEN LOOKING AT CLOSE RELATIONSHIPS, LAUGHTER IS A PHENOMENALLY USEFUL INDEX OF HOW PEOPLE ARE REGULATING THEIR EMOTIONS TOGETHER. THEY ARE NOT JUST EMITTING IT TO SHOW THAT THEY LIKE EACH OTHER; THEY ARE MAKING THEMSELVES FEEL BETTER, TOGETHER. THIS MAY NOT BE LIMITED TO ROMANTIC RELATIONSHIPS, BUT MAY BE A CHARACTERISTIC OF CLOSE EMOTIONAL RELATIONSHIPS WITH FRIENDS. FOR EXAMPLE, IN A 'SERIOUS MOOD' SITUATION AMONGST FRIENDS LAUGHTER GETS THEM OUT OF AN EMBARRASSING, PAINFUL, DIFFICULT SITUATION, INTO A FUNNY SITUATION. IT IS A BASIC REACTION.

People underestimate how often they laugh. When laughing, people are actually accessing a really ancient evolutionary system that mammals have evolved to make and maintain social bonds, to regulate emotions, and to make themselves feel better.

SONGS OF MADNESS

Sean Baumann

Scientific or naturalistic accounts of madness or psychotic experiences are inadequate and impoverished by a limited objective perspective. Literary and accounts in other media in the wide range of the humanities too often lack authenticity and tend to treat madness as a metaphor for personal and social ills. This project arises from a concern that the plight of the seriously mentally ill is either ignored or profoundly misunderstood, and that these responses significantly contribute to the suffering of those deemed mad.

"snake in man" from Songs of Madness – Fiona Moodie

The writer is a clinician who has worked as a specialist psychiatrist in the domain of the psychoses for approximately twenty years. The experiences described and the first – person accounts are authentic; they derive from clinical encounters with patients and others involved in their lives. The aim is an attempt to both enter the world of psychosis and to present the phenomena of madness in a respectful manner that seeks to be as truthful as possible given the mysteries of the mind in turmoil.

Sean Baumann

THE METHOD IS TO USE MUSIC, GRAPHIC ANIMATION, DANCE, SONG AND THE SPOKEN WORD IN AN ATTEMPT TO PORTRAY THE COMPLEXITIES AND ALSO THE WONDER OF THESE STRANGE AND ULTIMATELY UNKNOWABLE WORLDS. THE CENTRAL THEME IS THE TENSION, AND THE SHIFTS BETWEEN HARMONY AND NOISE, COHERENCE AND INCOHERENCE, PATTERN FORMATION AND LOSS: THE TONE IS INTENDED TO BE ENERGETIC AND HOPEFUL AND CELEBRATORY OF THE MYSTERIOUS WAYS OF COPING WITH EXTREME AND ALTERED STATES OF MIND.

A preliminary version of " Songs of Madness " ,"Madness a short Opera", was performed in the Groote Kerk in Cape Town on the 9th and 10th March 2015 to launch the Infecting the City Festival.

The project was conceived by Sean Baumann who also wrote the libretto. Neo Muyanga composed the music for the preliminary version and it was performed by the Khayelitsha choir. Fiona Moodie was responsible for the visual imagery and Koeka Stander for the animation. The venue was filled to capacity and the feedback received was extremely enthusiastic. It has been proposed that the fuller version be presented at the World Psychiatric Association Conference due to take place in Cape Town in November 2016. The new composer is Dizu Plaatjies.

Sean Baumann is a Senior Specialist in the Department of Psychiatry and Mental Health , Faculty of Health Sciences, University of Cape Town; Consultant psychiatrist, male acute services, Valkenberg Hospital; Editor "Primary Care Psychiatry", now in its 3rd Edition. **Correspondence: sean.baumann@uct.ac.za**

POEM

MENTAL STATUS EXTRICATION (MSE)

Thirusha Naidu

shattered mirrors

I, poised on the edge
of reason, sway.
While you, weighing differentials,
strike a diagnostic match
igniting fiery thoughts and
cogitating a multi-axial symptom overload.
I, wording my life, flounder.
Gasp, a fish on the table.
You and I fray over
shattered mirrors reflecting only
I in mine and you in yours.
You ask about my mother.
She was there, but not where
I, could find a history
In the splayed shards that
You, compose into me
With an assertive air.
Pill purveyor, dream voyeur.
I have seen izangoma*, priests, witchdoctors.
Did they see me? I cannot know.
You a doctor of Which? When? What?
Questions to throw my bones.
To read where they lie.
To determine my status of mind.
I rise unpatient-like and cross a canyon in bare feet,
encountering you midway, adrift.
You trying to put yourself in my shoes
You still in your own feet.

Thirusha Naidu

**South African Zulu diviners who use methods including the throwing of bone fragments to divine causes and treatments for physical, psychological and spiritual ailments.*

The poem was first published in Med Humanit - 2015;41:e5. - doi:10.1136/medhum-2014-010635

Thirusha Naidu (PhD) is a clinical psychologist at King Dinuzulu Hospital Complex and a lecturer in the department of Behavioural Medicine at UKZN. She has a special interest in creative expression in health professionals' research and practice. Dr. Naidu is currently conducting research projects on creative expression and mindfulness-based practices with caregivers in rural community settings as well as developing intern clinical psychologists skills in case formulation through creative reflexivity , drama, poetry and literature and the fine arts. She has published poetry in various academic journals including BMJ Humanities and Qualitative Inquiry. **Correspondence: Naidut10@ukzn.ac.za**

A VALUE PROPOSITION

While the regular Hamilton Russell Vineyards Chardonnay was never cheap, the prestige "Ashbourne" label launched white wine prices into a new orbit over R100 a bottle,' I wrote in One Hundred Wines – An Insiders' Guide to South African Wine, co-authored with Woolies wine guru Allan Mullins in 1998.

David Swingler

Fast forward to early October this year, when a barrel selection of the premium red blend Kanonkop Paul Sauer 2012 fetched R12 200 per six-pack at the Cape Winemakers Guild Auction. That's a few bob shy of R2320 a bottle with VAT, before retail margins… What on earth has happened in the interim?

The short answer is, 'lots'. SA wine emerged from its laager and the current generation of winemakers is far more globally savvy than their fathers. Coupled with the rise of the 'independents', wine quality is much improved.

THERE IS FRESH INTEREST TOO: EBEN SADIE LEFT SALARIED EMPLOY AND LED THE SWARTLAND REVOLUTION ABOUT FIFTEEN YEARS AGO, WHILE THE NEXT WAVE OF YOUTHFUL VINOUS ACTIVISTS – LOOSELY GROUPED AS 'THE ZOO BISCUITS' (SOME HAVE CALLED THEM THE 'LUNATIC FRINGE'…) – HAS EVEN SADIE LOOKING OVER HIS SHOULDER.

CWG Auction 2015

And foreign interest has burgeoned. After early disdain – such as pinotage tasting of 'rusty nails' – there is renewed critical focus on our wines, with regular review in influential British and American press, and while cadet journos may have been sent to Africa in the past, Neal Martin (Robert Parker's The Wine Advocate), Jancis Robinson (Financial Times, inter alia) and Tim Atkin (Tim Atkin Special Report) now visit themselves. Investment has not been far behind: Indian entrepreneur Analjit Singh who founded Max India, a health business, followed up his acquisition of swaths of Franschhoek vineyard with a stake in Swartland's hot-shot Mullineux (now Mullineux & Leeu Family Wines), and the purchase of Le Quartier Francais on 01 September this year.

David Swingler

'Foreign interest' was very much the focus of Cape Wine 2015, the international trade shindig hosted mid-September in Cape Town by Wines of South Africa, the collaborative marketing collective http://www.capewine2015.com/pressroom_images.php. Held every three years since 2000, there were 1 900 visitors from 58 countries this time around, 27% up on 2012. Delegates from the Americas, the UK and Europe, Africa, Australasia, China and Japan – where SA wine imports rose nearly 20% year on year to 2013 – spanned all sectors of the drinks business at this, the biggest wine show in the southern hemisphere.

Many – and I mean, many – wine marketing events are tagged onto or sewn in and around Cape Wine, while the entourage is in town. Amongst them, the Nederburg Auction, held the weekend prior https://www.nederburgauction.co.za/gallery/gallery-2015/nggallery/gallery-2015/2015-nederburg-auction.

ONCE THE PREMIER WINE EVENT ON THE CALENDAR – ALL SELF-RESPECTING WINOS WOULD EXHAUST EVERY AVENUE TO GET A TICKET (I ONCE WENT AS MEVROU TRUTER, I KID YOU NOT…) – IT LOST ITS IDENTITY, AND ITS WAY, SOME YEARS AGO.

Now being rebuilt as a serious trading floor for rare wines (which is how it started 41 years ago), the results are instructive: Total sales of R6.163 million

Dani Pick of the Butcher Shop and Grill

were a shade off 2014, as was the average price per litre of R576 (just under R500/bottle VAT inclusive, 'wholesale'). Tsogo Sun had the biggest wallet (R642 800) with Spar Western and Eastern Capes combining at R758 600. International sales grew 5%.

Nothing could hold back the rival 31st Cape Winemakers Guild Auction a month later, however. 2 here – wine bottle photos The CWG began as a technical tasting group of independent winemakers with aspirations of making great wine; none could have foreseen the juggernaut their annual auction has become, smiling impishly at the restricted economy. Buyers managed to part with R11 815 800 (before VAT and transport) in just six hours, finishing in good time to watch the Springboks subdue Scotland at the Rugby World Cup!

Apart from the Kanonkop jewel, five other red wines – Hartenberg Shiraz, Boekenhoutskloof Syrah, Etienne le Riche Cabernet Sauvignon, Beyerskloof Pinotage and Rust-en-Vrede Estate Wine – and four white wines (Ataraxia Chardonnay, AA Badenhorst 'Geel-Kapel Muscat de Frontignan and Jordan Chardonnay) topped last year's record highs. 153 buyers, including 22 foreign customers who accounted for 16% of sales (up 6%), paid an average price of R767 per bottle – that's R873 with VAT before any resale margins…
The irrepressible Miguel Chan, Group Sommelier of Tsogo Sun, committed over R2-million of his employer's reserves, while The Butcher Shop and Grill and Restaurant Mosaic also had active paddles.

SOME TRUSTY FRIENDS AND I MANAGED A FEW BOTTLES OF SAUVIGNON BLANC AROUND R300 EACH; SLIM PICKINGS IN THE WAKE OF THE BIG BOYS. BECAUSE, WHILE I'VE ALWAYS ADVOCATED THAT 'VALUE' WINES ARE SELDOM THE MOST EXPENSIVE, AND NEVER THE CHEAPEST, THE PRICES WERE WAY BEYOND EVEN MY GENEROUS WORLD VIEW OF THE FRUIT OF THE VINE. SO WHO WOULD SEE THEM AS WORTH IT – 'VALUE'? AND WHY? WITH QUALITY A GIVEN AND RARITY A POWERFUL DRIVER, EXCLUSIVITY AND A SENSE OF 'OWNERSHIP' OF THE BRAND BECOME INTOXICATING.

The preface of One Hundred Wines boasted a price key, achingly quaint in today's terms: Under R20 was 'Inexpensive', R20-R35 'Moderate', R35-R50 'Luxury' (how cute!) and above R50 deemed 'Expensive'. That's per bottle. Perhaps we should just add a nought to bring it up to date…

Miguel Chan

Kobus Du Plessis of Restaurant Mosaic

Left to Right: Peter Moyo, Shakes Matiwaza, Beki Moyo (bidding), Douglas Munatsi

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

Grace OF MONACO

A film review by Franco P. Visser

A YRF Entertainment and Stone Angels Presentation
A film by Olivier Dahan

At long last I received a copy of the film *Grace of Monaco*, delivered to my door. I left everything else, popped it into the DVD player and what my eyes beheld was pure magic! Grace Patricia Kelly was born on 12 November 1929 in Philadelphia, U.S.A. She became one of Hollywood's brightest actresses, her path to stardom ensured by her exceptional performance in the film Mogambo alongside Clark Gable in 1953. She also played in films such as Dial M for Murder, To Catch a Thief and High Society. It was her performance in The Country Girl which earned her an Academy Award for Best Actress in 1954. It was following her work on the film High Noon in 1956 that Grace Kelly 'retired' from acting to marry His Serene Highness Prince Rainier III. The 'wedding of the century' took place on 19 April 1956 following a civil ceremony the previous day in Monaco's Palace Throne Room. Grace went on to have three children with Rainier – Albert, the current Prince Regent, Princess Caroline and Princess Stephanie, all three of whom have led turbulent lives. Princess Grace died tragically, too soon, aged only 52 years after suffering a stroke whilst driving her car from Roc Agel, the Grimaldi family's country home high up in the hills overlooking Monaco. I can still remember a distraught prince Rainier and Princess Caroline walking behind Princess Grace's coffin, with a young Princess of Wales, Diana, attending the funeral and shedding tears in the Saint Nicolas Cathedral in Monaco.

The film Grace of Monaco briefly shows the highlights of Grace's voyage to Monaco, her triumphant arrival in Monaco Harbour in front of thousands of Monegasque people trying to get a glimpse of their new Princess. The main storyline surrounds Grace's consideration to return to acting after a visit from Alfred Hitchcock. He proposed that she play the lead role in a film called Marnie. It goes without saying that this idea did not go down well with her subjects, the Monegasque people, nor was her husband impressed with her.

The Monegasque people had a rather dim view of screen actresses and entertainers, although the vexatious and scandalous company they kept at their dinner tables and nightclubs were welcome as long as they had money, and lots of it – Aristotle Onassis being case in point here.


Franco P. Visser

Grace's consideration of acting in the film Marnie could not have come at a worse time as Monaco had reached such a deadlock with France with regards to taxation and other matters that General de Gaulle threatened to invade Monaco in the early 60's. The Monegasque throne itself was being undermined from close quarters within the palace. In the middle of all of this is a young mother, Princess Consort, chatelaine and patron, struggling to find her feet in her new country and in the hearts of her new subjects.

To fill in the gaps here with detail as to 'whom' 'what', 'where' and 'when' would for me be tantamount to doing you, the viewer a great disservice. I love the vibrancy, the intensity and the beauty of the film – one that was exceptionally well made. The lengths to which the producers have gone into making the film as true to real life as possible need to be applauded. Nicole Kidman, who plays the role of Princess Grace, stars alongside Tim Roth as Prince Rainier III and Frank Langella, who plays the role of Father Francis Tucker, a spiritual pillar to both Grace and Rainier.

With the film's release in 2014 the Palace of Monaco issued a statement in which they in no uncertain terms distanced themselves from the film's content and the makers. This is truly sad, as the film does nothing more than portray a period of struggle and strife from which a great beauty rises like a phoenix from the ashes into a self-assured role and function within the country that she had adopted. There is one scene in the film where Grace descends a staircase to an awaiting Prince Rainier before a state banquet that took my breath away – it was as if I saw the real Princess Grace with my own eyes. Tender, passionate, vibrant, tensed, glamorous, serene... these are but a few words that I can use to describe the film. It is a must see for any avid movie goer. My admiration for the lady behind the facade of a Princess has grown exponentially.

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

PART 2

CARNEGIE-WITS ALUMNI DIASPORA PROGRAMME

Visiting Professor presents seminars at Wits University - Department of Psychiatry, 23rd and 24th June June 2015

The article was written by Dr David Webb
Medical writer, Pattacus Medical Consulting, Johannesburg.
Correspondence: dawebb@mweb.co.za
The content was reviewed by Professor Feinstein

Part 1 was published in the August 2015 issue of South African Psychiatry

SEMINAR 1

DEVELOPING AND VALIDATING A PSYCHIATRIC RATING SCALE

Various rating scales for self-assessment of psychological distress and psychiatric morbidity have been developed for use in Western populations. Although these tools may also be useful in other populations, they may need to be adapted to allow for differences in language and culture, and then must be validated to ensure that the results are reliable and applicable to that population. This is also true when rating scales are used across clinical disciplines. For example a scale may be developed to screen for major depression among otherwise healthy individuals, but would need to be validated for use in a population of HIV-positive patients.

WHEN DEVELOPING AND VALIDATING A RATING TOOL FOR A NEW POPULATION, EITHER AN ETIC OR AN EMIC APPROACH MAY BE APPROPRIATE. THE ETIC APPROACH AIMS TO STANDARDISE THE SAME TOOL ACROSS CULTURES, ASSUMING THAT MENTAL ILLNESS (OR OTHER PATHOLOGY OF INTEREST) SHOWS A COMMON PHENOMENOLOGY AND THAT THE SCALE WILL PROVIDE DATA THAT CAN BE TRANSPLANTED ACROSS CULTURES. ALTHOUGH IT ALLOWS FOR EDITING AND REWORDING TO MAKE THE QUESTIONNAIRE LOCALLY AND CULTURALLY APPROPRIATE, ESSENTIALLY THE SCALE REMAINS UNCHANGED.

In contrast, the emic approach assumes that mental illness differs depending on the culture and beliefs of local people and that an assessment tool may only be developed with a knowledge and appreciation of that culture. The requirement for development of

Professor Anthony Feinstein

new culture-specific tools limits the practicality of this approach and means that the data provided cannot be compared across cultures.

Although the etic approach is broad and ignores or minimises local influences, it is the easier and more practical of the two methodologies, allowing for adaptation of existing validated tools and comparison of data from different populations.

Professor Feinstein described the etic validation process using the General Health Questionnaire (GHQ)-28 as a practical example. This self-report instrument has 4 standard subscales addressing the somatic, anxiety, social dysfunction and depression domains of psychological stress. Although it cannot be used to make a formal diagnosis, it is useful to elicit specific signs and symptoms that may indicate referral for a formal diagnosis and treatment. It has been widely used and translated and provides data that is relevant across cultures.

In order to adapt the rating tool to a new population, it must be translated into a local language. The accuracy of translation is confirmed by back-translation into English by a translator who is blinded to the original version. Thereafter it should be validated by comparing the scores generated in the population group against another clinically meaningful measurement of psychiatric distress, such as a structured clinical interview based on DSM5 criteria. Agreement is tested by comparing results from at least two different interviewers. Because the order of the tests may be important, a counterbalance technique is often used, where the

population sample is divided into two groups who complete the rating tool and clinical interview in a different order. The results from the two groups are then compared for homogeneity.

Reliability is tested by comparing the consistency of results from the four subscales across individuals. Finally, all of the potential scores on the rating tool should be compared with the results from the comparator assessment to determine a cut-off threshold value that defines 'caseness' (i.e.an individual with a score suggesting clinically significant distress).

SEMINAR 2

COGNITIVE DYSFUNCTION IN MULTIPLE SCLEROSIS (MS):

developing a computerised assessment MS is commonly associated with cognitive dysfunction, which occurs in up to 40% of patients from community samples and in up to 60% of those receiving treatment at MS clinics. Cognitive changes correlate with brain pathology observed with magnetic resonance imaging (MRI). These MS brain lesions are dynamic and wax and wane considerably over time. They may occur in the absence of physical impairment.

THE HALLMARKS OF COGNITIVE DYSFUNCTION IN MS ARE REDUCTION IN COGNITIVE SPEED AND SLOWNESS OF INFORMATION PROCESSING. PROBLEMS WITH WORKING MEMORY ARE CHARACTERISTICALLY THOSE OF RETRIEVAL RATHER THAN ENCODING. THERE MAY ALSO BE DEFICITS IN ABSTRACT THINKING AND IMPAIRMENT OF ATTENTION AND VIGILANCE. IN CONTRAST TO DEMENTIA, LANGUAGE IS SPARED AND THERE IS LITTLE AGNOSIA OR APRAXIA. BECAUSE IT FOCUSSES LARGELY ON LANGUAGE, THE MINI MENTAL STATE EXAMINATION (MMSE) TOOL IS NOT USEFUL IN PATIENTS WITH MS. SCREENING BATTERIES FOR COGNITIVE FUNCTION IN MS SHOULD INCLUDE AT LEAST TESTS OF VERBAL AND NONVERBAL MEMORY AND VERBAL FLUENCY.

Tests of executive function, working memory and processing speed may also be useful. The most sensitive test of cognitive dysfunction in MS is the symbol digit modality test (SDMT), which screens for impairment of nonverbal memory. Because it is quicker and simpler for patients to complete, does not require expertise to administer, is less expensive, and because the computer calculates and provides immediate scoring, computerised testing is simpler and more accessible than paper-based assessment tools. Likewise it facilitates wider screening of individuals than would usually be possible by conventional means.

SIX TOOLS ARE USUALLY INCLUDED IN COMPUTERISED TESTING OF COGNITIVE FUNCTION AMONG PATIENTS WITH MS.

They include the Stroop test (colour reading interference), SDMT, paced visual serial addition tasks (PVSAT) at 2 (PVSAT2) and 4 (PVSAT4) second intervals, simple reaction time and choice reaction time. As a single test the SDMT has a sensitivity of 66.7% and specificity of 87.7%. When the PVSAT2 and PVSAT4 are used in conjunction with SDMT, sensitivity increases to 83.3%. These three tests can be administered by computer in approximately 10 minutes.

More information about the computerised testing may be obtained from the Department of Psychiatry at WITS University.

ABOUT PROFESSOR FEINSTEIN

Prof Feinstein received his medical degree in South Africa at the University of the Witwatersrand. Thereafter he completed his training in Psychiatry at the Royal Free Hospital in London, England, before training as a neuropsychiatrist at the Institute of Neurology, Queen Square in London. His Master of Philosophy and doctorate degrees were obtained through the University of London, England. In 2000-2001 he was awarded a Guggenheim Fellowship to study mental health issues in post-apartheid Namibia.

Prof Feinstein is the author of a number of books, including *Dangerous Lives: War and the Men and Women Who Report It* (Thomas Allen, Toronto 2003), *In Conflict* (New Namibia Books, 1998), *The Clinical Neuropsychiatry of Multiple Sclerosis* (Cambridge University Press, 1999, with a second edition in 2007), *Michael Rabin, America's Virtuoso Violinist* (Amadeus Press, 2005, with a second edition in 2011) and J*ournalists Under Fire: the Psychological Hazards of Covering War* (John Hopkins University Press. 2006). His most recent book is *Battle Scarred* (Tafelberg Press, 2011). He has published widely in peer reviewed journals and has authored many book chapters.

In 2012, a documentary, "Under Fire", produced by Prof Feinstein and based on his research of journalists in war zones was shortlisted for an Academy Award. The documentary received a 2012 Peabody Award.

TARGETING MORE THAN ONE MECHANISM TO EFFECTIVELY TREAT MAJOR DEPRESSIVE DISORDER [1]

Efficacy, Tolerability, Simplicity... [1,2,3]

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PART 2

EXAMINING CRITICAL MENTAL WELLNESS TECHNIQUES: SLEEP, NUTRITION & SOCIAL CONNECTEDNESS

The content of this article is based on a workshop by Professor Rakesh Jain, Clinical Professor, Department of Psychiatry, Texas Tech School of Medicine, Texas, USA as part of The Pfizer Mental Wellness Roadshow held at Melrose Arch in Johannesburg, South Africa on 28 March 2015

The article was written by Dr David Webb
Medical writer, Pattacus Medical Consulting, Johannesburg.
Correspondence: dawebb@mweb.co.za
Part 1 was published in the August 2015 issue of South African Psychiatry

NUTRITION FOR OPTIMAL MENTAL HEALTH

Obesity and mental health

Obesity is a common, multifactorial condition associated with significant health risks, including, among others, cardiovascular disease, type 2 diabetes mellitus, sleep apnoea, other respiratory conditions and cancer.[9]

Obesity also has a significant impact on mental health. There is a deleterious bidirectional relationship between obesity and depression. In a group of females aged 40 to 65 years the prevalence of moderate or severe depression among those with normal body weight (body mass index (BMI) ≤25 kg/m2) was 6.5%, but this increased to 26% among those with BMI >35 kg/m2. Independent of obesity, depression was significantly associated with reduced physical activity, and in women with BMI >30 kg/m2, with increased caloric intake. Conversely, whereas just over one quarter of the women without depressive symptoms were obese, obesity was present in more than half of those with depression.[10] Similar results have been observed in prospective longitudinal studies. In the Nurses' Health Study, over a 10-year follow-up period, baseline depression was independently associated with weight gain and baseline obesity was significantly associated with development of depressive symptoms.[11]

A physiological explanation for the association between obesity and depression may, at least partly, lie in the observation that adipose tissue is metabolically active and associated with activation of the immune system. Inflammatory cytokines increase the risk of depression through their interaction with virtually every pathophysiologic domain relevant to depression, including neurotransmitter metabolism, neuroendocrine function and synaptic plasticity.[12]

In addition to mood disorders, higher BMI has been associated with a significant increase in the lifetime risk of other psychiatric diagnoses and psychological problems, including bipolar disorder, generalised anxiety, panic and agoraphobia.[13] Furthermore, in depressed patients, the response to antidepressant medication was significantly slower and less pronounced in those with BMI >25 kg/m2 than in those with BMI ≤25 kg/m2.[14]

Vitamins and mental health

Modern diets consist of an overabundance of macronutrients, calories, fats, and carbohydrates, but insufficient micronutrients, such as vitamins and minerals. In order to improve mental health and overall wellness this needs to be rectified, balancing a healthy intake of proteins, healthy fats and carbohydrates with sufficient micronutrient intake.

Deficiency of micronutrients plays a significant causative role in mental illness, exacerbation of symptoms and interferes with recovery. In particular, B vitamins (B2, B6, B9 and B12) are required for proper functioning of the methylation cycle, which controls monoamine production (including serotonin, dopamine and noradrenaline), DNA synthesis and maintenance of phospholipids, such as myelin. Fat-soluble vitamins A, D, and E play important roles in genetic transcription, antioxidant recycling and inflammatory regulation in the brain.[15] Deficiencies can therefore directly influence brain function.

Deficiency of vitamin B9 (folate) is common among patients with mood disorders. It increases the risk of depression and correlates with the severity of symptoms. Furthermore, in addition to dietary deficiencies, variations in the genes coding for folate metabolism may also play a role in mood disorders. Before it can be used in the brain, folate from dietary

sources must be converted to L-methylfolate by the enzyme methylenetetrahydrofolate reductase (MTHFR). Approximately 10% of people are homozygous for a variant of the MTHFR gene caused by a point mutation (C677T) in the coding region for the MTHFR binding site, consequent to which alanine is substituted by valine. This C677T allele produces a less active form of the enzyme.[15-17] Deficiencies in L-methylfolate will be compounded by the TT genotype, especially when dietary intake of folate is inadequate. In comparison to CT heterozygotes or CC homozygotes, the TT genotype is associated with major depression, bipolar disorder and resistance to treatment with antidepressants.[15] Supplementation with L-methylfolate bypasses the MTHFR gene and, in a clinical study, 15 mg/day significantly augmented the response to SSRI therapy in patients with major depressive disorder and partial or no response to previous treatment with an SSRI.[18] Higher intake of dietary folate is associated with a reduced risk for both major depressive disorder and dysthymia.[19]

The TT genotype is also associated with hyper-homocysteinaemia, which in turn, is associated with endothelial dysfunction, excitotoxicity and oxidative stress, and increased risk for coronary artery disease, myocardial infarction and stroke.[16,17,20]

Specific dietary recommendations for patients with mood disorders

Healthy dietary choices need to be emphasised with all depressed patients. In line with the Mediterranean diet and Healthy Heart diet, general recommendations are to increase consumption of micronutrient-rich foods, omega-3 fatty acids and fibre-rich foods, and reduce or cut out consumption of saturated fats and refined carbohydrates.[21-24]

1. Increase intake of fruit and vegetables (at least 8 servings per day).
2. Reduce or stop intake of red meat.
3. Significantly increase consumption of fish, and especially oily fish.
4. Increase consumption of fiber.
5. Increase consumption of nuts (preferably mixed nuts).
6. Stop all processed foods.
7. Individualise micronutrient advice.

It is important to emphasise that, as far as possible, nutrient intake should come from food. Among otherwise healthy individuals, general vitamin supplements are, at best, of uncertain value and, at worst, may be harmful.[25,26] Furthermore, many of the nutrients and cofactors required for the health benefits of individual foods have not been identified and will not be contained in pharmacological or 'natural' supplements. Nevertheless, where indicated, augmentation with specific supplements, such as L-methylfolate, is useful to improve clinical response and recovery.

SOCIAL CONNECTEDNESS AND ITS ROLE IN MENTAL WELLNESS

What is social connectedness?

Social connectedness relates to the construction and successful maintenance of reciprocal interpersonal relationships and identification with a larger group (social integration). Sustainable connectedness requires specific social, moral and emotional competencies.

The relationships provide support, companionship, emotional wellbeing and access to resources. Of course, negative interactions may also occur. These attributes of social connectedness are associated with health outcomes. However, social connectedness is frequently impaired in psychiatric patients. Encouraging and facilitating socialisation and establishment of social networks is an important intervention to improve both mental and overall health.[27]

Characteristics of the social environment that are beneficial to health

Different aspects of socialisation promote health through different mechanisms. Two important social constructs that have been shown to influence health are social integration and social support (Table 9). Social support refers to the provision by the social network of psychological and material resources intended to benefit an individual's ability to cope with stress. Different types of support may be required depending on the nature of the stressor and on the individual's personal characteristics.

Table 9. Key aspects of social support and social integration[27]

Social support	
Instrumental support	Provision of material aid (e.g., financial assistance or assistance with daily tasks).
Informational support	Provision of information that enables the individual to cope with current difficulties (e.g., advice and guidance).
Emotional support	Expression of caring, empathy, reassurance and trust. It provides opportunities for expression of emotions and venting.
Social integration	
Behavioural	Engagement in a wide range of activities and/or relationships.
Cognitive	Sense of commonality; identification with one's social roles.

Social integration refers to participation in a broad range of social relationships, both behaviourally and in terms of identifying one's own role and place in society. As such, social integration helps to form a protective society and also to regulate behaviour.

Stress may influence health by encouraging maladaptive coping strategies, such as smoking, alcohol and substance use and sleep disruption. It also activates physiological systems, such as the sympathetic nervous system and hypothalamic-pituitary-adrenocortical axis. Repeated and prolonged exposure to these consequences of stress impact on both physical and mental health. By helping to place events into perspective, promoting effective coping strategies, and encouraging healthy behaviours (e.g., exercise, hygiene, nutrition and rest), social support helps to redefine the interpretation of stressful experiences and reduce or eliminate the impact that they may have on the individual's health. In clinical studies, social support, especially in times of high stress, has been shown to be associated with lower rates of depression, anxiety and mortality.

On the other hand, social integration helps to promote emotional wellbeing and positive feelings of identity, purpose, self-worth and security independently of whether stress is present or not. In doing so, it induces physiological responses that are beneficial to both mental and overall health. Furthermore, being part of society motivates one to care for oneself.

BOTH QUALITY AND QUANTITY OF THE SOCIAL INTERACTIONS ARE IMPORTANT.

Quality in terms of level of happiness and positive thinking of the individuals involved in the interaction, strength of the bond between individuals, level of conversation and enjoyability of the interaction; and quantity in terms of regularity, where daily contact is ideal.

Community-based studies suggest that positive health benefits of social integration may extend to increased longevity, and lower levels of cancer, fatal cardiovascular events, depression and anxiety; less severe cognitive decline with aging; improved immunity and reduced susceptibility to viral infections. Positive relationships improve happiness and wellbeing. In contrast, negative and conflictual social interactions are a source of stress that may have adverse health effects.[27-30]

Interventions to improve social connectedness

In addition to improving socialisation, improving social connectedness requires training to develop the skills required to make and manage friendships. Examples of these are listed in Table 10.

Table 10.
Interventions to improve social connectedness[27]

Interventions to increase socialisation[27]
1. Increasing the availability of social support within existing social networks by improving individual social skills or by building stronger ties to existing network members.
2. Increasing social integration by creating and nurturing close and peripheral ties between an individual and his or her community.
3. Reducing negative interactions.
Skills required to make and manage friendships[31,32]
1. Commonality and participation
• Recognising shared interests.
• Identifying common goals.
• Graceful participation.
• Being cooperative.
• Accepting people for who they are and their limitations.
• Being open to include others.
• Offering trust-worthy support.
2. Sharing information about the other & providing support
• Paying attention to nonverbal communication.
• Encouraging people to talk and knowing when to listen.
• Listening to and respecting feelings.
• Empathizing with another's perspective.
• Understanding when it is good to let a person unload their feelings and emotions in your company.
• Practising compassion.
• Knowing how to help friends resolve problems by offering alternatives or steps in problem-solving.
3. Sharing information about yourself & seeking support
• Understanding how to let people know your own feelings, including your caring for them.
• Knowing how to pace self-disclosure in order to avoid premature relationships or discomfort.
4. Mutually respectful relationships
• Knowing how to be tactfully assertive.
• Being aware to avoid inappropriate taking advantage of others, or allowing others to take advantage of you.

Conclusion

Sleep disorders, dietary insufficiencies and social isolation are common, but modifiable risk factors that can hinder optimal outcomes in psychiatric patients. Engaging patients and helping them to understand the physiological and psychological effects of these deficiencies and the impact that they have on recovery and quality of life is an important part of management that is too often overlooked.

References are available from: Rakesh Jain.
Correspondence: jaintexas@gmail.com

THE ATTENTION DEFICIT HYPERACTIVITY DISORDER SPECIAL INTEREST GROUP OF THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS (THE ADHD SIG)

On Friday the 25th of September 2015, there arrived a new kid on the block! After months of focused energy, planning and behind the scenes work and negotiation, the ADHD SIG was launched at the Biological Congress at the Lord Charles Hotel, Somerset West. Dr Rykie Liebenberg is the convenor of the ADHD SIG, while Dr Renata Schoeman is the co-convenor.

Renata Schoeman

Attention-Deficit / Hyperactivity Disorder (ADHD) has received increased scientific, clinical and public attention over the past few decades. However, in South Africa, access to care and treatment for ADHD is limited and research is lacking. In the first South African study exploring the situation with regard to the prevalence and treatment of adult ADHD (*Schoeman, 2015) the population prevalence of adult ADHD was estimated at 1.09 percent, while the prevalence in clinical psychiatric settings is as high as 52.5 percent. Conditions comorbid with adult ADHD is common with psychiatric conditions in up to 20.43 percent of individuals. Psychiatric comorbidity was also more prevalent than in the general psychiatric population for both anxiety disorders (13.1% vs. 8.1%) and mood disorders (13.8% vs. 4.5%). The presence of adult ADHD also more than tripled the prevalence of multiple comorbidity (9.09% vs. 3.9%), and doubled the healthcare costs of individuals. In this study lack of knowledge of adult ADHD and lack of funding for the treatment thereof were identified as the two main access barriers to diagnosis and treatment. Recognition of adult ADHD as a chronic disorder which needs chronic treatment is therefore crucial. A comprehensive diagnostic approach as well as access to multi-disciplinary and multi-modal intervention in preventing the long-term costs of adult ADHD are needed. *Reference available from the author

The overall objective of the ADHD SIG is to improve the basket of care available to our patients with ADHD. This is only possible through a combined and concerted effort of individuals with a special interest in and passion for ADHD to improve knowledge about and funding for the care of individuals with the disorder.

From left to right:1st row: Renata Schoeman, Kali Tricoridis, Rykie Liebenberg, Farzana Mohideen-Botes, Moira Niehaus, Anita Ganagaram, Richard Sykes 2nd row: Janus Steyn, Nai'm Moolla, Jack Kryzstofiak, Frans Korb, Suntheren Pillay, Pieter Plenaar, Marius Pretorius, Bernard van Rensburg

THE AIMS OF THE ADHD SIG ARE:

- to promote, maintain and protect the honour and interest of the discipline of psychiatry as a medical speciality as far as it relates to the diagnosis and provision of comprehensive care of individuals with ADHD
- to provide a forum within SASOP to clarify concepts and professional/ethical boundaries, as well as for continuous education for psychiatrists, medical practitioners and allied mental health professionals with regard ADHD and psychiatry
- to develop South African guidelines for the diagnosis and treatment of adult ADHD specifically, and update guidelines for the treatment of child, adolescent, and adult ADHD

- to facilitate workshops and conferences for the diagnosis and treatment of ADHD and psychiatry: both at regional and national level
- to serve the community through informing and relating issues with regard to ADHD and psychiatry to the accepted evidence-based principles underpinning the discipline of Psychiatry

THE SPECIFIC OBJECTIVES OF THE ADHD SIG ARE:

- to monitor, evaluate and advise on policies related to the delivery of clinical services and the protection of human and patients' rights responsibilities as it pertains to ADHD
- to maintain ethical standards and professional boundaries with regard to the diagnosis and treatment of ADHD and psychiatry by peer review
- to promote appropriate and relevant continuing education and professional development with regard to ADHD and psychiatry
- to advise on and promote appropriate training and evaluation of standards of undergraduate and postgraduate students with regard to ADHD and psychiatry
- to promote research appropriate to ADHD in South Africa
- to promote and uphold the principles of human rights, dignity and ethics while opposing unfair discrimination in the field/practice of psychiatry
- to promote the de-stigmatisation of ADHD specifically, and psychiatry in general, and increase the awareness of mental illness in the context of education and place of work
- to foster good relationships among the members of the SIG internally and SASOP as a whole through its different regional subgroups
- to promote cooperation with other associations involved in (mental) health
- to explore appropriate dialogue and cooperation with other associations involved in ADHD and (mental) health

For more information on our activities and to join the ADHD SIG (currently we consist of 24 members), please contact Dr Renata Schoeman at renata@renataschoeman.co.za.

REFERENCES: 1. Janssen Data on file. 2. IMS, March 2015 TPM Data.

For full prescribing information, refer to the latest package insert (April 2015). JANSSEN PHARMACEUTICA (PTY) LTD, (Reg. No. 1969/011228/07), Building 6, Country Club Estate, 21 Woodlands Drive, Woodmead, 2191. www.janssen.co.za. Medical Info Line: 0860 11 11 17.
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BIOLOGICAL PSYCHIATRY 2015

Lisa Selwood, Medical Scientific Liaison: CNS (Janssen)
lselwood@its.jnj.com

Janssen had the privilege of hosting Dr Susan Young at the Biological Psychiatry conference, held from the 24 – 27th September 2015 at the Lord Charles Hotel in Cape Town. Dr Young is a clinical senior lecturer in forensic clinical psychology in the Centre for Mental Health, Imperial College London. Her main area of expertise is working with offenders in low, medium and high security settings, with the ultimate goal of ensuring enhanced service delivery and care coordination for people with serious mental illness involved in the criminal justice system. In addition, Dr Young has been integral in the development of the British Association of Psychopharmacology (BAP) and the National Institute for Health and Clinical Excellence (NICE) guidelines for the management of ADHD across the lifespan. She has extensive experience in the assessment and treatment of youths and adults with ADHD. Whilst working at the Maudsley Hospital, she set up and developed the neuropsychology service at the first adult ADHD service in the United Kingdom

The Janssen stand

BREAKFAST SYMPOSIUM: 25 SEPTEMBER 2015

'Comorbidities and outcomes of adhd'

Despite the early start, there were 121 attendees at the breakfast symposium, which was chaired by Dr Anusha Lachman (Child psychiatrist at Tygerberg hospital). Dr Young began by examining the developmental impact ADHD has throughout the lifespan, and highlighted the golden thread of the presentation: Comorbidity is the rule and not the exception when treating ADHD.

Dr Susan Young, Dr Anusha Lachman

Children and adolescents:

One of the main comorbid conditions in children is Disruptive Behaviour Disorders. Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD) affect 40 to 60% of children with ADHD. If left untreated, this group of children may go on to develop personality disorders in adulthood, and it is a progressive pathway to rule breaking behaviour and delinquencies.

Also of note in adolescents is risky sexual behaviour, presumably due to the inattentive symptomatology. Promiscuity runs the risk of sexually transmitted diseases, including HIV and unwanted pregnancies. Additionally, it is the latter end of this age group that are learning how to drive and research has shown a clear correlation between untreated ADHD and an increase in motor vehicle accidents, speeding and drinking and driving.

Adults:

Substance Use Disorder (SUD) is a comorbid condition which has sparked a lot of interest over the past few years due to the devastating consequences on occupation and performance in the workplace, relationships and social interactions and associated societal costs. The prevalence of SUD in adults with ADHD ranges from 15 – 23%. There are many hypotheses as to why this may be the case: (Table 1)

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TABLE 1: SUD HYPOTHESES	
HYPOTHESIS	**EVIDENCE**
Self-medication – patients use substances to alleviate some or all of the symptoms of ADHD, as well as the impairments the symptoms impose on their lives	Negligible
Behavioural inhibition- disposition towards novel sensation seeking behaviours	Proven
Comorbidities – incorporates self-medication and behavioural inhibition	Proven
Sensitization – Early use of stimulant medication may alter the dopaminergic pathway, making patients more susceptible to SUD in later years	Proven to be untrue*

* THIS IS A PARTICULARLY SALIENT POINT, AS MANY PARENTS EXPRESS A CONCERN SURROUNDING EARLY STIMULANT USE AND A PERCEIVED LINK TO VULNERABILITY TO SUBSTANCE USE LATER ON IN LIFE. IN FACT THE REVERSE MAY BE TRUE – TREATING ADHD AT AN EARLY AGE MAY DECREASE THE RISK OF SUBSTANCE MISUSE IN LATER YEARS.

Attendees at the breakfast symposium

Other common comorbidities in adulthood include major depressive disorder (prevalence: 18.6%) and bipolar disorder (19.4%). Personality disorders are also common in adults with ADHD.

Treatment

Although it is best to ensure children with ADHD are recognized, diagnosed and treated as early as possible, studies have shown that there will be an improvement in outcomes regardless of when treatment was initiated. In particular, the most improved outcomes included driving, self-esteem, social functioning, academic achievement and improvement in anti-social behaviour. Pharmacological treatment should form part of a comprehensive treatment plan, which includes a psychological component.

COCKTAIL SYMPOSIUM: 25 SEPTEMBER 2015

'ADHD and offending'

It has been well established that untreated ADHD carries with it a host of far reaching consequences, including but not limited to academic and occupational underachievement, an increase in motor vehicle accidents, relationship impairments and an increase in the use of substances. A growing area of interest is the impact untreated ADHD has on criminality.

At a cocktail symposium, chaired by Dr Shaquir Salduker (Psychiatrist in private practice in Durban), Dr Young presented to 83 attendees on the topic 'ADHD and offending'.

HER PRESENTATION BEGAN BY HIGHLIGHTING THE TYPE OF CRIME ADHD OFFENDERS TYPICALLY BECOME INVOLVED IN; WHICH IS MAINLY OPPORTUNISTIC CRIME, PRESUMABLY DUE TO THE IMPULSIVITY SYMPTOMATOLOGY. THERE ARE HIGH RATES OF RECIDIVISM IN THIS PATIENT GROUP, AND WHEN INCARCERATED THEY ARE MANAGEMENT PROBLEMS. IF ADHD IS NOT IDENTIFIED, AND CORRECTLY TREATED, THERE IS A DEMONSTRABLE DECREASED CAPACITY TO ENGAGE IN THE JUDICIAL SYSTEM AND RECEIVE APPROPRIATE REHABILITATION.

Dr Susan Young, Dr Shaquir Salduker, Ms Lisa Selwood (Janssen)

Janssen staff - Lisa Selwood, Debbie Joubert, Pauline Timothy, Claudette Barton, Gonny Moodley

A meta analysis of international prison studies found 30% of youths and 26% of adults screened positive for ADHD. When looking specifically at gender differences, 26% of male and 18% of female offenders had a positive screening for ADHD. In addition, there was generally a younger age of conviction compared to those offenders who did not have ADHD. These statistics are particularly relevant, given the prevalence of ADHD in the general population is estimated to be 4 – 5%.

A SMALL SWEDISH RANDOMIZED CONTROLLED TRIAL (N=30) EXAMINED PRISONERS WITH ADHD WHO WERE TREATED WITH STIMULANT THERAPY VERSUS PRISONERS WHO HAD ADHD AND WERE NOT GIVEN STIMULANT MEDICATION. THE TRIAL WAS DOUBLE BLINDED AND PLACEBO CONTROLLED. FINDINGS INCLUDED A LARGE TREATMENT EFFECT, WITH A DECREASE IN SYMPTOM SEVERITY AND IMPROVED GLOBAL FUNCTIONING IN THE TREATED COHORT. IN ADDITION, THE THERAPEUTIC EFFECT CONTINUED TO IMPROVE DURING THE OPEN LABEL EXTENSION PHASE. THE OVERALL FINDING OF THIS STUDY WAS THAT MEDICATION REDUCES THE RISK OF FUTURE CRIMINALITY.

In addition to the two highly informative presentations outlined above, Dr Young also provided some valuable resources for use in patients with ADHD, most of which can be downloaded for free from the websites listed below.

TREATMENT RESOURCES

RAPID – REASONING AND PROBLEM SOLVING FOR INATTENTIVE DETECTIVES.

This is a cognitive behavioural psychoeducational group program which teaches cognitive, social and emotional skills and moral values to boys and girls (age 9 – 12) who have problems associated with ADHD.

R&R2 FOR ADHD YOUTHS AND ADULTS

- The Reasoning and Rehabilitation program is a structured CBT prosocial competence training program which can be implemented in schools, counselling centres, social service agencies and in probation, prison or hospital settings. The program contains five modules viz. neurocognition, problem solving, emotional control, social skills and critical reasoning. More information about this program can be found at: **www.cognitivecentre.ca**

STARS (SUBSTANCES AND TRANSITIONS ADDICTION RATING SCALE)

was developed to investigate the pathways and mechanisms underlying substance misuse. The questionnaire is designed to incorporate all aspects of substance misuse including factors associated with initiation, transitioning, persistence, dependence and cessation. It is a self-report measure, which can be completed by an individual or in group settings but it is recommended that it is completed under supervision so queries and clarifications can be addressed.

Available at **www.psychology-services.uk.com**

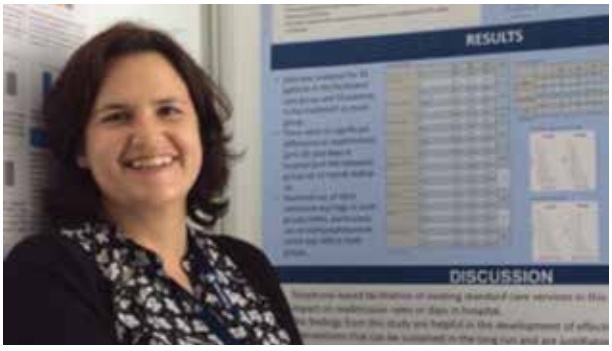
ECNP 2015

Lisa Selwood, Medical Scientific Liaison: CNS (Janssen)
lselwood@its.jnj.com

The 28th European College of Neuropsychopharmacology congress took place from 29 August 2015 until 01 September 2015, in Amsterdam, The Netherlands and was attended by almost 5,000 delegates from all over the world. As part of Janssen South Africa's ongoing efforts to promote medical education within the psychiatry community, eight doctors were sponsored to attend the conference.

Janssen EMEA hosted a satellite symposium, attended by over three hundred people. The overarching theme for the symposium was 'Schizophrenia – neurobiology and functional recovery. How close are we to personalized treatment?' and was chaired by Professor Philip Gorwood from France who also lead the discussion portion. Oliver Howes (UK) presented on 'The Neurobiological Perspective', Ludger Hargarter (Germany) spoke about 'Providing Optimal Treatment' and the third speaker, Andrew Molodynski (UK) presented on 'Functioning and living well'. Advances are continuing to be made in genetics, brain imaging, integrated care and pharmacological and psychosocial therapies, which means widespread provision of personalized treatment for schizophrenia may soon become a reality and the symposia provided attendees with education around this.

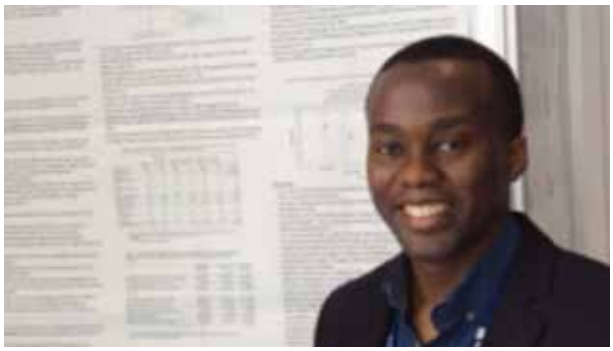
Two delegates from the South African contingent, Dr Ulla Botha (Stellenbosch University, Tygerberg) and Dr Bonga Chiliza (Stellenbosch University, Tygerberg) presented posters at the congress.



Dr Ulla Botha (Stellenbosch University, Tygerberg)

Dr Botha's poster topic was entitled 'A randomized control trial assessing the influence of a telephone based intervention on readmissions for patients with severe mental illness in a developing country'. The conclusions from her work was that telephone based facilitation of existing standard care services in this setting did not have any impact on readmission rates or days in hospital. The findings from this study are helpful in the development of effective, affordable discharge interventions that can be sustained in the long run and are justifiable in an under resourced setting.

Such services would need to be comprehensive, and incorporate a unique approach to support the distinct population of dual diagnosis patients.



Dr Bonga Chiliza (Stellenbosch University, Tygerberg)

Dr Chiliza's work looked at 'Changes in body mass and metabolic profiles in patients with first episode schizophrenia treated for 12 months with a first generation antipsychotic'. His study showed that the cohort included in the study gained considerable weight over the first twelve months of treatment, and weight gain was already substantial at six weeks. There were also changes in the lipid profiles, namely an increase in triglycerides (TG) and a reduction in high density lipoprotein (HDL) levels.

This is of concern because the TG/HDL ratio is an atherogenic marker and predictor of all cause mortality and cardiovascular events.

Below are summaries of some of the lectures attended by the delegates, which they found to be of particular interest.

ADHD ACROSS THE LIFESPAN

(Speaker: David Coghill)
-Dr Indhrin Chetty (Psychiatrist, Sterkfontein)

In the UK, ADHD is still undertreated even in the youngest age group, which has the highest prevalence of the condition. 66% of patients with ADHD will continue to have functional impairments and symptoms as adults.

Lisa Selwood (Janssen), Dr Constant Mouton (The Netherlands), Dr Bonga Chiliza, Dr Indhrin Chetty, Dr Natali Raman and Dr Alma Kalaba (Front)

75% of causality can be linked to genes. The other 25% can be contributed to environmental and psychosocial factors. Mothers with ADHD have a higher risk for smoking, and for smoking during pregnancy. A link has been proven between smoking in pregnancy and future ADHD in children.

Methylphenidate reduces symptoms and improves cognition but these are not necessarily correlated. There may be more to the diagnosis than the DSM 5 and ICD 10 definitions suggest. The core symptoms described in the aforementioned diagnostic classification systems does not completely describe the whole picture of ADHD.

INTERESTING THEMES FROM THE CONGRESS

- Dr Jerrie Bezuidenhout (Psychiatrist, Vista Clinic)

Bipolar mood disorder:

The risk of suicide in patients with Bipolar Mood Disorder (BMD) is highest in the first year of contact with psychiatric services. 34% of patients with mania have more than three depressive symptoms and 72% of these patients had additional symptoms of irritability, agitation and anxiety.

Frontal lobe dementia:

Selective Serotonin Reuptake Inhibitors (SSRI) active the inhibition centre in the brain. This is the action that improves behaviour in patients with frontal lobe dementia, even in the absence of depression.

Generalised anxiety disorder (gad):

GAD reacts moderately to SSRIs. Non pharmacological approaches which improve the symptoms include prayer, bathing in lavender oil, relaxation and specific breathing techniques. Mindfulness can also reduce negative thinking.

Schizophrenia:

Patients with schizophrenia have abnormal presynaptic dopamine synthesis and this is not changed by drug treatment. When medication is stopped, it leads to a relapse due to this inherent abnormality. There is an 80% chance of relapse in the first five years of the illness. Long acting injectables / depots reduce the risk of relapse by 30% over oral medical.

Exercise can reduce negative symptoms and improve neuronal activity. In addition, patients enjoyed the social contact that came as part and parcel of the exercise.

TREATMENT RESISTANT DEPRESSION – NEW AUGMENTATION STRATEGIES

- Dr Natali Raman (Psychiatrist, Vista Clinic)

The lecture provided an introduction to two new partial dopamine agonists, namely cariprazine and brexipiprazole. Aripiprazole has been used in the past in treatment resistant depression, however many patients experienced akathisia as a side effect resulting in low tolerability and acceptability for this medication. The two new products have preferential affinity for the dopamine D3 receptor, which promises to have lower rates of akathisia.

South Africans spotted at the congress! - Lisa Selwood, Dr Marius Mathey, Isabel Laas, Dr Shaquir Salduker, Pauline Timothy

Cariprazine has three indications – schizophrenia, bipolar mood disorder and treatment resistant depression. It shows D2/D3 partial agonism, with higher affinity for the D3 receptor. It also possesses antagonistic activity at 5HT-2b receptors and is a partial agonist of 5HT-1a. Thus the receptor profile of the drug may translate into benefits for affective and cognitive symptoms.

Brexipiprazole has indications for schizophrenia, major depressive disorder, post traumatic stress disorder and agitation in Alzheimer's dementia has D2, 5HT-1a and D3 receptor partial agonist activity, as well as 5HT-2c, alpha 1a, alpha 2c and H1 receptor antagonism.

We await to see these two new additions to the pharmacology currently used in depression.

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MESSAGE FROM THE PRESIDENT

ECNP neuroscience applied

October 2015

At the end of August, Science published a major study on the reproducibility of psychology experiments (http://www.sciencemag.org/content/349/6251/aac4716.full). As the authors point out, replication is the defining feature of science. Speaking personally, it is what attracted me to it in the first place. So much else in the politics of everyday life is Neanderthal by comparison.

The struggles of hunter gathers to gain power over each other and feed their families implicates us all. The scientific method offers relief from politics, ideology, religion, and, more positively, the path to a kind of truth. So it comes as an undeniable shock to find out how much of what gets published as science is actually false.

The authors of this report conducted replications of 100 experimental and correlational studies published in three psychology journals. They took great efforts to optimize their experimental practice in the replication. The measured effects were half the size of the original effects and only 36% of the replications reached statistical significance. Combining the results of the two experiments gave 68% statistically significant. So is the glass 68% full or 32% empty? And does it matter?

This problem has not been as widely appreciated as it should have been considering that John Ioannidis published a paper a decade ago (PLOS Med. 2,

e124 (2005)) with the best title ever: 'Why most published research findings are false'. He has been cited over 3000 times, but maybe fewer people have actually read and understood his point.

Concern about valid statistical analysis and reproducibility has also influenced clinical trials practice for much longer than a decade. Currently failure to replicate seems to be a problem that most concerns laboratory biomedical science, psychology and experimental medicine.

The publishing culture of science receives much of the blame for the present state of affairs, and it will be interesting to see if some sort of regulation can reduce the recognized bias without making publication more slow and painful than it already is. Maybe publishing has to become less about individual papers in a print volume and more about how we synthesize and map progress for a whole field using information technology (that may have to be invented for the purpose). Genomics may be the motor for such a change: masses of shared data, making sense of complex phenotypes, applying discoveries to innovative treatment.

Guy Goodwin

The problems for industry are very similar. There is no point in patenting drugs on the basis of science that does not replicate. Furthermore, patent attacks on successful drugs (usually by pharmaceutical companies who want to market generic versions of drugs nearing the end of their patent life) can focus on any discrepancy between what the data promised and what the drug delivered.

In this respect, industry based scientists have probably been under more pressure to improve practice than their peers in academia. They can probably teach academic centres something important in how to reduce the more obvious risks.

ECNP provides the meeting between academia and industry where solutions or developments can take place in this area. We should make good practice central to the training we offer junior scientists and clinicians and there may be scope to develop a new network initiative that looks more deeply into possible solutions to the bigger challenge of data quality and data synthesis.

At the end of the day, science still works, but we now understand how inefficient and misleading some of our current practices have become, and that is also how science works.

Guy Goodwin
ECNP President

headline
NOVEMBER 2015
OFFICIAL NEWSLETTER OF THE SOCIETY OF PSYCHIATRISTS OF SOUTH AFRICA (SASOP)

SASOP: THE ALTERNATIVE SOLUTION

FROM THE EDITOR


Ian Westmore

The last time a SASOP Headline saw the light was around 2011. Unfortunately, we have not been able to find a willing editor since then, but the need for a newsletter has remained obvious. Our experience is that there is so much going on "behind the scenes" that keeps South African Psychiatry the vibrant and challenging discipline that it is, but members at grass roots level are often unaware of what is being done on their behalf by a team of dedicated individuals and groups. I hope that this first edition of ***Headline*** in almost four years will start to "fill the gaps".

We have spoken often of the need to develop both our external and internal communication at SASOP, as befits an active professional group. The ***Headline*** is one way of improving the communication between ourselves, and so when the opportunity arose for ***Headline*** to be incorporated into *South African Psychiatry*, we were delighted and grabbed the opportunity. Our thanks to Professor Christopher Szabo for making this possible.

As space is limited, I hope to be able to cover the activities of subgroups, special interest groups, task teams and divisions on a rotational basis and as news becomes available. It would be ideal if this could be used to inform members at especially subgroup level. The SASOP website could then, for instance, be used as a platform for debate that emanates from the news contained in ***Headline***.

I look forward to working alongside my colleagues as we develop this newsletter. Happy reading!

Ian Westmore

FROM THE PRESIDENT,

(report to National Council Meeting, 24 September 2015).

When I present this report to the National Council it will be the first meeting since I took office where all National Council members have an opportunity to attend the Board of Directors meeting. We are also halfway through my term of Presidency. The key goals of my presidency that I report on below are Unity within SASOP, African Psychiatry and the 2016 WPA International Congress. Over the past two years, the SASOP National Council has undergone some restructuring and streamlining that we hope will make SASOP even more effective. The Board of SASOP was saddened by the resignation of Dr Robin Allen as a Pubsec representative in April 2015. Dr Lesley Robertson has taken over the role of being a Pubsec Representative. Dr Bonga Chiliza has taken a leave of absence from being the Honorary Treasurer since August 2015. Dr Kali Tricoridis accepted my request to be an Acting Honorary Treasurer until November 2016. Dr Grobler is currently overseeing the activities of Pubsec in our effort to strengthen this Vocational Group.

UNITY WITHIN SASOP

SASOP hosted a successful Dr Reddys/Pubsec annual meeting in May 2015 as well as the PsychMg weekend in June 2015. Progress is being made in getting the Pubsec and Private Psychiatry Vocational Groups working even more closely and tackling projects together. The Pubsec Vocational Group Committee attended the PsychMg weekend, and they in turn held their committee meeting during the PsychMg weekend. I am looking forward to having the PsychMg Board and the Pubsec Committee attending each other's meetings. The preparations for the 2016 Pubsec and PsychMg weekends are in progress. The Pubsec meeting will be held on the

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

weekend of the 15 to 17 of April 2016 and the date that is being considered for the PsychMg weekend is the weekend of 29 to 31 July 2016. Projects that are in progress that require the cooperation between Pubsec and PsychMg include the NEML, NHI, Admission of Children, PMB's, Deinstitutionalisation/ Reinstitutionalisation, to mention a few. Great progress is being made on the NEML under the leadership and championship of Dr Robertson.

AFRICAN PSYCHIATRY

The SASOP-Africa Task Team was established on the 19th of June 2015.The focus is to assist AAPAP in having its governance structures strengthened. The next AAPAP meeting will be held on 14-17 October 2015 in Accra, Ghana. SASOP will present a Symposium on Xenophobia, Migration and Service Delivery strikes. I have been in contact with some Psychiatrists in the Southern African region.

There is great interest in SASOP hosting a meeting whose agenda will focus on how we in Southern Africa can collaborate on training, research, clinical practice and membership of our Societies. I am in the process of sourcing funding for this meeting. I am hopeful that we will be able to host such a meeting in the first half of 2016.The establishment of the African Journal has been delayed because of the lack of progress in the reforms of AAPAP and the challenges that SASOP is experiencing with the SAJP.

2016 WPA INTERNATIONAL CONGRESS

The plans for this congress are in order. The Congress Company was established. The members of the Congress Company are Dr Talatala, Dr Grobler and Prof Janse van Rensburg.

The members of the Congress Organising Committee are Dr Talatala, Dr Grobler, Prof Janse van Rensburg, Prof Rataemane and Dr Westmore.The Scientific Committee has been established under the chairmanship of Prof Rataemane.

OTHER SASOP MATTERS

COMMUNICATION

Several meetings have been held regarding the development of the SASOP Communication Strategy. Dr Motlana has been appointed as the Convenor of the Communications Division. The Advocacy and Antistigma Division has been absorbed into the Communications Division.

MENTORSHIP, YOUNG PSYCHIATRISTS AND REGISTRARS

The Mentorship Division is progressing very well under the leadership of Dr Westmore and Dr Melapi. The highlights for this year include the meeting that was held in Gauteng for young psychiatrists at the end of August on financial management as well as the upcoming Registrar Finishing School in November 2015.

SUBGROUPS

We are at an advanced stage of moving the management of Subgroup accounts to HealthMan. I will visit Limpopo in October during the Lundbeck/ PsychMg Roadshow. Dr Zingela has requested that I visit the Eastern Cape in the first half of 2016. The Subgroups that I have not visited are the Gauteng Subgroups.

LIAISON WITH NDOH

I am in regular liaison with Mr Sifiso Phakathi of the National Mental Health Directorate.

INTERNATIONAL LIAISON

APA – I attended the APA Annual Meeting that was held in Toronto in May 2015. At this meeting, Prof Rataemane, Prof Janse van Rensburg and I attended the meeting that was hosted by the Royal College of Psychiatrists pertaining to Training of Psychiatrists.

In attendance were the APA, the Canadian College of Psychiatrists, and the Royal Australia New Zealand College of Psychiatrists. This was a successful meeting. The proceeds of this meeting are being compiled and we will have an opportunity to map further steps.

A meeting with the CEO of the APA, Dr Saul Levin, and his team was held. From SASOP, Prof Janse van Rensburg and I attended. The APA is very interested in supporting the 2016 WPA International Congress. They are keen on even bringing speakers.

Sharing of membership was further discussed with APA. Dr Levin is interested but he needed further consultation from his side in order to decide on the subsidy SASOP members could get from APA.

Prof Rataemane was confirmed as the APA International Fellow.

Dr Mvuyiso Talatala
President

FROM THE PRESIDENT - ELECT

Prof Bernard Janse van Rensburg reported on a wide scope of activities which fall under his portfolio, to the National Council meeting on 24 September 2015. These include:

THE SASOP SOCIAL CONTRACT - EDUCATIONAL PROGRAM

"The South African Society of Psychiatrists' scope of practice and social contract with society" as a build up to the 2016 WPA Congress in Cape Town. This includes:

- MDT and scope of practice meeting held on Saturday 30th October 2015. This meeting has confirmed attendants from PsySSA, CPF, OTASA, (DENOSA), Psychiatric Nursing Association, SA Academy of Family Physicians; SAMA, SASP, and PHASA.
- A media meeting during October.
- A seminar was held during the Biological Congress on 25th September 2015 entitled "Stake holder groups in Psychiatry's and psychiatrists' social contract" .

PUBLICATIONS DIVISION

WEBSITE

The webmaster, Dr Grobler is in the process of negotiations for sponsorship for a package of services from E2Solutions (including member management system, CPD management system, website, and APP)

HEADLINE

A proposed agreement with *South African Psychiatry* and Prof. Christopher Szabo to publish designated content as the SASOP Headline newsletter has been discussed and finalized. Dr. Ian Westmore has accepted a proposal to act as Editor.

SIG Division

There was follow-up correspondence with SIG Conveners regarding meetings which were held during the Biological Congress. Specifically, guidelines for SASOP SIG activities have been drawn up.

WPA INTERNATIONAL CONGRESS 2016 CONGRESS TASK TEAM

A document entitled "WPA 2016 INTERNATIONAL CONGRESS IN CAPE TOWN – CONCEPTS, REQUIREMENTS, FACTORS, PRINCIPLES AND ACTIVITIES" has been drawn up that outlines the approach, policy and principles incorporated in the planning and hosting of the congress.

Current stage of activities:

- Confirmed speakers have been presented to the Advisory Committee.
- The Scientific Committee is finalizing the Abstract Management System.
- November 2015 will see the opening of registration and call for abstracts.
- The Local Organizing Committee held meetings on 28th July and 10th September 2015.
- There are plans to attend meetings to attract delegates including Accra, Ghana (15-17 Oct 2015); the Brazilian National Society (4-7 Nov 2015); WPA International Meeting in Taipei (18-22 Nov 2015); and the meeting of the German National Society (22-25 Nov 2015).

EXTRACTS FROM THE NATIONAL COUNCIL MEETING 24 SEPTEMBER 2015.

A meeting was held at the Lord Charles Hotel prior to the commencement of the Biological Psychiatry Congress. This is the one time in the year when the SASOP Board of Directors (BOD) meets with all subgroup chairpersons, task team and division convenors. It is an opportunity for the "greater SASOP" leadership to meet and give feedback on its activities around the country. (During the rest of the year, the BOD invites these leaders to attend meetings in Johannesburg on a rotational basis to keep abreast of developments). Matters highlighted include:

- Concern over Child and Adolescent Services: there is concern about the ongoing lack of appropriate and adequate provision of services to this vulnerable group. Considering that young people make up a sizeable portion of the population in South Africa, it is extremely worrying that authorities are not prioritizing mental health issues for children and adolescents. It was agreed that a statement from SASOP would be forthcoming to highlight this issue.
- Subgroup elections to coincide with AGM every year: it was agreed that the subgroups would streamline their elections to ensure that local office bearers would officially take office at the time of the SASOP Annual General Meeting (AGM).
- Getting younger colleagues to attend Psychiatry Congresses: an initiative has been started by the organizing committee of the Biological Congress to stimulate interest in the discipline of Psychiatry. Final year medical students who have shown an interest in Psychiatry were invited to the Congress, and it is hoped that this will continue for future congresses, including the National Congress where students from the local universit(ies) will be invited.
- The Clincal Trials Special Interest Group has been dissolved due to inactivity.
- Adult ADHD Special Interest Group launched: with there now being some data available on the condition in South Africa, it was agreed that such a group could now be constituted. One of the aims of this group will be to work on putting together guidelines for the treatment of this condition that will be locally relevant.
- SASOP Publishing Strategy re-looked: over the years it has become more and more evident that communication needs to be more effective within SASOP. Prof Bernard Janse van Rensburg (the SASOP President-Elect) also heads up the Publications Division at SASOP, which includes the

South African Journal of Psychiatry (SAJP) as well as the (resurrected) Headline newsletter and the SASOP website.
- The Headline will now be published as part of South African Psychiatry four times a year.
- The SAJP will now be published by a different publishing house, after termination of the contract with the previous publishing house.
- Membership of the American Psychiatric Association (APA) for SASOP Members at a discounted rate was discussed. This still needs to be finalized.
- Telepsychiatry for South Africa: Dr Rene Nassen has been looking into the use of telepsychiatry as an option for use in psychiatry in South Africa. It is being used with success in other parts of the world where it has proven particularly useful in reaching patients in rural areas. There is much to be explored still, including how to code and claim for services for telepsychiatry in the private sector. She will be assisted further by Prof Rita Thom.
- Disablity Guidelines to be reviewed: Dr Gerhard Grobler, SASOP Past President, is heading up a team that is reviewing these guidelines.

NEWSFLASH!

Members should please take note of the following regarding Requests for extended sick-leave from the Dept of Basic Education:

It has been brought to our attention that the Department of Basic Education often demands that Psychiatrists put teachers on prolonged sick leave in order for the schools to obtain a replacement teacher. Sick leave is at the discretion of the Psychiatrist. The time-off allocated should be in keeping with clinical findings and the Health Professional Council of South Africa (HPCSA) rules.

If the Department of Basic Education wishes to engage with SASOP regarding the matter they can request a meeting with the SASOP President.

Dr M Talatala
(President)

SPECIAL INTEREST GROUPS (SIGs)

NEW APPROACH TO SPECIAL INTEREST GROUP (SIG) ACTIVITIES

In any growing and dynamic organization, the way that things are done sometimes needs to be reviewed in order to streamline its activities and ensure that they remain relevant. Prof Bernard Janse van Rensburg is the convenor of the SASOP Special Interest Groups Division.

The current SASOP Rules on the activities of SASOP SIGs incorporate a new approach to cluster SIGs in terms of subspecialties and Biological/Psych-Social clusters and subcommittees. Here is a look at how the SIG's are grouped in terms of clusters and subspecialties:

BIOLOGICAL CLUSTER AND SUBCOMMITTEES

- Biological SIG
- Clinical Trials SIG (now discontinued)
- HIV and Neuropsychiatry SIG
- Cellular & Molecular SIG
- Pain SIG, Substance Use and Addiction SIG
- Adult ADHD SIG

- Child and Adolescent Psychiatry SIG
- Old Age Psychiatry SIG
- Forensic Psychiatry SIG
- Psycho-Social-Spiritual/Cultural Cluster and Subcommittees
  - Philosophy of Psychiatry SIG
  - Psychotherapy SIG
  - Social Psychiatry SIG
  - Spirituality and Psychiatry SIG

BIOLOGICAL PSYCHIATRY SIG

It was reported by Prof Seedat that the main focus of the SIG has been the Congress which was held at the Lord Charles Hotel in Somerset West from 24 - 27 September 2015. The Congress attracted 499 delegates (as at 21 September 2015); an International Invited Faculty of 10 members and a local invited faculty of 5 members. There was significant involvement from the pharmaceutical industry and once again this congress proved a highlight on the SASOP calendar. The theme for this year's meeting was "Trends and Treatments: The Changing Landscape".

HIV AND NEUROPSYCHIATRY SIG

Dr Rene Nassen in the current convenor. The focus points for the SIG for 2015 have been:

- Incorporation into the Biological Psychiatry SIG, and
- Roll-out of educational initiatives to improve mental health screening/detection of CMD's among HIV infected adults, children and adolescents. This has included exploration of options involving Medecins Sans frontiers (Doctors Without Borders), collaboration with Rita Thom (ANOVA training material) and the SA HIV Clinicians Society. The group has also been looking at the use of technology based modalities/ telepsychiatry/podcasts online training modules.

CELLULAR AND MOLECULAR PSYCHIATRY SIG

The convenor of the group is Dr Kobus Roux.This relatively new SIG has as its goal "to empower

ourselves and other clinicians with the knowledge, to keep up with the explosion of information in the field of molecular and cellular medicine."
They aim to do this though two projects, namely workshops and a bi-annual publication with Review Articles; and clinical applications.

Regarding the bi-annual publication, it has been decided to make it a "non-peer reviewed journal", (something like Serenity Magazine); also to work together with other medical specialities on this project, because in the field of cellular and molecular medicine there seems to be a large overlap.

REGARDING THE WORKSHOPS:

The group hosted a workshop on Pharmacogenetics at the Biological Congress on Thursday 24 September 2015. Another workshop is planned for the 2016 Cipla Neurosciences Meeting, and possibly for the WPA 2016 Congress.

FORENSIC PSYCHIATRY SIG

Prof Mo Nagdee is the current convenor. Activities of the SIG have included the following:

- Forensic psychiatry as subspecialty: Regulations & Portfolio of Learning have been finalized and posted on the College of Psychiatrists website.
- Sub-specialist registrations at the HPCSA:
  - Increasing numbers are now registered as forensic subspecialists (Weskoppies - 3, Sterkfontein - 1, Fort England - 3, Valkenberg - 2 & Fort Napier - 1)
  - Curriculum development & site-accreditation for sub-speciality training is in progress.
  - Some sites have commenced a subspecialty training programme.
- Remuneration of private psychiatrists on observation panels: feedback is awaited on tariff reviews from the Dept of Justice.
- Observanda & State Patient waiting lists: most centres report trends of reduction of waiting times for Observanda but increasing for State Patients awaiting forensic hospital admission is reported in many centres.
- Media & forensic psychiatry: Concern has been expressed regarding media portrayal of high profile forensic cases.
- Forensic research: Promising outlook exists at various centres (especially M.Med projects); a National study on forensic mental health of female offenders is ongoing.
- National forensic mental health professional database has been established and is well utilized for forensic communications.
- Remuneration of private psychiatrists on observation panels: Dept. of Justice & Constitutional Development has responded on the matter: a new tariff structure has been approved; awaiting legislative framework and ministerial approval.

PHILOSOPHY OF PSYCHIATRY SIG

Prof Werdie van Staden is the convenor. News from this group includes:

- The Division for Philosophy & Ethics of Mental Health at the University of Pretoria has recently expanded and become the Centre for Ethics and Philosophy of Health Sciences, for which he is the director. This Centre continues to host the MPhil-programme in Philosophy and Ethics of Mental Health, PhD-students in the field, and a number of post-doc fellows.
- A one day colloquium was presented during November 2014 at the University of Pretoria on Culture and Mental Health.
- Preliminary discussions with colleagues in South Africa and abroad suggest that 2 – 3 symposia may be put together for the WPA conference in Cape Town 2016.
- The Oxford Handbook of Psychiatric Ethics (94 substantive chapters, about 2000 pages) has been published in July 2015, edited by John Sadler (Texas), Werdie van Staden, and Bill Fulford (Oxford). It is a landmark publication and the most comprehensive in ethics for any medical speciality.

MEMBERSHIP FEES 2016:

IT WAS AGREED IN 2012 TO INCREASE THE MEMBERSHIP FEES INCREMENTALLY, UP TO AN AMOUNT OF R3000 PER ANNUM. AT THE RECENT AGM, THE FEES APPROVED FOR 2016 ARE AS FOLLOWS:

Full members: R3 100 per annum
Associate members: R 1550 per annum
Registrars: R 780 per annum
Pensioners: R 780 per annum
Remember that PsychMG members have their SASOP fees included in their annual membership fee.

SUBGROUPS NEWS

Eastern Cape:

The current chairperson is Dr Z. Zingela. The subgroup has one main meeting per year, as they experience several challenges due to having to travel long distances to attend meetings. This year's meeting was held in May and featured a talk on epigenetics. The subgroup has been involved in providing sponsorship to some of its members to attend congresses.

Dr Zingela is the new WSU Academic Head for Psychiatry, after the province lost Prof Alonso Betancourt and Dr Mariceles. Challenges within the public sector services remain and the subgroup is actively engaging with the local DoH to address these issues.

Northern Gauteng:

Dr C Kotze was elected the new chairperson in June this year. In May, the subgroup offered a presentation

by Prof CW van Staden on "Ethics in all healthcare decisions". The annual symposium was held on 27 June 2015 at the CSIR in Pretoria. The topic was "Female Mental Health" with four presentations. The event was fairly well attended and the feedback received was positive. A similar symposium is planned for 2016, to be held at Weskoppies hospital.

However, Dr Kotze reported to the National Council meeting that, in the subgroup, events are generally poorly attended and it is difficult to engage members to become involved with the subgroup.

Southern Gauteng:

The current committee was elected in October 2014, and the chairperson is Prof Rita Thom. This subgroup has also tried to "mirror" the structures within SASOP nationally. A registrar function for new registrars in the Department of Psychiatry at Wits was held in January 2015. Twelve new members signed up at the function. The subgroup combined with the Northern Gauteng subgroup to hold a very successful CPD event on Public Mental Health in April 2015. This was well attended by members of both sub-groups, as well as by members of the Gauteng Department of Health Mental Health Directorate, as well as representatives of the National Department of Health Pharmaceutical Services.

The core committee meets regularly with the Gauteng DoH Mental Health Directorate. The aim of these meetings is to engage with the Department, and to provide support to the Directorate. The subgroup sponsored the prize for the best registrar presentation at the Wits University Department of Psychiatry Annual Research Day, which was held in June.

The Young Psychiatrists held an event on 29th August, which focused on personal finance for young psychiatrists.

TOO MANY ECT'S?

It was reported by the Eastern Cape subgroup that the Mental Health Review Board in Port Elizabeth has lodged a non-specific complaint with the HPCSA reporting that "too many" ECT's are being performed by the private sector in Port Elizabeth. These were not based on patient complaints and it is unclear what parameters are being used to determine the "finding" of too many ECT's. Most of the psychiatrists in private practice were asked to comment by the HPCSA on these allegations (no distinction was made where the numbers vary in quantities from 18 ECT's to 200 per psychiatrist). MPS has been involved and will follow up with the HPCSA in this regard.

SASOP MENTORSHIP, YOUNG PSYCHIATRISTS AND REGISTRARS DIVISION

This division comprises of Dr I Westmore (Convenor), Dr Tando Melapi (Chair: Young Psychiatrists), Dr M Talatala (SASOP President), and Dr Bonga Chiliza (SASOP Treasurer).

- Attempts have been made to draw up a national database of registrars – to be updated six monthly (after every College exam). This has been a challenging process as the way that this information is treated by different university departments varies. Subgroups have been encouraged to appoint a registrar rep on their subgroup committee.
- Dr Westmore attended the meeting of the Royal College in Birmingham in July and made valuable contacts with those involved in mentoring and revalidation, as well as those involved in early career development.
- A committee has been established to specifically plan and organize an Early Career Symposium at the WPA 2016 congress. Young Psychiatrists will be actively involved in the process of planning this exciting symposium.
- The Southern Gauteng subgroup organized a morning symposium for Young Psychiatrists with the focus on Financial literacy on 29.08.2015 in Midrand. Dr Melapi needs to be thanked, and congratulated for his work in putting this together as it was both a very useful, but also enjoyable morning. Other subgroups should be encouraged to organize similar workshops!

It is hoped that by investing in our early career colleagues and registrars, there will be a more enhanced and longer term involvement in SASOP.

ROYAL COLLEGE OF PSYCHIATRISTS MTI (MEDICAL TRAINING INITIATIVE) SCHEME

This provides an opportunity for the training as psychiatrists (post qualification, an opportunity to gain more experience, or experience in an area of interest) in the UK for a 2 year period and an associated special visa, stipulating that the recipient return to their country of origin afterwards to avoid a "brain drain".

(More details can be found on http://www.rcpsych.ac.uk/workinpsychiatry/internationalaffairsunit/medicaltraininginitiative.aspx.)

PSYCHMG AND PRIVATE SECTOR GROUP

Dr Sebolelo Seape is the convenor of this vocational group. Administration and Finances are managed by HealthMan who assists in negotiations with funders, regulatory authorities and the pharmaceutical industry as well as providing practice support for problem accounts and queries. They are the leaders in alternative reimbursement and have successfully pursued a number of legal challenges and High Court actions on behalf of doctors.

- PsychMg members enjoy the benefit that their membership fees for SASOP, SASOP, SAPPF, WFSBP are paid by PsychMG
- Membership currently stands at 218 members.

CHALLENGES FACING PRIVATE PRACTICE:

- PMBs under threat: Currently the provisions of Regulation 8 of the Medical Schemes Act provide for the responsibility of schemes to fully fund the costs of treatment at the usual rate charged by the provider are under threat, both from the Department of Health and a court action initiated by Genesis Medical Scheme.
- If these actions are successful, schemes will remunerate doctors for treating PMB conditions only at scheme rate or at the 2006 NHRPL rate (adjusted for inflation). Co-payments by patients will not be permissible.
- HPCSA Investigated: The Minister of Health, Dr Aaron Motsoaledi, has appointed a Ministerial Task Team to investigate allegations of administrative irregularities, mismanagement and poor governance at the Health Professions Council of South Africa ("HPCSA"). Many complaints were received about governance, efficiency, effectiveness and sometimes even the competency of the management of the HPCSA. The public was invited to make submissions to the enquiry, and numerous organisations and individuals did so, including SAMA and SAPPF. Feedback is expected in the near future.
- It is clear that both the Certificate of Need and the proposed NHI will soon re-emerge.
- The impact of the Private Healthcare Market Inquiry initiated by the Competitions Commission remains uncertain.

PSYCHMG CODING GUIDE AND CURRENT CODING STRUCTURE IN SA

- The codes, descriptors and units of all codes in the PsychMg Coding Guide, has been fully aligned with CPT4, the baseline for codes in SA.
- The SAPPF and SAMA coding committees accepted these codes, descriptors and units during the 2014 coding engagements and all codes are included in the current Medical Doctors Coding Manual.

MEDICAL SCHEME ENGAGEMENT

- PsychMg and HealthMan continue to represent members with forensic investigations at medical schemes.
- Doctors are utilizing the standard DSM5 enrolment forms for hospital admissions and progress reports.
- PsychMg continues to engage with schemes (GEMS, Discovery, Medihelp, Polmed, Momentum, etc) on relevant matters.
- PsychMg is planning a workshop with GEMS to discuss the role of Physiotherapy in hospital.
- The PsychMG leadership will meet again with Discovery in the near future to continue work on a Psychiatry Governance Project, Alternative Reimbursement Models and Psychiatric Profiling.

PMBS AND THE COUNCIL OF MEDICAL SCHEMES (CMS)

A SAPPF delegation recently met with senior representatives from the CMS to try and resolve a number of issues around Prescribed Minimum Benefits (PMB's). Senior representatives from their Policy and Business Unit; Accreditation Unit; Legal; Clinical Unit and Stakeholder Relations Unit attended the meeting. It was a positive meeting with both sides reporting similar frustrations and problems with Medical Schemes who cunningly try and avoid compliance with the provisions of Regulation 8 relating to PMB's.

The following issues were discussed:

1. Non - payment of the invoiced PMB service at cost.
2. Appointment of Inappropriate DSP's by medical schemes.
3. The use of inappropriate chronic Medicine Formularies by schemes.
4. The use of outdated/inappropriate protocols by schemes.
5. Benchmarking of the outdated 2006 NHRPL by schemes.
6. The need for PMB condition sufferers to re-register annually.

The CMS reported that in many instances their "hands are tied behind their backs" and even when complaints are reported to them, they have little "teeth" to hand out meaningful punishment to schemes that regularly fall foul of the law.

SASOP GUIDELINES

The "SASOP guidelines for Major Depression as operationalised by PsychMg" are nearing completion. Dr Eugene Allers and Dr David Webb will finalise this by the end of 2016. The process will then continue for other conditions.

PSYCHOTHERAPY

PsychMg is in the process of planning psychotherapy workshops in the different regions in the near future. PsychMg will continue to respond on matters relating to Scope of Practice and the role of other disciplines in providing psychotherapy.

SUSTAINABILITY OF PRIVATE PRACTICE

The vision of the Board of Directors of PsychMg is to ensure the sustainability of private practice. In this regard the membership of SAPPF is important. SAPPF represents more than 3000 private practitioners of approximately 20 disciplines in SA. They have been acting on regulatory issues on behalf of PsychMG members.

INSTRUCTIONS TO AUTHORS

South African Psychiatry **publishes original contributions that relate to South African Psychiatry. The aim of the publication is to inform the discipline about the discipline and in so doing, connect and promote cohesion.**

The following types of content are published, noting that the list is not prescriptive or limited and potential contributors are welcome to submit content that they think might be relevant but does not broadly conform to the categories noted:

LETTERS TO THE EDITOR

* Novel experiences
* Response to published content
* Issues

FEATURES

* Related to a specific area of interest
* Related to service development
* Related to a specific project
* A detailed opinion piece

REPORTS

* Related to events e.g. conferences, symposia, workshops

NEWS

* Departments of Psychiatry e.g. graduations, promotions, appointments, events, publications

ANNOUNCEMENTS

* Congresses, symposia, workshops
* Publications, especially books

The format of contributions does not conform to typical scientific papers. Contributors are encouraged to write in a style that is best suited to the content. There is no required word count and authors are not restricted, but content will be subject to editing for publication. Whilst references may be noted in text, they will not be published with content but noted as available from the author/designated author where there are multiple authors. All content should be accompanied by a relevant photo (preferably high resolution – to ensure quality reproduction) of the author/authors as well as the event or with the necessary graphic content. A brief biography of the author/authors should accompany content, including discipline, current position, notable/relevant interests and an email address. Contributions are encouraged and welcome from the broader mental health professional community i.e. all related professionals, including industry. All submitted content will be subject to review by the editor-in-chief, and where necessary the advisory board.

All content should be forwarded to the editor-in-chief,
Christopher P. Szabo - Christopher.szabo@wits.ac.za

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

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