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**CONSPIRACY
THEORIES:**
A RE-EMERGING PHENOMENON
IN THE COVID-19 ERA

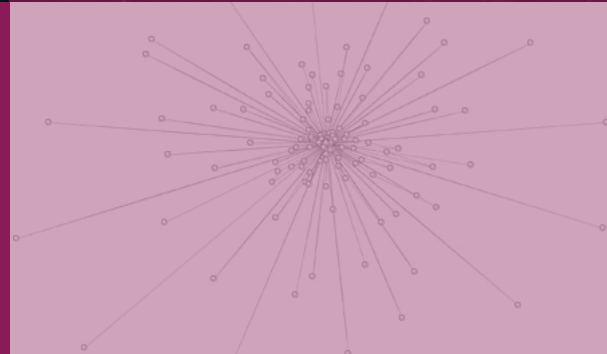
AN EXPLANATION FOR SOME OF THE
**EXTREME
VULNERABILITY
DURING COVID-19**
AND PRACTICAL WAYS TO MANAGE IT

**KETAMINE
COVID & SUICIDALITY**

**A CALL TO
ACTION**

LISTENING TO
COVID-19

**THE LIGHT SHINES
THROUGH THE CRACKS:**
MANAGING OPIOID WITHDRAWAL AMONGST
THE HOMELESS DURING COVID-19 LOCKDOWN



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Editor-in-Chief: Christopher P Szabo - *Department of Psychiatry, University of Witwatersrand*

Advisory Board: Soraya Seedat - *Head, Department of Psychiatry, University of Stellenbosch*

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Headline Editor: Bernard Janse van Rensburg

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Web: www.southafricanpsychiatry.co.za

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

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COVER IMAGE: 'multiple exposure', etching by Deborah Glencross, 2013. Used with permission, courtesy of the artist.

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Dear Reader,

welcome to the 3rd issue of the year and our second since the COVID-19 lockdown began¹...all those months ago. At that time we entered into what was to have been a 3 week phase – to flatten the curve, and currently we are living through the surge as we find ourselves, as a country, to be a world leader in this regard... I'll comfort myself in knowing that for the next 4 years we are world champions – at rugby. An invitation in the May 2020 issue to contribute content related to personal clinical experience of the pandemic elicited a response from a colleague in Sweden, Christer Allgulander, and his *Perspective* in this issue makes for interesting reading. My own personal experience to gauge what is happening clinically locally, together with anecdotes from colleagues, suggests it has been tough. The current issue has a plethora of content related to COVID 19, and all contributors are thanked for sharing their experiences and thoughts. What is reassuring – noting the content - is that in spite of the current circumstances our community of mental health professionals, both in their individual capacities and within the context of the *South African Society of Psychiatrists (SASOP)*, is facing up to the challenges and continuing to not only deliver but to adapt and innovate...and *South African Psychiatry* is proud to provide a platform to not only promote their efforts but to hopefully motivate others under difficult circumstances. Everything ends...we need to be sure we are still standing when it does.



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kindly donated funds to the Solidarity Fund.

Finally, arising from the May 2020 issue (as announced in that issue) *South African Psychiatry* made a donation to the Solidarity Fund on behalf of itself and its loyal advertisers (Donor Reference Number is 400000495)... and ultimately South African psychiatry...we hope it will be spent wisely (*Corruption threatening patient care – SA Medical Association* <https://www.samedical.org/cmsuploader/viewArticle/1311>)

Further to the donation to the Solidarity Fund on behalf of South African Psychiatry and our advertisers, we have decided that we will continue to make a donation to a suitable charity or charities for all subsequent issues that appear only in an online format. Given that poverty and related starvation exist and have been exacerbated by the current COVID19 pandemic we felt that this would be our next focus. Accordingly, we have selected two well-established Non Governmental Organizations i.e. [Operation Hunger](#) and [Meals on Wheels](#) (content hyperlinked). We will donate based on proceeds arising from the forthcoming August 2020 issue. Industry support for *South African Psychiatry* is greatly valued and aside from contributing to the discipline – such involvement now extends into the broader community through these donations.



At the time of writing, we are in the process of engaging with industry regarding their thoughts and ideas related to the publication and as readers we always welcome any of your thoughts, ideas...and contributions. I hope you will enjoy this issue.

¹ An interesting infographic...albeit from April 2020...provides perspective...and raises questions...
<https://alfinnextlevel.files.wordpress.com/2020/04/deadliestpandemics-infographic-28-10april.jpg>

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PERSONAL REFLECTIONS

Anonymous

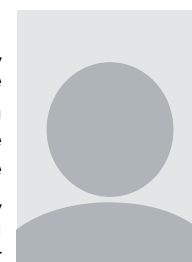
When I first came across the article 'Eating, or starving, in a time of COVID-19 – Consequence of the lockdown' written by Prof Christopher Szabo in the May 2020 edition of *South African Psychiatry*, my initial reaction was along the lines of 'This will be interesting - in a similar vein to the eating patterns experienced in an illness such as depression... An increased appetite, owing to so-called 'comfort eating', or a decreased appetite because of a loss of interest or pleasure in daily life activities because there are other more pressing concerns'.

After reading the article, I experienced a sense of discomfort, unease...and guilt. In a nutshell, the piece was less about signs, symptoms, why a difference in eating patterns might occur and what to do about it (which in retrospective had me wondering what I was expecting - it seems I had the vague concept of a *Cosmo* article in mind) but more an opinion piece highlighting yet again the vast inequities that exist in a South African context.

THERE WERE THOSE, WHOM IN THE DAYS BEFORE THE LOCKDOWN BEGAN, SPENT THOUSANDS OF RANDS PILING THEIR WOOLIES TROLLIES HIGH WITH HOUSEHOLD 'ESSENTIALS' VS THOSE FOR WHOM DYING FROM THE VIRUS OR DYING FROM HUNGER WERE TWO QUITE EQUAL, PLAUSIBLE SCENARIOS.

Let's add another layer of complexity. I have experienced some sort of disordered eating for most of my adult life (Eye roll, what female hasn't). My experience of eating, or starving, during lockdown has been different to either situation described above but, I expect, is by no means unique to me. With most forms of exercise 'taken away', I began to cut down what I was eating to compensate for those extra kilojoules which I wouldn't be burning (And because, apparently, if you hadn't baked banana bread, you hadn't lived through a lockdown). Soon, I cut down a bit more because my metabolism was bound to have, annoyingly, slowed down out of its own accord. There are no friends or colleagues around to

see, comment or call me out, and amidst all the uncertainty and fear, this is one thing I am certain of, one thing which I know, one thing I can hang on to that no one can take away from me. You can see where this is going right? Two months later, my BMI is teetering on the edge of a moderate to severe eating disorder episode and I am left to question, why, at my age, with my collective experiences, I am in this place again.



Anonymous

So, when I read this article, I feel a flush of hot, intense guilt. Guilt that I am not 'more appreciative' of what I have, and that many are, quite literally, dying from (non-imposed) starvation. I consult my psychiatrist (Cue more guilt because I have access to healthcare. Add an extra dose because for all intents and purposes, this is 'self-inflicted'). We agree on a tenuous plan of action; one in which the steps are so tiny, to most it wouldn't seem as though this is any progress whatsoever. How I am feeling now though, even a tiny move in the right direction would be a win. And I go to bed that night congratulating myself on the 17g of biltong I ate as a snack (Yes, I weighed it), whilst pushing to the back of my subconscious with almost as much force as I pushed the half eaten tin of tuna to the back of the fridge earlier, that maybe it's not normal to take two hours and twelve minutes (Yes, I timed it) to eat a salad.

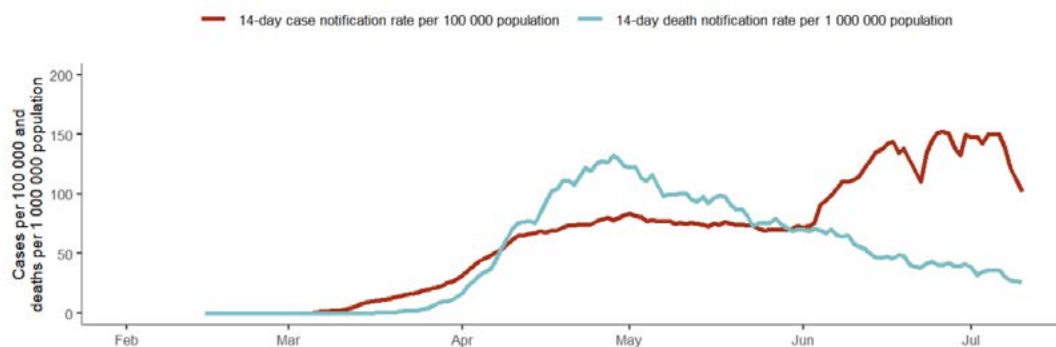
Maybe you went to bed last night, sufficiently satiated, with other things worrying you. Maybe you couldn't sleep last night because you didn't know where your next meal was going to come from. Or maybe, you went to bed with a stomach half filled with food, and half filled with a heavy, uneasy guilt. Whatever the situation, I am again reminded that everyone is living in an altered reality. And even if comprehension of what that reality means to others is beyond our scope or capabilities right now - just acknowledging that concept is a reminder that, as much as we are different, we are all the same. At the end of the day, we are all humans living in unprecedented times. Trying our best to survive? I can only speak for myself on this one.

SWEDEN AND THE PANDEMIC, SOME GOOD NEWS

Christer Allgulander

Sweden: 14-day COVID-19 case and death notification rates

National totals as of 10 Jul 2020: 74 333 cases (earliest 1 Feb, latest 10 Jul 2020), 5 500 deaths (12 Mar, 10 Jul 2020)



Source: Epidemic intelligence, national daily data

SNAPSHOT – SWEDEN:

Migration into Sweden started 11 000 years ago, the new kid on the block.

Pop. 10 million. About 20% are 65+ years old (South Africa 5%).

Cannabis users 3.6%, daily tobacco 8%, Alcohol Use Disorder 4%. In 2018, 69 children were diagnosed with foetal alcohol spectrum disorder.

Welfare benefits: Child allowance, parental allowance, summer vacation, daycare, tuition, old age care, national health care.

Pervasive egalitarian ethos.

Experts speculate about Sweden's approach to the pandemic. Journalists, in search of selling headlines, blow up assumptions that turn out to be misleading and false. We are still far from a position which would allow a proper evaluation of the national policy. There was no lock down, no face masks. Primary schools and daycare centres remained open. No ban on sales of alcohol beverages. The Public Health Agency, in frequent press conferences, advised the public to keep physical distancing, to stay at home if symptomatic, to wash hands frequently, to curb sneezing and coughing,

and to not visit elderly relatives. Most deaths, 89%, have been among the elderly 70+, median age 84, peaking in mid April. The disease incidence is highest among people born in Turkey, Ethiopia, Somalia, Chile and Iraq. The highest mortality rate is among those born in Finland. The policy worked. The curve of contagion has been flattened.



Christer Allgulander

WE ARE IMMERSSED WITH BAD NEWS ABOUT THE PANDEMIC. NOW FOR SOME OF THE DYNAMIC POSITIVE EFFECTS.

There are some positive effects of staying at home with your family: More time with your kids, with cooking, reading, and exercising in front of the TV. Commuting to work is substituted with logging in from home, reducing stress, fatigue and pollution. People are more reflective, slowing down, appreciating being healthy.

Neighbours are helping each other with grocery shopping and other errands. Home owners fix their houses and gardens. While many are used to vacationing abroad there is now a surge in the

interest for domestic vacation cottages, hiking in the mountains, bird watching, and picking berries in the forests. The countryside is experiencing a revival after years of migration to urban areas. Pleasure boats are in increasing demand.



Staying at home entices creative baking

Law enforcement has solved thousands of crimes because police officers do not need to guard sport events from hooligans. Yet gang shootings remain frequent since the street drug market is more competitive with the guarded EU country borders. Illegal web pharmacies compensate and deliver.



Bird-watching haven on the Swedish island of Öland in the Baltic where migratory swallows and terns from South Africa pass in May.

More students have applied to nursing and medical schools. Working as a physician and a nurse has gained higher status. For a while, people opened their windows at 8 in the evening to applaud the courageous medical staff. Medical staff has resumed charge of running services, a task that was increasingly lost to ignorant and unaccountable bureaucrats in the public health care sector.

Telemedicine is finally taking off. Instead of going to the emergency room people meet physicians, nurses, psychologists and psychiatrists online. It is cost-efficient and provides better continuity of care.

Many elderly stay at home to abide with the government recommendation. Since so many are

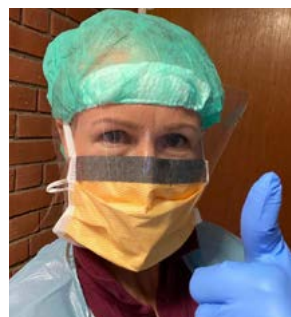
isolated, you would think they all suffer. Actually it reportedly renders a surprising shared feeling; *I am isolated and so are my neighbours. Better than being on a ventilator.* On the whole, the elderly, according to surveys report better mental health than before the pandemic. Why? Perhaps they feel safe at home when they receive all the bad news in the media about pandemonium. They increasingly use the internet for chess and other digital games, they exercise, make digital doctor appointments, face time with grandkids, all counterweights to the physical isolation. They learn to pay bills and order groceries online. In the nursing homes, when asked about their position on resuscitation and life-extending antibiotics and nutrients, some say no thanks. Their children though experience emotional difficulties from not being able to visit their loved ones.

OVERALL, CONSUMPTION OF ALCOHOL HAS NOT INCREASED DURING THE PANDEMIC. THIS IS ACCORDING TO THE GOVERNMENT MONOPOLY. THE DECREASES IN DUTY-FREE IMPORT AND RESTAURANT BEVERAGE SALES ARE OFF-SET BY INCREASED SALES IN THE GOVERNMENT STORES.

What has happened in the psychiatry department? I asked Åsa Törnkvist in Uppsala, an excellent administrator who lectured for Soraya Seedat at Tygerberg Hospital. She said not much. Measures were taken to reduce contagion. There was a transitory decrease in visits to the psychiatric acute intake unit. Services quickly went from physical to digital.

SINCE MANY INTERVENTIONS WERE PUT ON HOLD ACROSS THE HOSPITAL, A SURGE IN DEMAND IS EXPECTED ONCE THE GRIP OF THE PANDEMIC IS LESSENED.

Researchers at Karolinska Institutet initiated a brief online study of CBT to ameliorate dysfunctional worry related to the pandemic: <https://psyarxiv.com/rdka2>



Karin

My daughters Karin (R.N.) and Ingrid (M.D.) both work in advanced home-based palliative care. Karin is shown with her protective gear. Both did electives at the UCT as part of their undergraduate training. They have a very, very proud father.

Christer Allgulander is a psychiatrist affiliated to the Department of Neuroscience, Uppsala University, Uppsala, Sweden and an Honorary Professor, Department of Psychiatry and Mental Health, University of Cape Town, South Africa.

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ART . . .

IMAGE AND MEANING...

THEN AND NOW

Christopher P. Szabo

I was alone in my study...hanging on the wall was a picture... it had been there for years...I liked it, both aesthetically and because it seemed to represent to me a comment on atmospheric pollution...the current concerns with climate change...the title - **Welcome to Paradise**...a slightly sarcastic, tongue in cheek take, in my view, on emissions that required us to wear masks such as the one depicted...but on this day as I gazed once more at the picture I thought "how apt" - the mask...and it occurred to me that whatever the artist's motivation to create the work, noting it had been undertaken many years earlier (certainly 2014 or before)...it had in no way been a commentary on the current pandemic...that had us mired in a lockdown...globally...had confined us and radically transformed life as we know it...it was certainly no paradise.



Christopher P. Szabo

I decided to contact the artist, Deborah Glencross. I wanted her story, to establish the meaning - her meaning - for this work.

SHORTLY AFTER MY ENQUIRY SHE SENT ME A FEW MORE IMAGES...OTHERS THAT HAD TOGETHER WITH THE ONE HANGING ON MY STUDY WALL FORMED A COLLECTION OF WORKS...I WAS TAKEN ABACK...HOW HAD SHE YEARS AGO BEEN SO INSPIRED TO CREATE WORKS THAT APPEARED TO HAVE BEEN TAILOR MADE FOR NOW... THE PANDEMIC OF 2020, THE COVID-19 PANDEMIC?



Deborah Glencross, 2014. "Welcome to Paradise". [Limited edition etching with spite bite aquatint, drypoint and burnishing].

And so began a journey of understanding...one that I had not previously considered undertaking... but one that within the confines of the lock down restrictions would be the only one I would be taking for some time to come. The images that followed were of masked men...*gangsterish*...accompanied by her explanation...the narrative that formed the inspiration...but captured in one word for me...

initially - power...but then others came to mind... arrogance...deceit...and these descriptors started to build a composite of someone who could easily be...a politician...an industrialist...an abuser...these were dark images...and befitting of the time... and amidst these images...the masked children...which suggested something different...and yet must have been connected, thematically...were these the ones on the receiving end of what I had understood...who themselves needed to be protected...with a mask... or hidden, disguised...or...silenced...robbed of their voice...to oppose, protest...dissent...I wondered... the artist provided her narrative... I could see what her intention was...and how work from years ago, and based on a completely different premise was so apt now...as it had been then.

THE IDEA FOR THIS PIECE AND TITLE ART... IMAGE AND MEANING...THEN AND NOW CAME TO ME...TODAY'S VIRUS HAD INDEED TAKEN ME ON A JOURNEY BACK IN TIME...TO FIND THAT IT WAS RIGHT ON TIME...THE TIMELESSNESS OF ART.

THE WORDS OF THE ARTIST...



Deborah Glencross, 2014. 'Feverish'. [Limited edition etching with spite bite aquatint, drypoint and burnishing].



Deborah Glencross, 2014. 'Multiple Exposure'. [Limited edition etching with spite bite aquatint, drypoint and burnishing].

For the work, 'Multiple Exposure', I was inspired by an image of children shown in a documentary about the 1918 Spanish Influenza pandemic. It started me thinking about how we can protect children in this modern age against dangers that are hidden, not necessarily only infective, but others not obviously evident, like those present when they access the Internet.

IT WASN'T ABOUT THIS THOUGH PER SE - I WAS FASCINATED BY THE IMAGE OF CHILDREN WITH MASKS AND IT GOT ME THINKING OF MODERN CONTEMPORARY THREATS LURK ON THE INTERNET AND THREATEN OUR CHILDREN IN OUR OWN HOMES.



Deborah Glencross, 2018. 'political climate'. [Monoprint, 1/1].

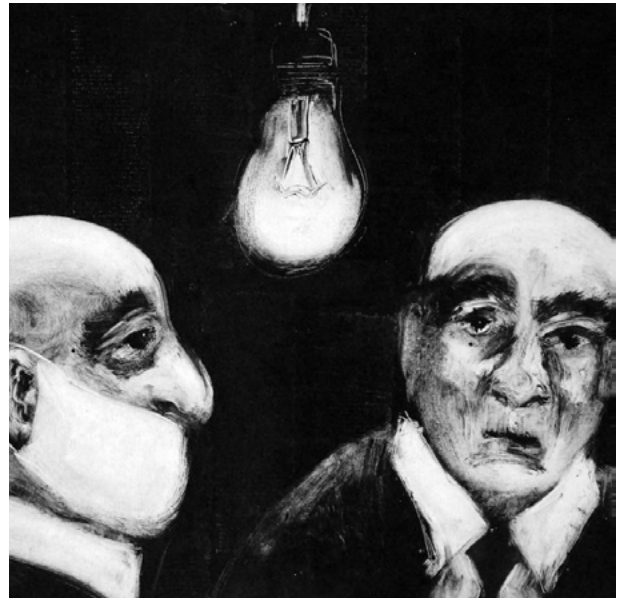
I was left with an overwhelming feeling of desperation and hopelessness - the image of children with masks haunted me. I could not help thinking about how we protect our children in a modern world. As parents, we think we know but we really have no idea. A new threat now lurks, more ominous and dangerous in our homes as children access the Internet.

UNKNOWN THREATS ARE EVER-PRESENT AND PERVASIVE, AND ALTHOUGH WE, AS ADULTS, THINK WE CAN TAKE CHARGE WITH VIRTUAL MASKS LIKE ANTIVIRAL SOFTWARE AND FIREWALLS, WE CAN NEVER FULLY PROTECT OUR CHILDREN IN THIS VIRULENT 'VIRAL' AGE.

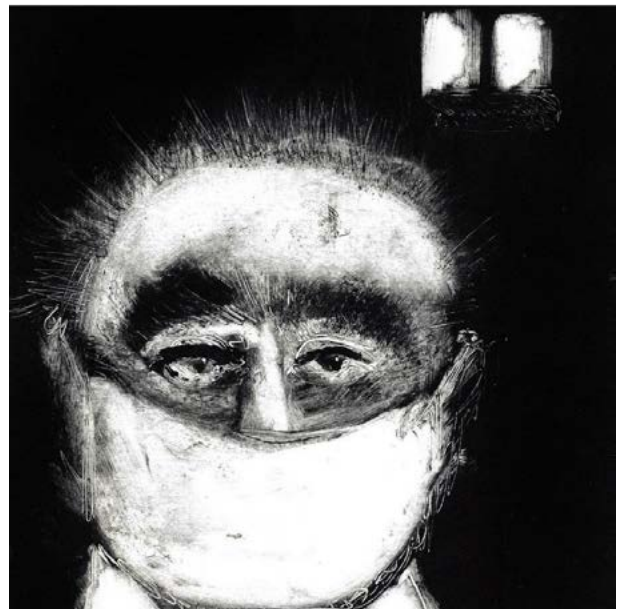
The masks of the suited men represents them protecting themselves, a virtual protection against the consequences of their actions, their lack of morality and abuse of their power.

In other words, the masks protect powerful men against being held accountable for their actions.

For further information regarding availability of any of these works, please contact the artist. Email: glencross@roussos.co.za ■



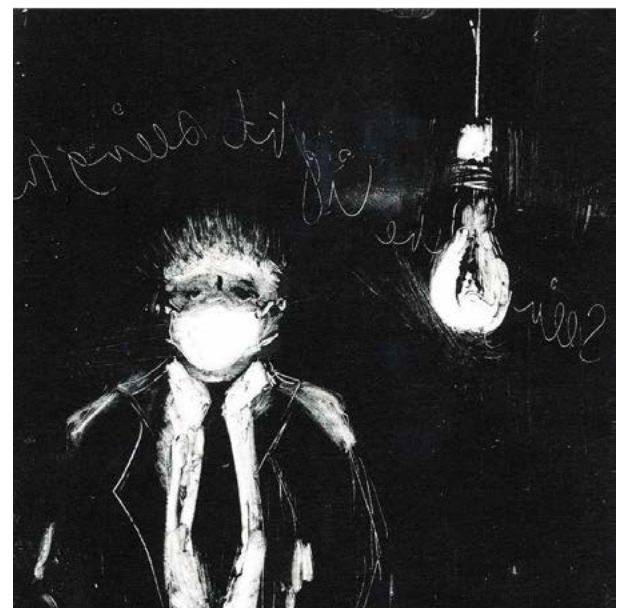
Deborah Glencross, 2012. "Moral expedience" (aka '..but I am Berlusconi!'). [Monoprint, 1/1].



Deborah Glencross, 2012. '...it just went viral...'. [Monoprint, 1/1].



Deborah Glencross, 2012. 'the virus'. [Monoprint, 1/1].



Deborah Glencross, 2012. 'political analyst'. [Monoprint, 1/1].

THE LIGHT SHINES THROUGH THE CRACKS: MANAGING OPIOID WITHDRAWAL AMONGST THE HOMELESS DURING COVID-19 LOCKDOWN

Shaquir Salduker, Monique Marks, Michael Wilson

This title is derived from the song *Anthem*, written by Canadian lyricist, Leonard Cohen. An astute philosopher and social commentator, Cohen reminds us that hope can be found in the darkest of places. He reminds us too that we should abandon our desire for perfection in an imperfect, or cracked, world. The Corona virus is one such massive crack. It brought with it many medical complications and mortality. But it also forced many social and psychological changes; some harmful but others much needed.

IT FORCED HUMANITY TO SLOW DOWN AND TAKE A LOOK AROUND, TO NOTICE THINGS IT WOULD ORDINARILY NOT HAVE NOTICED AND TO SEE PEOPLE IT WOULD ORDINARILY NOT SEE. ONE OF THE FORCED CONSEQUENCES OF THE PANDEMIC WAS LOCKDOWN, THE GREATEST PSYCHOLOGICAL EXPERIMENT KNOWN TO MAN (VAN HOOFF).

The lockdown forced the hand of many systems-families, communities, municipalities, provinces, countries – to come to a halt. One such system was the homeless community in every city in the world. This heterogenous fluid population made up of mental health care users, victims of economic destruction, helpless and often hopeless cast offs

of dysfunctional family systems and long-term users of substances of abuse. This population grouping is generally considered to be vulnerable. This vulnerability is in regard to a range of illnesses (particularly those that are transmitted) as well as to human rights abuses from other groupings such as the police and other social elites.

Recognising this vulnerability, the eThekweni Municipality in KwaZulu-Natal, together with a group of NGOs and a university, established a team to ensure the homeless were protected during lockdown. This was led by the Deputy Mayor, Belinda Scott. The lockdown presented them with the unique situation where they had to gather the people off the streets and place them in safe shelters so that they did not get infected by this deadly virus and did not become vectors of spread of the infection given that they are a mobile and unregulated body of people. Protecting the homeless population from being infected and from others being infected by them required a multifaceted approach. The response could not be simply about providing shelter and food during the lockdown period, but also medical assistance particularly with regard to dealing with acute and chronic illnesses.

One of the biggest challenges that faced the effort was that of the substance users, who made up over 60% of the population. The most problematic substance was opiates- injected heroin and brown

heroin, usually smoked. The street names in Durban for this brown heroin are *whoonga*, *sugars* and *nyaope*. Before the safe spaces for the homeless were constructed, it was recognized that a large percentage of the homeless in the City-run safe spaces would be cut off from their drug supply and would therefore enter into a period of forced withdrawal. If not managed properly, this would create reason for those with an opioid use disorder to attempt to leave the safe spaces in search of drugs, or alternatively to endure the incredible physical and psychological trauma of withdrawal. Either way, this had the potential to create an extremely difficult situation to manage, particularly for those responsible for law enforcement and for maintaining the integrity of the lockdown.

TO THIS END A TEAM WAS PUT TOGETHER TO TRY AND MANAGE THIS EMERGENT SITUATION. WE RECRUITED 3 REGISTERED NURSES, A TEAM OF SOCIAL WORKERS, A GROUP OF VOLUNTEER PSYCHIATRISTS FROM THE PRIVATE SECTOR, AND EXPERIENCED MEMBERS OF NON-GOVERNMENTAL ORGANIZATIONS (NGOs) AND UNIVERSITIES ACCUSTOMED TO DEALING WITH ISSUES OF THE HOMELESS AND PROBLEMATIC DRUG USE.

Private donor funding supported this programme. With the knowledge of the imminence of forced withdrawal, the plan was to institute a withdrawal management programme in the homeless safe spaces. Those experiencing mild withdrawal were provided with what were known as 'symptom packs', using over the counter medication to deal with body pain, nausea and other known symptoms. Included in these packs was paracetamol, anti-histamines, anti-diarrhoeals, anti-emetics and anti-inflammatories. Those assessed to be in moderate to severe withdrawal, using the Clinical Opiate Withdrawal Scale (COWS) which scores the level of withdrawal symptomatology, were provided the option to access short term opioid substitution therapy using methadone. There were two objectives to these medically assisted programmes for those in states of opioid withdrawal. Firstly, in easing the withdrawal symptoms the containment of this population in the safe shelters was made possible. Secondly, recognizing the deficits of the hegemonic abstinence and punitive approach to resolving opioid use disorders, preference was given to a harm reduction approach. The harm reduction approach allowed us to meet the user community where they were at, and provide evidence-based interventions that allowed beneficiaries to begin to normalize their lives. This was an enormous accomplishment given that globally homeless people were unable to access harm reduction services during lockdown periods and this remains difficult during the current phase of Covid-19.

The conditions under which this medical and psycho-social response was established were far from ideal or typical. From the start, and for a 13 week period, this programme was set up with no physical infrastructure, in open grounds where people were housed in tents and in an undercover car park. The funding for this programme was from private donors. Initially these funds were housed by a faith-based organization in the city, until the vagaries of politics and personalities amongst the NGO world forced the team to find another fiscal vehicle for this fund. Having to do this was a setback in terms of the emotional wellbeing of the medical withdrawal team that was already operating in circumstances that were not only suboptimal clinically, but also in a period of immense anxiety and fear as Covid-19 cases were beginning to rise and the rest of the population was under strict lockdown.

Despite this setback and the difficult structural conditions, we managed to initiate a methadone based short term Opiate Substitution (OST) programme that reached the worst 260 people afflicted by the withdrawals. Over a period of a week we enrolled these patients onto a program which included comprehensive biodata documentation, administration of the COWS and screening for basic medical conditions. The methadone was obtained via private funding from donors and we had to purchase various other basic psychiatric medication to deal with the secondary and co-morbid conditions commonly associated with substance use.

THE 3 REGISTERED NURSES WHO WERE ON SITE WORKED SEVEN DAYS A WEEK. THEY PLAYED THE MOST CRITICAL ROLE IN DISPENSING THE MEDICATION AND MONITORING THE PATIENTS ON THE PROGRAM.

For the first 13 weeks, the lead private psychiatrist, Dr Shaquir Salduker, provided daily observation of those on the programme. This allowed him to monitor the beneficiaries' progress and manage the dosages of the methadone and other medications required. The social workers conducted individual and group therapy programs in line with a harm reduction philosophy. Key NGOs such as TB HIV Care provided ongoing support to beneficiaries by screening for TB, HIV and Hepatitis and linking those who required chronic medication to a public facility who could provide this during lockdown and beyond. Within the space of two short weeks we assembled a team of over 20 volunteers who ran this program for the next 10 weeks. For the very first time ever, homeless people with an opioid use disorder were provided with a platform (medical and psycho-social) to normalize their lives and to improve their general health and hygiene. In interviews conducted toward the end of the lockdown level 5, many beneficiaries commented that while the Covid-19 lockdown in South Africa was viewed by most people as a curse, for them it was a

bleasing – an opportunity to radically transform their lives. The majority of recipients were young males – between the ages of 20 and 32 – and had been in active drug use for around ten years.

THIS PROGRAMME WAS THE FIRST OPPORTUNITY TO BE SUPPORTED IN AN ATTEMPT TO ABSTAIN FROM PROBLEMATIC DRUG USE OR TO RADICALLY REDUCE THEIR USAGE AFTER LOCKDOWN. DURING THE FULL LOCKDOWN PERIOD, BENEFICIARIES SPOKE ABOUT USING THIS TIME OF 'CLEAR-MINDEDNESS' AS AN OPPORTUNITY FOR REFLECTION AND RECONNECTION WITH SIGNIFICANT PEOPLE IN THEIR LIVES.

This outcome can be attributed not only to the efficacy of the medications used – as is well documented internationally – but perhaps equally so to the relationships between the clinical team and beneficiaries. The user community was treated with dignity and respect, and the relationships established became what could best be described as bi-directional. Relations of trust, friendship, and care emerged between those on the programme and the clinical and psycho-social team. The police, usually sceptical of harm reduction interventions, soon became the greatest champions and guardians of the programme.

IN ONE OF THE SITES, ALBERT PARK, THE POLICE ASSISTED THE NURSES IN ADMINISTERING THE METHADONE. THE RESULT OF THIS WAS A DEFINITE MENTAL PARADIGM SHIFT IN THE MINDS OF A KEY STAKEHOLDER GROUP I.E. LAW ENFORCEMENT.

But most significant was the transformation of self that emerged amongst the beneficiaries. Psychiatric and psychological problems emerged as the withdrawal symptoms eased up. The COWS assessment was redone at the 9 week mark and scores in this second round were between zero and three, indicating withdrawal symptoms had been successfully managed. At around this time we began seeing mood and anxiety disorders, psychotic disorders and many personality disorders. The rate of dual diagnosis was notable, although perhaps not as high as expected. The lack of funding as well as logistical complications in a period of a pandemic lockdown, meant that we were hampered in our efforts to properly address the many other complex issues that arose during this time. Linked to this ever-growing fear of contracting the Corona virus infection which was a constant companion during this entire time, meant that we were not able to get the necessary access to healthcare and psychological

support needed to fully address the dual diagnosis problems. The City Health Department was overstretched and the Provincial Health Department was dealing with the surging COVID-19 pandemic.

The question that is likely to be asked is what now? The programme is still operational and is located at a city owned building close to the Central Business District. Around 90 homeless people are now on the programme with an ever-increasing number of walk-ins indicating the massive need for OST (long and short term) in an urban context such as Durban. The same protocols developed during the lockdown period are currently being adhered to, and the team remains intact despite three of the team members having to balance their regular work with the requirements of the programme. It is remarkable, given the disaster management circumstances under which this programme was established, that every beneficiary has a full clinical file, allowing for easy referral to a private or public medical facility.

THE CURRENT SPACE IN WHICH THE PROGRAMME IS BEING RUN IS FAR MORE FUNCTIONAL AND 'HEALTHY' ALLOWING FOR GREATER ATTENTION TO BE PAID TO PSYCHOLOGICAL AND PSYCHIATRIC ISSUES PRESENTED.

We remain reliant on private funding to operate and the programme is managed fiscally by the South African Network of People who Use Drugs (SANPUD). Going forward, plans are underway for the establishment of a Harm Reduction Centre in Durban offering the full range of World Health Organization (WHO) recommended interventions for people with a substance use disorder. Interventions would include an OST programme, a needle syringe programme, an overdose prevention space, general medical testing and treatment (particularly for TB, HIV and Hepatitis) and psycho-social services. This initiative is bringing together unlikely partners – psychiatrists, public health specialists, city officials, property developers, urban planners and social scientists. This will be the first of its kind in South Africa, and on the continent. COVID-19 is without doubt a dark moment. But as with any others, there is light that shines through such as the coming together of this remarkable intervention of hope when panic and fear dominated the general psyche.

The COVID-19 pandemic may have caused havoc all over the world, but for this one small group of people in this one city on the east coast of the tip of Africa it has provided hope and the beginnings of what we hope will be a beacon to many in future.

Shaquir Saldaker is a psychiatrist in private practice in Durban. **Correspondence: shaquir@shrink.co.za**

Monique Marks is a research professor at the Durban University of Technology.

Michael Wilson is a public health specialist and director of Advanced Access and Delivery ■



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COULD SUPPORTIVE PSYCHOTHERAPY HELP US WITH COPING DURING THE TIME OF COVID-19?

Amy Glover, Olivia Matshabane

Supportive psychotherapy is one method which could help many South Africans to cope with the mental health stresses experienced due to COVID-19.

WHAT IS SUPPORTIVE PSYCHOTHERAPY?

What is supportive psychotherapy? Supportive psychotherapy plays an active and directive role in helping an individual improve their functioning. The focus of this type of therapy is on improving behaviour, enhancing self-esteem and promoting positive subjective feelings. Supportive psychotherapy can help to reduce anxiety, promote better stress management and improve healthier use of one's psychic defenses. It uses techniques which are empirically tested and evidence-based in order to enhance an individual's strengths, coping skills, and capacity to use social supports while reducing their subjective distress and improving behavioural functioning. Supportive psychotherapy can also be used to assist people who have existing psychiatric diagnoses to gain a degree of practical independence and to foster their autonomy in treatment decisions. While this form of therapy can be used in cases where there is a known diagnosis, it is also effective in cases where individuals have symptoms that could indicate distress but do not necessarily meet the criteria for a mental illness. Supportive psychotherapy can also be used to help people cope with everyday stresses.

WHY IS SUPPORTIVE PSYCHOTHERAPY INCREASINGLY NEEDED DURING THE COVID-19 PANDEMIC?

Now more than ever before, the harsh realities of injustice and inequality have become evident for all of society to see. During these challenging times with multiple restrictions on our lives, many people have lost their jobs and as a result are struggling to feed their families and cope with everyday life. It is estimated that the pandemic will result in millions of people around the world being pushed to extreme poverty. In the South African context, we have been flooded with news about the disturbingly high levels of poverty which have increased exponentially since the onset of the pandemic. Some people are understandably experiencing increased anxiety about their job security and about the future. The

education system has shifted to online learning, which has also caused some anxiety amongst students and educators.

SENIOR LEARNERS HAVE BEEN REQUESTED TO RETURN TO SCHOOLS – AND THIS DECISION HAS ALSO CAUSED ANXIETY AMONGST PARENTS, EDUCATORS AND LEARNERS.

Healthcare workers and essential staff have also expressed increased anxiety as they are continuing to serve our society while their own lives and those of their family members are at increased risk. Many people are isolated on their own in their houses and feeling bored and lonely. Some are isolated in cities or countries which are far from home without means to return. Other people are spending more time with family members than they ever have before. Being around the same people 24/7 has also been reported to take an emotional toll on relationships. Additionally, most professionals are now working from home and having to split their time between helping children with homeschooling, housework (i.e. including cooking, cleaning and laundry) and meeting their work deadlines. Understandably so, in addition to the uncertainties of the pandemic and the very real fears about how it could impact our health and the health of our loved ones, many people are experiencing escalating levels of stress and anxiety. These transient emotional disruptions can be profound and given the unpredictability of when the pandemic will end; these disturbances may likely be prolonged. This unfortunately creates fertile ground for our lives and our mental health to be impacted, given there is no clarity around when things could restabilize.



Amy Glover



Olivia Matshabane

In addition to the environmental effects of COVID-19 which themselves need processing; people are also dealing with multiple psychological challenges. One of these includes the decrease in physical touch and in-person human interaction and connection. People have turned to finding new ways to continue engaging socially despite the social distancing regulations. Many people have shifted to virtual platforms for meetings – including both professional and social meetings. Even though these platforms have been beneficial to some extent, many have reported these virtual meetings to be somewhat exhausting. Despite those feelings however, the upsurge in the use of technology to communicate is a clear sign of how we are psychologically, emotionally, cognitively and spiritually 'hardwired for connection'. Connection is an indispensable commodity which boosts our functioning. Not being able to physically meet friends, family and colleagues has taken a toll on many people. As author and researcher Brené Brown says, "true belonging, real connection and real empathy require meeting real people in real space in real time".

WE ARE ALL LONGING FOR THAT KIND OF CONNECTION BUT CAN NOT RECEIVE IT DURING THIS UNPRECEDENTED TIME AND THAT HAS AN IMPACT ON OUR PSYCHOLOGICAL WELL-BEING. ONE METHOD WE COULD USE TO HELP US COPE WITH OUR CHANGED REALITY COULD BE SUPPORTIVE PSYCHOTHERAPY.

HOW CAN SUPPORTIVE PSYCHOTHERAPY HELP?

Supportive psychotherapy can be helpful to consider as it can be provided both online or in person. One need not have to wait for a specific diagnosis to engage in this type of therapy. This approach to therapy focuses on the client and improving adaptive skills; meaning how you cope in times of stress using the skills you already have. Sometimes having a space to process and receive reassurance and encouragement can help one recognize what it is that you DO have and that can make an incredible difference in the reduction of anxiety and in one's view of a problem. Your therapist would only use this approach if it is suitable to you but it can help in getting advice, an objective opinion and learning to reframe and name a problem that you might be facing. This tends to improve one's agency and help one feel more empowered to address to what they are facing with better awareness of what it is.

In this way, supportive psychotherapy can also in this way help individuals who seek it to feel more in control of their lives and serves to prevent future mental health challenges if there is early intervention. The goal and the focus is on wellness and not illness. Some final thoughts on how this approach may help - it need not be a long or in-depth process, as this may not be suitable for many South Africans in terms of time or financial constraints. A broader impact that this approach

could have is to normalize seeking support, since we still find many South Africans fear mental health professionals or seeking help and this approach can be non-threatening and accessible to many. Of course, like any therapy it will not work for everyone but it could certainly help many people have a positive experience of therapy and seek support prior to more severe challenges or crises; making it easier to address and intervene. Supportive psychotherapy is one method which could help many South Africans to cope with the mental health stresses experienced due to COVID-19.

HOW CAN ONE ACCESS SUPPORTIVE PSYCHOTHERAPY?

1. You can visit or contact your GP, local doctor or mental health nurse at local clinics and ask if they have any referrals.
2. You can google your area for psychologists, usually you will get a range of results and direct websites of practitioners to browse - most of whom you can call or email directly to book an appointment. Don't be afraid to ask about rates, medical aid rates, cash rates or if the practitioner has any reduced rate offerings.
3. TherapyRoute – you can find a therapist near you, this is a great South African platform with good search parameters.
4. Psychology Today, many psychologists listed here.
5. Medpages, many medical and mental health professionals listed here.
6. Therapists Online; again you can search professionals here.
7. Search Therapist Directory, here you can find psychologists and counsellors in SA.
8. Search Findhelp; here you can browse through listed psychologists, therapists, social workers, occupational therapists, psychiatrists, and counsellors.

Amy Glover is a practicing Clinical Psychologist based in Cape Town. She has her masters degree in Clinical Psychology and Community Counselling (cum laude) from the University of Stellenbosch. She divides her time between a private practice in Vredehoek, Cape Town and developing practitioner-led resources to equip professionals to navigate online platforms for mental health services. She is passionate about preventative mental health and works with individuals and couples. Amy Glover is available to see clients online for therapy. **Correspondence:** amygloverpsychologist@gmail.com

Olivia Matshabane has a PhD in Medicine and a Masters degree in Psychology. She is a lecturer in social and developmental psychology at the University of Cape Town. She is also a postdoctoral research fellow in the Department of Medicine at UCT. She is trained in psychology, ethics and genomics. Her research focuses on the ethical and psychosocial implications of genomics research on African populations. She is passionate about promoting mental and public health for all.

This article is written based on the personal views of the authors and does not reflect the views of any institution. ■

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CONSPIRACY THEORIES: A RE-EMERGING PHENOMENON IN THE COVID-19 ERA

Marc Roffey

Conspiracy theories have been prominent on online and social media forums during the Covid-19 pandemic. They are of interest to mental health professionals because of the conviction with which they are held and the vehemence with which they are defended, features shared by true delusional beliefs. This article will briefly discuss why they appear to be emerging to such a degree at this time, how we can understand the psychology of these phenomena, and whether they hold any psychiatric significance.

INTRODUCTION

'The first principle is that you must not fool yourself and you are the easiest person to fool.' Richard P. Feynman, Nobel Prize winning physicist.

A South African journalist, writing on conspiracy theories a few months ago, noted that the word conspiracy derives from the Latin word 'conspiraire', meaning 'to breathe together'.¹ This is of course an ironic observation in the Covid-19 era, given that profound respiratory distress is experienced by those severely afflicted with the illness, but the important element suggested by the derivation is that conspiracy theories are held jointly, by more than just one individual.

A further, core feature of conspiracy theories is that secret, sinister and powerful groups, often existing at a governmental or political level, cause important events. This may indeed often be plausible, although unlikely, and proof of the existence of such groups and motives is usually lacking. However, like delusions, conspiracy theories often veer off into frankly bizarre and completely implausible directions, embedded in a bewildering, internet-driven 'post-truth' mire of 'fake news', 'deepfake', pseudoscience and 'alternative facts'. Conspiracy theories can be local or global in their concerns, and they usually revolve around a particular issue, such as the Covid-19 pandemic.

Well-known conspiracy theories include the moon landing was a hoax, global warming is also a hoax, and that 9/11 and the assassination of President JF Kennedy were both caused by the US government. It was only after the latter event that the term 'conspiracy theory' assumed a derisory, negative connotation, and the term itself has been used since the mid-nineteenth century, becoming more frequent in use since the 1950s.²

CONSPIRACY THEORIES, ALTHOUGH RANGING WIDELY IN SCOPE AND PLAUSIBILITY, OFTEN REFLECT ELEMENTS OF TRUTH (REAL CONSPIRACIES EXIST!), AND THIS ACCOUNTS IN PART FOR THEIR APPEAL, AND WHY THEY ARE SO WIDELY HELD.

One need only think of our own country's recent political history, with its entangled web of deception and corruption around the 'state capture' narrative, to realise this. It is in fact likely that everyone believes in at least one conspiracy driven idea, although true conspiracy theories lack proof, and continue to be held despite evidence to the contrary.

INDEED, CONTRADICTORY CONSPIRACY BELIEFS ARE SOMETIMES HELD BY THE SAME INDIVIDUAL.

CORONA AND RELATED CONSPIRACIES

There are two main categories of Covid-19 related conspiracy theories: that the pandemic is an elaborate hoax, and therefore does not exist; and that the SARS-CoV-2 virus has been deliberately engineered as a bioweapon.³ Both categories have been strongly promulgated from within the USA, including by President Donald Trump.

Trump claimed, early on in the pandemic, that Covid-19 was the Democrats' 'new hoax'. This view was more recently endorsed by his son Eric, who stated, at a time when the US had 1.5 million cases and 90 000 deaths, that the virus would "magically" disappear after the November elections.⁴

Within the second category lies the central belief that the virus was artificially created in China and was deliberately unleashed upon the world; an extension of this theme, promoted on social media, proposes that the virus has been specifically reverse-engineered in such a way that it responds to the anti-viral agent remdesivir - so that Bill Gates, who owns shares in the Chinese company which manufactures it, can benefit from its sales.

Bill Gates does not come off lightly in corona-related conspiracies. He often plays a central role in them, and has been portrayed as a genocidal eugenicist, working in cahoots with the WHO or George Soros to somehow control the world with a Covid-19 vaccine - this vaccine, furthermore, will be tested in Africa and render all African males sterile.

An additional conspiracy theory which has emerged with recent prominence is that the virus is somehow linked to 5G technology. The specific idea that the virus is disseminated by 5G mast towers led to the destruction of some of these towers in the UK in April of this year.⁵ A related theory, which again involves Bill Gates, is that a vaccine developed by him will contain a microchip which will control people injected with it, using 5G technology.

Perhaps the most disturbing conspiracy theories to intensify during the pandemic involve 'QAnon'.^{3,6} This is a supposed organisation which exists to expose a 'deep state' which controls the US, and whose members include Barack Obama, Hillary Clinton and the actor Tom Hanks. Satanic paedophiles by nature, 'deep state' operatives (which include public health officials), sexually abuse and murder children, and then drink their blood so that they can become intoxicated by the chemical 'adenochrome', produced by the body in states of fear and terror. President Trump's role in this drama is to allegedly save the US from the 'deep state'. 'Fall cabal' is a similarly themed idea which purports to document and prove this narrative on video-channels which are easily found on the internet.

MANY OF THE ABOVE THEORIES ARE LINKED TO OTHER POPULAR THEORIES INVOLVING 'BIG PHARMA', THE 'ANTI-VAXXER' MOVEMENT, AND THE WHO, AND ARE ALARMINGLY PREVALENT IN THE US.

A representative sample of over two thousand North Americans polled in March of this year revealed that almost a third believed that Covid-19 was deliberately created and spread, and a similar proportion believed that it was deliberately exaggerated in a bid to undermine Trump before the November elections.³ Roughly a quarter believed that the dangers of vaccines and 5G technology had been concealed, and just over forty percent believed in an extrajudicial 'deep state'. Of the twenty-two conspiracy theories that were included in the poll, responses to the purely political ones included a belief in just over a third of the respondents that Trump colluded with Russia to win the 2016 election, while twenty percent still believed that Barack Obama faked his US citizenship.

The interesting intersection that exists between US political and corona conspiracies is surely in part because Trump himself appears to be a conspiracy theorist, and his support for corona-related conspiracy theories is to his political advantage, as they further his anti-China agenda and appeal to his large right-wing political support base. In addition to being a climate-change denialist, Trump has steadfastly maintained the 'birtherism' idea, which is that his predecessor was not born in the US, and therefore lacked legitimacy as President, and has consistently promoted the idea that the pandemic has been deliberately created in China. He has also claimed that mortality figures from Covid-19 in the US have been exaggerated, as part of an attempt to

discredit him. Trump has also been at odds with his medical advisory pandemic team, notably Anthony Fauci, and is also a proponent of pseudoscience, continuing to support the use of chloroquine in the face of scanty evidence for its efficacy, and suggesting that light and injectable disinfectants are useful treatments for Covid-19.

THE ROLE OF THE INTERNET AND SOCIAL MEDIA

The internet, whilst enabling the 'democratisation of knowledge', has also, in the context of the pandemic, allowed information to flourish which is all seen as falsely equivalent, often with little regard for discernment by users, and it has encouraged the devolution of expertise. Immediate, frequent, and global access to online information, and the easy segregation of ideas and opinions on social media pages, groups, forums, and video-channels, leads to their widespread dissemination, which can then be 'liked' and shared.

IN FACILITATING THE SEEKING AND SHARING OF INFORMATION THAT IS CONGRUENT WITH ONE'S BELIEF SYSTEMS, WHILE IGNORING OPPOSING INFORMATION ('ECHO CHAMBERS'), AND THE ACTION BY ALGORITHMS TO SELECT INFORMATION BASED ON PERSONAL PREFERENCES ('FILTER BUBBLES'), USE OF THE INTERNET READILY LEADS TO CONFIRMATION BIAS.⁷

An example which alarmingly demonstrates the power of the internet to sway public opinion is the growing anti-vaccination movement. A recent study investigated 1 300 pages, followed by about 85 million individuals, and showed that anti-vaccination pages, whilst having fewer followers, outnumber pro-vaccination ones, and are linked to a far greater degree to undecided groups, such as parent associations at schools.⁸ Computer models of these trends suggests that the views of 'anti-vaxxers' could significantly predominate and influence public opinion on vaccination within the next decade.

Somewhat counter-intuitively, there is little evidence that social media is responsible for the increasing emergence of corona-related conspiracy theories.³ It is true rather that social media platforms such as Facebook, Twitter, WhatsApp, and YouTube, facilitate the spread of ideas that would anyway have arisen from major events, such as the emergence of Covid-19.

This is true for conspiracy theories about Covid-19, as well as for misinformation about other aspects relating to it, such as claims of spurious treatments. In the words of misinformation researcher Gordon Pennycook, "Social media doesn't incentivise truth ... it incentivises engagement".⁹ In work done earlier this year, his experiments with participants revealed that ten percent more of them would share a mixture

of true and fake Covid-19 news on social media, than if they had paused to assess the veracity of the information before sharing, in which case they would preferentially share accurate news. This suggests that a proposed intervention of 'nudging' people to reflect on accuracy is a simple but effective way of improving the choices people make when sharing.

COUNTERING THIS IS THE FACT THAT SOCIAL MEDIA ENABLES THE FREQUENT REPETITION OF MISINFORMATION, WHICH CAN THEN BE INTERNALISED AS BEING TRUE.

This is enhanced by the deliberate use of pictures (perhaps as simple as the inclusion of a schematic of the virus), the inclusion of the names of medical authorities and associations, and related facts and figures, and the use of pseudoscientific language.⁹ Other tactics include the use of a convincing, readable style, engaging personal accounts, and appeals to emotion, such as fear, blaming, social grouping and solidarity, rather than to rational thought.

Cognitive reflection tests (CRTs), which provide a means to assess an individual's ability to inhibit an immediate and intuitive response to a problem, are central to research in this area.⁹ The following is an example of one of the first such tests to be devised: if it takes 5 machines 5 minutes to produce 5 gadgets, how long will it take 100 machines to produce 100 gadgets? A likely immediate response would be 100 minutes, whereas the correct answer is 5 minutes. This 'cognitive miserliness', or the tendency to rely on habitual cognitive strategies, or apparently obvious solutions, has been shown in studies to make people more susceptible to Covid-19 hoax theories.⁹

Interestingly, social media companies have recently taken the unprecedented step of deleting social media accounts of popular and influential people who spread misinformation and conspiracy theories about Covid-19. These include David Icke, a strong proponent of the idea that 5G causes Covid-19, and who believes that reptilian aliens control the world, and Judy Mikovits, a former research biochemist who expressed her Covid-19 conspiracy theories in 'Plandemic', a documentary video that has now been removed from the internet. Whilst such measures constitute an ethically questionable curtailment of free speech, they do indicate an appropriately deep level of concern about the internet's ability to spread misinformation about the pandemic.

EXPLANATORY MODELS FOR CONSPIRACY THEORIES

The internet, as the above suggests, plays a large role in the ease with which conspiracy theories can be spread. What, however, are the underlying factors that lead to their initial genesis? The current pandemic has led to governmental restrictions on civil liberties, mass job losses and crippled economies, and the

adoption of alienating, paranoia-inducing public health measures such as self-isolation, physical distancing, and the wearing of masks. When coupled with widespread fear, uncertainty, and anxiety across the world, the resulting situation is ripe for the development of conspiracy theories. Simple denial may be an initial response (a stance adopted by our own government at the start of the AIDS epidemic in South Africa); the subsequent development and adoption of explanatory narratives is empowering and comforting, both for individuals, and the groups which later arise and integrate from them.

DOES POOR PUBLIC LITERACY ABOUT THE SCIENTIFIC METHOD, AND DIFFICULTY IN NAVIGATING THE COMPLICATED TERRAIN OF THE FIELDS OF VIROLOGY, EPIDEMIOLOGY, PUBLIC HEALTH, AND OTHER MEDICAL DISCIPLINES CONTRIBUTE TO THE DEVELOPMENT OF CORONA-RELATED CONSPIRACY THEORIES?

Compounding this has been the conflicting opinions often expressed by experts in these fields as the pandemic has evolved - although this is often due to new and rapidly changing information rather than professional uncertainty, it has been seized upon by conspiracy theorists as evidence of subterfuge and manipulation.

RATHER THAN READ AND EVALUATE INFORMATION FROM REPUTABLE ONLINE SOURCES, CONSPIRACY THEORISTS FREQUENTLY FAVOUR ONLINE VIDEO DISCOURSES, PROMPTING THE CREATION OF THE INTERNET MEME, "CONSPIRACY THEORIES ARE PUBLISHED ON YOUTUBE, SCIENCE IN PEER-REVIEWED JOURNALS". FACTS POSTED IN SUPPORT OF SCIENTIFIC DISCUSSIONS ABOUT THE PANDEMIC ARE SIMPLY DISCREDITED, TOGETHER WITH FACT-CHECKING SITES SUCH AS SNOPE.COM AND FACTCHECK.ORG.

Therefore, rather than resulting in a renewed global respect for science, which would have been a welcome consequence of the pandemic during an era characterised by poor scientific literacy, a surge in pseudoscientific thinking, and increasing public wariness of medical orthodoxy, the pandemic has unfortunately to a large degree had the opposite effect. This cannot be simply accounted for by scientific illiteracy, and a person who famously demonstrated this was the late Kary Mullis, who won a Nobel Prize for his discovery of the polymerase chain reaction (PCR) technique, but who was an AIDS and climate change denier. Medical professionals, whom one would expect to know better, have also been voices of scientific dissent

during the pandemic. A mental-health professional who demonstrates this is Kelly Brogan, a US board-certified, self-styled 'holistic psychiatrist' who does not believe in "germ-based contagion", and who has stated that "it is not possible to prove that any given pathogen has induced death".¹⁰

A large-scale example of pseudo-scientific medical practice occurred in April, in the state of Kerala in India. Although homeopathy has been discredited, the state distributed vials of homeopathic medicine to 4.5 million of its citizens as a response to Covid-19.¹¹ Its health officials claimed that the medication was an immune booster, and that it had been used with success in the past during outbreaks of previous epidemics in the state, including dengue, typhoid and chicken pox.

In conclusion, it is unlikely that poor scientific literacy per se is a significant contributing factor to the thought processes underlying conspiracy theories. Failures of logic, a reluctance to test hypotheses, and adhering to ideas which conform to underlying schemas and worldviews are likely to be more robust factors. For example, Occam's razor, or the most parsimonious solution to a problem, suggests that the pandemic is simply a zoonotic infection which originated in bats and now has been transmitted to humans, a view for which there is considerable evidence. Despite this, very many people hold on to theories that it is a synthetic virus which has been purposefully unleashed onto the world.

Magical thinking, cognitive distortions, and cognitive biases can reasonably be expected to play a role in conspiratorial thinking. Cognitive miserliness and confirmation bias have already been mentioned, and others of significance include the Dunning-Kruger effect (in which confidence and belief in one's knowledge and abilities is in excess of actual possession of these attributes), 'jumping to conclusions' bias, belief inflexibility, and attributional, anchoring and self-serving biases.⁷ Cognitive biases are, of course, equally at play in people not prone to believe in conspiracy theories. The presence of personality factors and traits should also be considered, and significant ones might include schizotypal and paranoid traits.

ONE PSYCHOLOGICAL MODEL OF CONSPIRACY THEORIES SUGGESTS THREE EXPLANATORY MOTIVES FOR THEIR ORIGIN: EPISTEMIC (WHICH RELATES TO THE UNDERSTANDING OF ONE'S ENVIRONMENT), EXISTENTIAL (THE DESIRE TO FEEL SAFE AND IN CONTROL OF ONE'S ENVIRONMENT) AND SOCIAL (THE MAINTENANCE OF POSITIVE SELF AND SOCIAL GROUP IDENTITY).¹²

Epistemic motives provide meaning and reduce anxiety when random environmental events occur, for which insufficient or conflicting explanatory

information is available, and maintain internal belief consistency when such information is lacking. Existential motives seek to increase autonomy and reduce anxiety by, for example, choosing alternative over official accounts, thereby promising safety in the knowledge that role-players portrayed as dangerous are recognised and thus are no longer a threat. Social motives enable positive identity through assuming a higher moral ground in the face of malevolent others, to whom blame for failure can be attributed. Despite these motives driving people to believe in conspiracy theories, there is little available evidence that they actually fulfil them; they more likely end in conferring less empowerment and agency, and may be a "self-defeating form of social cognition".¹²

FINALLY, PERHAPS MORE PROSAIC FACTORS ARE ALSO AT WORK IN THE EVOLUTION OF CONSPIRACY THEORIES. HUMANS LOVE BEING ENTERTAINED, AND LOVE TELLING STORIES, AND HAVE DONE SO FOR COUNTLESS MILLENNIA. FILMS AND SERIES, WATCHED BY BILLIONS OF PEOPLE ACROSS THE PLANET, THRIVE ON THEMES OF INTRIGUE, DECEPTION, DOUBLE-CROSSING AND ESPIONAGE. IT IS PERHAPS SIMPLY IN OUR NATURE TO CREATE CONVENIENT FICTIONS AND MYTHS IN THE FACE OF CALAMITOUS DISASTER.

PSYCHIATRIC IMPLICATIONS - ARE CONSPIRACY THEORISTS 'MAD'?

Confronted by the more bizarre pandemic-related conspiracy theories currently in circulation, and their apparent pervasiveness, it is tempting to ask whether their followers are not delusional, and one despairingly wonders whether a collective madness has not gripped the world?

With the defining and phenomenological features of true delusional beliefs in mind, it is evident that conspiracy theories, although falsifiable, can be fixed and unshakeable. When they are held with conviction which wavers, they can perhaps be considered as overvalued ideas ('strongly held ideas' is an alternative term used in DSM-5). They can also be bizarre, complex, and systematised – as a 'QAnon' supporter stated, "Go deep enough down the rabbit hole and everything does seem to interconnect."¹³ Kendler et al's five dimensions of delusional intensity¹⁴ can therefore be successfully and integrally applied to conspiratorial belief systems: conviction, extension (the degree to which the belief involves areas of the individual's life), bizarreness, disorganisation (the degree to which the beliefs are internally consistent, logical and systematised), and pressure (the degree to which the individual is preoccupied and concerned with the beliefs).

A DELUSIONAL BELIEF HOWEVER, WHEN IT REQUIRES CLINICAL ATTENTION, IS INVARIABLY SELF-REFERENTIAL (WHICH RELATES TO THE QUALITY OF 'EXTENSION'), TO A DEGREE THAT THE INDIVIDUAL ACTS ON THE BELIEF OR EXPERIENCES SIGNIFICANT DISTRESS FROM IT, AND THIS FEATURE IS PROBABLY ATTENUATED IN MOST CONSPIRACY THEORISTS.

Clinical experience also suggests that psychiatrically significant delusions are unique to the individual and are held alone by that individual, and in this way they differ crucially from conspiracy theories, which typically are held by groups of people, often numbering in the millions.

AS CONSPIRACY THEORIES ARE WIDELY HELD, THEY CAN ALSO BE CONSIDERED AS BEING CULTURALLY SANCTIONED, THUS DIFFERING FROM TRUE DELUSIONAL BELIEFS, WHICH OFTEN LIE OUTSIDE OF CULTURAL AND RELIGIOUS NORMS.

Special mention should be made here of the intriguing case of shared delusional disorder (or 'folie à deux', which was removed from DSM-5, but appears in earlier editions): in this condition a delusion, held by a primary individual, is shared by one or more secondary persons, who live in close proximity to or who are in a close relationship with the affected individual; clinical examples furthermore suggest that the affected groups often live in relative isolation from the world. Cults, and the bizarre belief systems often seen in them, are perhaps a related and extended form of this, but these, and shared delusional systems, appear to manifest very differently from conspiracy theories.

A VAST RANGE OF BEHAVIOURS MAY RESULT FROM BELIEF IN CONSPIRACY THEORIES, SUCH AS REFUSING TO ADHERE TO CORONA-RELATED PUBLIC HEALTH MEASURES, A REFUSAL TO HAVE ONE'S CHILDREN INOCULATED AGAINST CHILDHOOD DISEASES, AND NOT SUPPORTING SOCIETAL EFFORTS TO REDUCE GLOBAL WARMING (OVER THIRTY PERCENT OF AMERICANS BELIEVE THAT CLIMATE CHANGE IS A HOAX¹²).

Such behaviours are not necessarily unusual, and would not constitute functional impairment in the psychiatric sense of the word (although this is not required if the belief is held to such a degree that a diagnosis of delusional disorder is considered); they could however be seen as constituting collective damaging behaviours, with far-reaching and long-term health and socio-political consequences.

These are complex issues, perhaps better addressed by social scientists. The role of mental health professionals may simply be to provide explanatory psychological models for the mechanisms of thinking and behaviour which underlie conspiracy theories, to approach their adherents with understanding and empathy, rather than confrontation, and to explore whether their belief-systems play any role in distress or abnormal behaviour, should they present to mental health services.

CONCLUSION

CONSPIRACY THEORIES WILL BE WITH US FOR A LONG TIME TO COME, AND NEW ONES WILL ARISE, AS THE WORLD BECOMES INCREASINGLY CHAOTIC, FRAGMENTED AND UNEQUAL. THEIR ORIGIN IS COMPLEX, MULTIFACTORIAL AND POORLY UNDERSTOOD.

They will continue to always intrigue, sometimes amuse, and often frustrate us. Perhaps the best approach currently is to consider them as *quasi*-delusional belief systems. Their existence is clearly of interest and relevance to mental health professionals, and they are worthy of our attention, scrutiny and research.

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Marc Roffey is a consultant psychiatrist at Valkenberg Hospital and the Department of Psychiatry and Mental Health, University of Cape Town, Cape Town, South Africa.
Correspondence: medical@marcroffey.co.za ■

AN EXPLANATION FOR SOME OF THE EXTREME VULNERABILITY DURING COVID-19 AND PRACTICAL WAYS TO MANAGE IT

Lindsay Braithwaite

There is a tsunami of information on the subject of human emotion circulating at the moment. The mainstream media and social media are awash with reports of increasing levels of anxiety and depression. Having become an instant source of news, real and contrived (and frequently impossible to determine which), they are paradoxically a source of comfort, connection and education, and also of insecurity, uncertainty, loneliness and vulnerability.

Nevertheless, the relatively new advent of accessible instant communication between people in different places locally and abroad, and especially the face to face meeting enabled by video streaming, has facilitated sharing of emotion as never experienced before. It seems that it is becoming acceptable to share emotions and feelings of anxiety and uncertainty. If nothing else positive emerges from this time of extreme confusion, may this sharing of our humanness continue.

People are now able to express levels of anxiety and confusion without fear of judgement or marginalisation and can seek help should they need to. In these times of 'not knowing', our emotions are like yo-yos, and from moment to moment we may find ourselves moving from some semblance of centeredness to a state of high anxiety and vulnerability. One perspective towards understanding some of the reasons for these challenges is offered by Dr David Rock's SCARF Model, which draws on the basic reasoning of the mind to explain behaviours and emotions.¹

The brain rapidly labels experiences and information, at both a conscious and unconscious level, as either a threat or a reward. Any perceived threat triggers an *Away* response and a perceived reward, a *Toward* response.

THREAT PERCEPTION IS MORE PREVALENT THAN REWARD PERCEPTION, AND BOTH RESPONSES WILL LINK TO RELEVANT NEUROTRANSMITTERS WITH SUBSEQUENT EFFECTS ON BOTH NEUROLOGICAL ACTIVITY AND PHYSIOLOGY.

Perceived threat results in varying degrees of 'shut down' in the pre-frontal cortex, which is responsible for, among other functions, our higher-level thinking, clear planning and emotional regulation. The opposite is true when a *Toward* response occurs, we produce greater levels of dopamine and experience an increased sense of purpose and meaning with feelings of reward. We experience increased well-being, creativity and higher energy. A sense of being 'on our game'.

The SCARF model identifies five critical domains of human experience (status, certainty, autonomy, relatedness, fairness) that motivate emotion and behaviour under these circumstances. It provides a framework and basis for practical actions that we can implement ourselves at this time and share with our patients and colleagues who are expressing difficulty.

STATUS

A perception of where I am in the 'pecking order' – what is my relative credibility as a human being and how acknowledged am I in my world?

The threat to one's status activates the same brain circuitry as the experience of physical pain. For example, being dismissed in a meeting will be experienced in areas of the brain common to root canal treatment! Many of us are feeling that our own status may have shifted over the last few weeks. As professionals in our work environments, we are in a space of redefining and exploring 'where we are' and for some, 'who we are'. The new normal of work-related roles could potentially be very different.

WITHIN FAMILY STRUCTURES DURING LOCKDOWN, ROLES TOO HAVE SHIFTED. PERHAPS UNDER THE CONFINES OF THE PRESENT WAY OF LIVING, WE ARE NOT RECEIVING THE USUAL PERSONAL AFFIRMATION AND ACKNOWLEDGMENT FROM PEOPLE AROUND US, WHICH IS INTEGRAL TO OUR PERCEPTION OF INDIVIDUAL STATUS AND SENSE OF SELF-WORTH.

WHAT CAN WE CONSIDER DOING?

There is great value in affirming and acknowledging the people with whom we are engaging, and expressing their value in our lives. We can look for opportunities to do this as often as possible.

NOT ONLY WILL OUR OWN DOPAMINE LEVELS RISE, BUT THEIRS WILL TOO. LIKEWISE, WE NEED TO BE KIND, COMPASSIONATE AND FORGIVING TOWARDS OURSELVES.

Revisit your values. If you are unsure of them, start exploring what they might be. One of the most effective ways to maintain self-worth is by trying to do what is of personal value, on a regular basis. This could be as simple as getting up and making your bed, exercising, journaling daily, etc. If you ignore or avoid these values, you might experience a sense of personal disappointment and a decrease in levels of self-worth.

Most importantly we need to acknowledge that if we are feeling anxious or vulnerable, it is not a failure of stoicism. It is a natural human reaction to the world as we find it now. Many people are feeling like this. Not because they are weak. On the contrary, it is because they are human.

CERTAINTY

The brain operates as a prediction machine and will engage all the patterns and previously experienced information in order to simplify making sense of the future.

It does not take a neuroscientist to recognise that one of the principal causes of stress right now is not knowing. Generally speaking, human beings don't like to not know; to feel uncertain. At the time of writing (1 June), we don't know how long it will last, how severe it will be, how it will affect those around me, how it will affect me or how it will affect the world in general. It is no wonder that there may be unprecedented levels of stress, and as a result, fear and vulnerability.

WHAT CAN WE CONSIDER DOING?

Start by trying to create as much certainty as possible. Continue routine activities in daily life from work to exercise to household chores. The more certainty the brain has, the more the prefrontal cortex is liberated to think clearly and creatively rather than reduced to levels of panic and confusion. Continue to do what is necessary to create a sense of purpose and routine, no matter how small that might be right now.

PERHAPS TAKE ASSURANCE FROM A SMALL CERTAINTY IN RUMI'S PHRASE, 'THIS TOO SHALL PASS'.

AUTONOMY

The brain responds positively to the perception of having choice – a sense of control over one's own destiny.

The measures to limit the spread of COVID-19 have all but eliminated autonomy of the individual. We no longer have a sense of control over how we might choose to live, where we can go, or work; and the freedom of options previously experienced.

WHAT CAN WE CONSIDER DOING?

Perhaps the question to ask ourselves is 'what might I have autonomy over?' It may be who you are choosing to speak to and how you engage with media, how much news you choose to take in, where you choose to focus your attention in your work, what you are choosing to flag as important and relevant and what not. All these small choices will create a heightened sense of autonomy. Look for any opportunity to do this.

RELATEDNESS

Human beings need social connection. We need to find our tribe and be reassured that we belong. COVID-19 has placed us in isolation – not only from friends and loved ones, but from society in general. One of the most important things to a human being is to feel safe. Much of that feeling comes from face to face contact. We read each other's facial expression, body language, gestures. We listen to vocal pitch and expression. Speaking over video does not accurately convey these things. It cannot replace the interconnectedness we experience while we are in each other's company. We lose eye

contact, subtleties and softening in the movement of mouth and eyes, and the musicality of the other's voice. At the moment, worse still, in public, we cover our faces almost completely with masks.

Is there any wonder that, even though it could seem we are communicating, we might feel a bewildering and overwhelmingly inconsolable sense of aloneness?

WHAT CAN WE CONSIDER DOING?

Try as best you can to stay connected – even when you would rather not. Consider relationships that have been neglected and need revisiting. When we feel connected with others, we produce oxytocin, creating greater feelings of trust and compassion. Compassion for others enables us to better receive compassion from others. In turn, this helps us to cultivate greater compassion for self.

We have the benefit of connection through social media platforms, which were either previously unavailable or infrequently used. Choose what works best for you and make a regular practice of keeping connected.

BUT BE AWARE OF WHAT IS LOST THROUGH THESE PLATFORMS AND, WHERE IT IS IMPORTANT, MAKE EXTRA EFFORT TO EXPRESS THOUGHTS AND EMOTIONS, GRATITUDE AND COMPASSION. WHEN POSSIBLE, MAKE AN EFFORT TO SPEND TIME IN THE COMPANY OF OTHERS.

When connecting with colleagues and employees make this connection sincere and meaningful. Remember that everyone is needing reassurance and no matter how small the gesture, it will have a profound impact on the person receiving it.

FAIRNESS

A perception of fair exchange.

The brain is highly tuned to interpreting information as either fair or unfair. A sense of unfairness can produce high levels of stress. Parents know how quickly children pick up on perceived unfairness. An effective manager will be aware of the importance of minimising perceptions of unfair leadership in the workplace. Research has shown that we would rather go without, than accept what we perceive to be unfair.

WHAT CAN WE CONSIDER DOING?

As best you can, focus on gratitude for what you have. During this pandemic, the unfairness is global – we are all in this 'unfairness' together. When you start the process of itemising how much you can be grateful for, feelings of unfairness will be reduced.

Try to be less judgmental and more curious. This encourages us to ask questions; "Why are the decision makers doing what they are doing?", rather than "This is not going to work for me. I think it is a stupid decision". Curiosity opens up possibility.

FINAL REMARKS

The more mindful we are in noticing "what and how" we are experiencing during this period in our lives, the better able we are to cope. Consider the above 5 brain domains and perhaps introduce the following simple actions into your day:

- Speak to people who acknowledge you and affirm you own personal sense of self-worth – your status.
- Label what you are feeling. Be it uncertainty, despair, optimism or hope, identify it, and the brain will settle, merely as a result of the *certainty* of a label.
- Actively find your daily *autonomy*. Where do you have the independence to make decisions for yourself?
- Remain close to your tribe, whoever they may be. *Relate* to them every day in one way or another. As far as possible, face to face.
- Acknowledge that *unfairness* is part of the experience of life. It applies, to varying extents, to everybody. Although much of life is indeed fair, right now a bigger consideration is perhaps the issue of rampant unfairness, and rampant inequality throughout the world, which now has the potential to emerge firmly under the spotlight. Perhaps there is something we can do about it?

There is potential to create a connection as one global tribe of humanity by being kind to ourselves and to each other.

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Lindsay Braithwaite is a Lead with Humanity Associate. She is a specialist in people development, having worked for 30 years as a facilitator, and more recently in the past 12 years, as a Life and Business Coach. Her focus is on emotional intelligence (EQ) and coaching, using the latest advancements in applied neuroscience. She has a Postgraduate Certificate in Mindfulness from The Department of Family Medicine, University of Stellenbosch and uses the practice of mindfulness in all areas of her work. **Correspondence: thwaite@yebo.co.za**

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KETAMINE, COVID & SUICIDALITY – A PERFECT FIT FOR A PERFECT STORM

Alan Howard

WHY KETAMINE?

Molly.

Molly (*not her real name*) was a 50-something frequent flyer in our Emergency Department in the North West of Ireland. A habitual self-harmer and polypharmacy overdoer, she was the quintessential treatment resistant depressive with co-existing Axis II issues. The psychiatry unit had all but washed their hands of her, and all those involved in her frequent care simply went through the motions, presentation after presentation, month after month. I lost count of the sutures I had placed in her self-inflicted wounds and would have recognised her by her glottis, so often had she been tubed in our ED. That she lived literally minutes from our Emergency Department had undoubtedly played a role in the longevity of this troubled soul.

"Molly is on her way in again," remarked one of my registrars on a busy Thursday afternoon. "Sounds quite serious." It was.

PARAMEDICS HAD BEEN CALLED TO MOLLY'S HOUSE AFTER YET ANOTHER FLARE-UP OF LETHAL SUICIDAL INTENT. IN FRONT OF THEM SHE GRABBED A KITCHEN KNIFE AND SLIT HER OWN THROAT. SLIT, AS IN EXPOSED HER STERNOMASTOIDS AND ALL BUT TRANSECTED HER LARGE VESSELS.

Having miraculously dissected around any vital structures, Molly's latent surgical skill had spared her a visit to theatre or the afterlife. I elected to repair the damage in layers in the Emergency Department and reached for my go-to procedural sedative, ketamine. A few boluses were required during the 30-minute procedure. As I secured a Yeat's drain and waited for Molly to come around while a bed was found in the psych unit, I wondered when a successful attempt would eventually end the destructive cycle that was

her life. I arranged for her to come back for a follow up and moved on to an unstable DKA.

A week later and I had all but forgotten about Molly until notified by the clerk that she had arrived. Were it not for the neat Mepore dressing on her neck, I would not have recognised her. She had metamorphosed from an unkempt, withdrawn, and pitiful human being to an engaging, presentable and, dare I say, cheerful lady. And no, she is not bipolar.



Alan Howard

"I feel great!" she remarked, while I scanned her notes for the miracle drug that had hitherto evaded the attention of the entire psychiatry department. There was none. Just the same old monoaminergic and mood-stabiliser combo staring back at me like a well-used recipe for pancakes in a dogeared cookbook. Molly shook her newly coiffured head and laughed. I realised it was the ketamine.



Molly's attempted suicide – before and after repair of her self-inflicted neck laceration under ketamine. A week later, all suicidal ideation had disappeared, and her demeanour had changed dramatically. (With permission)

In truth, I had read about the effect of ketamine on mood and, come to think of it, had even recognised unexplained and dramatic changes in demeanour

in patients I knew to be depressed (even suicidal) who had serendipitously received ketamine as procedural sedation for unrelated conditions as diverse as dislocated shoulders and ankles. (I use a *lot* of ketamine as an Emergency Physician).

Quite coincidentally, shortly after Molly (who was not seen again in the Emergency Department for about four months, when she presented with a cracked rib), I was lent *The Ketamine Papers* by a registrar with an interest in psychedelics. I researched and read anything I could find about ketamine and mood disorders and was intrigued by the successes of Steven Mandel (an anaesthetist) at his Ketamine Clinics of Los Angeles. (To date, his clinic has administered over 9500 infusions).

After 20 years abroad as an Emergency Physician (12 of which were spent at the same Emergency Department in Ireland working blocks of a few months at a time interspersed with visits back to the Natal Midlands), I decided to call it a day and return home.

I tested the waters by approaching a few psychiatrists I knew and administering ketamine infusions (with the requisite monitoring and emergency backup) à la the Los Angeles model. The response, demand and outcomes exceeded expectation. Ketamine Clinics of South Africa (KCSA) was born and I bade farewell to the Emerald Isle and Molly for good (See article which follows).

MADDOX, STEVENS, AND SOME PRISONERS.

CI-395 was synthesised by Harold Maddox in Detroit Michigan in 1956. Renamed phencyclidine, marketed by Parke-Davis as Sernyl and abused on the street as PCP or Angel Dust, CI-395 was rapidly consigned to the pile of 'really bad ideas', much to the relief of men in blue across the USA. Users went completely bananas. Disorientated, manic and violent behaviour coupled with immunity to pain, were the hallmark effects.

In 1962, Prof Calvin Stevens tinkered with CI-395 and came up with a somewhat milder analogue, CI-581. Ketamine had been discovered. Two years later, unsuspecting prisoners in Maddox's old stomping ground, Michigan, 'volunteered' to try the stuff with some gentle persuasion from a Dr Domino. The results were pleasing. Anaesthesia was achieved, the prisoners were all quite manageable and, curiously, they reported weird out of body experiences and believed their limbs had become detached. Henceforth, ketamine became labelled a 'dissociative' anaesthetic, a term coined by Dr Domino's wife.

In the 1960s treatment and understanding of depression was firmly focussed on the monoaminergic theory with iproniazid having been synthesised the decade before. Had Stevens, Domino et al only known that they had stumbled across the first glutamatergic antidepressant half a century ahead of time, how differently might history have unfolded. Perhaps they noticed that the prisoners were unusually cheerful for a few weeks.

ACRONYMS, MORE ACRONYMS, AND THE VIETNAM WAR

In 1966 the **USPTO** (United States Patent and Trademark Office) awarded a patent for ketamine as a dissociative anaesthetic in humans. In 1970 the **FDA** (Food and Drug Administration) approved ketamine for use in all ages. In 1985 the **WHO** (World Health Organisation) added ketamine to their list of essential medicines. During the early 70s, Ketalar™ was the most widely used analgesic and anaesthetic agent on the battlefields and in the field hospitals of the Vietnam War. In 1999, the **DEA** (Drug Enforcement Administration) classified ketamine a Schedule III controlled substance citing only 'moderate or low physical dependence potential' with 'less potential for abuse than substances in Schedules I & II'. Nobody from these eras recognised the antidepressant potential of ketamine.

RATS, MICE AND FINALLY SOME PATIENTS

In the early 90s, with the help of some despairing rodents, Trullas and Skolnick first demonstrated the major role played by the NMDA receptor complex in antidepressant action.¹

Berman et al first studied the antidepressant effect of ketamine in human subjects with MDD and published their findings in 2000.²

It took a further six-years for Carlos Zarate's seminal randomized trial of ketamine in treatment-resistant major depression³ to get the ball rolling, and it has been gathering momentum ever since.

Numerous trials have been conducted to date studying response to either a single ketamine infusion or series of infusions. 'Response' is deemed as at least a 50% reduction in depressive symptoms as determined using mostly HAM-D or MADRS scales. The effect of ketamine on reducing suicidal ideation specifically has also been the subject of several randomized controlled trials and 'significant reduction' is universally reported (approaching 80%).

The most remarkable finding has been the rapidity with which ketamine usually reduces or reverses suicidal ideation (within hours). This feature has enormous implications as a 'safety net' while longer term treatment and therapy is planned and implemented - not to mention avoiding costly hospitalisation.

A review of all the literature available at time of printing (2016) is systematically presented in Professor Sanjay Mathew and Carlos Zarate's excellent book *Ketamine for Treatment-Resistant Depression, The First Decade of Progress*.⁴

"REVERSAL OF SUICIDAL IDEATION IS OBSERVED IN 70-80% OF PATIENTS WITHIN HOURS AFTER A SINGLE KETAMINE INFUSION."

IF THE ONLY TOOL IN YOUR BOX IS A HAMMER, EVERYTHING STARTS LOOKING LIKE A NAIL

For 40 years or more, the hammers in the treatment of depression have been monoaminergic antidepressants. There have been various iterations of this hammer over time, and hammering has worked for several patients. There has been little else. Now there is a new target – the glutamatergic receptors.

One evening, a few months back, I settled down to read chapter one of *The NMDA Receptors*, edited by an eminent Japanese scientist. I still understand extraordinarily little about NMDA receptors, (so complex is the subject), but can strongly recommend the book as an alternative to zolpidem.

In a nutshell, ketamine is primarily a non-competitive antagonist of the NMDA receptor. Its effect is to increase levels of the amino acid glutamate, the major excitatory neurotransmitter in the central nervous system. Modulated by the inhibitory neurotransmitter GABA (of which glutamate is, curiously, a precursor), glutamatergic neurotransmission has dramatic and rapid effects on normal and pathological mood and behaviour.

There are several types of glutamatergic receptors each of which serves a unique purpose within the brain. It is postulated that the glutamate burst caused by ketamine stimulates AMPA receptors leading to increased expression of BDNF and consequently neuroplasticity and synaptogenesis. Interestingly, there is also evidence from more than one study that it may in fact be the R-enantiomer of ketamine producing most of ketamine's antidepressant effect and, in particular a sustained effect. (See comments about esketamine later).

It matters less how it works and more that it works. While the science is fascinating, the profound effect that I have seen on patients' lives is even more so. Ketamine has been dubbed 'chemical ECT' (without detrimental cognitive effects). I prefer to think of it as 'limbic liberation'. A breaking and reset of the destructive loop between the elements of the limbic system that fuels and escalates depression to the point of suicide.

WHO SHOULD ADMINISTER KETAMINE?

Shortly after I launched KCSA in August 2019, a colleague remarked: "What's an Emergency Physician doing administering an anaesthetic to psychiatry patients?"

A perfectly reasonable question and one worthy of careful consideration given the blend of disciplines involved. I have since had a discussion with a psychiatrist who believed only they were qualified to administer the drug as an antidepressant, and yet another conversation with an anaesthetist who felt exactly the same (from the perspective of her profession).

This quandary raises two especially important issues: appropriate patient selection and safe administration of an anaesthetic agent. The first relies on accurate diagnosis of MDD and suicidality or bipolar disorder

and careful exclusion of schizophrenic patients or those who are manic or hypomanic. The second, equally if not more important, recognises that ketamine is an anaesthetic and, notwithstanding an impeccable safety record due largely to a self-maintained airway and intact gag reflex, airway (and other) emergencies can and do arise. The ability to recognise and deal with such emergencies is, in my view, non-negotiable when administering ketamine (by any route). Therefore, even intranasal esketamine (Spravato™) is administered in a hospital setting in the US.

"KETAMINE REMAINS AN ANAESTHETIC AGENT. THE ABILITY TO RECOGNISE AND MANAGE EMERGENCIES IS PARAMOUNT."

In our Irish Emergency Department, we would not permit registrars to administer ketamine for procedural sedation unless they had attended a recognised sedation course and had advanced airway management skills. In South African practice the attitude is somewhat more gung-ho, and interns and community service doctors administer large doses of ketamine with impunity and little oversight. That there are not more adverse events speaks to the safety of the drug and in no way justifies any misguided sense of invincibility felt by the inexperienced junior doctor administering it.

It is worth mentioning that ketamine via the intramuscular route (used at times for acute trauma when vascular access is not immediately achievable) is no safer than intravenous ketamine. Absorption can be unpredictable, and any adverse effects cannot be curtailed by 'switching-off the infusion'.

THE LEFT HAND DOESN'T KNOW WHAT THE RIGHT IS DOING, OR DOES IT?

Ketamine is cheap.

Call me cynical, but this is why ketamine infusion, despite a wealth of evidence, is not yet mainstream therapy for treatment resistant depression and, in particular, suicidality. The racemic (50:50) mixture of the left and right mirror-image enantiomers (like a left and right hand), cannot be monetised for use in resistant mood disorders or KNAI (ketamine for non-anaesthetic indications). The patent has long since expired, along with Maddox, Stevens, Domino *et al*. To boot, ketamine is on the WHO list of 50 essential medicines with all of the associated financial implications and constraints on pricing.

Enter Spravato nasal spray. Realising that ketamine actually works for depression, Janssen in a chemical sleight of hand, isolated the left-enantiomer of racemic ketamine, esketamine, and were successful in patenting this and achieving FDA registration for use in resistant depression. Squirting it up the nose might hint at a possible outpatient utility but, no, it still has to be given under controlled clinical conditions – and, obviously, it costs a bomb. (A nuclear bomb).

Spravato costs, on average, \$750.00 per treatment (two squirts) in the US. The recommended regimen

of 8-treatments in the first month followed by one every other week translates to an annual cost of \$24,000.00 (R460,000.00). I concede that esketamine in isolation may have around five times the potency of its right-handed mirror image R-ketamine, but then the bioavailability nasally (at best 50%) cannot compare with that of the intravenous racemic mother compound. Bearing in mind that the aforementioned costs don't even include cost of monitoring in a clinical environment, this mode of administration is a non-starter in South Africa, particularly considering the exchange rate. There is no compelling evidence that the efficacy of intranasal esketamine exceeds or even matches that of intravenous racemic ketamine.

KETAMINE, SUICIDE, AND A VIRUS

The global disease burden of depression is massive. Ironically, authors of the most consequential of all antidepressant trials (STAR*D) back in 2006⁵ predicted that in 2020, depression would be the second leading cause of disability globally. Subsequent researchers predicted that 2030 would see depression as the leading cause. Had these soothsayers only known about COVID-19, how might they have adjusted their predictions?

Reger *et al* in an article published in JAMA Psychiatry in April 2020⁶ describe suicide mortality and COVID-19 as a 'perfect storm'. Suicide hotlines around the world are reporting a threefold increase in calls. Given that South Africa already boasts a suicide rate four times the global average this uptick alone probably poses a risk to life greater than the mortality from the virus itself.

Consider that the unemployment rate in isolation corresponds to a linear increase in suicide rate – then add the isolation of lockdown, domestic abuse, and fear of the virus itself. It is hard to imagine depression and suicidality not reaching the top spot (certainly in South Africa).

"THE UPTICK IN THE SOUTH AFRICAN SUICIDE RATE SINCE LOCKDOWN WILL PROBABLY ACCOUNT FOR MORE MORTALITY THAN THE VIRUS ITSELF."

At such a time as this, if there were an affordable treatment that could offer a rapid and robust antidepressant effect with reversal of suicidal ideation in most cases, why would this remain in the wings? This is ketamine's time. Not at the expense of traditional monoaminergics, mood stabilisers and CBT but as an adjunct, and a crucial one at that.

"SUICIDE HOTLINES ARE REPORTING A THREEFOLD INCREASE IN CALLS SINCE LOCKDOWN."

STAR*D showed that only one third of patients respond to a single antidepressant, a further third requires up to four medications and the balance are termed 'treatment resistant'. Furthermore, the study concluded

that for most patients, 'remission requires repeated trials of sufficiently sustained, vigorously dosed antidepressant medication' and that physicians should 'give maximal but tolerable doses for at least 8-weeks before deciding that an intervention has failed'. Is ketamine infusion not custom-made to offer remission during this period of tinkering? What of the one-third who remain 'treatment resistant'?

Is it not time, given the anticipated flood of newly diagnosed depression and exacerbation of the condition in existing sufferers to move racemic ketamine out of the shadows and into the spotlight in both the private and public sectors? This is already happening in the NHS.

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

Dr Howard founded Ketamine Clinics of South Africa (KCSA) in August 2019 and is president of the Society of Ketamine Practitioners of South Africa (SOKePSA). He is a member of the American Society of Ketamine Physicians (ASKP). **Correspondence: info@ketamineclinics.co.za** ■

¹ Van Schaik Publishers 2006 ISBN 0 627 0263 1 1

² Howard A, *et al*, Cranial burr holes in the Emergency Department: to drill or not to drill? *Emerg Med J* 2019;0:1-4. doi:10.1136/emmermed-2019-208943

A KETAMINE CLINIC IN THE HILLS

KETAMINE CLINICS OF SOUTH AFRICA (KCSA) HILTON

Alan Howard

Our flagship ketamine clinic is located just off the N3 in the undulating hills of the Natal Midlands. Notwithstanding the fact that any new initiative always takes time to gather momentum and that COVID forced us to all but close for several weeks, we have administered over 700 infusions to more than 120 patients in around six months of operation. Our patients have ranged in age from 14 to 73.

Our clinic is based in a modern medical centre adjacent to the Hilton Life Hospital. Patients are treated in two infusion cubicles in comfortable, mechanised recliners. Eye shields, noise cancelling headphones and a range of gentle music are offered. Vital parameters are continuously monitored (pulse rate, respiratory rate, SpO2, NIBP, ECG) and finely calibrated syringe drivers administer the ketamine. A well-stocked resuscitation trolley is immediately at hand, including a defibrillator, oxygen, and a range of airway adjuncts. In the unlikely event intubation is ever required, drugs (including paralytic agents) are always stocked.

THE CLINIC IS STAFFED BY DOCTORS AND ANAESTHETISTS FAMILIAR WITH KETAMINE AND WITH THE REQUISITE TRAINING IN AIRWAY MANAGEMENT.

At KCSA, we rely on the diagnoses of experts in psychiatry and psychology, who are our primary referral source. They, in turn, trust in the clinical skills (airway management chief amongst them) of the doctors, anaesthetists and ICU-trained nurses caring for their patients in our clinic. It is a collaboration that works – but it does require a recognition and acknowledgment of personal limitations and egos need to be set aside. I vividly recall administering ketamine to an Irish teenager with a dislocated ankle. I didn't know he was schizophrenic. The emergence



KCSA's flagship ketamine clinic is in a modern medical centre in the Kwa-Zulu Natal Midlands.

precipitated a florid psychosis, but he survived unscathed. I hate to imagine the distress that would be caused by a paradoxical respiratory arrest and desaturation after ketamine administered in an inappropriate environment by someone unprepared and ill-equipped to deal with such an event.

"OUR CONTINGENT OF NURSES AT KCSA ALL HAVE ICU TRAINING AND EXPERIENCE."

While we do actively market and advertise our infusion service publicly and hope to reach all those battling resistant depression and suicidality, patients are always advised to discuss ketamine infusion as an option with their psychiatrist and general practitioner first. Formal engagement with and referral to KCSA by treating practitioners is our preferred route. We will always endeavour to contact, remain engaged with, and provide follow up to referring colleagues. Patients are instructed not to change any existing medication without first consulting the

prescribing practitioner and to maintain scheduled consultations and CBT. We find that CBT is reported to be more effective in those undergoing a series of ketamine infusions.

We do liaise with referring practitioners to discuss advisability of reducing or stopping certain medications before ketamine infusions owing to probable GABA / Glutamate conflict with certain drugs like lamotrigine and benzodiazepines. These may reduce the efficacy of ketamine but are by no means contraindicated.

Patients have access via our website, to online forms used to track progress. These are submitted via a secure server. We use the PHQ-9 form, which is simple, subjective, and well validated against both the HAM-D and MADRS. On completion of an infusion series (usually six infusions over a two to three-week period), patients submit online feedback. Several patients present for maintenance infusions on a monthly or six-weekly basis and remission is thus well maintained. Feedback is provided to patients' GPs and psychiatrists.

Several patients have travelled to our facility from other provinces for a two-week treatment regimen. The proximity of superb yet affordable accommodation has proved extremely useful.



Patients at KCSA are constantly monitored during infusions and recline in comfortable infusion chairs.

Our results have been heart-warming. Below are comments from a few patients, submitted after completion of their infusion series:

"Ketamine has definitely made a vast difference to my overall wellbeing."

"Those six infusions have given me my life back."

"This has given me hope for the future, and for that I am incredibly grateful."

"Now I feel capable of doing and achieving so much."

"This treatment has normalised my daily living."

"My thinking is no longer affected by fear, anxiety and hopelessness."

"I take care of myself. I shave more often, shine my shoes, apply body lotion – things I struggled to do for the past 25 years."

"Haven't felt like my normal self in over two-and-a-half years – life just feels like a blur and I've loads of catching up to do."

"From being suicidal to getting out of bed and being interested in life again is actually a miracle."

"I love me now."

"I truly believe that this has saved her life." (Mother of a 14-year old suicidal girl who tried to hang herself.) – the child herself wrote this:

Please describe in your own words the effect your Ketamine infusions have had on your life.

at first I didn't think that it would work. I only realized how sad I was until I was happy. Ketamine worked really well and I can't wait for the rest of this year. I'm actually having good days at school.

KCSA TO EXTEND ITS REACH

The lockdown curtailed plans to clone our Hilton clinic elsewhere in South Africa. Nevertheless, and particularly at this time of soaring depression and suicidality, this will rapidly get back on track.

I welcome approaches from colleagues (individually or corporately) interested in running a ketamine clinic in their area using the KCSA blueprint and branding. To this end, very accommodating franchise arrangements are in place, and training for nursing staff is offered at our Hilton branch.

"THOSE INTERESTED IN OPENING A KETAMINE CLINIC WILL BE GIVEN ACCESS TO THE KCSA BLUEPRINT AND BRANDING, AND WE OFFER TRAINING FOR NURSING STAFF AT OUR HILTON BRANCH."

FUNDERS AND THE COURT OF PROFESSIONAL OPINION

Any therapy outside of the mainstream is understandably subjected to extra scrutiny. Ketamine infusion is no exception. It does feel though, as if the bar for acceptance of ketamine as an effective and rational choice for a specific cohort of patients is raised substantially higher than that for other mainstream, and generally less effective options. To what extent convention bias drives this is open to debate. Nobody expects monoaminergics to 'cure' depression in the short term, yet they can be extremely effective treatment in responsive patients.

IF KETAMINE WERE HELD TO THE SAME STANDARD, PARTICULARLY IN RESPECT OF ONSET OF ACTION AND EFFECT ON SUICIDALITY, IT WOULD COME THROUGH WITH FLYING COLOURS.

All of the patients treated at KCSA Hilton thus far have one thing in common; they could afford the treatment privately. Patients who are members of medical aid

schemes are frequently turned away as, inexplicably, their funders do not provide benefits for ketamine infusions. Their members continue to trudge along the trajectory of costly conventional polypharmacy, often ECT and frequently hospitalisation. Many end up in expensive, longer-term inpatient facilities. Several, sadly, end their lives.

At KCSA, we neither support nor condone claiming benefits on behalf of patients for ketamine infusions under other guises, for example, as in-patient ECT. This happens frequently. These infusions are often given in inappropriate surroundings and efficacy is reduced if minute attention is not paid to the therapeutic milieu. We would rather (through the agency of SOKePSA – see later) engage with funders transparently and seek their recognition and acceptance of ketamine infusion as appropriate and beneficial for selected patients.

I recently approached a major funder who, to their credit, researched Cochrane reviews, meta-analyses and trials. They concluded that funding should be denied as: *'there is no evidence showing long-term benefit'* (after a single infusion). In the same email, they conceded that their research had shown that: *'ketamine provided a rapid antidepressant effect with a maximum efficacy reached at 24-hours'* and that *'its effect lasted for 1-2 weeks after infusion.'* After a single encounter with any drug, this sounds like something to get excited about.

I frequently hear detractors advance safety concerns as a reason to view ketamine with extreme prejudice. I remind them that ketamine has a safety record spanning half a century, is on the WHO's list of fifty most essential medications, and is the commonest procedural sedative worldwide given literally thousands of times a day at three to four times the dose used for depression. In fact, if one considers that, in the third world in particular, clinically unstable children with severe burns have dressing changes every few days for extended periods under ketamine boluses, the perceived risk is hard to fathom. Sure, a few hundred ketamine addicts in China ingesting grams of ketamine daily developed ulcerative cystitis and psychological addiction can occur with frequent use, however the benefit of appropriate administration far outweighs risk.

"KETAMINE HAS A SAFETY RECORD SPANNING HALF A CENTURY."

As alluded to earlier, the very nature of ketamine infusion demands multidisciplinary input. It occurred to me that to protect patients, those administering ketamine and to preserve ketamine's reputation, consensus guidelines and oversight might be achievable through the formation of a society with a multidisciplinary board. It is my sincere hope that such a united voice engaging with funders might succeed in securing benefits for patients at this time of greatest need.

THE SOCIETY OF KETAMINE PRACTITIONERS OF SOUTH AFRICA (SOKEPSA) WAS FORMED IN APRIL 2020. THE BOARD INCLUDES A PSYCHIATRIST IN PRIVATE PRACTICE, A PROFESSOR OF PSYCHIATRY, A CLINICAL PSYCHOLOGIST, A SPECIALIST ANAESTHETIST, EMERGENCY PHYSICIAN AND A PROFESSIONAL ICU NURSE.

Applications for membership of SOKePSA are open to professionals from any discipline, whether directly involved in the prescribing and administering of ketamine or not, who espouse the safe, regulated, and appropriate administration of ketamine for treatment resistant depression and suicidality.

As a board, we hope to model SOKePSA on the highly successful American Society of Ketamine Physicians (ASKP) and offer clinical guidelines, webinars and other resources to members.

Through the establishment of a national registry of patients and our partnership with UKZN department of Psychiatry we aim to generate valuable prospective data needed for research. To this end database and analytical software has already been written for upload and analysis of multiple parameters and variables.

THE FINAL WORD

Society of Ketamine Practitioners of South Africa



I am passionate about bringing ketamine infusion therapy to those enslaved by resistant depression. What for me began as curious anecdotal observations in patients

who had received ketamine in my Emergency Department became more focused research and ultimately first-hand observation of the multiple patients I have treated at KCSA in Hilton, Kwa Zulu Natal. I do hope readers will be equally intrigued by what is no longer a truly novel therapy but is moving rapidly towards the mainstream. To those who share my vision and views, please join SOKePSA and become part of this initiative. When Sernyl was assigned to the scrap heap over 50-years ago, we almost lost ketamine for ever. Thank goodness for Stevens and his tinkering.

- **Dr Alan Howard can be contacted on 082 416 9643**
- **More information about KCSA can be found at www.ketamineclinics.co.za**
- **Those interested in SOKePSA membership, please email info@sokepsa.co.za**
- **Should you wish to discuss developing and running a KCSA clinic in your area, please email info@ketamineclinics.co.za or contact Dr Howard directly on the number above ■**

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* Depression, as defined by DSM-IV Criteria; DPNP = Diabetic peripheral neuropathic pain
Reference: 1. Yelate 30/60 package insert. Dr. Reddy's Laboratories (Pty) Ltd. December 2012

Yelate 30/60. Each capsule contains duloxetine hydrochloride equivalent to duloxetine 30/60 mg. Reg No's 44/1.2/0114;0115. Dr. Reddy's Laboratories (Pty) Ltd. Reg no. 2002/014163/07. 204 Rivonia Road, Block B, Morningside, Sandton. 2057. www.drreddys.co.za. ZA/01/2020-22/Yel/001

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

DR. REDDY'S: CORONAVIRUS DISEASE (COVID-19) OUTBREAK THE RIGHTS, ROLES AND RESPONSIBILITIES OF HEALTH WORKERS.

Dear Healthcare Practitioner,

In the interests of best healthcare and safety practices, Dr. Reddy's is supporting you and your team with this WHO poster, detailing the rights, roles and responsibilities of health workers.

We invite you to download the poster from [MEDePRO](#) to display in your offices, surgeries, clinics, hospitals and pharmacies. Stay safe, and thank you for all you are doing for your community in this era of COVID-19.

Dr. Reddy's ■

Coronavirus disease (COVID-19) outbreak: rights, roles and responsibilities of health workers, including key considerations for occupational safety and health.¹

Interim Guidance, 19 March 2020. World Health Organization



BACKGROUND

Health workers are at the front line of the COVID-19 outbreak response and as such are exposed to hazards that put them at risk of infection. Hazards include pathogen exposure, long working hours, psychological distress, fatigue, occupational burnout, stigma, and physical and psychological violence. This document highlights the rights and responsibilities of health workers, including the specific measures needed to protect occupational safety and health.

Health worker rights, roles and responsibilities:

Health worker rights include the expectation that employers and managers in health facilities:

- assume overall responsibility to ensure that all necessary preventive and protective measures are taken to minimize occupational safety and health risks;
- provide information, instruction, and training on occupational safety and health, including:
 - refresher training on infection prevention and control (IPC);
 - use, putting on, taking off and disposal of personal protective equipment (PPE);
- provide adequate IPC and PPE supplies (masks, gloves, goggles, gowns, hand sanitizer, soap and water, cleaning supplies) in sufficient quantity to those caring for suspected or confirmed COVID-19 patients, such that workers do not incur expenses for occupational safety and health requirements;
- familiarise personnel with technical updates on COVID-19 and provide appropriate tools to assess, triage, test, and treat patients, and to

- allow health workers to exercise the right to remove themselves from a work situation that they have reasonable justification to believe presents an imminent and serious danger to their life or health, and protect health workers exercising this right from any undue consequences;
- not require health workers to return to a work situation where there has been a serious danger to life or health until any necessary remedial action has been taken;
- honour the right to compensation, rehabilitation, and curative services for health workers infected with COVID-19 following exposure in the workplace – considered as an occupational disease arising from occupational exposure;
- provide access to mental health and counselling resources; and
- enable cooperation between management and health workers and their representatives.

Health workers should:

- follow established occupational safety and health procedures, avoid exposing others to health and safety risks, and participate in employer-provided occupational safety and health training;
- use provided protocols to assess, triage, and treat patients;
- treat patients with respect, compassion, and dignity;
- maintain patient confidentiality;
- swiftly follow established public health reporting procedures of suspected and confirmed cases;
- provide or reinforce accurate IPC and public health information, including to concerned people who have neither symptoms nor risk;
- put on, use, take off, and dispose of PPE properly;
- self-monitor for signs of illness and self-isolate and report illness to

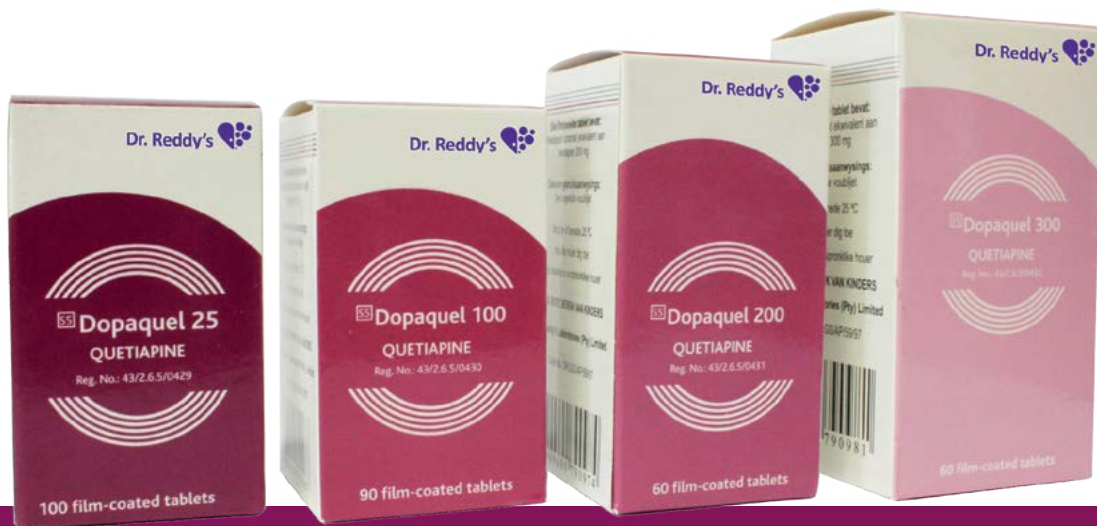
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1. IQVIA, TPM data, Nov Mat 2019; Impact RX, Mat. November 2019.

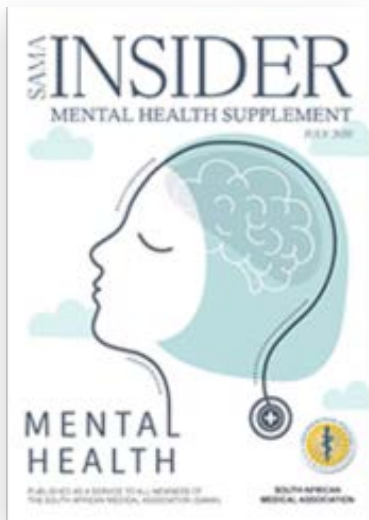
SR Dopaquel 25/100/200/300. Each tablet contains quetiapine fumarate equivalent to quetiapine 25 mg/100 mg/200 mg/300 mg. Reg No's 43/2.6.5/0429;0430;0431;0432. Dr. Reddy's Laboratories (Pty) Ltd. Reg no. 2002/014163/07. 204 Rivonia Road, Block B, Morningside, Sandton. 2057. www.drreddys.co.za. ZA/01/2020-22/Dopaquel/003

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SAMA INSIDER

MENTAL HEALTH

SUPPLEMENT



During COVID-19, mental health among healthcare workers is paramount as we reel under the pressure of this pandemic. "Now is the time for each healthcare worker to ensure that . . . we do not neglect an essential part of this equation - ourselves," says Prof. Zuki Zingela in her guest editorial. This mental health supplement has been compiled with this mind. <https://hmpgjournals.co.za/issues/si/202007-sup/>

Diane de Kock,
Editor ■



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MESSAGE FROM THE WPA PRESIDENT

Colleagues, 2020 has been a challenging year. Globally, we have all felt the effects of the COVID-19 pandemic. At a local level, many countries have also had to contend with additional crises – fires, floods, earthquakes, mass displacements, political and social unrest, and more.

TRAGICALLY, JUST OVER A WEEK AGO, OUR FRIENDS AND COLLEAGUES IN BEIRUT EXPERIENCED NEW AND HEARTBREAKING LOSS IN ALL CORNERS OF THEIR COMMUNITY FOLLOWING A LARGE EXPLOSION THAT DEVASTATED MANY OF THE CITY'S MOST POPULATED AREAS. THIS TRAGEDY COMES AT A TIME WHEN THE COUNTRY IS ALREADY BATTLING THE PANDEMIC, ECONOMIC CRISIS AND OTHER MAJOR PROBLEMS. THERE IS LITTLE DOUBT THAT THE MENTAL HEALTH IMPACTS WILL BE GREAT.

At WPA, we extend our heartfelt sympathy to the Lebanese Psychiatric Association (LPA) and to all in Lebanon, standing ready to support our colleagues and their communities in any way we can. Colleagues in Lebanon have a strong record of coordinated and expert work in dealing with

grave adversities. At this time, the WPA's emergency response executive and the Advisory Committee for Responses to Emergencies (ACRE), are working with them to understand how we can best be of practical help.

Establishing ACRE over the last few month positions WPA to respond rapidly, and as effectively as possible, to such a new challenge. At the same time, we are aware that coping with the pandemic remains a preoccupying and distressing reality for many colleagues across the world. ACRE continues to focus on responding to this – whether it be with advice, tools, counsel, connections or even funding for priority projects. Our website remains a key portal for information in this regard and, for this reason, I include here links to our COVID-19 resources library, news stories and our meetings pages detailing the new dates or formats of forthcoming meetings.

Our solidarity as an association of psychiatrists is a precious attribute that we continue to nurture and use in times of crisis.

We hope soon for better times.

Best wishes

Helen

Prof. Helen Herrman AO
WPA President ■



20TH WPA WORLD CONGRESS OF PSYCHIATRY
NEW DATES BANGKOK, 10-13 MARCH 2021

PSYCHIATRY
 IN A TROUBLED
 WORLD

20TH WORLD CONGRESS OF PSYCHIATRY BANGKOK RESCHEDULED TO 10-13 MARCH 2021

The 20th WPA World Congress of Psychiatry has the impact of COVID-19 on many areas of our lives is indisputable. All over the world we have seen strict limitations imposed on social contact and travel – and for many countries that doesn't look set to change any time soon. With many of the restrictions unlikely to be lifted by October 2020, WPA has made the decision to postpone the 20th WPA World Congress of Psychiatry in Bangkok to 10-13 March 2021.

Why didn't you do an online meeting instead?

Online meetings have some terrific benefits, but one of the key reasons so many of you come to the WCP is to meet and network with colleagues in person. Moving the Congress means we can have the same great program with the same networking benefits

What if I'm already registered for the October meeting?

Don't worry! All current registrations will be transferred to the new dates.

What if I can no longer attend?

Get in touch with us so we can work out a solution.
<http://redirect.kenes.com/dh0JFnitFIOk800U6U110Q0>

Does this mean I have more time to submit an abstract?

Yes, it does! See alongside for more details.

We know there are more questions to be answered, and we will continue to provide updates on the

Congress website and also directly to our faculty, industry partners and registrants.

In the meantime, click [here](#) to find answers to some of the most frequently asked questions.

SOME GOOD NEWS – ABSTRACT SUBMISSION IS RE-OPENING

The COVID-19 pandemic emphasizes the importance of global collaboration in advancing science – and we have seen an abundance of research and initiatives supporting mental health during this time. The research we do today will provide the data that informs the future.

Submit an abstract and make your contribution to the advancement of mental health worldwide.

The Abstract submission system will re-open on 8 June 2020.

Make your contribution: <http://redirect.kenes.com/UlyF06K0JU1QhG01nt000V8>

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DEPARTMENTS OF PSYCHIATRY

UNIVERSITY OF THE WITWATERSRAND



COVID - 19 UPDATE *Prof Subramaney – Academic Head*

- The past 3 months have been dominated by the COVID-19 pandemic with ramifications throughout. As with all other centres no doubt, it has had a significant impact on the academic activities in the Department of Psychiatry.
- Due to concerns around gatherings of groups of people, academic meetings such as journal clubs, registrar tutorials and case presentations were mostly suspended in March, with the commencement of the lockdown period. More recently, certain sites have begun to conduct these meetings virtually.
- The postponement and suspension of the CMSA examinations has affected registrars at various levels. A lot of anxiety has however been allayed by the fact that registrar posts were extended or medical officer posts provided for those affected. The spin-off of course is that delay in the CMSA exams did provide the senior registrars with additional time to complete research and finalise logbooks before writing finals
- We have moved to a virtual world with online content of lectures being available, with the energies of our PG COORDINATOR Dr Ralf Brummerhof coming to the fore in the provision of an active e-learning website. Audio presentations for lectures have been uploaded onto the e-learning platform along with the PowerPoint presentations
- Regarding research: registrars have been able to continue with protocol development, data collection and analysis as well as final write-up.
- It has been quite a challenge as we have been forced to balance the need for teaching, with the need to social distance. We have also been dealing with heightened levels of anxiety around the disease (both from our colleagues as well as our patients) as well as many changes in the operations of sites, and additional clinical duties.
- In community psychiatry, in keeping with DoH recommendations we had to temporarily close down some of our smaller clinics and give three months repeat scripts to our stable users. This plan has however posed a lot of difficulties because of medication shortages in Gauteng, so our clinic numbers have not decreased.
- Generally, people have been somewhat anxious and distracted by the COVID-19 situation - which may have had a negative impact on people's abilities to focus on their academic (and other) activities. Certainly, the practical role of the registrar/MO has expanded to include all the COVID-related clinical responsibilities - e.g. conducting COVID tests, managing suspect cases in isolation, quarantining new patients, etc. - which have been a stressful burden. And some who have undergone testing themselves have found the experience (including issues such as stigma from others for being possibly COVID positive) quite traumatic - all quite disruptive to the normal academic and clinical roles of a registrar.
- Staff appear to be getting more comfortable with the use of online platforms for academic and other activities - such as webinars and online meetings on platforms such as MS Teams or Zoom. Staff are still getting familiar with and learning the etiquette around online interaction. But with being "forced" to do things online over the past couple of months, the whole online concept is much less foreign and intimidating now - a positive spin-off of the COVID situation.
- At general acute hospitals on the circuit for the first week after stage 5 lockdown, we had a spurt of admissions relating to substance withdrawal, especially alcohol. The numbers entering casualty reduced then spiked again once alcohol was readily available. There was an increase in substance related disorders overall, not just alcohol

- Staffing: Several members have tested positive or had concerns regarding symptoms and went for testing, which required time off waiting results.
- Staffing numbers have therefore waxed and waned with the remaining workforce picking up the slack. Burnout amongst staff that are overstretched is a real worry.
- On July 1 we welcomed the following new registrars to the Wits circuit:

Dr. R Moshori	Dr. Z Dlamini
Dr. A Badat	Dr. L Mabulwana
Dr. M Mathekga	Dr. L Narayan
Dr. B Mhle	Dr. M Stopford ■

MEMORIAL SERVICE - PROFESSOR JANSE VAN RENSBURG *Sanushka Moodley*

Where there is great grief, there is great loss...

On the 23rd of April 2020 we received the devastating news of the untimely passing of Professor Bernard Janse van Rensburg, a man who meant so much to so many. We continue to mourn the loss of a leader, a mentor, a passionate academic, an advocate for those most vulnerable and a dear friend. This loss is far reaching and ever expanding, not only to our profession but also our community.

Professor Bernard Janse van Rensburg's passing came at a time when South Africa was forced to rapidly adapt to the COVID-19 pandemic. The way we were to grieve and mourn had to adapt in the wake of these unprecedented times. We needed to find a way to honour him, to remember him, to celebrate him and to mourn this loss as his passing created ripples in our lives. There was an international outpouring of tributes and a growing need to find a way to honour this great man. There was a flood of tributes and beautiful anecdotes received from psychiatry registrars who were mentored by him; which speaks to his character, his passion for facilitating the growth of others and his far reaching impact – how he would have smiled with that sparkle in his eye had he read these. In a time where we were unable to gather together to reflect and honour his legacy, where we were unable to give each other the comfort of physical presence, a hug or the holding of a hand, it became clear that we needed to be like the reed and bend, not break. We'd like to think he would be proud of us, adapting to a new format so quickly and when needed – he himself inspired many of us to adapt and change as needed, in the teaching and learning space.

A virtual memorial service was held for Professor Bernard Janse van Rensburg on the 6th of May 2020. There were many moving speeches and the written dedications were set to Chopin's prelude number 4 in e minor, especially for him. The virtual memorial service was attended by over 200 people, and served as a reminder of how many lives he touched and provided a space to give comfort as we mourned; and gratitude as we remembered.

The online memorial service was most importantly attended by his family, in the hope that we would be able to offer our heartfelt condolences to them and offer our appreciation for sharing their husband and father with us, for which we will be forever grateful ■



A LIFE REMEMBERED PROFESSOR BERNARD JANSE VAN RENSBURG 12/04/1960 – 23/04/2020

[Click here to access the full powerpoint document](#)

To those of us who knew him well, and those who admired him from afar, this is no doubt a huge shock and leaves us numbed by the reality of his passing. As the Board of Directors of SASOP, we are overcome by grief, and the loss of a colleague, a leader, a mentor, a dear friend, an academic and kind gentle soul. Bernard was the Immediate Past-President of the South African Society of Psychiatrists. Amongst his numerous other leadership roles in psychiatry, he was the Secretary of the World Psychiatric Association (WPA) Section on Religion, Spirituality and Psychiatry and an honorary member of the WPA. He was also the chair of the SAMA Academic Doctors Association (ADASA). He was an experienced organizer and convener of CPD-accredited academic meetings, including chairing the local organizing committee of the WPA International Congress in Cape Town, co-hosted by the SASOP in November 2016.

Prof Bernard Janse van Rensburg was an Associate Professor of Psychiatry at the University of the Witwatersrand (WITS) in Johannesburg, South Africa, and head of the psychiatric unit at the Helen Joseph Hospital. He completed his medical training in 1983 and qualified as a psychiatrist in 1996. He obtained a PhD from WITS in 2010 on the role of spirituality in psychiatric practice and his experience included health planning and epidemiology, general and consultation liaison psychiatry, research development and governance of professional associations. He also completed a Post Graduate Diploma in Health Sciences Education in 2018, consolidating an approach to teaching and learning theory, as well as under and post graduate curriculum planning, teaching methods and assessment. He was appointed in March 2019 as Assistant Head of School for Cluster B (Psychiatry, Internal Medicine, Neurosciences and Radiation Sciences) of the School of Clinical Medicine of



the WITS Faculty of Health Sciences. Perhaps we will best remember Bernard for championing the establishment of the National Mental Health Alliance of mental health organisations during his presidency in order to strengthen advocacy for mental illness. He was passionate about the social contract that psychiatrists have with our society. He was also instrumental in the stance SASOP took against the Gauteng Marathon Project that led to the Life Esidimeni tragedy. His meticulous record keeping enabled SASOP to easily demonstrate all our efforts in advising the government against the project.

Lastly, he put a huge amount of effort, at great personal sacrifice, in order to successfully host the WPA International Congress in Cape Town in 2016. This congress was an important catalyst to showcasing South African psychiatry on the world stage. Those of us who were fortunate to serve with him would probably say that he had an amazing mind of seeing how different parts of a puzzle fit together, a beautiful heart, and deeply passionate about psychiatry. While we remember him fondly, we salute his immense personal sacrifices as the past president of SASOP and we mourn the loss of a gentle giant in Psychiatry in South Africa.

Rest in Peace Beloved Bernard

Solly Rataemane

We express heart felt condolences at the sad and untimely demise of Prof Bernard Janse van Rensburg, Past President of the South African Society of Psychiatrists (SASOP) and Chair of the local organizing committee of the WPA International Congress, Cape Town 2016.

We join Bernard's family, friends and colleagues in this hour of grief.

Yours sincerely,

Roy

Secretary General, World Psychiatric Association

I have learnt with deep sorrow the passing on of Professor Bernard Janse van Rensburg. At least to me, Prof. Bernard Janse van Rensburg was easygoing, humble and listened carefully and contributed to what was being discussed whether in a group or one on one. He had leadership skills that your Society (South African Society of Psychiatrists) recognized when you elected him your President and the

University recognized to Head the Department of Psychiatry. He will be missed by all he touched. On behalf of all Psychiatrists in Zone 14, please accept my condolences -Extend these on my behalf to his family and his colleagues at the Department. Our thoughts are on your Society and the family as you all go through this.

Yours faithfully,

David Ndetei

WPA Zone 14 Representative

Thank you, Prof, for never once leading by instruction, but always by example. Thank you for teaching me what the textbooks could never: that there is always time to check in on how someone is really doing, that no concern is too small to be shared, and that an open door invites not only physical presence, but a space to reflect on failures, strategise growth and take in the present circumstance.

Thank you for coaching me to use my reg time not only to become a psychiatrist, but to explore who I am, what I stand for and establish what I genuinely want out of life.

Thank you for being different. Thank you for making a difference. You were, indeed, my trusted adviser.

Jade Bouwer



Prof Janse van Rensburg was a kind, humble and caring person. Prof always showed respect to anyone he encountered, be it colleagues, trainees, staff or patients. He knew all the doctors, nursing staff, security and cleaners that worked with and around him, always greeting them by name. Those that had the privilege to know him, or just spend some time with him, did not leave the same. He had the capacity to positively influence others, to make them feel important and ultimately make them better people. Even though Prof's academic achievements are a marvel in themselves, they are dwarfed by his compassion and love for people. Although his passing came much too soon, he more than achieved the goal of life: to leave a legacy of change. The world is a better place than when he came into it and he will be sorely missed. We are ever grateful to have had the opportunity to be in his company.

Dr JW Erasmus

Dear Bernard,

I will always remember you as a very kind person. You noticed me. You made me feel so nurtured and so safe. You always smiled at me when you came into a room I was in. You gave me a sense of self worth – you validated me. You will always be truly special to me.

With all my love

Helen



The Lord bless you and keep you
The Lord make his face to shine upon you
And be gracious unto you
The Lord lift up the light of his countenance upon you
And give you peace
Amen

John Rutter



Professor van Rensburg has had a profound impact on my registrarship, and it is difficult to capture his essence in words. Perhaps my first and last encounter with Prof will shed some light onto how much he has shaped me as a future psychiatrist.

The first time I spoke to Prof was when I was a community service doctor at South Rand Hospital. It was a brief phone call, that left me with a sense of calm when I was engulfed in a storm. At the time, I was the sole doctor in a ward of 31 male psychiatric

patients. We were having bed shortages and there was a lot of pressure to discharge patients. I called Prof to ask if Helen Joseph Hospital could assist. His response was that he would personally set up a meeting with the management of South Rand Hospital, and that these were not my battles to fight.

I did not know Prof at the time, yet he took on my predicament as if it were his own. He reminded me that my primary commitment as a clinician was towards my patients, and bureaucratic burdens were not mine to carry. This lesson will stay with me for as long as I am a doctor: my foremost priority should be patient care. Even while juggling administrative duties, academic obligations, managerial roles, political agendas etc. (the list goes on), Prof still made time to come to the ward or emergency department to review a patient with me.

Tejil Morar

Dear Colleagues,

The sad and untimely demise of Dr Rensburg is shocking news. I was fortunate to meet him at Berlin in 2017 and was in touch with him since then. He was full of life and was very cordial. The Gods above have this habit of taking away good people much before their time.

We share the grief of the bereaved family and friends. Our thoughts are with them.

Dr(Brig) M S V K Raju

Veteran Armed Forces Medical Services of India

Member World Psychiatric Association (Hon)

International Distinguished Fellow American Psychiatric Association



Dear colleagues,

This is such sad news. I met Prof Janse van Rensburg several times, he was always gracious, kind and insightful. His humanity always shone through, even my wife and children who met him just once recall this. Bernard will be deeply missed, and heartfelt condolences to his family and loved ones.

In sympathy,

Sonu

Dr. K. Sonu Gaind, MD, FRCP(C), DFCPA, FAPACHief of Psychiatry/Medical Director of Mental Health, Humber River Hospital Co-Director, Adult Psychiatry Health Systems, University of Toronto Department of Psychiatry WPA Zone 1 Representative Governor & Associate Professor, University of Toronto



I so wish I could have had the opportunity to work more closely with Prof Van Rensburg. From the brief time I did have the privilege of working with him, especially over the past few months, my impressions were that of a man with an unquenchable thirst for excellence, boundless energy, compassion and a camp fighter for the rights of the most vulnerable – our patients. May you rest in peace, Prof, and may your legacy live on in the work that we do. You have left giant footsteps to walk in.

You truly encapsulated the words of young American activist, Mattie J. Stepanek, when he said, *'While we are living in the present, we must celebrate life every day, knowing that we are becoming history with every work, every action, every deed.'*

Dr Alicia Swart



He will be remembered for being a constant paternal presence in psychiatry. His insights and thoughts and mindful inputs will always be cherished. His inclusion of the MDT team in his teachings were appreciated and internalized. *Lala ngoxolo Prof.*

Regards

Lunga

Bara psychologist

Dear Prof,

Words don't do justice to describe the warm natured, kind spirit that you exuded. Your strength, was the way in which you listened and actually heard each comment no matter how minor it may have been. Thank you for the constant support. *Rest in Peace our Dear Prof.*

Jasmin

Our cherished and highly esteemed 'Prof' will be appropriately acknowledged in many tributes. These will extol his excellence in humanitarian, academic, and clinical aspects of leadership, and will also show him to have been a highly respected spokesperson, administrator and researcher. But today I want to briefly mention something that I feel was iconic of Prof – he was "personable".

It is not often that one meets a man of such distinction who can still engage with interest in the concerns of all his staff, registrars, medical officers and interns alike. His "open door" policy meant that whilst you may have had to queue with other colleagues hoping to catch a moment with him, he always made time to listen, causing him often to be the last to leave the department. He would opt to do administrative work after hours, having prioritised staff needs. He taught through example. His aim as a psychiatrist, to make people whole, was extended to all in his care. He offered suggestion rather than judgement, always seeking opportunities for our development.

He was known for his "Standard Operating Procedure" file, that sits in Helen Joseph ED. A thick detailed collection of directives – written with thought for both his staff and patients, ensuring quality of care for those who felt dismissed, disregarded or overlooked. He was a fastidious collector of information, both through his logbooks for staff, and in the black soft cover notebook he would scribble into endlessly.

His sudden passing has shocked us all, and we will feel his absence in many areas of academia and clinical psychiatry acutely. On a personal level, I am greatly saddened at not having had an opportunity to work more closely alongside him, as my mentor, colleague and inspiration.

Thank you Prof. for the person you were to all of us...a fine professor and human being.

Jess

Dear Prof,

It is with great difficulty that I start to realize that I will never be able to quickly come past your office again to ask a question or get some advice. Thank you for always sharing your knowledge with us. You will truly be missed.

Liesel Aldrich

We bid farewell to a gentleman who stood head and shoulders above his peers. His absence leaves a gaping hole in our country at a time when leadership in the medical field is so needed.

Prof was a man of integrity, dignity and a fountain of wisdom. He distinguished himself in every facet of the medical world. He inspired hope in the meek and lowly. He will be missed immensely by his registrars and of course by his patients, he is irreplaceable. He served them with distinction. A man of deep conviction and a profound sense of compassion, his absence will be felt among all who interacted with him.

Prof you have toiled and succeeded and achieved what only the rarest of your breed have dared to do, now Rest In Peace, as you have earned your place among the greats.

Dr Juanita Subraydoo



The sudden passing of our dear Professor Bernard van Rensburg left us all in shock and deeply saddened. The Southern Gauteng branch of SASOP is reeling from this loss and pays tribute to the huge contribution Prof van Rensburg has made to the field of Psychiatry, and the valuable role of mentoring and supporting our subgroup.

In a time when humanity is uniting against COVID-19, we've lost our biggest humanitarian who taught us all to give selflessly of ourselves and to use our skills to effect positive social change.

Prof is remembered for his selfless determination to advance the social contract psychiatry owes to society; his ideas and values far beyond most people of current times. His dedication was constant and tireless and he was so very humble about his immense achievements.

A soft spoken leader who never dictated, but through example, sincerity and good natured demeanor steered many careers and committees, to the greater good of psychiatry. A mentor that mentored through kindness and a leader that led with great humility. His many contributions to SASOP include the pivotal role he played in bringing justice to victims of the Life Esidimeni tragedy, promoting advocacy and highlighting the human rights violations of the mentally ill.

We are saddened to lose a valuable colleague; we are heartbroken to lose a most kindhearted friend.

Rest In Peace Professor Bernard van Rensburg. Gone too soon, but never forgotten. Your legacy lives on in those of us you've inspired.

Southern Gauteng SASOP Committee



Dear Bernard

Hearing of your passing left me with a puzzled disbelief. How was it possible that someone, such a vital human being, who meant so much to, and did so much for so many was no longer here?

Your impact on our community, in our profession, in our country and for our country has been immeasurable and will be acknowledged today and for a long time to come.

On a personal note, I would like to say, thank you.

Thank you for your encouragement, guidance and patience; your steady nurturing of young academics, activists and leaders in psychiatry. Thank you for your leadership, for standing up and taking mental health and psychiatry forward. For always doing this with honesty and integrity. Thank you for your vision; for having the big picture view and insisting that we participate in that. Thank you for always adding a bit of artistic flare to that vision. Thank you for your determination and excitement; for pushing on even in the face of being shouted down (a tea room full of grumpy registrars springs to mind).

Thank you for your good-natured humour and grace, for putting up with the teasing when explanations

got complicated and intense, and we were lost on the third slide. Thank you for your monumental effort; for exceptional dedication to everything that you took on and helping us understand that it all mattered. Thank you for the inspiration; for carving out really big foot prints in which we can hope to follow, and for reminding us of our priorities.

You will be deeply missed and always cherished.

I wish you gentle rest, and wish your family great comfort as life continues forever changed

Wendy Duncan

Prof was very, very humble, kind and always available. Many people come into our lives and leave. But he came into our life and left footprints on our hearts and we will cherish the moments we shared with him. His smile is heart warming and infectious. He was an exceptional person.

As Maya Angelou says: *A great soul serves everyone all the time. A great soul never dies, it brings us together again and again.*

He was indeed a **great** soul.

An excerpt from the eulogy by South Rand Hospital's Mental Health Team.



Words can not express our sadness at learning of the unexpected passing of Professor Bernard Janse van Rensburg. Our thoughts go out to all those who knew and loved him. He will be remembered as a dear friend, teacher, mentor and beloved colleague.

We will forever admire his advocacy for the the rights of the mentally ill. He was endlessly passionate and strove tirelessly to improve the patients' access to care and ensure equality in service delivery for people with mental illness. He focused on bringing about sustainable change that would help not only the patients under his care, but impact those at a national level.

He was always meticulous and had unparalleled organizational skills, which speaks to the breadth of his contributions to the wider community of psychiatry.

In addition he still found time to mentor budding psychiatrists and students. He was always approachable and willing to listen to the voices of junior doctors and never failed to support his team.

His leadership and supervision in research helped many to realise its importance. His contributions to the field of

psychiatry will live on in those who, because of his influence, continue to add to its body of knowledge.

"No one is finally dead until the ripples they cause in the world die away...The span of someone's life is only the core of their actual existence." Sir Terry Pratchett

Bernard, you will be missed but the impact you had on the lives of those who knew you will continue to ripple on.

Chris Hani Baragwanath Academic Hospital: Psychiatry

I am very grateful and proud to have met you and to be under your supervision. I know it became so hard at some stage but the end product is that you produced the best clinical officer in management of mental health users. You taught me perseverance, endurance, resilience, love, care and to be an advocate for mental health care users.

May your beautiful heart warming soul rest in peace.

Dr Niamane

South Rand Hospital



Every week seems to bring about a host of new challenges, almost exclusively centered around COVID-19 and rightly so. However, the viral cloud that suspends itself in our minds, may have blinded some of us to circumstances that have simultaneously created massive change and shaken communities.

This post is intended to honour an incredible human being who was taken from us, so suddenly.

Professor Bernard Janse van Rensburg, the Mental Health World is shaken. Your leadership, dedication to Psychiatric patients, mentorship, vision, intelligence, and above all else, kindness...will be deeply missed.

Thank you for being a part of our lives, each one of us who had the privilege of working with and alongside you. You are not forgotten, and your legacy will continue indefinitely.

Kim Laxton





I am lost for words. We have lost a true servant of the nation. A genuine public servant professional.

Prof Lukhele

Working with you was such a blessing - all the lessons learnt, your gentle, kind nature- even in correcting one - a rare trait in leaders these days. As you rest- Thank you always. You will be missed.

Dr J Malaka



This was Christmas 2017. We distributed hampers to the patients in the ward.

The Prof who literally had an open door policy. You will be missed.

Karishma Lowton

I unfortunately did not have many opportunities to work closely with Prof. The time that I did spend with him, however, showed me that Prof was extremely passionate about 3 things in particular: Research, patient care and stats. (Those stats!)

He was so generous with his time and once spent over half an hour with me while I was on call to help me manage a difficult patient. He always gave me confidence to believe that I can always do better than I think I can!

I cannot believe that I won't be able to learn more from him when I do my Helen Joseph rotation.

My deepest condolences to his friends, family and colleagues who worked closely with him. If he touched my life so deeply in such little time, I can just imagine the loss you all must be feeling .

Dr Dalene Gouws

The failure to find words during this time is symbolic of the void that Prof Van Rensburg has left in us all. My journey into psychiatry began with a nervous call to Prof in 2016. I was hoping he would remember me as one of his interns at Helen Joseph the year before. He did not, but he spoke to me with the kindness and encouragement that carried me on my first steps into specializing.

We later shared many moments together in the department. Prof counselled me through many mishaps and mayhem, especially in my early days as a registrar. One of the moments that stands out to me occurred after a particularly traumatic incident involving a patient. Prof, in all his wisdom, reminded me that all I could ever do was to do my best with each patient, but not to try to play the role of God.

We have lost a giant.

We have lost a cornerstone.

May he live on in the work that we do.

Dr Natsai Nhiwatiwa

THE DEDICATION FROM PROF JANSE VAN RENSBURG'S PHD

In this time of concern about the environment and about the well-being of the variety of ecosystems into the future, this thesis is dedicated to the conservation of a healthy, sustained bio-psycho-socio-spiritual environment in which people - like trees - can grow and achieve their full integrated capacity, meaning and purpose ■

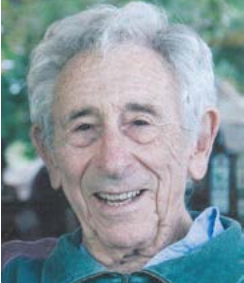




UNIVERSITY OF CAPE TOWN

OBITUARY: PROFESSOR LYNN GILLIS

Dan Stein and Joan Raphael Leff



Prof Lynn Sinclair Gillis (1924-2020), a pioneering figure in South African psychiatry, was recruited to the University of Cape Town and Groote Schuur Hospital in 1962 as the first consultant and Head. He had previously served as Senior Psychiatrist and Neurologist at Tara Hospital.

Lynn was one of the first proponents of community psychiatry, aiming to diminish stigmatization among other things. He furthermore courageously defied apartheid segregation by integrating staff across wards.

A thoughtful and inspiring mentor to his students; he grew the number of registrars and senior registrars over the years, establishing one of the leading training programs on the continent. In 1968, he initiated the first Medical Research Council Unit in psychiatry.

He served as Head of the Department of Psychiatry & Mental Health at UCT for 27 years, retiring in 1989. The clinical, teaching, research and social responsiveness strengths of the existing Department are in no small measure due to Lynn's pioneering work.

During his career, Lynn held many positions of responsibility, including President of the South African National Council for Mental Health. His contributions were acknowledged with several awards, including the SALUS Medal (silver) for Meritorious Service to Medicine (1989); and a Merit Award for Outstanding Services, by the Medical Association of South Africa (1990).

Lynn Gillis was a wonderfully warm man, who positively influenced the lives of many colleagues, students, and patients. He was a true "mensch"; a man of integrity, and a man who always had a kind word. Lynn will be sorely missed ■



A BRIDGE BETWEEN PHILOSOPHY AND PSYCHIATRY

Andrea Palk

Andrea Palk, our first postdoctoral research fellow in philosophy and psychiatry, was recently appointed as a permanent lecturer in the Department of Philosophy at Stellenbosch University.

She will continue focusing on ethical and philosophical issues related to mental health. Her future goal is to create a postgraduate level course at SU in the philosophy of psychology and psychiatry ■

WELCOME TO STAFF



We warmly welcome Dr **Stephan Rabie**, a Research Psychologist and Senior Research Officer based in the HIV Mental Health Research Unit.

His research interests include HIV mental health, mental health improvement interventions, and cross-cultural assessment. Dr Rabie is currently the project director of a randomised controlled trial testing the effectiveness of a coping intervention among HIV-infected women with sexual trauma.

A warm welcome also to **Nada Lagerstrom** who was appointed as a Senior Lecturer in the CL Division at Groote Schuur hospital ■

SIYABULELA MKABILE TRANSFERS TO ALEXANDRA HOSPITAL

Toni Abrahams



Division member and Senior Clinical Psychologist, **Siyabulela Mkabile**, transferred from Lentegeur Psychiatric Hospital Intellectual Disability Services (IDS) to Alexandra Hospital in April this year.

Siya has a wide range of experience with children, adolescents and adults with intellectual disabilities and is now providing psychological services to patients who have chronic mental health problems admitted to the Complex Care Unit and those seen in the outpatients department.

He is currently busy with his PhD study focused on explanatory models of child intellectual disability from the perspectives of caregivers, spiritual and traditional healers in Khayelitsha ■

NEW DIVISIONAL SCHOLARS

Sharon Kleintjes

This year has seen 4 new registrations for masters and doctoral studies in the Division of Intellectual Disability.

Toni Abrahams has registered for a doctoral study focussing on Respite Care to support families of people with intellectual disability and complex care needs.

The division was also successful in securing NRF funding to support two doctoral students and one masters student to investigate several dimensions of Self-Advocacy by adults with intellectual disability, in line with international trends calling for improved attention to their participation in public policy and service developments ■



Above: New NRF funded doctoral students **Cole Goldberg** (top right) and **Babalwa Tyabasha-Phume** (bottom right) and masters student **Siphesihle Zihlazi** (bottom left) during their first online study seminar with supervisor **Sharon Kleintjes** (top left).

PSYCHOPHARMACOLOGY AND BIOLOGICAL PSYCHIATRY ARTICLE ON HOW TO MANAGE OCD UNDER COVID-19

Toni Abrahams

Prof Dan Stein co-authored a recent article on how to manage Obsessive Compulsive Disorders (OCD) under COVID-19 in which a consensus statement provides practical guidance for what is an unusually complicated challenge.

The authors note that people living with OCD may be particularly impacted by the COVID-19 pandemic which has the potential to exacerbate pre-existing anxieties.

The authors acknowledge the changes clinicians have to face, in how to treat this population and make suggestions for future research. The article can be viewed at <https://doi.org/10.1016/j.comppsy.2020.152174> ■

THE DIVISION OF CHILD & ADOLESCENT PSYCHIATRY SUPPORTS INTERNATIONAL TOURETTE AWARENESS DAY

Petrus de Vries

Every year, the 7th June is used to raise awareness around the globe about tics and Tourette syndrome. This year, Prof Petrus de Vries from the Division of Child & Adolescent Psychiatry at UCT, joined the 'Kwela' team on television for an awareness-raising programme about tics and Tourette's. The full interview (in Afrikaans) can be viewed here: https://www.youtube.com/watch?v=i2jd_4aMFKw ■

THE 2020 LOREN LECLEZIO LECTURE

Petrus de Vries

Once every year, the Social Responsiveness Committee in the Department of Psychiatry & Mental Health hosts a 'Loren Leclezio Lecture'. The lecture is named after Dr Loren Leclezio, who was a MSc (Med) Neuroscience student in the department between 2012-2014 and a PhD student from 2014-2017. She died early in 2018 after a short battle with cancer.

She was particularly passionate about the importance of participatory research.



Loren Leclezio



Prof Relebohile Moletsane presenting to audience via Zoom

We were therefore delighted to have Prof Relebohile (Lebo) Moletsane from the University of KwaZulu-Natal (UKZN) as speaker for the 2020 Loren Leclezio Lecture. Prof Moletsane is the Pro Vice-Chancellor for Social Cohesion at UKZN, and the JL Dube Professor in Rural Education in their School of Education.

In a very powerful and sobering presentation entitled "Nothing about us without us. Ethical dilemmas in disseminating participatory research with girls in the context of sexual violence in rural communities", Prof Moletsane described some findings of a 6-year long participatory research project on sexual violence towards girls and young women ■

MESSAGES FOR MOTHERS

Maggie Marx

The team from the Perinatal Mental Health Project (PMHP) housed at the Alan J Flisher Centre for Public Mental Health (CPMH) recently teamed up with other organisations to create the Messages for Mothers (M4M) platform as a response to the COVID-19 pandemic.

They collaborated on M4M to keep mothers in South Africa informed, connected and encouraged using digital channels like social media and WhatsApp. You are welcome to learn more at <https://messagesformothers.co.za/> ■

PSYCHOTHERAPY TELEHEALTH: TRIAL AND ERROR IN THIS MOST TURBULENT OF TIMES *Waseem Hawa*

The delivery of clinical services has been profoundly changed by COVID-19. Public and private sector clinicians have to deliver essential services that address the presenting problem of the client while also reducing the risk of exposure to the virus.

Psychological services, at the state level, which traditionally operates on a weekly session basis for each client, was particularly challenged by the pandemic and the subsequent lockdown.

Telehealth was therefore swiftly introduced at all five UCT aligned hospitals as the method through which to preserve services both within the outpatient settings of the hospitals and in the outreach services to the community clinics.

It has become evident that telehealth will continue to remain a core method of service delivery. Consequently the Division of Psychotherapy has established a task team to drive the process of developing and promoting best practice within the field of telehealth.

The task force will focus on four key areas, i.e. teaching, training, documentation and research. Teaching will involve the skills development of Intern Psychologists and Psychiatric Registrars linked to the UCT aligned hospitals ■

THE TREATMENT OF PWIDD *Charlotte Capri*

Shortly prior to South Africa's Covid-19 response, the 10 March 2020 On My Mind Series talk with the title "The treatment of people with intellectual and developmental disabilities (PWIDD)" considered questions critical to the treatment of people with intellectual and developmental disabilities (PWIDD) in South Africa.

To illustrate widespread healthcare disparity, a Lancet study using a UK example found that twice as many PWIDD than the general population die from causes that could have been prevented by good quality health care (McCallion and McCarron, 2014).

In a case study that laid bare South Africa's attitude toward the care of PWIDD, you were 71.5% more likely to have survived the 2018 Esidimeni tragedy if you

were transferred to a facility that considered your health support needs and was able to provide the most basic of adequate care – infection control, hydration, heat, and food (Capri, Watermeyer, Mckenzie, and Coetzee, 2018; Robertson and Makgoba, 2018).

Current COVID-19 South African triage policies exclude many disabled people from accessing lifesaving intensive care and ventilation if becoming ill – especially people with physical and intellectual impairments (CCSSA, 2020).

Let me leave you with this thought (Mulibana, 2020): please consider people who live with any kind of disability when responding, as healthcare practitioners, under current South African COVID-19 South African triage policies ■

ASSET *Maggie Marx*

In February of this year ASSET partners from the Alan J Flisher Centre for Public Mental Health, Prof Crick Lund, Dr Zulfa Abrahams and Maggie Marx, as well as partners from across the globe, met in Addis Ababa, Ethiopia, to discuss the research progress and challenges of the year past and to plan for the remainder of the project ending in 2021.

ASSET is a National Institute for Health Research (NIHR) Global Health Research Unit on Health System Strengthening in Sub-Saharan Africa. This award forms part of £120 million funding for Global Health Research ■

COMPILED BY:

Delcia Liedeman-Prosch
Senior Clinical Psychologist
Female Acute Unit
Lentegeur Psychiatric Hospital / University of Cape Town
Chief Directorate: General Specialist and Emergency Services
Department of Health
Western Cape Government

Email: Delcia.Liedeman-Prosch@westerncape.gov.za

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TRAUMA, FROBSCOTTLE, AND THE IMPORTANCE OF JUMBLY, DELUMPTIOUS REMEMBORIES

Claudia Campbell

'Delumptious', 'jumbly', 'Frobscottle' and 'rememories' may seem more the basis for psychiatric diagnosis than 'perspective'. Trust me, they're not. So, please bear with me for the next 1419 words.

Frobscottle! The liquid needed to quench the thirst of giants - 'sweet, jumbly, and delumptious'. The adult me feels a deep gratitude to Roald Dahl for inventing those words. They remain waypoints I use to navigate to a place of fanciful escape when life becomes overwhelming. These words helped me to know that sometimes you need more than the words in a common dictionary to tell your story.

The house I lived in when I read Roald Dahl's BFG (1982) had the longest passage in the whole world! Also, my 6ft dad was the biggest, strongest man ever, and the jumbly, delumptious gingerbread house we made was so big we could sleep in it. I cherish the lingering disproportionate reality of 7-year-old Claudia's mind.

I REALLY, REALLY HOPE CHILDISH MARVELS LINGER IN YOUR MIND. BECAUSE, I DON'T THINK ONE CAN MEASURE THE IMPORTANCE THAT INNOCENT, WIDE-EYED, LOPSIDED WONDER HAS ON HUMAN LIFE.

There is essential beauty in those impossible imaginings. It's a beauty that hopefully remains embedded as a lifelong waypoint to find your way back to reason.

Rememory - a little piece of urban vocabulary that has become part of the fabric of my current existence. The words 'memory' and 'memories' lack that which rememory embodies. My rememory is more than that which allows me to recall a past moment, the act of activating my memory. A rememory exists not only in my mind, it's something visceral that tugs

at strings attached to my heart, to my nerves and to the photobooks of my mind. A standard feature of my rememory is that its lens is always rose-tinted. My rememory also comes with filters that strain away fear, anxiety, tension. My rememory results in rememories that are visceral and warm and comforting to everything that I am. My rememory exists alongside my memory. Rememories are not the same as memories - and they are not mutually exclusive.



Claudia Campbell

My memory helps me to recall skills, events, information for 'doing life' in a productive way. I need my memory to survive. My memory is what enables me to function in a way that enables continued existence. Until recently spending long hours lingering in my rememory felt like a guilty indulgence that risked me losing 'groundedness'. My rememory was not something I considered vital for survival. Things have changed. As of 2020 I believe my rememory is perhaps more important to my survival than my memory. It's my rememory that grounds me now. It's my rememory that seems to equalize the fact that the majority of current mental input is saturated with anxiety.

This week I questioned whether or not the levels of anxiety I am experiencing are 'normal' or pathological. Am I relapsing? Is my mind reverting back to its 'unreliable' former ways? Has the face of mental illness risen to the surface of my psyche again? It was when my grandmother paralleled our current Covid-19 existence to that of life in central Europe during World War II that I began to feel my current experiences are not pathological. Unlike 1942, in 2020 the enemy is invisible to the naked eye. The vigilance, restrictions on freedom, the oppression of collective fear, the uncertainty of any future beyond tomorrow - it's war, and no matter how you reason it, anxiety is fundamental to the

experience of war. So, it was with some measure of relief that I decided my current levels of anxiety are perhaps not 'normal' but at least proportionate to the present circumstances – proportionately similar to the anxiety experienced by most right now.

.... It was four weeks ago that I left off writing the previous paragraph. Over this time positive Covid-19 cases have increased by more than tenfold in my province. Echoing the words of our Health Minister, for almost all of us Covid-19 now has a name, a face, and an address (Mkhize, 2020). The trauma is global, and for many our collective emotional and mental reserves are sputtering on the dregs of our metaphorical fuel tanks. During this time, I experienced a mild relapse of my own PTSD symptoms – triggered by an unexpected turn of events in my family. Although not directly related to Covid-19, I am certain an almost empty fuel tank contributed towards the erosion of my usual level of psychiatric robustness. Attempting to deal with historical PTSD whilst knowing that those treating you, are themselves, in the midst of their own experience of current international trauma is odd. In a way it feels as if there has been an equalising of sorts and we're all trying to limp through this together. Bizarre combinations have emerged as levels of empathy and anger seem to share an upward trajectory, as do compassion and despondence, resilience and fragility.

I'M NOT SURE THAT ANYBODY'S MEDICAL OR MENTAL HEALTH CARE EDUCATION AND TRAINING HAS EFFECTIVELY PREPARED THEM FOR ENTERING THE DEMANDS OF THE CURRENT CRISIS.

And so, as I sombrely acknowledged the dark hue the reel of trauma can wrap around the story of one's life – past, present and future, I wondered about the relevance of rememories, and jumbly, delumptious Frobscottle. Instead of feeling a triviality towards them, I experienced a sense that never have these sentimental words felt more important. This was reiterated when, in response to the resurgence of my PTSD symptoms, my psychiatrist requested that I try to immerse myself in recollections of happy times, of adventures, blissful travels, and joyful occasions. I realised that part of his psychiatric intervention was a request for me to tap into rememories. Each one of the things I have just mentioned was always shared by feelings such as the exhaustion of arranging wedding flowers until 2am, wishing that 15 hour journeys would end, and feeling terrified before taking a giant-stride water entry to explore waters I knew were inhabited by sharks. My psychiatrist was not asking me to immerse myself in these recollections, but rather the rememories of my best friend walking down the aisle as the most radiant bride, of feeling the curves of mountain passes breeze past me, and of the awe and privilege of observing the exquisite beauty of ocean reefs.

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

A few weeks back my husband and I hung a new painting in our bedroom. Every time I look at it I'm filled with jumbly delumptiousness, without fail I smile a little. The painting is whimsical, a 2 metre black and white silhouette of girl on an impossibly high swing, about to glide through the clearing in the fragrant foliage of the trees around her. When I sent my mother a photo of our new installation she exclaimed "but that is a picture of you!". It's true, my mom rummaged through an old photo album, and there it was, a photograph of me as an 11-year-old, swinging on an impossibly high swing, swooshing through a clearing amongst the tallest alpine trees. It genuinely is the highest swing I've ever seen, and being on it felt like I was flying: soaring right over the new, raw pain of my father's death. That photo is the very essence of a rememory. Pure delight is engendered when I look at it, however my complete memory of that year is mostly made up of grief.

SO, WITHOUT DENYING MY MEMORY, I CHOOSE THE REMEMORY, BECAUSE IT'S THE REMEMORY THAT REMINDS ME I AM CAPABLE OF FEELING JUMBLY AND DELUMPTIOUS EVEN IN THE WORST OF TIMES.

As ridiculous as it might sound, I feel that psychiatrists should include 'jumbly', 'delumptious', 'Frobscottle', and 'rememories' into their treatment vocabulary. Teach them to your patients. I don't think this is an outlandish and nonsensical suggestion at all, because right now, each of us could do with a reprieve from trauma – whatever its source. If they were real, I would suggest that a bottle of Frobscottle and pair of rose-tinted glasses are utterly necessary to survive the chaos around us. However, I think whether on our own, or with a little help, we can all access our inner Frobscottle and make the effort to indulge in it – perhaps not so much that it results in a case of the Whizzpoppers. For those of you who don't know what this means I suggest you put down *The Lancet* for a moment and replace it with *Roald Dahl's BFG*. Trust me, you'll be a better doctor for it ;-)

Finally, I thank you for being part of the medical army dealing with the horrendous, multifaceted face of Covid-19. Stay safe. And remember to take a daily glug of Frobscottle.

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AFRICA GLOBAL MENTAL HEALTH INSTITUTE - COVID-19 AND MENTAL HEALTH CARE DELIVERY LESSONS LEARNED FROM THE USA IN PROVIDING CLINICAL CARE TO PATIENTS IN THE CONTEXT OF COVID-19



David Webb

A webinar was hosted by the South African Society of Psychiatrists on Thursday 21st May 2020. A recording of the webinar is available [here](#)

The featured **discussants** were:



Hannah E Brown, MD

Director of Wellness and Recovery after Psychosis (WRAP) Program, Boston Medical Center, Assistant Professor of Psychiatry, BU School of Medicine



Kevin Donnelly-Boylan, MD

Director of Consultation and Liaison Psychiatry, Boston Medical Center, Instructor of Psychiatry, BU School of Medicine



Alison M Duncan, MD

Director of Psychiatric Emergency Services, Boston Medical Center, Instructor of Psychiatry, BU School of Medicine



David C Henderson, MD

Psychiatrist-in-Chief, Division of Psychiatry, Boston Medical Center; Professor & Chair, Department of Psychiatry, BU School of Medicine

The moderators were:



Bonga Chiliza, PhD, MBChB, FCPsych

Associate Professor, Chief Specialist & Head of the Department of Psychiatry, University of KwaZulu-Natal; President, South African Society of Psychiatrists



Michelle P Durham, MD, MPH

Adult, Child & Adolescent Psychiatrist and Residency Training Director, General Psychiatry, Boston Medical Center, Assistant Professor of Psychiatry, BU School of Medicine

Dr Brown is responsible for an outpatient early psychosis program, which serves patients of all ages with a primary diagnosis of a psychotic disorder. The COVID-19 outbreak has necessitated various adaptations of the program, including the following:

- To minimise exposure of both patient and doctor, consultations are being done on the phone or via video (telemedicine), so that patients do not need to come to the hospital for a consultation with the psychiatrist. This has worked well. It is flexible in terms of time, facilitates connection between doctor and patient, increases frequency

of consultations, and has reduced the rate of patient non-attendance at appointments. Both phone and video are used. Video is preferable, because it is important for the psychiatrist to be able to see the patient during the interaction, especially to monitor for extrapyramidal side effects and tardive dyskinesia.

HOWEVER, IT HAS BEEN CHALLENGING TO GET PATIENTS TO USE VIDEO – THEY PREFER THE PHONE. PATIENTS ARE ASKED TO WEIGH THEMSELVES AND MEASURE WAIST CIRCUMFERENCE TO MONITOR FOR METABOLIC SIDE EFFECTS.

- For patients in shelters, telemedicine can be challenging requiring a lot of coordination with colleagues. There may be a social worker who can facilitate the consultation in terms of time and providing a venue for the patient to use a phone.
- A few patients are seen in person. They include those who require close monitoring for treatment-related adverse effects and those who require injectable medicines.
- **WHERE IT IS APPROPRIATE, STABLE PATIENTS WHO WOULD NORMALLY BE SEEN EVERY MONTH ARE NOW BEING SEEN EVERY THREE MONTHS.**
- Where feasible, patients on injectable medicines have been changed to oral formulations, although this does carry risks of symptom recurrence. In some cases it has been possible for nursing staff to visit patients at their home and administer injections there. However, this is not acceptable to some patients who do not want a stranger coming to their home.
- There have been two patients with COVID. Both were older with comorbidities. One died. It was difficult to follow-up with the other.
- This patient population is particularly vulnerable and there are challenges in implementing basic protective strategies such as washing hands, using masks and social distancing. Some have severe cognitive impairment and executive dysfunction and may not have access to all of the rules and restrictions around COVID. We try to remind them about the rules and give them a flyer explaining healthy hygiene.

The effects of COVID will be long-lasting. Many of the patients have become unemployed during the pandemic and are worried about housing and

basic needs. A lot are homeless, living in shelters and homes in close quarters, increasing susceptibility to viral transmission. We don't yet know how the COVID pandemic will affect the patients in the long-term.

Dr Donnelly explained some of the challenges relating to management of hospitalised patients. The psychiatric liaison services have been restructured. In order to minimise their exposure to COVID patients, students are not allowed at present. COVID patients are only seen by the psychiatrist in an emergency, since personal protection in the hospital is a challenge.

PATIENTS IN ICU HAVE HAD PROTRACTED DELIRIUM AND ARE ON POLYTHERAPY. WEANING THEM OFF THESE IS CHALLENGING. POTENTIAL FOR DRUG INTERACTIONS BETWEEN PSYCHIATRIC MEDICINES AND SOME OF THE DRUGS THAT HAVE BEEN USED TO TREAT COVID (E.G., HYDROXYCHLOROQUINE AND ANTIVIRALS) HAS COMPLICATED THE SELECTION OF APPROPRIATE PSYCHIATRIC MEDICINES. IN ADDITION, THERE HAS BEEN A SHORTAGE OF SOME PSYCHIATRIC MEDICINES.

There are challenges in maintenance of mental health of both psychiatric patients and medical staff during the pandemic. Psychiatric patients do not cope well with isolation and attempted suicide is a concern. Managing the pandemic daily and COVID-related deaths among colleagues has increased stress and burnout levels, affecting not only medical, surgical and psychiatric staff, but everyone who works at the hospital. A mental health support program has been implemented at the hospital and use of that is increasing daily.

Dr Duncan explained that since COVID started, the volume of patients presenting to the psychiatry emergency services has dropped by 70-80%.

UNDER NORMAL CIRCUMSTANCES, PATIENTS INCLUDE THOSE WHO ARE SUICIDAL, THOSE WITH SUBSTANCE USE DISORDER, AND ACUTELY PSYCHOTIC OR MANIC PATIENTS, WHEREAS SINCE COVID ONLY THE MOST ACUTELY PSYCHOTIC AND MANIC PATIENTS ARE SEEN.

Challenges include testing patients, who must be proven COVID negative, limited space, which does not allow adequate distancing among staff and between staff and patients, availability of personal

protective equipment (PPE), and frequent changes in the regulations relating to PPE requirements and admissions.

IN ORDER TO MINIMISE EXPOSURE TO THE VIRUS, COVID-POSITIVE PATIENTS PRESENTING TO THE EMERGENCY DEPARTMENT ARE SEEN ONLY BY EMERGENCY STAFF. IF A PSYCHIATRIC CONSULTATION IS NECESSARY, IT IS DONE EITHER ON THE PHONE OR WITH THE DOCTOR AND PATIENT SEPERATED BY GLASS OR A CURTAIN.

Testing psychiatric patients for COVID has been very challenging, especially if the patient is agitated. The test itself is invasive, painful and requires close contact with the clinician. There are a limited number of test kits available. In-house results take 2-4 hours, whereas outsourced laboratories take 24 hours to return the result, delaying psychiatric care. Some hospitals have created COVID-positive units to care for patients in that hospital who need psychiatric referral.

Dr Henderson said that the Boston medical center started to take in COVID-positive patients early on in the pandemic. Aproximately 1200 positive patients have been admitted and 300 staff have tested positive. Many patients have been unable to decrease potential exposure to the virus. They cannot afford to work at home and social distancing at home and at work may not be possible. The hospital will need to consider what steps to take when staff become ill.

PSYCHIATRIC APPOINTMENTS FOR APPROXIMATELY 90% OF PATIENTS WERE CHANGED FROM A HOSPITAL VISIT TO TELEPHONE AND THIS HAS WORKED WELL. THE NO-SHOW RATE IMMEDIATELY FELL FROM AROUND 45% TO 10%. TELEMEDICINE HAS ENABLED THE PSYCHIATRIC SERVICES TO REACH CONSIDERABLY MORE PATIENTS, INCLUDING SOME WHO WOULD NOT NORMALLY HAVE BEEN SEEN DUE TO TRANSPORT PROBLEMS OR FEAR OF STIGMA.

David Webb is a medical writer having qualified as a medical doctor with stints in industry. He is an associate at the Houghton House Group of alcohol and drug addiction rehabilitation facilities. His book of poetry recounting a journey through addiction *The Saint of Travellers* is available to download in pdf format at www.poetryofaddiction.com **Correspondence:** dawebb@mweb.co.za

There are several vulnerable patient groups who remain a concern. They include those with mental illness, substance use disorder, unemployed people and those who have found it difficult to cope during the pandemic.

THE NEED FOR MENTAL HEALTH SERVICES IS EXPECTED TO INCREASE SUBSTANTIALLY, AND IF LEFT UNTREATED, THE DECLINE IN MENTAL HEALTH IS LIKELY TO SIGNIFICANTLY IMPACT LIVES AND ABILITY TO WORK.

It will be important to find innovative ways to reach these people.

Suggested reading: <https://www.sciencedirect.com/science/article/pii/S2215036620303072>

EDITORIAL COMMENT (CHRISTOPHER PAUL SZABO) :

As can be noted from the discussant affiliations, all are based in Boston, MA in the USA. As such, their experience needs to be viewed within that context. This raises a critical issue of relevance i.e. the experience of a developed world country for a developing world country.

NOTWITHSTANDING DIFFERENCES IN ENVIRONMENT, THERE WERE MANY ASPECTS OF WHAT WAS RELATED THAT HAVE OVER TIME BEEN NOTED TO BE APPLICABLE IN THE SOUTH AFRICAN SETTING, ALBEIT THAT EVEN LOCALLY THERE IS NO HOMOGENEITY OF PATIENT POPULATIONS OR RESOURCES AVAILABLE.

If there is one take home message it would appear to be that medical personnel and services have and will adapt to the prevailing circumstances. The pandemic presents unique challenges, which require a flexibility to develop best practice strategies as circumstances unfold. Whilst this places a significant burden on caregivers, who are vulnerable and must protect themselves accordingly whilst rendering care, the situation has potentially brought about novel ways of delivering a service which may have implications for the future.

COVID-19 PANDEMIC LIKELY TO LEAVE MANY SOUTH AFRICANS TRAUMATISED

On behalf of Akeso Alberton

Challenge posed by post-traumatic stress syndrome requires urgent addressing

Experiencing some traumatic stress is an inescapable part of life and few of us are completely untouched by it. The current COVID-19 pandemic, however, has introduced a great deal of additional uncertainty in our lives and this is likely to leave many vulnerable people traumatised.

“The fallout brought about by the pandemic has resulted in additional potential for traumatic experience, including the stress if a loved one becomes ill and needs hospitalisation, having to live in isolation from your extended family and friends, or having a relationship fail under the strain caused by uncertainty and fear. For others, the traumatic stress may be caused by ongoing financial hardships, events such as being retrenched and anxiety about the future,” says Dr Marshnee Naidoo, a psychiatrist who practises at Akeso Alberton mental health facility in Johannesburg.

“Most people experience some degree of distress after a traumatic event, or a period of trauma, in their lives, as they try to come to terms with it, but after a period of a few weeks, or months, they tend to recover from the shock and do not develop lasting mental health difficulties as a result of it,” she adds.

“However, a sizable number of people — between 18% and 25% — experience severe ongoing symptoms in the months or even years following such an event or period of trauma. When symptoms last longer than four weeks, it may indicate a deeper level of psychological distress known as post-traumatic stress disorder, or PTSD.

PTSD SEVERELY DISRUPTS MENTAL HEALTH AND CAN SUBSTANTIALLY RESTRICT THE PERSON’S ABILITY TO FUNCTION,” DR NAIDOO EXPLAINS.

“PTSD presented a major challenge to our mental healthcare system even before the COVID-19 pandemic, which I believe will only serve to exacerbate the incidence of PTSD and the pressure

on the system. We will therefore need to pay much greater attention to this condition as a nation going forward,” she says.

Dr Naidoo explains that each person’s response to traumatic situations is highly complex and unique. Certain individuals may be so sensitive to trauma that they may even experience news footage they see on television as deeply disturbing.

“IT IS NOT ALWAYS EASY TO ESTABLISH WHO IS MOST AT RISK OF DEVELOPING PTSD, BUT INDIVIDUALS WHO EXPERIENCED A GREAT DEAL OF TRAUMA EARLY ON IN THEIR CHILDHOOD HAVE BEEN SHOWN TO BE PARTICULARLY VULNERABLE TO BEING RE-TRAUMATISED LATER IN LIFE AND SUFFERING ONGOING PTSD SYMPTOMS,” NOTES DR NAIDOO.

“Many individuals are unfortunately faced with not just one traumatic experience in their lifetime, but several. The South African Stress and Health [SASH] study survey found that 56% of respondents had experienced more than one trauma.¹ Multiple traumatisation, or ongoing re-traumatisation can occur over a long period of time and can have a devastating impact on their lives.”

Dr Naidoo says other individuals who may be at high risk of PTSD are those who are continually exposed to ongoing traumatic situations in their line of work, such as paramedics, nurses and other healthcare workers working at the frontline of the pandemic.

“Unfortunately there remains a widespread ignorance about PTSD and sometimes stigma attached to those who seek professional help. Some people still have the attitude that we should be able to deal with our traumatic experiences ourselves. So often our response to a stressful event is ‘I’m fine’ as we feel compelled to carry on as though what happened was normal, and fail to acknowledge its immense impact on us. As a result,

many people with PTSD are not diagnosed and suffer the consequences of their trauma in silence, which can be very detrimental to their lives," she adds.

"PTSD can be difficult to diagnose as it is an exceptionally complex condition that can mimic, or appear as, other mental health conditions. It consequently is often not diagnosed or is misdiagnosed by family medical practitioners. An additional complicating factor is that trauma can also have a significantly negative impact on other existing psychological conditions such as depression, anxiety and bipolar disorder that a person may already be experiencing."

So what could be indications that one has PTSD? Dr Naidoo says that many trauma survivors avoid talking about what happened, feel emotionally numb when they think about the trauma, and withdraw from contact with other people. Other symptoms may include depression, anxiety disorders, drug dependency, distressing thoughts and memories of the traumatic event, sleeping difficulties, guilt, and hyper-alertness to any signs of danger.

"PTSD can be diagnosed and successfully treated by a multi-disciplinary team of healthcare practitioners, including psychiatrists and psychologists, who are experienced in the management of the condition. They will work to assist the individual to regain a sense of control over their lives," explains Dr Naidoo.

Individuals suffering from PTSD usually require long-term treatment that may include a combination of medical treatments and therapies to assist in their recovery. The psychiatrist may prescribe medication to assist in managing symptoms such as depression and anxiety. One-on-one psychotherapy with a psychologist experienced in the treatment of mental trauma, as well as group therapy sessions, have also shown good results.

"HUMAN BEINGS IN GENERAL HAVE A REMARKABLE CAPACITY TO ADAPT TO THE MOST EXTREME STRESSORS AND WE TEND TO HAVE RESERVES OF STRENGTH WE NEVER THOUGHT IMAGINABLE."

Working within the field of traumatic stress, I am constantly reminded that there is a most extraordinary strength in the human spirit. Sometimes, however, we need professional help and support to 'take back' our lives, and we should not be afraid to acknowledge this to ourselves and to seek such assistance, particularly at this challenging time," concludes Dr Naidoo.

SIDEBAR

What can people who have suffered a traumatic experience do to assist in their recovery? Dr Marshine Naidoo, a psychiatrist who practises at Akeso Alberton mental health facility in Johannesburg,

says that the following tips may assist those who have suffered a trauma, or a number of traumas:

- Seek support from trusted people, such as friends and family. Persons with good support systems tend to cope better with traumatic experiences.
- Be kind to yourself. Keep in mind that the trauma was not your fault and you dealt with it in the best way possible under the circumstances.
- **BE HONEST WITH YOURSELF — ARE YOU REALLY OKAY OR COULD YOU BENEFIT FROM PROFESSIONAL ASSISTANCE AND SUPPORT? IF THE LATTER, FIND THE NECESSARY HELP.**
- Make use of trauma debriefing and counselling services that may be available, for example through your employer's staff wellness programme, even if you think you are relatively unaffected.
- Try to avoid bottling up the experience and isolating yourself, which is a fairly common response to severely traumatic experiences. Consider finding a trauma support group if you think you would benefit from sharing your experiences with others who have had similar experiences.
- Try to develop positive coping strategies to assist you in dealing with the traumatic event and see how you may possibly learn from it. In other words, you may be able to frame the event in a more positive manner so that it may contribute to your personal development and growth.
- Should you be concerned that you or a loved one have been severely traumatised, seek the assistance of mental healthcare professionals who are experienced in diagnosing and treating mental trauma.
- Ensure that symptoms related to traumatic experiences, or to pre-existing psychological conditions, such as depression and anxiety, are appropriately treated ■

REFERENCE AND FURTHER READING

1. "The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders", *South African Medical Journal*, 2009 May: 339–344.

For further assistance, please contact Akeso Alberton on 087 098 0456, the Akeso helpline on 0861 435 787, or email info@akeso.co.za

Issued by: MNA on behalf of Akeso Alberton
 Contact: Martina Nicholson, Graeme Swinney and Meggan Saville
 Telephone: (011) 469 3016
 Email: martina@mnapr.co.za, graeme@mnapr.co.za, meggan@mnapr.co.za

COVID-19 : CAN EMPLOYEES WITHDRAW FROM THE WORKPLACE?

Kenneth Coster

Employees returning to work from the COVID-19 lockdown will need to show reasonable justification if they halt work on the basis that they are exposed to the virus.

Legal provisions allowing employees to withdraw from a hazardous working situation could, in the context of COVID-19, be open to abuse by unprincipled employees or trades unions.

This is because employers will be obliged to continue remunerating employees who have withdrawn their labour on the basis of their belief that they may contract COVID-19, unless it can be proven that employees acted in bad faith (which may be difficult or even impossible to do). Only if bad faith can be proven would there be a justification to withhold remuneration (on the basis of no work no pay).

THE MINE HEALTH AND SAFETY ACT (MHSA) AND THE OCCUPATIONAL HEALTH AND SAFETY ACT (OHSA) GRANT EMPLOYEES THE RIGHT TO WITHDRAW FROM A DANGEROUS WORKING PLACE. DISASTER MANAGEMENT ACT (DMA) REGULATIONS OR RELATED DIRECTIVES COULD ALSO CONFER THIS RIGHT, WHEN DRAFTED.

Under the MHSA, employees may withdraw from the workplace if there is "reasonable justification" to believe that there is a serious danger to their health and safety or if a health and safety representative directs them to withdraw. We believe this section contemplates what may be called "*a clear and present danger*". The act also requires employees to hold dialogue with their employers on these issues to mitigate the danger so work can be conducted safely.



Kenneth Coster

THE OHSA DOES NOT GRANT EMPLOYEES AN EXPRESS RIGHT TO WITHDRAW FROM A DANGEROUS WORKING PLACE BUT REQUIRES THEM TO REPORT THE SITUATION TO THEIR EMPLOYERS OR HEALTH AND SAFETY REPRESENTATIVES.

The first difficulty with managing the workplace hazard of COVID-19 virus is that it is invisible, because it is a microscopic virus, and even its host may be

unaware and asymptomatic. The second difficulty is that, even though we still know relatively little about the virus, what we do know is that it is highly contagious.

Where employers have provided all relevant instruction, health and safety protocols and personal protective equipment (PPE) to safeguard employees, is it reasonable and rational for employees to exercise the right to withdraw from the workplace because they are (subjectively) apprehensive of contracting COVID-19 there?

PRACTICALLY SPEAKING, THERE CAN CERTAINLY BE NO ISSUE WITH GRANTING EMPLOYEES THE RIGHT TO WITHDRAW FROM A WORKPLACE DUE TO COVID-19, WHERE THEY HAVE REASONABLE JUSTIFICATION. HOWEVER, IN OUR VIEW, IN THE ABSENCE OF SOME OBJECTIVE CRITERIA, IT WILL BE IMPOSSIBLE FOR EMPLOYEES TO SHOW REASONABLE JUSTIFICATION. ONLY IF EMPLOYEES PRESENT SYMPTOMS OF THE VIRUS TO THEIR CO-WORKERS OR TEST POSITIVE FOR COVID-19 (AND THAT INFORMATION BECOMES KNOWN TO THEIR CO-WORKERS), CAN OTHER EMPLOYEES BE SAID TO HAVE REASONABLE JUSTIFICATION TO WITHDRAW FROM THE WORKPLACE.

Even then, this may not constitute reasonable justification when the employer has taken appropriate steps, such as disinfecting the workplace and screening (on an ongoing basis) all employees who came into contact with the infected employees.

In our view, employers should at least:

- constructively engage with Government to set clear parameters on what will be acceptable measures to establish and maintain a safe workplace;
- ensure that an adequate risk assessment is conducted prior to the commencement of work, specifically dealing with any potentially unsafe areas or conditions, and ensure that adequate control measures, including the availability and suitability of PPE, are implemented;
- comply with physical distancing requirements in

accordance with the risk assessment, sanitising, screening, isolation and all other requirements set out in the DMA regulations, where applicable;

- comply with all requirements of employers prescribed in the Department of Labour's Occupational Health and Safety Directive, where applicable; and
- regularly and frequently convene health and safety committee meetings to proactively monitor the workplace and address any concerns raised by employees about COVID-19 transmission risk.

IF, DESPITE ALL THESE MEASURES, EMPLOYEES WITHDRAW FROM THE WORKPLACE, EMPLOYERS SHOULD FIRST CONSIDER WHETHER, UNDER THE CIRCUMSTANCES, EMPLOYEES HAVE A REASONABLE JUSTIFICATION FOR DOING SO. IF THEY BELIEVE IT IS REASONABLE, EMPLOYERS MUST REMEDY THE ALLEGEDLY UNSAFE WORKING CONDITIONS.

If employers do not agree that a reasonable justification exists, they may consider the following legal recourse:

- notify employees that their withdrawal from the workplace is unjustified and accordingly unlawful and call upon employees to return to work. If they do not return, it may be regarded as either unauthorised absence or unprotected industrial action. In those circumstances, the employer could, in our view, advise that it will apply the principle of no work, no pay;
- **INITIATE LEGAL ACTION SEEKING TO INTER ALIA INTERDICT EMPLOYEES' WITHDRAWAL FROM THE WORKPLACE AND/OR REFUSAL TO TENDER THEIR SERVICES OR MANDATE THE EMPLOYEES TO TENDER THEIR SERVICES.**

Employers should engage practically and constructively with employees and trade unions to attempt to resolve concerns when they arise.

Kenneth Coster is a partner at Webber Wentzel. Issued by NADINE VAN TONDER/ TS COMMUNICATIONS
Correspondence: nadine@tscomms.co.za ■

PSYCHEDELIC- ASSISTED THERAPIES – ATTITUDES SURVEY

Much public debate has ensued since the U.S. Food and Drug Administration's consideration of some psychedelics as potential treatments in clinical practice, yet little is known about the opinions of mental health professionals surrounding this issue.

As a registered South African psychiatrist or clinical/counselling psychologist, you are invited to participate in a **short online questionnaire** that aims to determine attitudes towards **psychedelics and psychedelic-assisted therapy** among psychiatrists and psychologists.




IF YOU CHOOSE TO PARTICIPATE, PLEASE CLICK ON THE LINK AT THE END OF THE ARTICLE TO AN ANONYMOUS ONLINE SURVEY THAT WILL ASK QUESTIONS ABOUT YOURSELF, AND YOUR VIEWS ON PSYCHEDELICS AND PSYCHEDELIC-ASSISTED THERAPY.

The study has obtained ethics clearance through the University of the Witwatersrand's HREC (protocol H20/06/07). The questionnaire should take you approximately 15-40 minutes to complete. The purpose of the study is to gain insight into the attitudes towards psychedelics and psychedelic-assisted therapy among mental health experts, and investigate individual factors that could influence these attitudes.

All appropriate measures have been taken to ensure that any information you provide is strictly confidential and anonymous. **You will not be asked to provide any specifically personally identifying information.**

If you would like to contribute to a South African body of research into this emerging topic, **click the link below** to be directed to the survey, as well as some more information about the study:

<https://www.surveymonkey.com/r/PAThery> ■

 UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG	
Research Office HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL) ROOM 1004E Coaxer	
CLEARANCE CERTIFICATE	PROTOCOL NUMBER: H20/06/07
PROJECT TITLE	Attitudes towards psychedelics and psychedelic-assisted therapy among South African mental health care providers
INVESTIGATOR(S)	Ms K Coaxer
SCHOOL/DEPARTMENT	Human and Community Development*
DATE CONSIDERED	19 June 2020
DECISION OF THE COMMITTEE	Approved Risk Level: Low
EXPIRY DATE	28 July 2023
DATE 27 July 2020	CHAIRPERSON  (Professor J Knight)
cc: Supervisor: Professor K. Bair DECLARATION OF INVESTIGATOR(S) To be completed in duplicate and ONE COPY returned to the Secretary at Room 10004, 10th Floor, Senate House University. Turn over to the application number and date the clearance given by the HREC. (Janine Mearns)	
I, the fully understand the conditions under which I am/are authorized to carry out the above-mentioned research and I/we guarantee to ensure compliance with these conditions. Should any opportunity to be contemplated from the research procedure as approved I/we undertake to re-submit the protocol to the Committee. Ending to completion of a yearly progress report.	
Signature 	Date 27 / 07 / 2020
PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES	

THE MASKED HEROES CAMPAIGN

TO PROTECT COMMUNITY CARE WORKERS **LAUNCHED**

Masked Heroes, a national campaign to protect and support community care workers (CCWs) during the COVID-19 pandemic has officially launched, and has started delivering personal protective equipment (PPE) to community-based organisations across the country.

Coordinated by the DG Murray Trust (DGMT) in partnership with REDISA and the Centre for Learning on Evaluation and Results at the University of the Witwatersrand, the campaign will be providing personal protective equipment, psychosocial support, information and communication to tens of thousands of community care workers across the country in the coming months.

THIS EFFORT IS IN RESPONSE TO A BOTTOM-UP DEMAND, AND COMPLEMENTS THE GOVERNMENT'S DISTRIBUTION OF PERSONAL PROTECTIVE EQUIPMENT (PPE) TO HEALTH FACILITIES.

Community Care Workers include community health workers, emergency services personnel, social workers and social auxiliary workers, child and youth

care workers, as well as food and other relief workers. As the COVID-19 pandemic continues to unfold, protection of frontline community care workers is crucial in preventing them from becoming both victims and vectors of infection.

KEEPING CCWS HEALTHY WILL ALSO HELP ENSURE THAT SUPPORT, RELIEF AND COUNSELLING SYSTEMS ARE IN PLACE AS COMMUNITIES EXPERIENCE EXTREME DURESS AND RISING MORTALITY.

Lorrie Allen from the Charlize Theron Africa Outreach project said, "The age of COVID has drawn into sharp clarity how crucial it is for ALL communities to be within reach and have access to healthcare—whether it be through the distribution of much-needed PPE, or the support of women and children experiencing gender-based violence at home during lockdown."

The efforts of community care workers often go unseen. Dr Jonathan Broomborg, Health Response Lead for the Solidarity Fund says "We salute community care workers for the critical role they play in the country's efforts to keep our communities

functioning. We pay tribute to them for their courage and dedication.” Executive Director of ELMA Philanthropies, Bernadette Moffat shared this sentiment, adding that, “we cannot let these heroes provide such service unprotected.”

WHEREVER POSSIBLE, THE PROCUREMENT TEAM HAVE WORKED WITH LOCAL PROVIDERS OF PPE, INCLUDING THE STELLENBOSCH NANOFIBER COMPANY (SNC). “WHEN WE SAW THE PANDEMIC WAS LEADING TO A GLOBAL SHORTAGE OF PPE, WE DECIDED TO REFOCUS OUR EFFORTS ON HELPING TO SOLVE THIS PROBLEM LOCALLY,” SAID DR. EUGENE SMIT, BUSINESS DEVELOPMENT MANAGER AND CEO. “SNC SET OUT TO DEVELOP A NANOFIBER BASED SURGICAL MASK THAT WOULD MEET MEDICAL DEVICE REQUIREMENTS.”

Distribution of the much-needed PPE, as well as COVID-19 educational content is coordinated through a bespoke logistics system developed and managed by REDISA. Coca-Cola in South Africa, which comprises of its bottling partners Coca-Cola Beverages South Africa and Coca-Cola Peninsula Beverages, has to date provided distribution support of PPE to community-based organisations (CBOs) supporting CCWs across Gauteng and the Western Cape.

IN TURN THESE CBOs WILL MANAGE AND DISTRIBUTE STOCK TO REGISTERED CCWS IN THEIR COMMUNITIES. ADDITIONALLY, MANY OF THEM WILL UNDERGO TRAINING THROUGH THE MASKED HEROES CAMPAIGN’S TEAM OF PSYCHOLOGISTS TO PROVIDE MUCH NEEDED PSYCHOLOGICAL FIRST AID SUPPORT TO CCWS.

Masked Heroes project manager, Sinazo Nkwelo shared that “the successful delivery of PPE and other forms of support to community care workers is also testament to the power of great collaboration, how the private and NGO sectors can together, efficiently and effectively meet social needs. This project could not be possible without the uniquely important contributions of everyone involved. Thank you to our funders who responded very quickly and with great compassion toward this urgent need and thank you also to all our partners, without whom we would not be able to reach and serve community care workers.” To the tens of thousands of community care

workers across the country, our unsung heroes, we appreciate the contributions and sacrifices you make daily - thank you!

The Masked Heroes campaign is supported by The Solidarity Fund, The ELMA South Africa Foundation, Coca-Cola in South Africa, which comprises of its bottling partners Coca-Cola Beverages South Africa and Coca-Cola Peninsula Beverages, the Johnson and Johnson Foundation, the Entertainment Industry Foundation, the Charlize Theron Africa Outreach Project (CTAOP) and the Horace W. Goldsmith Foundation.

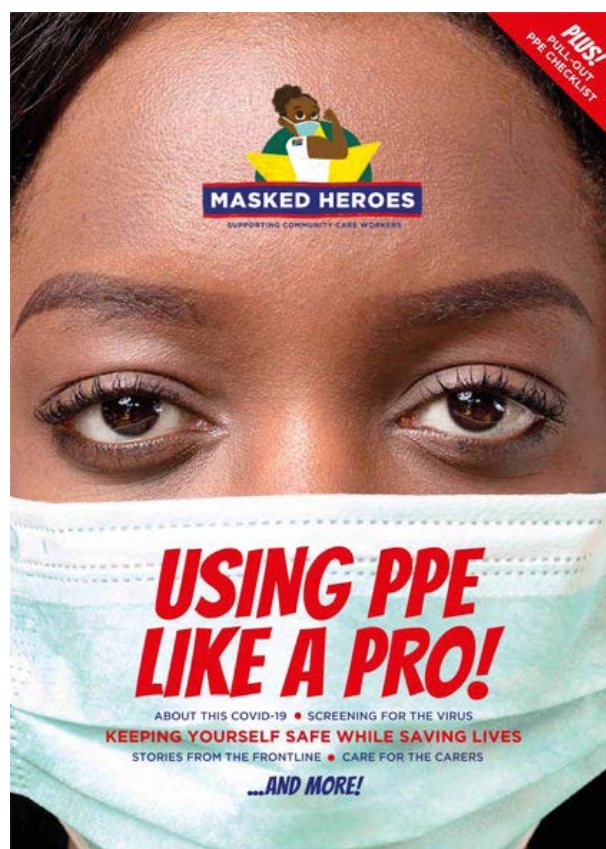
For more information visit maskedheroes.org.za, find us on Twitter at @MaskedHeroesSA, or email us at info@maskedheroes.org.za.



DGMT is a South African foundation committed to developing South Africa’s potential through public innovation and strategic investment. Our goal for South Africa is a flourishing people, economy and society (www.dgmt.co.za).

Masked Heroes is a campaign to protect and support community care workers in South Africa throughout the COVID-19 pandemic.

For more information please contact Corné Kritzinger at come@dgmt.co.za ■



Masked Heroes Magazine, available to download from their website



KN95 MASKS FOR SASOP SOUTHERN GAUTENG MEMBERS

Dear Colleagues, SASOP Southern Gauteng Subgroup embarked on an initiative to get sponsorship for the supply of PPE, initially for the public healthcare psychiatric units. We were fortunate to receive a donation from a mining company, Vedanta Zinc International, of KN95 masks and hand sanitizers.

Recognising the significant contribution made by our private sector colleagues in this vital frontline work, we have been able to set aside KN95 masks (pack of 10) for each SASOP Southern Gauteng member in the Private Sector, available for collection by 30 August.

Follow the link at the end of the article for **A Guideline on the use and recycling of masks**, with thanks to Chris Hani Baragwanath Academic Hospital Psychiatry Department and Dr TGA Leonard of the CHBAH Anaesthesiology Department and PPE Committee for sharing it.

Kindly arrange to collect your masks at one of the following Collection Points:

Midrand & Surrounds	Anusha Rama Sunninghill Medical Centre cnr Edison Crescent & Maxwell Drive (Opposite Eskom) reception@drarama.co.za 011 803 5738
Sandton	Pevashnee Naicker Tara H Moross Hospital 50 Saxon Road, Sandhurst pevashnee@gmail.com 083 680 1647

Randburg	Thriya Ramasar Akeso Crescent Clinic cnr President Fouché & Hawken Avenue Bromhof, Randburg drtramasar@gmail.com 011 792 8674
West Rand	Thuli Mdaka West Rand District Health Services Thuli.sithebe@gmail.com 072 125 8667
Parktown & Surrounds	Lolita Mostert Akeso Parktown 6 Junction Avenue, Parktown admin@memorycare.co.za 071 842 2731
Johannesburg South & Sedibeng	Vinusha Juggath Akeso Alberton 15 Clinton Road, Alberton juggathvinusha@gmail.com 011 907 1459 / 082 901 2775
East Rand & Ekurhuleni	Latisha Raghubir 18 Russel Street, Benoni reception.raghubir@gmail.com 011 362 6050

N95 Mask Recycling & Reuse Method:
<http://healthman.evlink9.net/servlet/link/59547/578116/1886150/2014054>

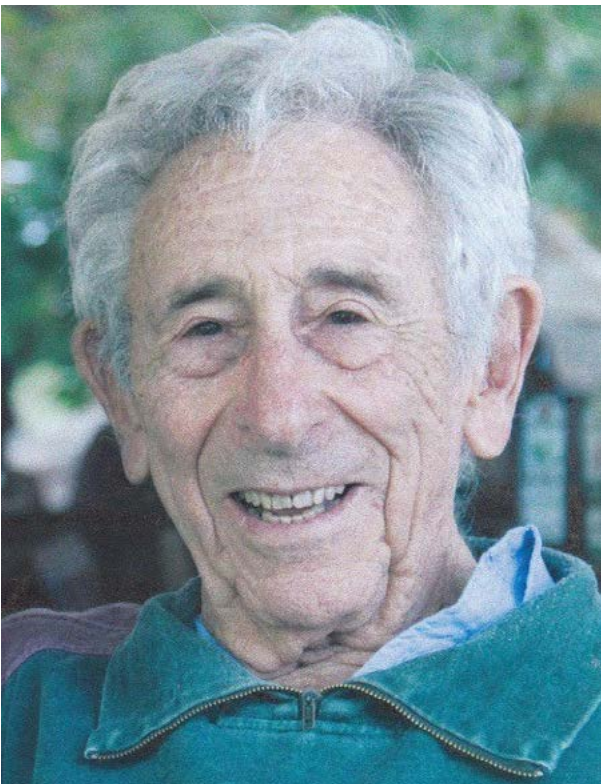
Yours sincerely

Dr Thriya Ramasar
Secretary
SASOP Southern Gauteng Subgroup



SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

A TRIBUTE TO PROF LYNN SINCLAIR GILLIS



GUARDIAN 'OTHER LIVES'

My close friend Professor **Lynn Sinclair Gillis** died on May 24th at home in Cape Town, aged 96. Born to emigrant parents who exchanged antisemitism in

the small Lithuanian town of Kretinga for Boerland Kroonstad (= 'Crown City', ironically named not after royalty but a favourite horse that drowned in the local stream). Lynn's father Julius, a dentist, grew competition prize roses as a hobby, and his mother Annie (nee Lynn), a concert pianist, gave music lessons. Late in life, Lynn recalled the chicken soup and Kneidels made by his granny, who lived with them. This parochial background grounded his fluent vernacular Afrikaans, a language he deemed second only to Yiddish in its rich array of metaphors and colourful curses.

PERHAPS TOO, IT UNDERPINNED LYNN'S INITIATIVES IN COMMUNITY AND SOCIAL PSYCHIATRY. HOSPITALISATION AT AGE NINE FOR SCARLET FEVER IN THE JOHANNESBURG CHILDREN'S FEVER HOSPITAL SIMILARLY PRIMED LATER INNOVATIVE IDEAS.

When the war broke out, he served in makeshift hospitals in Northern Africa and Italy. 1945-1962 he worked at Tara Hospital, a pioneering mental health facility in Johannesburg, taking a break in the 1950s to hold positions at the Maudsley Hospital in London, and becoming a founding member of the UK Royal College of Psychiatry.

These formative experiences bore fruit when he was recruited in 1962 to be founding Head of Department



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of Psychiatry & Mental Health at the University of Cape Town and first consultant at Groote Schuur Hospital. He initiated ground-breaking community services and clinics, unusually led by nurses. Under his guidance a day hospital was established, and a psychiatric Social Club promoting continuity of care for patients in the community, with outreach provisions to destigmatise mental illness. At the Government funded Valkenberg Hospital and Alexandra Rehabilitation Centre he courageously defied Apartheid segregation, by integrating staff across wards.

Lynn Gillis won many awards and held esteemed positions, among them President, of the S.A. National Council for Mental Health. We met in 1980 when as Director of the South African Medical Research Council's Clinical Psychiatry Research Unit he invited my husband Professor Julian Leff of the British Medical Research Council to participate in an extensive study of Life Events and ongoing precipitants of relapses in schizophrenia. Their findings revealed massive discrepancies in the different racial groups' lived experience.

We remained fast friends ever since, with reciprocal bi-annual visits (adjusted in the academic boycott years), between ourselves and Lynn and his late wife Shirley (nee Lourie, a clan who claim to trace their roots back to King David). All agreed that Professor Gillis was an inspirational teacher, mentor and author of numerous professional books and publications. Many eminent people in the field cite his singularly trusting style of leadership which encouraged their personal initiative.

Ever curious, Lynn was drawn to psychoanalysis, and pursued Buddhism. His fine appreciation of music, travel and art flourished in retirement when he also studied sculpture and created austere carvings in marble and rare woods.

ALWAYS AN AVID MOUNTAINEER HE REMAINED REMARKABLY HEALTHY AND AGILE, LUCID AND FIERCELY INDEPENDENT TO THE END OF HIS FULL AND FULFILLED PROFESSIONAL AND ARTISTIC LIFE.

He leaves a daughter Jenny, four adult grandchildren (Josh, Gabrielle, Jason, Danielle) and three great grandbabies (Nomi, Yael and Lev).

Professor Joan Raphael-Leff, PhD [Retired]

Psychoanalyst/Transcultural Psychologist, Fellow of the British Psychoanalytical Society & Member IPA. Leader, Academic Faculty for Psychoanalytic Research Anna Freud Centre, London

ROYAL COLLEGE OF PSYCHIATRISTS

Lynn Sinclair Gillis MD

FRCPsych, M.B.Ch.B., D.P.M.

Formerly Head of the Department of Psychiatry, University of Cape Town, and Consultant Psychiatrist, Groote Schuur Hospital, Cape Town, South Africa

Lynn Gillis who died recently at the age of 96 years, was, over a long period, one of the leaders of academic psychiatry in South Africa. In the 1960s and 1970s, he was a pioneer of community psychiatry and set up numerous community psychiatry services, mostly led by nurses. Under his guidance, a Day Hospital was established in 1963 in Cape Town, allied to a Community Service and Psychiatric Social Club, which promoted continuity of care for patients in the community. This linked outreach provisions with psychiatric advocacy, aiming to destigmatise mental illness. Outpatient clinics were established at most hospitals, and peripheral clinics were established in many parts of the country which catered mostly for patients who had been discharged from hospital. Later legislation in 1976 made formal provision for a community service in country areas associated with particular psychiatric hospitals. Over time, beginning with consultations at Red Cross War Memorial Children's Hospital and introducing an outpatient clinic in 1964, an active Division of Child & Adolescent Psychiatry was established in the department. In 1983 the division assumed responsibility for the psychiatric needs of patients at Sonstraal Adolescent Unit for behaviourally disturbed children at Valkenberg and for the psychiatric care of patients at Alexandra Care and Rehabilitation Centre.

COURAGEOUSLY DEFYING APARTHEID SEGREGATION, HE INTEGRATED STAFF ACROSS WARDS.

In 1968, he carried out a significant research project into the rate of mental illness and alcoholism in the Coloured People of the Cape Peninsula. A community service for alcoholism, staffed by a psychiatrist and psychiatric nurses, was opened in Heideveld in 1971. He developed Community services for the geriatric population and in 1976 specialised geriatric psychiatry beds were established at Valkenberg in close co-operation with the Division of Geriatrics (in the Department of Medicine) of Groote Schuur Hospital as an extension. This was the first such organised service in South Africa.



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In 1980 the Social Psychiatry MRC Unit established and headed by LSG focused further on the development and research into community based mental health. In collaboration with Professor Julian Leff of the UK Medical Research Council he carried out a number of studies of the social precipitants of relapse in schizophrenia. Their studies revealed massive discrepancies in the lived experience of the different racial groups.

Lynn's clinical teaching and research laid the foundations for the existing Department of Psychiatry in the University of Cape Town, now a leader of psychiatric research in the African continent. Professor Dan Stein, the current Head of the Department, recalls that 'the clinical, teaching, research, and social responsiveness strengths of the existing Department are in no small measure due to his pioneering work'.

AS WELL AS CLINICAL WORK AND CARRYING OUT RESEARCH, LYNN WROTE SEVERAL BOOKS DEALING WITH DIFFERENT ASPECTS OF CLINICAL PRACTICE IN PSYCHIATRY AND PSYCHIATRIC EDUCATION. TOWARDS THE END OF HIS LIFE HE WROTE A SERIES OF REFLECTIONS ON HIS RICH AND VARIED EXPERIENCE.

Lynn was born on 1 February 1924 to Jewish parents who had migrated from Kretinga in Lithuania. His father, Julius Gillis, was a dentist who grew competition roses as a hobby. His mother, Annie Gillis, (née Lynn) was a concert pianist who gave music lessons locally. He was first brought up in the small South African town of Kroonstad in the Orange Free State. As a result, he spoke vernacular Afrikaans, (a language he deemed second only to Yiddish in its rich array of metaphors and flamboyant curses,) with fluency. At the age of nine years, a year after the family had moved to Johannesburg, he contracted scarlet fever. His experience in the Children's Fever Hospital may have influenced his later ideas about hospitals as institutions.

He entered Witwatersrand medical school in 1941. He interrupted his medical studies to enlist as a medical assistant in the South African Medical Corps, serving in makeshift hospitals in North Africa and Italy. Returning to South Africa he worked from 1945 until 1962 at Tara Hospital, Johannesburg, a pioneering mental health facility where he was influenced by the indomitable Dr. Mary Gordon, a migrant from Russia. In the 1950s Lynn took a break from Tara

to hold positions at both the Maudsley Hospital in London and St. Francis Hospital, Haywards Heath in Sussex. In 1962, he was recruited to fill the position of founding Head of the Department of Psychiatry and Mental Health at the University of Cape Town and first consultant at Groote Schuur Hospital (posts he held for 27 years).

During his career, Lynn won numerous awards, among them the SALUS Medal (silver) for Meritorious Service to Medicine (1989) and Merit Award for Outstanding Services, Medical Association of S.A., (1990). He also held many positions of responsibility, including President, of the South African National Council for Mental Health (1969-1970/1976-1978/1981-1983), President, Society of Psychiatrists of South Africa (1969-1971). He was an elected member of the International Brain Research Organisation (1977-1989); President, of the South African Geriatric Society (1978-1980), President of the South African Gerontological Association (1982-1993); and Chairman of the National Research Programme on Aging of the South African population, Human Sciences Research Council (1987-1991).

HE WAS A FOUNDING MEMBER AND LATER FELLOW OF THE ROYAL COLLEGE OF PSYCHIATRISTS (1971).

Although a reserved man, Lynn's warmth, compassion and mischievous humour influenced several generations of psychiatrists, psychologists and allied practitioners as much as his professional capacities as inspirational teacher, mentor and author of many publications. He had a long-lasting effect on his trainees, many of whom rose to eminence in South Africa, USA and the UK. Today, they still acknowledge the lasting legacy of his singularly trusting style of leadership which fostered personal initiative. Ever curious, his awareness of the many contradictions and unconscious processes of the human mind drew Lynn to psychoanalysis, and he pursued a lifelong interest in Buddhism. He always had a subtle appreciation of beauty, art, and music. In retirement he studied sculpture and became a prolific creator of many austere carvings in marble and rare woods. An enthusiastic mountaineer, he remained remarkably healthy and agile until his last years. He was lucid and fiercely independent to the end of his full and fulfilled professional and artistic life. He died on 24th of May, 2020.

Shirley (née Lurie) his wife of 64 years, died in 2015. He leaves a daughter (Jennifer), four grandchildren (Josh, Gabrielle, Jason, Danielle) and three great grandchildren (Nomi, Yael and Lev).

Joan Raphael Leff ■



S T A T E M E N T

RECOMMENDATIONS & CONCERNS REGARDING MENTAL HEALTH CARE ACT USERS DURING THE COVID-19 PANDEMIC

We should expect an increase in the number of psychiatric admissions not only from known psychiatric patients but the general public as well due to the stress that comes with the fear of contracting the virus, awareness that there is no proven treatment for it as well as loss of income and social support.

The above will unfortunately occur in the background of chronic psychiatric bed shortage and lack of psychiatric medication in the District Health System that could possibly treat/manage/contain these relapsed or new patients. The former long-standing situation has been highlighted by several organizations and tribunals including the Health Ombud's report on the Life Esidimeni Investigation, Advocate Moseneke's Tribunal on the same Life Esidimeni tragedy plus the South African Human Rights Commission's report that followed the aforementioned panels.

A further misfortune is that the government has not had time to address these well-accepted shortcomings, before COVID-19 landed on our shores in March 2020. Its high transmission rate, which is higher than that of influenza, has caught many countries including high income ones, unprepared to cope with the need for hospital beds. A total and prolonged lockdown that will enable governments to create beds for both COVID-19 patients as well as non-COVID-19 patients, has not been possible because economies would suffer, perhaps irreparably.

A FURTHER COMPLICATION IS THAT, BEING A NOVEL VIRUS, IT'S BECOMING CLEAR THAT ONE CANNOT PREDICT WHERE OUTBREAKS WILL OCCUR AND IF THESE OUTBREAKS WILL RESULT IN HIGH NUMBERS OF SEVERELY ILL COVID-19 PATIENTS WHO WILL NEED MANY INTENSIVE CARE BEDS WITHIN A SHORT SPACE OF TIME.

Worse still, it should be accepted that, whilst a great majority of patients will have a mild version of COVID-19, it comes with caveat that this is based on observations only. In some villages, towns, cities, regions, provinces and countries, they may experience a higher number of severely ill COVID-19 patients than would be expected.

The assertion that Africa's youthful population could possibly buttress the continent from reaching high levels of COVID-19 cases and deaths as seen in some countries in Europe, North and South America, should be guarded against as the youth, with or without co-morbidities could suffer moderate to severe COVID-19 effects warranting admission to hospitals.

Therefore, it is clear to SASOP that like the government's Ministerial Advisory Committee on Coronavirus Disease 2019 (MAC-COVID-19) suggested in March 2020, we are yet to see the worst of the pandemic



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even as the number of cases in South Africa climbs beyond the 570,000 mark and the number of deaths reach beyond 11,000. This is especially so, as the lockdown eases and more and more citizens return to work and possibly interacting in close quarters with others.

SUPPORT FOR INCREASING THE HOSPITAL BED NETWORKS

Under these circumstances, whose duration cannot be predicted, SASOP calls on health authorities at all levels in South Africa, to re-double their efforts to build a large hospital bed network, that involves the non-government organization sector, public healthcare sector and private healthcare sector that will cater for COVID-19 and non COVID-19 cases.

With cancelled surgeries, intermittently closed clinics, reduced healthcare staffing levels in some emergency departments and medication shortages as main supplier countries undergo lockdowns, it should be accepted that the surge in patient numbers will not only be in COVID-19 affected patients but in non-COVID-19 patients suffering illness and death from other conditions that would have been otherwise prevented or managed.

THE NEED TO INCREASE HOSPITAL BED CAPACITY IS THEREFORE NOT ONLY FOR THE SAKE OF THE PANDEMIC ITSELF, BUT FOR THE UNINTENDED MEDICAL CONSEQUENCES OF MEASURES TO QUELL THE PANDEMIC.

CONSIDERATION OF VULNERABILITY AND CO-MORBIDITIES

Whilst it is well accepted that the middle-aged, the elderly and those with co-morbidities, are vulnerable to develop severe forms of COVID-19, SASOP would like to highlight that psychiatric patients, whether in healthcare facilities or in the community, are also vulnerable to acquiring COVID-19 and may end up having the severe form of the disease compared to others patients.

This is due to the following reasons:

- Crowded living conditions in psychiatric hospitals where common dining and bathroom spaces are shared
- Poorly equipped psychiatric facilities especially when it comes to protective equipment
- Standard psychiatric treatment that requires participation in group activities
- Patients' long-standing difficulties of poor self-control and self-care

- Cognitive impairment in severely and chronically ill patients making it difficult to maintain infection control measures
- Unhealthy habits of many patients, including smoking, on top of underlying and undetected health conditions

PROTECTION OF PSYCHIATRIC BEDS

Having pointed out the above, SASOP would like to advise health authorities, who may be in a desperate need to build the abovementioned hospital bed network due to the needs brought on by the pandemic, against using any psychiatric beds, whether at District or Tertiary level, to add to this capacity.

The reasons are obvious and patently stated as follows:

- there is an acute psychiatric bed shortage
- there is also a contracted bed shortage due to rapid de-institutionalization without the required non-governmental organizations' residential beds to absorb discharged patients
- there is limited social support for some stable and ready to discharge patients who end up staying in District and Regional Hospitals for a far longer period than necessary
- there is an expectation that an increased number of psychiatric patients will relapse and that there will be a surge of previously mentally well persons becoming psychologically distressed and even considering suicide
- severely mentally ill patients are liable to acquire COVID-19 more easily and may not recognize the early symptoms and seek help timeously
- some patients may forgo clinic attendance due to fears of being infected and later on relapse enough to require hospitalization.

CONCERNS AROUND PSYCHIATRIC ADMISSIONS AND COVID-19

The twin peaks of increased rates of COVID-19 amongst psychiatric patients and increased incidence of relapses and new psychiatric cases, is bound to have these two distinct groups of patients arriving at the door steps of District, Regional and Specialist psychiatric facilities throughout the country at the same time, and possibly in large numbers. With no possibility of delaying the admissions, health authorities may consider admitting these two groups of patients into one ward. This essentially sanctions the accommodation of a COVID-19 positive patient and a COVID-19 negative patient. **This is clearly**



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unacceptable, for both ethical (do no harm) and humanitarian (lack of justice for a vulnerable and defenceless member of the society) reasons.

Furthermore, such a practice, would be against the "COVID-19 Disease: Infection Prevention and Control Guidelines Version 2 (21st May 2020)", which states under the "Environmental Controls for IPC measures in COVID-19: Patient Placement" section that "Confirmed or suspected patients with COVID-19 not requiring ICU care should be accommodated either in a single room or in cohort isolation".

THEREFORE, THERE SHOULD NOT BE A MIX OF COVID POSITIVE OR COVID-19 SUSPECTED PSYCHIATRIC PATIENTS WITH COVID-19 OR THOSE NOT SUSPECTED OF COVID-19 PATIENTS IN ONE WARD.

The correct assumption that anyone could have COVID-19 even without symptoms, should not negate or diminish the sound ethical and legal basis for abovementioned stance by the National Department of Health.

SASOP would like to point out this stand-alone directive from the National Department of Health provides no caveat for health authorities to amend this decision based on "availability of resources".

This should be complimented for several reasons:

1. there should always be a demonstrable and sustained effort on the part of health authorities to show that indeed no resources were available OR could not be procured to follow this directive
2. psychiatric patients have for many years suffered from a minimal allocation of national healthcare resources to meet their needs and now, at a time that they are most vulnerable from the "Twin Peaks of COVID-19 Infection and Relapse", they cannot once again be denied their rightful place next to fellow medical/surgical patients for whom such mixing of patients would hardly be considered.

SASOP WOULD LIKE TO RECOMMEND A NUMBER OF STEPS THAT SHOULD BE TAKEN BY HEALTH AUTHORITIES AND MENTAL HEALTH CARE PROVIDERS DURING THIS PANDEMIC.

1. Head of Health Establishments, healthcare providers, multidisciplinary mental health specialist teams and informal caregivers should continue to render mental health care services to mental health care users throughout this pandemic, as is our civil duty, employment requirement and Hippocratic oath to do so.

2. Mental health care services should be conducted in a manner that continuously protects the health of the mental health care provider and user. The service should also be in line with the COVID-19 Disease: Infection Prevention and Control Guidelines Version 2 (21st May 2020) which direct that non symptomatic or mildly symptomatic COVID-19 or suspected individuals should be a single rooms or in cohort isolation.
3. The "Guidelines for Mental Health intervention during the COVID-19 disaster" states that there has been no change in the policies regarding the management of mental health care users at primary health care facilities, which is where most psychiatric patients first present. The MHCA, which states that users should be treated as close to their homes as possible and undergo a 72 hour observation period at a primary health care facility that can admit the user, has not been suspended by Parliament during this pandemic. Therefore, there should not be any circumvention of these prescripts even during the pandemic. **The rights of mental health care users**, like that of ordinary citizens, should still be respected and the Mental Health Review Boards should ensure this is indeed the case.
4. Psychiatric patients with COVID-19 or suspected of having COVID-19 and in need of high care (eg, oxygen treatment via nasal cannulas) or intensive care bed management (eg, ventilation) should be transmitted to a medical facility without hesitation.
5. Mental Health Care Providers should be aware that the condition of COVID-19 or PUIs patients can change quickly and for the worst, therefore admission to isolated psychiatric hospitals should be conducted judiciously and in consultation with Internal Medicine colleagues.
6. The long practised sub-speciality of Consultation Liaison Psychiatry should be encouraged as it can provide sound and effective assistance to a patient and the attending medical team should the patient be unmanageable.
7. In anticipation of more psychiatric patients acquiring COVID-19 and/or relapsing from pandemic-associated stress, the capacity to accommodate psychiatric patients during this pandemic should be attended to with urgency.
8. The opening up of more psychiatric beds could be facilitated through a number of means including:
 - Quick processing of NGOs that have applied to become licensed NGOs that can accommodate users with profound and severe Intellectual Disability who have long been kept in acute or specialist psychiatric beds awaiting placement.



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With the availability of the Department of Health's stringent guidelines for the licensing of NGOs for users with profound and severe Intellectual Disability, a repeat of the failed Life Esidimeni user transfer marathon is not expected.

- Immediately increase the funding provided to licensed NGOs as the current subsidy falls far short of what is needed to adequately and professionally take care of our most vulnerable psychiatric patients. Placements of these users to licensed NGOs should not be compromised by the economic means of the parents or carers of these users. Some carers sometimes need to subsidize on top of the user's disability grant in order to get users placed in private and licensed NGOs when publicly licensed ones which are affordable are full.
- Re-procurement of contracted beds at larger long term facilities that can house users with complex mental illnesses with risk factors that cannot be contained in the community.
- Immediate inspection of all hospital facilities to search for underutilised wards (eg, TB wards that are no longer needed as more and more patients respond favourably to ARVs).
- Capacitate Infrastructure departments at

the local and provincial level to renovate and refurbish these wards into functional psychiatric wards as quickly as possible.

- Along with the Infrastructure department, more psychiatric staff should be pre-emptively hired to help current staff cope with the expected deluge and there should be a mix with medical staff or family physicians.
- Any decision to close an acute psychiatric ward should not be haphazard as this may lead to creation of COVID ward which may then lie unused for weeks or months. Rather, one hospital within the region should become a near complete COVID-19 hospital, accepting COVID-19 patients from nearby hospitals so that care of other non-COVID-19 conditions can continue. This is much like creating TB hospitals to unburden other hospitals.
- If all fails, engage the private sector, to assist in addressing any shortfalls in hospital bed capacity.

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Supported by the SASOP National BOD ■



SASOP

20th National Congress
of the

South African Society of Psychiatrists

20 - 24 October 2021

Champagne Sports Resort
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SAVE THE DATE





SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

AFRICA GLOBAL MENTAL HEALTH INSTITUTE -



COVID-19 & MENTAL HEALTH CARE IN RESOURCE CONSTRAINED SETTINGS

GLOBAL PERSPECTIVES FROM: KAMPALA, UGANDA; CAPE TOWN, SOUTH AFRICA; MONROVIA, LIBERIA; & NEW ORLEANS, USA

A webinar was hosted by the South African Society of Psychiatrists on Thursday 25th June 2020. A recording of the webinar is available [here](#)

The featured *discussants* were:



Dickens Akena, M BChB, MMED, PhD
Senior Lecturer & Psychiatrist, Department of Psychiatry, Makerere University



Qhama Cossie, M BChB, FCPsych, M Phil

Head of Division of General Adult Psychiatry, Senior Lecturer & Principal Specialist, University of Cape Town



Benjamin Harris, MD

Associate Professor & Chair of Psychiatry, A.M. Dogliotti College of Medicine, University of Liberia; President, College of Physicians and Surgeons (LCPS)



Denese Shervington, MD, MPH

President, Institute of Women and Ethnic Studies (IWES); Chair of Psychiatry, Charles R. Drew University

The *moderators* were:



Bonga Chiliza, PhD, MBChB, FCPsych

Associate Professor, Chief Specialist & Head of the Department of Psychiatry, University of KwaZulu-Natal; President, South African Society of Psychiatrists



Michelle P Durham, MD, MPH

Adult, Child & Adolescent Psychiatrist and Residency Training Director, General Psychiatry, Boston Medical Center, Assistant Professor of Psychiatry, BU School of Medicine





SOUTH AFRICAN SOCIETY OF
PSYCHIATRISTS

LAUNCH OF THE HEALTHCARE WORKERS CARE NETWORK CARING FOR THE CARERS BY THE CARERS



**HEALTHCARE WORKERS
CARE NETWORK**

Caring for the Carers by the Carers

Healthcare workers are exhausted, stressed, and at high risk for physical and mental illness as the COVID-19 pandemic continues to take its toll in South Africa. Top South African medical, clinical, and professional associations are collaborating to bring much needed support and care to healthcare workers across the country.

The Healthcare Workers Care Network (HWCN) is a nationwide healthcare worker support network spearheaded by partners SA Society of Psychiatrists (SASOP), SA Medical Association (SAMA), Psychological Society of SA (PsySSA), SA Society of Anaesthesiologists (SASA), and the SA Depression and Anxiety Group (SADAG). It offers all healthcare workers across the public and private sectors free support, pro bono therapy, resources, training and psychoeducation. The HWCN already has over 500 volunteer mental health professionals,

including psychiatrists, psychologists, GPs, registered counsellors, and social workers, who will provide help, intervention, and support to all healthcare workers.

THESE INCLUDE DOCTORS, NURSES, COMMUNITY HEALTHCARE WORKERS, FIELD WORKERS, HOSPITAL OR CLINIC PERSONNEL, INCLUDING HOSPITAL LAUNDRY STAFF, AND PORTERS.

The HWCN has launched a 24-hour toll-free Helpline (0800 21 21 21), SMS 43003 and website (www.healthcareworkerscarenetwork.org.za) so that all healthcare workers can access immediate counselling and support. "By providing as many touchpoints as possible for our frontline healthcare workers across South Africa, to ensure they have mental health support and intervention is crucial in ensuring that their mental health is looked after during this stressful time." Exposure to the virus, long working hours, psychological distress, looking after their own families and challenges with home-schooling, fatigue AND burnout are real hazards.

Every new COVID-19 diagnosis means longer hours, less sleep, and increasingly irregular meals for our frontline workers, resulting in weakened



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immune systems and lower resilience. "South Africa's healthcare workers are under enormous pressure," says Dr Antoinette Miric, a Johannesburg-based psychiatrist and SASOP spokesperson. "They are committed to fighting this disease and saving as many lives as possible, all while managing their personal risks and anxieties around the virus and its impact on their own lives and their loved ones. Healthcare workers are not used to reaching out for support for themselves. Still, I hope that this pandemic helps them to realise that they need to look after themselves first physically and emotionally, before they are able to look after others."

Looking after oneself is not natural for the healthcare worker, who in their nature help selflessly. However, in these circumstances, self-care is not just a buzzword – it is essential. Healthcare workers need to put on their oxygen masks before helping others."

THE HEALTHCARE WORKERS CARE NETWORK (HWCN) IS OPERATED BY QUALIFIED PROFESSIONALS WHO HAVE THE SKILLS TO HELP HEALTHCARE WORKERS MANAGE THEIR OWN FEARS AND STRESSES AROUND COVID-19, BY PROVIDING THE SUPPORT AND COUNSELLING TO PROTECT THEIR MENTAL HEALTH AND MITIGATE THE EFFECTS OF INCREASED RATES OF POST-TRAUMATIC STRESS, ANXIETY, AND DEPRESSION.

While waiting for the inevitable surge of COVID-19 patients to hit, healthcare workers have faced challenges to acquire personal protection equipment, roster changes, leave cancellations and financial stress amongst others. Everyday work activities in the healthcare sector have been disrupted as facilities across South Africa suspend all but the most urgent of emergency medical care.

Dr. Caroline Lee, Convenor of the SA Society of Anaesthesiologists Wellness in Anaesthesia Support Group, who has been supporting doctors suffering burnout for over 6 years, explains that the initiative gives healthcare workers immediate access to help whenever they need it. "It's critically important right now to be as supportive as possible of doctors, nurses, healthcare support staff, and allied medical personnel," she says. "These are dedicated people who have committed to seeing all of us through the COVID-19 crisis. They form the backbone and the frontline of our healthcare response. They are taking

on significant personal risk and too often working without adequate equipment to ensure all of us can receive the care we need. They are our guides, allies, and caregivers. They are tireless, innovative, inspirational, stressed, exhausted, and too-often undervalued."

THE HEALTHCARE WORKERS CARE NETWORK (HWCN) INITIATIVE IS A STRICTLY CONFIDENTIAL, FREE SERVICE RUN AND DELIVERED BY VOLUNTEER PSYCHIATRISTS AND PSYCHOLOGISTS AND AIMS TO SUPPORT EXISTING EMPLOYEE WELLNESS PROGRAMS.

It has a main preventative arm with resources for psychoeducation and training of leaders in healthcare as well as personalised support sessions for individual healthcare workers. This current healthcare crisis is not going to resolve itself any time soon. We must support these healthcare workers who are working tirelessly to save lives and treat those that are ill.

For any press interviews or expert comments, please contact:

Tracy Makute

074 379 8708 - research@anxiety.org.za

Petri Greef

079 453 8780 - help@sadag.org

Cassey Chambers

082 835 7650 - office@anxiety.org.za



24 hour Helpline 0800 21 21 21

SMS 43001

www.healthcareworkerscarenetwork.org.za

Fill in the online form on the homepage to request individual therapy and support. Online requests for support and counselling are accessible through the website, the SAMA page, the EMGuidance App as well as the Vulamobile App ■



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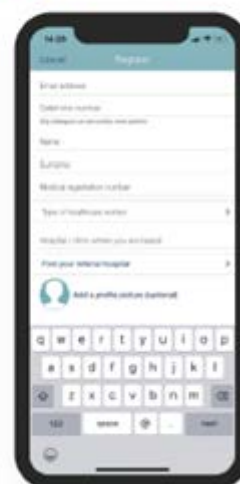
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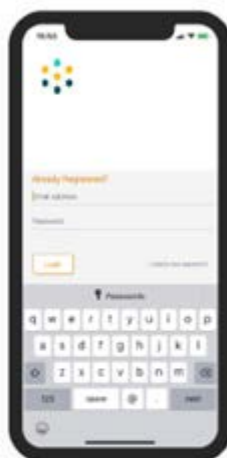


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Look out for an email from us with your password.
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5 Login using your email & password



6 Start sending & receiving referrals



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A CALL TO ACTION:

PROMOTING MENTAL WELLBEING IN SOUTH AFRICAN HEALTHCARE WORKERS

Rita Thom

The COVID-19 pandemic has highlighted the occupational stress that healthcare workers are exposed to, and although there are few studies documenting the prevalence of specific mental disorders in healthcare workers, there is literature on the phenomenon of “burnout” in healthcare workers from a range of settings^{1,2,3,4}. There is also evidence that suicide rates in medical doctors are higher than general population rates, and that specific medical specialties are at even greater risk⁵. Healthcare workers, particularly doctors, are also often reluctant to seek help for mental ill-health, feeling shame about their vulnerability, and fearing stigmatisation in the workplace⁶.

SYSTEMATIC REVIEWS OF INTERVENTIONS TO ADDRESS THESE PROBLEMS SUGGEST THAT INDIVIDUAL AS WELL AS ORGANISATIONAL INTERVENTIONS MAY HELP TO REDUCE STRESS AND BURNOUT IN HEALTHCARE WORKERS

However there is a need for larger randomised controlled trials to identify specific factors that increase the risk of distress and specific interventions that may mitigate risk and build resilience^{7,8,9}.

There are already reports in the literature on the impact of the COVID-19 pandemic on the wellbeing of frontline workers in other countries^{10,11}. Literature reviewing the impact of previous disasters and pandemics has highlighted the need for a pro-

active approach to promoting mental wellbeing in this group and in preventing mental ill-health^{12,13,14,15}. Some of the strategies developed from these events have helped to inform approaches to the current pandemic^{16,17}. It has been emphasised that a formal psychiatric or psychological approach is not necessarily helpful, but current evidence suggests that a trauma-informed model with Psychological First Aid as the initial intervention is beneficial¹⁸. The aim is to build and sustain resilience. A recent rapid review and meta-analysis found that “clear communication, access to adequate personal protection, adequate rest and both practical and psychological support were associated with reduced morbidity” in frontline healthcare workers in this and previous infectious outbreaks¹⁹. These measures need to be continuous throughout all phases of the pandemic.

EVIDENCE FROM OTHER COUNTRIES SUGGESTS THAT ENCOURAGING AND SUPPORTING COMPASSIONATE LEADERSHIP IN HOSPITALS AND COMMUNITY FACILITIES IS THE BEST WAY OF PROTECTING STAFF, EMPHASISING THE IMPORTANCE OF GOOD SELF-CARE FOR TEAM LEADERS AND INDIVIDUAL HEALTHCARE WORKERS, AND PROVIDING SUPPORT AND SPECIFIC MENTAL HEALTH INTERVENTIONS FOR THOSE WHO NEED IT²⁰.

South Africa has had some time to prepare for the pandemic. However, this has led to an escalation of anticipatory anxiety and other heightened emotional states amongst healthcare workers²¹. We are now in the early stages of the pandemic and certain parts of the country are experiencing increasing COVID-19 caseloads, as well as healthcare worker infections, resulting in more anxiety and distress. As the pandemic progresses, ongoing unremitting stress increases the risk of burnout, moral injury as well as specific psychiatric disorders. More than ever, leadership needs to be clear, informative, and supportive.

MORE THAN EVER, FRONTLINE WORKERS NEED TO PRACTICE GOOD SELF-CARE FOR THE BENEFIT OF THEIR PATIENTS, THEIR FAMILIES AND THEMSELVES.

A project in the Gauteng province initiated by a group of mainly private-sector psychiatrists and psychologists has expanded into a national initiative, the Healthcare Worker Care Network (HWCN) spearheaded by the South African Medical Association (SAMA), in partnership with the South African Society of Psychiatrists (SASOP), the South African Society of Anaesthesiologists (SASA), the South African Depression and Anxiety Group (SADAG) and supported by the Psychological Association of South Africa (PsySSA).

The project is taking a two-pronged approach:

- The first prong is preventive and has involved providing training and support to leaders in hospitals and other healthcare facilities.

THESE LEADERS HAVE INCLUDED CHIEF EXECUTIVE OFFICERS AS WELL AS CLINICAL AND NON-CLINICAL HEADS OF DEPARTMENTS. IT IS IMPORTANT TO EMPHASISE THAT ALL STAFF WORKING IN HEALTHCARE FACILITIES ARE FRONTLINE WORKERS IN THIS PANDEMIC.

To date over 600 people have attended this training (personal communication from Dr.Thriya Ramasar, secretary of the Southern Gauteng Subgroup of SASOP).

- The second prong is the provision of confidential individual or group counselling to frontline workers.

A NATIONAL DATABASE OF OVER 500 PSYCHOLOGISTS, SOCIAL WORKERS, REGISTERED COUNSELLORS AND PSYCHIATRISTS HAVE VOLUNTEERED TO PROVIDE 4 PRO-BONO SESSIONS TO HEALTHCARE WORKERS WHO REQUEST HELP.

Requests can be made in a secure and confidential manner through the SAMA website, the Vula or EMG Apps, the SADAG or Akeso helplines or the project website (<https://www.healthcareworkerscarenetwork.org.za>). This latter website also has a resources page with useful information material for team leaders and frontline workers.

While we anticipate that frontline workers are going to be at increased risk for burnout and the development of mental disorders, before, during and after the pandemic, we should also understand that this risk is superimposed on an already stressed population^{22,23}. We should be doing everything that we can to mitigate this risk and to help build resilience in our frontline workers. We should not forget however, that healthcare workers in South Africa have shown resilience and stamina in previous difficult situations, such as during the early stages of the HIV epidemic. This is an opportunity to build a more compassionate and healthy healthcare system. So, the call to action is to:

1. Leaders in the South African healthcare system: do all you can to create an enabling environment for healthcare workers to provide clinical care in this difficult time; learn how to support your teams, develop compassionate leadership skills and practice good self-care yourselves.
2. Individual healthcare workers and other workers in the frontline: pace yourselves, develop healthy self-care strategies, and have the courage to reach out for help. It is available.
3. Psychiatrists, psychologists and other allied health professionals: join this effort to make a difference and play a valuable role in the pandemic and beyond.

The HWCN initiative was officially launched by SADAG on 3rd June 2020.

<https://covidcaregauteng.co.za>

<https://www.healthcareworkerscarenetwork.org.za>

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Rita Thom is a psychiatrist in private practice and an honorary Adjunct Professor in the Department of Psychiatry, University of the Witwatersrand, Johannesburg, South Africa. **Correspondence:** Rita.Thom@wits.ac.za ■

LISTENING TO COVID-19

Lauren Gower

“All of our psyches and schedules are out of whack.”

(Quote from Gloria Demby psychoanalyst in Brooklyn NY. Gloria, her daughter Eta Demby, and a colleague, Nancy Goodman, a fellow psychoanalyst from Bethesda, Maryland recently set up a response team which called on colleagues from the US and other countries to offer pro bono sessions to frontline workers in the United States. Both Gloria and Nancy have extensive experience working with adults and children who have been in traumatic situations including transgenerational transmissions, with a particular emphasis on making human contact through witnessing).

The Healthcare Workers Care Network (HWCN) has been listening to mental health care issues arising out of the COVID-19 pandemic across the globe and locally in South Africa. The network now has over 500 psychotherapists and psychiatrists, social workers and counsellors who are volunteering pro-bono services to healthcare decisionmakers and workers. HWCN began in Gauteng two months ago, and is now a national network which includes the South African Medical Association (SAMA), the South African Depression and Anxiety Group (SADAG), the South African Society of Psychiatrists (SASOP), the South African Society of Anaesthetists (SASA) and is supported by the Psychological Society of South Africa (Psyssa).

To date the Gauteng branch of the HWCN has trained over 700 people at a number of public healthcare facilities. In their webinars and courses, they offer a clear model to enable decision-makers and their staff to cope more effectively with distress, loss and grief, as the pandemic sweeps the country. Their model which emphasizes compassion, care and containment, moves away from the now largely-discredited trauma debriefing model which research has shown can often retraumatize rather than heal. Listening compassionately requires therapists to be reflective, to raise thoughts and associations, and to stay close to their client's experience. Therapists are traditionally psychologists or counselors, but this model is equally helpful to anyone trying to make emotional contact with the person they're working with.

VOLUNTEERING BEHIND THE FRONTLINES

At the same time as the HWCN network is rolling out online training and support workshops, we are responding to the increasing need for therapists to offer individual and group listening sessions to

frontline workers. Acting as a national hub, HWCN is allocating requests for help from HCWs to individual therapists, many of whom have attended HWCN's training webinars. To provide individuals with support, HWCN is asking volunteer therapists to contact HCWs who have reached out for help.

BEING VOLUNTEERS INVOLVES MAKING OURSELVES AVAILABLE - TO BE VALUED, USED, REJECTED - AND MUCH IN BETWEEN.

Even though we know this, it is important to have few, if any, expectations around the listening and containing we are offering, and in our own ways, seeking. I am reminded of the British paediatrician and psychoanalyst, DW Winnicott's ideas here, of how the object needs to be available to be used, how all of us need others to be our objects at the same time as we perform the functions of being objects for others. We are there to be containers, coherent and leaky, vessels for thoughts and feelings, which in the best of circumstances, can become digestible, but which can also be unthinkable and unbearable. Being an available object carries with it the value of being useful along with the risk of being found wanting, and of being rejected. We may be gratefully taken in, but we can also be spat out.

STRIKING A BALANCE

How do we strike a balance without becoming intrusive when we are reaching out to someone in distress? We are all trying to find our way very sensitively around this. A number of volunteers with experience in the field, both during Covid-19 and in other disaster situations (like responding to Ground Zero during the 9/11 emergency) have found that many frontline

workers do not respond to a first, and sometimes to subsequent emails or phone messages. Given that many frontliners and first-responders have not sought psychological counseling before, and the fact that they are more likely to put their patients' and the public's needs before their own, we as volunteers need to find a balance between being caringly persistent and becoming intrusive when reaching out to frontliners. With another nod to Winnicott, we need to continue to be available when our emails aren't answered, or when sessions are cancelled (sometimes repeatedly). We need to be able to survive rejection. And we need to bear in mind that, whether or not we have made contact with the HCW who asked for help, we are in fact holding a mental space for that person.

Those we have reached out to may be feeling ambivalent, guilty or ashamed about needing help. These feelings, together with fluid working hours and unpredictable work conditions, may complicate frontliners' ability to keep the sessions we have scheduled with them. Volunteers may find that they only have one session with a HCW, or that they need to shift appointment times, and may also consider offering shorter or longer listening periods to accommodate the needs of frontliners.

CONNECTING AND THE UNCONSCIOUS

When we are connecting as therapists, although we may not be doing traditional therapy, we need to be alert to transferences, which despite the distance of virtual space, may still be profound. This requires us to have some awareness at the back of our minds that the individuals we are speaking to have chosen (just as we have) to be in a helping profession. Whether we have time or not to establish what this means for each person we speak to, it's important to remember that each person's choice is coloured by their own experiences.

JUST AS WE HAVE HAD OUR OWN PRIOR LOSSES AND STRESSES, WE MAY BE ABLE TO ENQUIRE ABOUT THE HCW'S CONTEXT AND BACKGROUND, TO HELP US BETTER UNDERSTAND THEIR UNIQUE SITUATION.

Stresses HCWs face are very broad and can include: having to make triage decisions which affect who gets treatment, and what level of treatment they receive; seeing many sick people, some of whom will not be allowed visits and who will die apart from their families; the lack of PPE, experience and treatment modalities to deal with COVID-19; losing a colleague, or friend or relative; being anxious and frightened about contracting the disease and of passing it on to their families; or something seemingly trivial, like whether public transport will be available so that they can reach their hospitals or clinics.

Therapists need to be aware of their own vulnerabilities, that they are navigating new, yet in some ways, familiar territory, albeit with tried and tested methods of listening carefully both to their

own feelings and to those of the person they are speaking to. Volunteer therapists may not be in direct contact with people on the frontline, or with those who are infectious, but they are still at risk of vicarious trauma and of moral injury when making ethically distressing decisions which can cause them to feel that they may be making mistakes, or that they have too little to offer, and that what they are offering is neither enough, nor good enough.

PEERS IN A PANDEMIC

It is becoming increasingly clear that in some ways we are all peers in this pandemic. As therapists we are simultaneously going through the same experiences as our colleagues and our patients. During the HIV epidemic we were forced to face the fact that infected or uninfected, we are all affected. What is profoundly different for many of us in this pandemic is that many of us are volunteering, and so are under no obligation to be in direct contact with patients. This is not the case for healthcare and allied workers, whether they are cleaners or nurses, physiotherapists or doctors.

THEY HAVE TO SHOW UP. THEY HAVE TO BE THERE FOR SICK PEOPLE AND THEIR FAMILIES.

I have been fortunate to attend a group zoom meeting hosted by Gloria Demby and Nancy Goodman. They set up a weekly zoom meeting they call 'Listening to the trauma of Covid-19' for volunteer therapists who have been supporting frontline HCWs. In keeping with their ethos of flexibility and care, the group is open and attendance is voluntary. Participants are free to share their thoughts and feelings about the work they've undertaken with frontliners as well as their own experiences of the pandemic and any thoughts that are on their minds.

UNCERTAINTY IS THE HEARTBEAT OF ALL ANXIETY.

Through talking and listening to each other, therapists in the group which has included mental health care workers from a number of cities in the US and from other countries, have been able to recognize the similarity of their experiences, despite their very different locations and contexts. They have shared their observations as well as their feelings about the many uncertainties of the future, and of the group itself. There has also been some discussion about the unfortunate narrative of healthcare workers being heroes. And there has been a nostalgic longing expressed by some participants for things to go back to where they were.

Recently Nancy Goodman, group leader, ended one of our sessions with the salutary observation that 'uncertainty is the heartbeat of all anxiety'.

Lauren Gower is a clinical psychologist and mental health advocate in Johannesburg. **Correspondence:** lauren.gower@live.co.za ; lauren.ruth.gower@icloud.com ■



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NOTICE OF REQUEST FOR COMMENT ON THE ADULT HOSPITAL LEVEL STGS AND EML (2019 EDITION)

Dear SASOP members, Dr Lesley Robertson has been appointed to a combined PHC-Adult Hospital Expert Review Committee for the next 3-year STGs review cycle.

Please see attached copy of the 2019 Adult Hospital STGs and notice of request for comment.

All comments may be submitted in track changes, with supporting literature where applicable, to Trudy.Leong@health.gov.za

Dr Robertson would also like to form a small support team of people interested in learning the process, conducting literature reviews, and contributing to the STGs. If anyone is interested please contact Dr Robertson directly - Lesley.Robertson@wits.ac.za

Kind regards
SASOP



NOTICE OF REQUEST FOR COMMENT ON THE STANDARD TREATMENT GUIDELINES AND ESSENTIAL MEDICINES LIST FOR ADULT HOSPITAL LEVEL OF CARE (2019 EDITION)

The ministerially appointed National Essential Medicines List (EML) Committee will start with the review of the Standard Treatment Guidelines and Essential Medicines List for Adult Hospital Level of care, 2019 edition.

The Adult Hospital Level Standard Treatment Guidelines and Essential Medicines List are aimed for use by doctors providing care at district and regional level hospitals to provide access to pharmaceuticals to manage common conditions at these levels.

Kindly circulate the request to relevant healthcare professionals at your institutions for comment. Constructive comment regarding the identification of gross errors, particularly diagnosis and treatment, will be appreciated. A short motivation to be included to substantiate any comment made.

Where an alternative medicine is recommended, this should be supported by appropriate evidence.

It would be appreciated if comments can be received by 15 September 2020.

Comments may be submitted via e-mail or by post to:

Trudy Leong:
E-mail: trudy.leong@health.gov.za
Essential Drugs Programme
Private Bag X828
PRETORIA
0001

Your co-operation in this regard is appreciated.

Kind regards

ASSOC PROF. AG PARRISH

CHAIRMAN: NATIONAL ESSENTIAL MEDICINES LIST COMMITTEE (NEMLC)

DATE: 31 JULY 2020

INSTRUCTIONSTO AUTHORS

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

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

LETTERS TO THE EDITOR

- * Novel experiences
- * Response to published content
- * Issues

FEATURES

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

REPORTS

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

PERSPECTIVES

- * Personal opinions written by non-medical contributors

NEWS

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

ANNOUNCEMENTS

- * Congresses, symposia, workshops
- * Publications, especially books

The format of the abovementioned contributions does not need to conform to typical scientific papers. Contributors are encouraged to write in a style that is best suited to the content. There is no required word count and authors are not restricted, but content will be subject to editing for publication. Referencing - if included - should conform to the Vancouver style i.e. superscript numeral in text (outside the full stop with the following illustration for the reference section: *Other AN, Person CD. Title of article. Name of Journal, Year of publication; Volume (Issue): page number/s. doi number (if available)*). **Where referencing is not included, it will be noted that references will be available from the author/authors.** All content should be accompanied by a relevant photo (preferably high resolution - to ensure quality reproduction) of the author/authors as well as the event or with the necessary graphic content. A brief biography of the author/authors should accompany content, including discipline, current position, notable/relevant interests and an email address. Contributions are encouraged and welcome from the broader mental health professional community i.e. all related professionals, including industry. All submitted content will be subject to review by the editor-in-chief, and where necessary the advisory board.

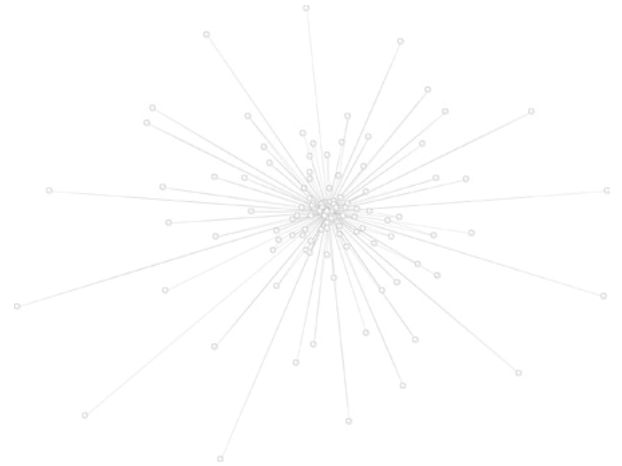
REVIEW / ORIGINAL ARTICLES

Such content will specifically comprise the literature review or data of the final version of a research report towards the MMed - or equivalent degree - as a 5000 word article

- * A 300 word abstract that succinctly summarizes the content will be required.
- * Referencing should preferably conform to the Vancouver style i.e. superscript numeral in text (outside the full stop with the following illustration for the reference section: *Other AN, Person CD. Title of article. Name of Journal, Year of publication; Volume (Issue): page number/s. doi number (if available)*); Harvard style or variations of either will also be acceptable
- * The submission should be accompanied by the University/Faculty letter noting successful completion of the research report.

Acceptance of submitted material will be subject to editorial discretion

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