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SUPPORTED EMPLOYMENT

THE NATIONAL MENTAL HEALTH POLICY

WHAT WORKS IN SOUTH AFRICA? EVIDENCE-BASED PSYCHOLOGICAL THERAPIES

NEW RESEARCH FOR PATIENTS LIVING WITH SCHIZOPHRENIA

WHAT SKILLS DO WE NEED TO PROVIDE MENTAL HEALTHCARE IN SOUTH AFRICA?

PUBLISHED IN ASSOCIATION WITH THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

BIOLOGICAL PSYCHIATRY CONGRESS HIGHLIGHTS 2017

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Features

SUPPORTED EMPLOYMENT

8

TOWARDS THE EMPLOYMENT FRONTIER FOR PEOPLE WITH PSYCHIATRIC DISABILITY

THE NATIONAL MENTAL HEALTH POLICY FRAMEWORK &

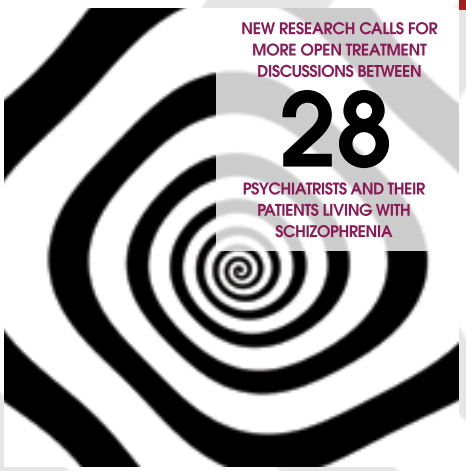
16

STRATEGIC PLAN 2013-2020: THE CASE OF THE EASTERN CAPE

WHAT WORKS IN SOUTH AFRICA?

21

EVIDENCE-BASED PSYCHOLOGICAL THERAPIES FOR RESOURCE LIMITED SETTINGS



NEW RESEARCH CALLS FOR MORE OPEN TREATMENT DISCUSSIONS BETWEEN

28

PSYCHIATRISTS AND THEIR PATIENTS LIVING WITH SCHIZOPHRENIA

WHAT SKILLS DO WE NEED

58

TO PROVIDE MENTAL HEALTHCARE IN SOUTH AFRICA?

NOTE: "instructions to authors" are available at www.southafricanpsychiatry.co.za

CONTENTS NOVEMBER 2017

5 FROM THE EDITOR

7 In Memory: **STEVE MARITZ**

8 **SUPPORTED EMPLOYMENT:** TOWARDS THE EMPLOYMENT FRONTIER FOR PEOPLE WITH PSYCHIATRIC DISABILITY

16 **THE NATIONAL MENTAL HEALTH POLICY FRAMEWORK & STRATEGIC PLAN 2013-2020:** THE CASE OF THE EASTERN CAPE

21 **WHAT WORKS IN SOUTH AFRICA? EVIDENCE-BASED PSYCHOLOGICAL THERAPIES FOR RESOURCE LIMITED SETTINGS**

28 **NEW RESEARCH CALLS FOR MORE OPEN TREATMENT DISCUSSIONS** BETWEEN PSYCHIATRISTS AND THEIR PATIENTS LIVING WITH **SCHIZOPHRENIA**

33 **WPA** NEWS

34 LETTER WPA ZONE 14

36 **WPA XVII WORLD CONGRESS OF PSYCHIATRY** BERLIN 2017

38 ADVANCED PRACTICUM **IN RATIONAL EMOTIVE AND COGNITIVE BEHAVIOUR THERAPY (Part 2)**

41 REALIZING THE VISION FOR GLOBAL MENTAL HEALTH **THROUGH PRIMARY CARE TRANSFORMATION**

44 **DEPARTMENTS** OF PSYCHIATRY NEWS

50 BIOLOGICAL **PSYCHIATRY CONGRESS HIGHLIGHTS**

54 UPA & AFCNP 2017 **JOINT SCIENTIFIC CONFERENCE 18 -19th JULY, SILVER SPRINGS HOTEL, KAMPALA**

57 **ELECTION RESULTS** COLLEGE OF PSYCHIATRISTS TRIENNIUM 2017 - 2020

58 **WHAT SKILLS DO WE NEED** TO PROVIDE MENTAL HEALTHCARE **IN SOUTH AFRICA?**

60 **NATIONAL PUBLIC MENTAL HEALTH FORUM** FOR REGISTRARS

62 **MOVIE REVIEW:** FENCES

66 **WINE FORUM:** DURBANVILLE GEM DISCOVERY

68 **CULINARY** CORNER

74 **CONSULTATIVE FORUM** WITH SOUTHERN AFRICAN PSYCHIATRISTS

77 **SASOP** HEADLINE

*** PLEASE NOTE:** *Each item is available as full text electronically and as an individual pdf online.*

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Dear Reader, greetings… with this the final issue…of 2017. Into our fourth year we head…

The Life Esidimeni arbitration hearing is in full swing as I write this with Makgabo Manamela, Dr Manamela, facing direct questioning from Judge Dikgang Moseneke…we await the return of Quedani Mahlangu…the question is whether there can ever be justice and whether the tragedy brings the discipline closer to accomplishing parity…I am not convinced of either. What it is has taught me is that as clinicians we must not serve political agendas. As public servants we serve the public, our patients…any decision must make clinical sense and ultimately this is the arbiter of agreement to proceed where requested to consider doing so. But of course we know all too well that there are seldom requests to be considered but more often instructions to be implemented. No matter where such a request or instruction emanates from…the final determinant is whether it makes clinical sense.

As clinicians we need to remain true to our fiduciary duties towards our patients…cognizant of administrative and political agendas which characterize the terrain of health care. We also need to be united as a discipline and unite with groups and organizations to advance the cause of optimal patient care. Limited resources…an oft cited issue…but poor management contributes to wasted resources, thus limited, and this would appear to be a central theme that must be addressed or else I fear that little will change. National Government spending on health as a percentage of GDP is not the issue. How money is spent is. But who spends the money, on what? This comes back to management, and another critical issue…clinician opinion. If I pay someone for their expertise, why would I ignore rather than be guided?

A lesson of the Esidimeni tragedy is the need for consultation, the need to respect opinion…clinicians have only one focus – optimal patient care…a proposal for change should never be dismissed without consideration…but consideration requires consultation and consultation with an understanding that considered opinion may not agree with political agenda and related policy. That is not obstructive… we see that it would have been life- saving. There are lessons to be learned…as this year closes, my wish for 2018 is that lessons learned through tragedy serve as the legacy that influences and provides for a better future. Season greetings to all! We advance towards 2018.

IN MEMORY
STEVE MARITZ
5 April 1943 - 28 August 2017

We were deeply saddened to learn of the untimely passing of Steve Maritz, founder of Lundbeck South Africa, and subsequently Lundbeck Australia.

Many of the South African psychiatric fraternity will remember his charismatic and larger than life presence, and many would have called him a friend.

Other than being an astute businessman he also reworked his life completely on retirement and his small start in woodworking progressed to furniture, and then guitars and then remarkably to violins!!

PERHAPS IN TIME, A GENUINE MARITZ VIOLIN WILL BECOME A SOUGHT AFTER ITEM, BUT EVEN IF THAT IS NOT THE CASE, HE LEFT THIS EARTH A HAPPY MAN! *(ALBEIT NOT BY HIS CHOICE REGARDING TIMING).*

His loss will be felt most strongly by his wife Liezl , sons Steven and Sean and a very young granddaughter – Mary-Jane.

SUPPORTED EMPLOYMENT:

TOWARDS THE EMPLOYMENT FRONTIER FOR PEOPLE WITH PSYCHIATRIC DISABILITY

Madri Engelbrecht, Zerina Hajwani

The unemployment level of the general South African population has been unacceptably high for the longest time. Currently, more than a quarter of South Africans who want to work, are unemployed. The unemployment rate amongst people with disabilities is even higher, as they are reflected in less than 2% of the workforce. People with psychiatric disabilities, as one of the most vulnerable groups, easily comprise 80% of the unemployed people with disabilities. This, while we fully understand the intimate relationship between work and psychological health. This worrying situation warrants serious consideration, and action, if the health-giving elements of work are denied to our clients, while it will so clearly contribute to their recovery and sustained wellness.

Admittedly, the issue of employment and people with psychiatric disability is not an easy one to tackle. Work can contribute to the trigger that makes our clients ill, and sometimes altogether gets blamed for a relapse. Returning to work after time off or hospitalisation is difficult because of the stigma attached to psychiatric illness, the client's loss of confidence and work endurance, and a multitude of other reasons. The apprehension about returning to the workplace can increase anxiety levels to the extent clients become symptomatic again, with the result that prescribed sick leave gets extended, prolonging the absence from work, delaying the benefits to be gained from participating in work, and increasing the risk of further ill-health, and eventual complete exclusion from work.

On the other end of the spectrum, sufficient evidence supports work as having both therapeutic and socio-economic benefits. Work contributes towards:

- Alleviation of poverty and less reliance on government assistance
- Uplifting one's socio-economic status and ability to support family
- The enhancement of self esteem, confidence and meaning
- Structured use of time that impacts on practice of a daily routine and the ability to be socially included in society as an equal member

Madri Engelbrecht

Psychiatrists, general practioners and allied health professionals tend to neglect the practical implications of this dichotomy, and the option of sick leave often takes precedence over a clear plan for return-to-work. Relief from work and time away has a place in recovery, but to do so in isolation with no action plan for efforts that enhance return to work often results in extension of sick leave that grows from month to month and even year to year. The person becomes not fit for work, but also not unfit for work until sufficient time has passed to show that long leave, with the use of a sick leave certificate, is perceived as proof that the person can no longer work. Evidence shows that the longer the person is out of or away from work, the higher the risk of future unemployment.

Action to reproach this dichotomy of sick leave versus return-to-work requires a mind shift from the health professional who holds the power to prescribe sick leave. Simple guiding questions to consider are:

- Has the conversation about a return to work plan (involving active participation) been explored in consultation with the client?
- Has a service provider been considered that encompasses dialogue with employers and managers in the workplace?
- Has the client and the family been educated about the severe side effects of long-term absenteeism?

Supported Employment (SE) is a strategy in mental health that effectively remediates impairments experienced by the person with a psychiatric illness, to allow a successful return to work, and/or to enter the open labour market for the first time. SE is an evidence-based, personalised, compassionate and cost-effective approach, that was developed in the early 1980's in the USA[1,2]. It involves a job coach who studies and analyses the employer's needs and demands, as well as assesses the abilities and needs of the prospective employee. The coach then establishes an optimal match between the employee's offering and the employer's requirements, and facilitates the implementation of short and/or long term on-the-job-support, in order to develop and further the career of the person with a disability.

SE is a preferred strategy in effecting positive employment outcomes for people with psychiatric disabilities across the world[3,4,5] and internationally its cost-effectiveness has been established through research[6]. In the South African context, research evidence about SE has started emerging over the past five years. Van Niekerk et al[7] have written about the essential needs for SE practice in South Africa, and later published the results of a time utilisation study of SE support elements by people with psychiatric disability[8]. A follow-up study that costs SE services to local mental health service users has further been conducted, and should be published in 2017.

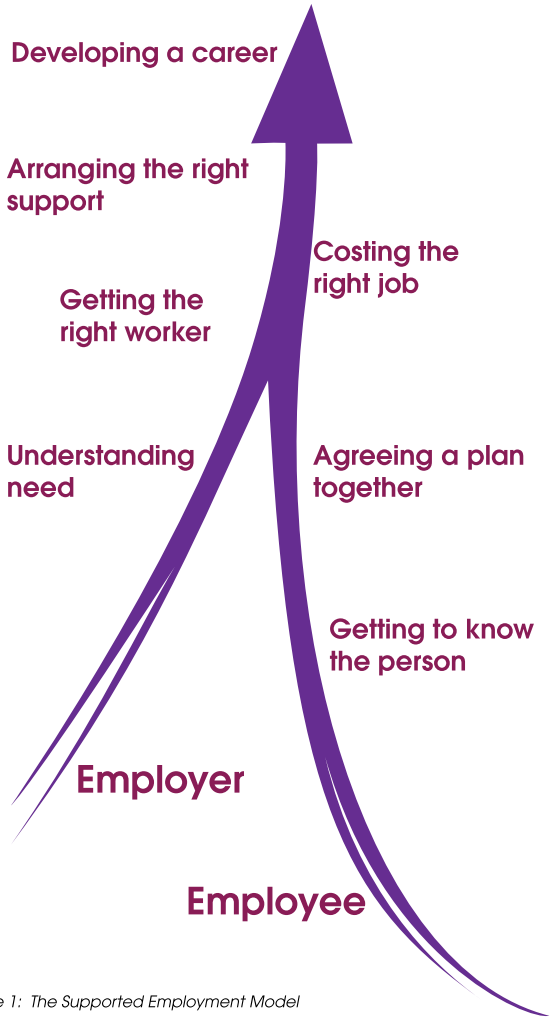

Figure 1: The Supported Employment Model

The model, or elements of it, has been used in South Africa for at least 20 years though, primarily by occupational therapists. Occupational therapists are uniquely equipped to implement the model due to their activity analysis skills, and their ability to assess and understand the impact of conditions and injury on a person's occupational performance. Furthermore, occupational therapists are trained to collaborate and partner with employers and managers of businesses who hold the power to employ and or assist with return to work for persons with disability.

As such, employers are clients of the occupational therapist and this relationship is built on mutual trust. Thus the occupational therapist plays a pivitol role in enhancing a partnership beteen the employer/co-workers and the person with a disability[9]. Many settings where occupational therapists practice though (e.g. government hospitals, private practice) do not allow for the full scope of SE services to be offered. This scope is summarised in the model as depicted by the British Association of Supported Employment, in Figure 1.

Two case studies will be used to illustrate the implementation of the model's elements in practice:

Case Study A: Supported Employment for unemployed people with disabilities

In 2014, Angie applied for a clerking position with a construction company. The company had recently identified that they need to employ people with disabilities, and engaged the services of a SE service provider. By the time that the recruitment of candidates ensued, preparation to employ had started months earlier with the employer. The business needed to be equiped and capacitated to employ people with disabilities. This included work site visits, jobs- and activity analyses, researching the company's culture, policies and operational needs, raising awareness about disability in the workplace, and sensitising staff to disability issues.

Angie herself completed a series of informal assessments, including a work trial with a different employer. The trial afforded her the opportunity to rebuild work endurance after she had been out of the labour market for approximately nine months, and supplied the job coach (SE service provider) with valuable assessment findings regarding her abilities in a real work situation. The trial confirmed a match between Angie's abilities and the job requirements of a clerk, and highlighted her needs for reasonable accommodation as a worker with Bipolar Affective Disorder.

Angie's worker profile was presented to the employer, along with an explanation of her reasonable accommodation needs, and she was invited for a

first interview. The anxiety created by the anticipation of and then participation in a job interview, needed to be carefully managed through support by the job coach. Angie was later invited for a second interview, which created further anxiety for her, though the tension created by waiting periods in between interactions with the employer proved most challenging for her. The job coach offered continuous support, and Angie was fortunate to be offered a 3-month contract with the company.

TWO YEARS DOWN THE LINE, IN 2016, ANGIE IS IN THE SECOND YEAR OF HER EMPLOYMENT WITH THE COMPANY, AND HAS BEEN PERMANENTLY APPOINTED. DURING THIS TIME, SHE HAS EXPERIENCED TWO NEAR-RELAPSES, AND WAS HOSPITALISED BRIEFLY DURING THE ONE EPISODE. ANGIE'S STRESSORS STEM MOSTLY FROM HER SOCIAL ENVIRONMENT AND PERSONAL LIFE, WHICH CAUSE HER TO BECOME SYMPTOMATIC, AND INFLUENCE HER PERFORMANCE AT WORK. THE JOB COACH OFFERED SUPPORT THROUGH INITIAL WEEKLY WORK VISITS, AND LATER 2-MONTHLY WORK VISITS.

Angie has thus been able to continue working, despite occasional flair-ups of symptoms such as mild depression, anxiety and panic attacks, because she received on-the-job, continuous support. To participate and benefit from SE, a person has to demonstrate a level of motivation to work as the only prerequisite. The type and severity of disability is irrelevant. Angie demonstrated a high level of motivation, as even when she was symptomatic, she wanted to be at work.

Case Study B: Return-to-work with an acquired disability

Sue (aged 43) worked as a salesperson for 15 years at one of South Africa's top retail companies, selling make-up. Her primary diagnosis is Bipolar Mood Disorder and she had severe relapses approximately five years apart that resulted in hospital admission.

Three years ago, she experienced manic features and this impacted on her behaviour at work in that she started to give "gift samples" away to customers for free; her work colleagues reported that she was "inappropriate" - undressing herself and serving customers wearing very minimal clothes and continuously walking around the shopping mall speaking to strangers instead of working.

Subsequently, she was admitted to a psychiatric state facility for 4 weeks. As she settled, she was discharged on sick leave for six months. During this stage, Sue was a recipient of a temporary disability benefit from the company's insurer. The case manager of the insurer referred Sue for a Functional Capacity Evaluation (FCE) and subsequent supported employment assistance to return to work.

An SE assessment with Sue entailed the following:

- A home visit to conduct elements of an FCE
- A work visit to perform analyses of Sue's job, work environment, and work place culture
- Family meetings
- Collateral information from her treating psychiatrist

The assessment findings confirmed that Sue's psychiatric illness had impacted negatively on her work performance. However, since her discharge there has been slow improvement with residual depression, lack of activity and routine in her life and a willingness to work. Both Sue and her work colleagues had reservations about her return to work. Sue felt embarrassed at her behaviour and was worried that everyone will think she is no longer capable of working.

This made her feel like resigning from her job. Her manager reported that she had a good work history but there was a concern by other staff that seemed afraid of Sue to return as she may upset customers and do inappropriate things to sabotage the business. The psychiatrist was hesitant that Sue could relapse if she returned to work.

The insurer then approved interventions based on the recommendation for Sue to receive SE services that would support her return to work. Intervention was offered on an individual basis as well as together with her work colleagues. Subsequent to this, Sue completed a work trial.

AFTER THE WORK TRIAL, BOTH SUE AND HER CO-WORKERS FELT CONFIDENT AND MOTIVATED TO EXPAND HER RETURN TO WORK PROCESS. AS SUCH, WEEKLY SUPPORT SESSIONS WERE HELD WITH THE EMPLOYER AND SUE RESPECTIVELY FOR ONE MONTH. SUE'S WORKING HOURS WERE THEN INCREASED TO WORK HER USUAL SHIFT HOURS EXCEPT FOR WEEKENDS AS THIS ALLOWED FOR HER TO REST, WHICH WAS IMPORTANT FOR HER MENTAL HEALTH SUSTAINMENT.

During the second month, support sessions offered to Sue and the workplace was reduced to once every two weeks. This allowed for further adaptations to be made, and queries to be resolved within the workplace before small situations escalated into a huge stressor.

During month three, support sessions faded but both Sue and the employer understood that support could be available as required.

In other cases, SE has successfully been used to facilitate open labour market employment for in-patients at a forensic psychiatric unit in Cape Town. Candidates who were suitable for a range of employment opportunities, were identified from forensic wards, and through collaboration between the job coach and ward staff, in-patients were allowed to leave wards for an 8-hour work day. In this case, it was a priority for the job coach to educate staff members and negotiate the necessary allowances for patients in order to receive meals and medication timeously and arrive at work punctually.

SE makes real, sustainable employment possible for people with psychiatric conditions, because of the model's focus on:

- The fit between the person's abilities and the job requirements
- Implementation of practical measures at job stations to remediate impairment when performing job tasks
- Regular needs-based guidance and counselling for the employee and co-workers
- Careful navigation and management of the working relationship between the employee and co-workers, including goal-setting and –planning
- Increasing the employer's knowledge and sensitivity about psychiatric disability and reasonable accommodation needs
- Continuous support to and liaison with stakeholders
- Liaison with and feedback to health professionals
- Increasing the family's knowledge and involvement in supporting the employee to sustain his/her employed status.

Apart from the needs-based support offered to all stakeholders in the employment environment, SE further differs from more traditional vocational rehabilitation approaches by following a place-and-train philosophy[2]. The person with a psychiatric disability re-enters the labour market rapidly, with job training and work hardening happening IN the workplace rather than OUTSIDE of it (e.g. in a rehabilitation centre). At all times the employee performs real work in a real work environment, with wages and salaries equivalent to their non-disabled counterparts, and related to the market norms.

BECAUSE NEEDS-BASED SUPPORT, AS THE CRUCIAL FACTOR IN THIS MODEL, AND IS AVAILABLE TO THE PERSON WITH A PSYCHIATRIC DISABILITY, HE/SHE CAN RETURN TO WORK WHEN SYMPTOMS START SUBSIDING, THROUGH THIS PROCESS FACILITATED BY A JOB COACH, AND SOONER GAIN THE INHERENT THERAPEUTIC BENEFIT OF WORK.

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COMMENTARY

Christoffel Grobler, Nika Oberholster

Supported employment in the psychiatric disability field

SUPPORTED EMPLOYMENT

Mentally ill persons who have either never worked or ceased working due to mental illness face the unfortunate reality of long-term unemployment.[1]

Apart from the well-known detrimental effects on physical- and mental health as well as quality of life, they also have to contend with long-term financial hardship.[2] All of these factors have an adverse effect on their mental illness.

For such individuals, getting the opportunity to obtain gainful employment can lead to major improvements in all these areas as well as improved self-image. Supported employment is one avenue of entering the labour force for such individuals.[3]

Supported employment is defined as competitive employment in an integrated setting with ongoing support services for individuals with the most severe disabilities.[4]

The purpose of supported employment programs is to promote self-sufficiency and a more integrated and improved quality of life by helping persons with disabilities pursue job opportunities in traditional work environments at equal pay to non-disabled persons.[5]

SUPPORTED EMPLOYMENT HAS BEEN SHOWN TO BE MORE SUCCESSFUL THAN TRADITIONAL VOCATIONAL REHABILITATION IN THE ACHIEVEMENT OF WORK OUTCOMES.

The concept of supported employment is based on the assumption that "when the right type, and intensity, of support is provided, people with the most severe disabilities can (and should be) integrated into the labour market".[6]

Christoffel Grobler

The steps taken as part of supported employment comprise the following:[7]

- Assessment
- Job finding
- Job analysis
- Job matching
- Job coaching

Supported employment presents employment opportunities for disabled people who fulfil the requirements of the job and are paid accordingly. Employment specialists, often called 'job coaches', provide ongoing support.[3]

The nature of support offered is determined by the needs of the worker, or by the particular supported employment program. Support could include:[7]

- Job advocacy such as advocating for a particpant at the job site with employers, co-workers and customers.
- Non-job advocacy, for example, advocating for a participant, but not related to work, with parents, landlords, case managers, therapists, school personnel, bank personnel, doctors, etc., evaluation such as analysing a person's employment potential by interviewing him or her, reviewing records, communicating with guardians or involved agencies, and observing the individual in real or simulated work settings.
- Training, for example, money handling, grooming, use of transportation, or the management of symptoms.
- Program development, including developing person-centered instructional plans such as behavioural intervention programs.
- Transportation.

REASONABLE ACCOMMODATION

In terms of supported employment, reasonable accommodation is an integral part of the process of reintegration into the labour market. Reasonable accommodation can be used to facilitate continued participation of disabled people in work.[3]

However, it has been the experience of the second author that successful accommodation depends upon the following:

- An accurate analysis of the job and the functional components (physical and mental) required for successful delivery of the key performance areas of the job
- Assessments that will indicate the difficulties experienced by the disabled person in relation to the job requirements
- Ensuring that accommodations are fair for both the disabled person and the employer
- Ensuring that accommodations are realistic for the disabled person in terms of achieving the outcomes of the job
- Collaboration between the disabled person, the therapist, the employer and job coach to ensure a smooth transition back into the workforce and to ensure that accommodations are effectively implemented.

Conclusion

SUPPORTED EMPLOYMENT HAS THUS FAR BEEN UNDERUTILISED AS A WAY FOR MENTALLY ILL PEOPLE, ESPECIALLY THOSE RECEIVING TREATMENT IN PUBLIC SERVICE SETTINGS, TO ACCESS THE OPEN LABOUR MARKET. COMPANIES LIKE SIYAYA SKILLS INSTITUTE, I CAN, DISABILITY WORKSHOP DEVELOPMENT ENTERPRISES (DWDE) AND ALTITUDE SUPPORTED EMPLOYMENT CAN PLAY AN IMPORTANT ROLE IN FACILITATING RETURN TO WORK FOR THIS POPULATION.

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THE NATIONAL MENTAL HEALTH POLICY FRAMEWORK & STRATEGIC PLAN 2013-2020: THE CASE OF THE EASTERN CAPE

Kiran Sukeri

South Africa's National Mental Health Plan[1] was formulated after a national summit, which included stakeholders from the mental health workforce (psychiatrists, psychologists and nurses), policy makers (provincial and national mental health directors), members of Mental Health Review Boards and patients. It was released by the National Department of Health in December 2012.

The plan allows for the transformation of mental health service delivery in the country within a seven year period. The Minister of Health, Dr. A Motsoaledi, emphasised the delivery of 'quality mental health services' that are accessible, equitable, comprehensive and integrated at all levels of the health system. [2]

While the plan appears comprehensive on paper, its applicability in the Eastern Cape is questionable for the following reasons:

1. The National Plan relied extensively on the World Health Organisation's (WHO) country report for South Africa[3] as one of its primary sources of evidence on service delivery capacity within the country. The Eastern Cape's Directorate of Specialised Services was unable to provide data in five key sectors for this report; these included policy and plans, financing of mental health services and service utilisation.[4] The current National Plan[1] states that the Eastern Cape has ten community residential facilities but no indication is made that all these facilities are provided by the non-governmental sector and are based in the western regions of the province.[5] While these numbers may be insignificant in a national perspective they have a serious impact on mental health policy, planning and service delivery for the province.

Kiran Sukeri

2. The South African Stress and Health Survey[6] provides an important window into the prevalence of mental disorders in South Africa, and it must be noted that this study which included 619 households in the Eastern Cape, does not indicate the spread of the sample between eastern and western regions of this province; as there are distinct differences between socio-economic, health and historical factors[4,5,7] that could have a serious impact on prevalence rates and therefore an effect on small area estimations in determining costs of service delivery packages.

3. Prevalence rates for children and adolescents were primarily based on research conducted in the Western Cape.[8, 9] A severe limitation is that the demographics of the Western Cape are not applicable to the Eastern Cape.

4. Points 2 and 3 refer to the obvious lack of research in this province. This will require urgent addressing prior to any blanket application of the National Plan.[1] Perhaps a starting point could be the establishment of more Alan J Flisher Centres for Public Health as suggested by Chipps and Ramlall in 2012.[10]

In the analysis of the failure of the national mental health plan in India, Goel[11] noted that the Indian plan set unrealistic targets as it did not consider the poor functioning of primary health care in general, the poor morale of health workers and the lack of administrative structures to monitor the progress of the plan in a decentralized manner.

These are factors that are present in the Eastern Cape and will therefore impede the application of the National Plan in this province.[4, 5, 7]

DEINSTITUTIONALISATION AND COMMUNITY SERVICES

The National Plan[1] sets out the development of community services within three years. The plan defines community based care as "care that is provided outside of institutional and hospital settings, as near as possible to the places where people live, work and stay." It will be imperative for mental health policy makers/commissioners to be cognizant of the impediments in the development of community psychiatric care and the phenomenon of transinstitutionalisation worldwide.[12, 13, 14]

In Denmark, deinstitutionalisation resulted in an increased suicide rate and higher levels of incarceration of the mentally ill in correctional facilities, while in Canada, 1/3 of patients discharged were re-admitted after six months, 20% were living in inadequate housing and 68% reported moderate to severe difficulty. [12]

Nasrallah[13] advocates that institutional care may be required for some patients, as deinstitutionalisation has resulted in increasing levels of poverty, substance abuse and crime among psychiatric patients.

IT HAS ALSO LED TO POOR ACCESS TO PRIMARY CARE, EARLY MORTALITY AND LACK OF SIGNIFICANT OR STABLE RELATIONSHIPS. IN ITALY, LAW 180 TRANSFORMED MENTAL HEALTH CARE OVERNIGHT.

However although that country began the process of deinstitutionalisation in 1978, it took two decades for psychiatric hospitals to close. Patients were admitted to small acute psychiatric units (~15 beds), located in general hospitals. During this process of deinstitutionalisation family members provided much support for the mentally ill.[14] Medeiros[14] provides a cautionary note that deinstitutionalisation is not simply about moving patients; governments need to ensure that adequate, appropriate and flexibly managed community care is available.

Kaliski[15] highlights the increasing number of State patients in the Western Province. Families who cannot cope with aggressive and psychotic family members are urged to lay charges at the local police station which results in an increase in forensic patients. This has led to an increase of State patients at a rate of approximately 50 new patients/year over the past 15 years. He further notes that Assertive Community Teams have managed to prevent only a few admissions, as they mainly focus on 'at risk' patients.

In Australia, where the process of deinstitutionalisation occurred over a period of fifty five years, Hempel[16] highlights the factors that influenced the satisfactory outcome of this process, which included:

- the importance of community membership for successful reintegration
- type of housing and living environment; patients should be consulted about their future living arrangements
- funding arrangements; well funded programs resulted in decreased homelessness among psychiatric patients
- a measure of skills and coping mechanisms at baseline will allow to provide the relevant training pre-discharge

AN INTERIM PLAN

In the Eastern Cape none of the factors listed by Hempel[16] have been explored to ensure a success of community psychiatric care.[5] Therefore, the author suggests that an outreach model may be more appropriate during the planning phase for this province.

Munk-Jørgensen[17] is careful to point out that community psychiatry 'runs of the risk of obstructing patients from access to new and better treatment. Instead he describes the advantages of an 'out-reach model' with expert diagnostic clinics based in outpatient clinics. Outreach service models have been shown to be beneficial to the homeless and in community-dwelling elderly patients.[18, 19] This type of service ensures that doctors are not alienated from in service training, education and continued professional development that is centrally based.

Considering the rurality and vast geographic expanse of this province it would be advantageous for all psychiatric hospitals to develop outreach services.

The following core questions that should be answered:

- Will these services target the general population or specific population groups?
- How will these services be organised?
- Who will pay for these services?
- Who will provide these services?

The disadvantage of such service is the lack of human resources, access to psychotropics and transport services.[4, 5, 7]

These factors can be resolved with careful planning.

- The pharmaceutical depots and/or pharmacy departments at each psychiatric hospital/unit should develop an outreach pharmaceutical

DEINSTITUTIONALISATION

service based on statistics collated from the outreach team. This can be factored into the budgeting for medication. Currently this is referred to as the 'down referral system'.

- Integration of specialists and non-specialists in the provision of care (task shifting).[20]

- If services are as local as possible then transport costs will be reduced. The province will need to provide transportation for these teams.

The aims of such a service would be to:

- provide clinical assessment

- provide ongoing treatment for patients discharged from hospitals

* case identification

- improve access to psychotropics and/or other interventions

- improve access to specialist assessment

- improve communication with primary health care staff

- decrease hospital utilisation

THIS SERVICE MUST AIM TO BRIDGE THE GAP BETWEEN CENTRAL HOSPITAL BASED SERVICES AND NEEDS WITHIN THE COMMUNITY IN WHICH PATIENTS RESIDE.

A major advantage will be cost shifting which is defined as a situation in which one budget holder incurs greater costs in treating a patient but the benefits of saving goes directly to another budget holder.[21] This will be due to decreased hospital utilisation, decreased length of stay, improved access to services and the temporary lack of need for the development of community residential facilities and therefore decreased human resource and other hidden costs.

While rational deinstitutionalisation is advocated; a province centered approach to this and community psychiatry is advised, to prevent as Munk-Jørgensen[17] states "postal code psychiatry.' The province should avoid the development of the phenomenon of 'new long stay patients' created by deinstitutionalisation.[22,23] These patients increase the utilisation of services at acute mental health facilities.

Commissioning authorities in the province should therefore take heed from the lessons of deinstitutionalisation from our western counterparts. Holloway[23] has clearly stated that the closure of mental hospitals in England has resulted in a 'virtual mental hospital', with a 'dispersed and poorly co-ordinated patchwork of hospital, residential and nursing home provision.'

The outreach model provides a mechanism in decreasing institutionalisation, diverting funding to the development of alternate forms of care and improving accessibility to mental health services.

CONCLUSION

Bagenstos[24] warns that policy makers should not yield to political pressure to close institutions without ensuring the development of effective services in the community; for the Eastern Cape this means the development of housing (custodial and/or supported) with adequate human resources.

National policy makers, should be made aware that a 'one size fits all' will not succeed. An understanding of local context is essential. While the National Plan[1] acknowledges that there are distinct differences between provinces it does not delineate how this will be addressed. Local research is required to inform local policies. [5]

JAIN & JADHAV[2] IN THEIR EXPLORATION OF A COMMUNITY MENTAL HEALTH PROGRAM IN NORTHERN INDIA EMPHASISED THE NEED TO UNDERSTAND THE LOCAL CONTEXT AND NOT ALLOW COMMUNITY PSYCHIATRY TO DISSOLVE INTO JUST THE PRESCRIPTION OF MEDICATION.

Mental Health Care practitioners should not have to repeat Prof. Kapur's obiter that the National Plan was 'more a wish list than a serious exercise'.[11]

The article was peer reviewed, anonymously.

FRAME WORK & STRATEGIC PLAN

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WHAT WORKS IN SOUTH AFRICA?

EVIDENCE-BASED PSYCHOLOGICAL THERAPIES FOR RESOURCE LIMITED SETTINGS

BRIEF REPORT FROM THE FIRST PSYCHOTHERAPY SYMPOSIUM 2017

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The inaugural Psychotherapy Symposium titled "What works in South Africa? Evidence-based psychological therapies for resource limited settings" was held on 10 and 11 August 2017 in Cape Town, South Africa.

RECENT YEARS HAVE SEEN A BLOSSOMING OF INNOVATIVE RESEARCH ON PSYCHOLOGICAL THERAPIES IN LOW RESOURCE SETTINGS IN SOUTH AFRICA AND OTHER AFRICAN COUNTRIES, SPURRED ON BY THE GROWING NEED FOR MENTAL HEALTH CARE IN COMMUNITIES AFFECTED BY POVERTY AND VIOLENCE.

As members of the organizing committee, we have been excited by this emerging field, and were interested in creating a forum where researchers, practitioners and policy makers from a wide range of sectors could meet to share their experiences and learn from each other. By fostering an open, collegial environment we hoped to allow participants to share evidence and gain a common understanding of what

Symposium conveners, from L-R: Crick Lund, John Joska, Lena Andersen

psychological therapies work, for whom, and under what conditions. The overall goal of the symposium was to consolidate evidence to improve the delivery of psychological therapies in low resourced primary care and community settings.

The symposium was well-attended, with over 90 participants from several sectors, including the Departments of Health, Social Development, and Education, various academic institutions, as well as non-governmental organisations and private practice psychologists and psychiatrists. We were also pleased to receive a number of international participants from Uganda and the United Kingdom. Although the symposium was held in the Western Cape, and attended by representatives of many provincial organisations, a number of participants attended from other parts of the country.

The conference was opened with keynote addresses, by Tracey Naledi, who set the policy context, and Crick Lund who covered some of the issues in defining evidence and measuring process and outcomes in psychological therapies. We then heard a wide array of presentations, covering a range of populations including patients with chronic diseases, substance abuse, perinatal women and children and adolescents. We also heard presentations of systematic reviews and studies on dissemination and

implementation. On day 2 we were privileged to hear a keynote address by Chilean psychiatrist Ricardo Araya, who shared his extensive experience in global mental health trials of psychological therapies in Latin America, Africa and South Asia.

Feedback from participants on the scientific content and debates was overwhelmingly positive, and there was a high level of enthusiasm and engagement on both days. Our hopes for the future are to attract a stronger level of participation from across South Africa, to make this a truly national event that would influence policy and practice. We plan to hold another symposium in 2 years, possibly to coincide with World Mental Health Day on 10 October 2019. In the interim we are also looking for opportunities for engagement with colleagues in all nine provinces, potentially in a round table discussion on psychological therapies and how to take these to scale in low resource settings, using task sharing approaches. The abstracts of the symposium presentations are published in this issue of South African Psychiatry, and we welcome comments and suggestions from colleagues around the country.

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ABSTRACTS

SOCIAL, EMOTIONAL AND ECONOMIC OUTCOMES OF DEPRESSION TREATMENT WITH GROUP SUPPORT PSYCHOTHERAPY IN NORTHERN UGANDA

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BACKGROUND:

Group support psychotherapy (GSP) is an effective treatment for major depression in persons living with HIV (PLWH). However, there are concerns that it may not have adequate intensity to treat co-morbid mental health problems like post-traumatic stress or hazardous alcohol use and may not be able to address socio-economic challenges in post-conflict settings such as northern Uganda.

METHODS:

Two cohorts of individuals with depression including 109 PLWH from Kitgum and 537 PLWH from three districts (Pader, Gulu and Kitgum) were randomly assigned to receive eight weekly sessions of either GSP or group HIV education (GHE). Primary care mental and general health workers were trained to deliver the interventions. The first cohort were assessed for post-traumatic stress symptoms using the Harvard Trauma Questionnaire (HTQ), alcohol use using the Alcohol Use Disorders Identification Test (AUDIT). The second cohort was asked to report on their income generating activities, savings, leadership positions, food security, disability days and acquisition of new assets prior to randomization. Data was analyzed by intention to treat using cluster-adjusted t-tests and chi-square tests as well as permutation tests. Both cohorts are part of randomized controlled studies registered with The Pan African Clinical Trials Registry, numbers PACTR201402000742370 and PACTR201608001738234.

RESULTS:

In the first cohort, GSP participants had greater reduction in post-traumatic stress symptoms and greater reductions in alcohol use than GHE participants. In the second cohort, 6 months after end of treatment, more GSP than GHE participants reported participation in income generating and saving activities and acquisition of new assets.

CONCLUSION:

Group support psychotherapy is not only effective against depression but also post-traumatic stress symptoms comorbid with depression, curbs alcohol consumption and improves socio-economic well-being of PLWH.

EFFECTIVENESS OF NURSE-DELIVERED CARE FOR ADHERENCE AND MOOD IN SOUTH AFRICA (ZIPHAMANDLA):

Andersen, L. S.[1], Safren, S. A.[2], O'Cleirigh, C.[3], Magidson, J.[3], Kagee, A.[4], Lee, J. S.[2], De Kock, N.[1] & Joska, J.[1]

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BACKGROUND:

South Africa has the highest rate of HIV infections in the world as well as the largest ART program. Mental disorders, such as major depressive disorder, are a major barrier to successful linkage to all aspects of the care cascade, including testing, treatment, suppression and retention.

Evidence-based psychotherapies for depression, such as cognitive behavioural therapy (CBT), are known to be effective in high-income countries. In resource-limited settings it has yet to be established whether CBT for adherence and depression (CBT-AD) is effective particularly when delivered by non-specialist health providers.

AIM:

The aim of the Ziphamandla randomized controlled trial is to examine the effectiveness of an isi-Xhosa adapted, nurse-delivered, CBT-AD treatment in improving adherence and depression in antiretroviral therapy (ART) users with chronic poor adherence. Chronic poor adherence is defined as having failed first or second-line ART and having an unsuppressed viral load (i.e. > 400 copies/mL).

Participants (n=160) are randomized into the active CBT-AD arm or an Enhanced Treatment-As-Usual (ETAU) arm. Participants in the CBT-AD arm receive eight therapy sessions consisting of Life Steps for ART adherence, Psychoeducation/Motivational Interviewing, Behavioural Activation, Problem Solving, Relaxation Training and Relapse Prevention.

In addition, nine booster sessions for skills review in the months before the final assessment are offered. Primary outcomes include adherence to ART as assessed by the Wisepill device (an electronic container that monitors pill box opening in real time), HIV viral load and CD4 count, and depression severity (measured using the Hamilton Depression Scale).

Participants are assessed at 4, 8 and 12 months after baseline enrolment. Participants in the CBT-AD condition are expected to experience a greater reduction in their depressive symptoms and a greater reduction in their viral loads at each follow-up time point. The outcome of this study has important implications for the identification and integration of an effective treatment for depression that targets adherence in chronic poor ART adherers.

MOOD

TASK SHIFTING A SCREENING AND PROBLEM-SOLVING INTERVENTION TO TREAT ANTENATAL SYMPTOMS OF COMMON MENTAL DISORDERS: FEASIBILITY, ACCEPTABILITY AND PRELIMINARY RESPONSES

Maxine F. Spedding[1] Dan J. Stein[2] Tracey Naledi[3,4] Bronwyn Myers[5] Katherine R. Sorsdahl[1]

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BACKGROUND:

Given the high prevalence rate of perinatal common mental disorders (CMD) and the large treatment gap in public mental health, support for screening and task-shifted evidence-based psychosocial treatments is growing. However, little is known about the feasibility, acceptability and potential outcomes associated with problem-solving therapy (PST) for the treatment of perinatal CMD symptoms in South African Midwife and Obstetric Units (MOUs). Furthermore, no research has used Registered Counsellors (RC) to conduct interventions. This study investigates the feasibility and acceptability of, as well as the preliminary responses to a PST intervention to treat perinatal CMD symptoms, delivered by a RC.

METHODS:

Thirty-eight women who screened 'high' on the Edinburgh Postnatal Depression Scale (EPDS) at their first antenatal visit were recruited to participate in the three-session PST intervention. Of these, 22 completed the pre- and post-intervention interviews. Using mixed methods, preliminary responses to the intervention, and participants' perceptions of its feasibility and acceptability were explored. Primary outcomes included psychological distress (Symptom Response Questionnaire; SRQ-20) and perinatal depression symptoms (EPDS). An in-depth semi-structured post-intervention interview was conducted three months after each participant's last session.

RESULTS:

Participants' mean session attendance was 2.03 sessions (SD=0.89). Significant reductions were seen on EPDS ($z=-3.0$, $p<0.01$) as well as SRQ-20 scores ($z=-3.5$, $p=<0.01$). Reductions in impaired functioning were also noted, with less disruption to work ($z=-2.3$, $p=0.02$), social life ($z=-3.3$, $p<0.01$), and home responsibilities ($z=-2.5$, $p=0.01$) on the Sheehan disability subscales. Significant reductions were seen on 'negative problem orientation' scores ($z=-3.1$, $p<0.01$) and 'avoidant style' scores ($z=-3.0$, $p<0.01$), reflecting improvements in problem-solving. The intervention's acceptability was primarily due to the opportunity to disclose problems in a confidential and non-judgmental environment. Barriers to attendance included lack of transport or money, work commitments and stigma.

CONCLUSION:

Data from this study support task shifting PST to RCs to treat antenatal CMDs. Research is needed on how such programmes might be integrated into MOUs, incorporating other non-specialists.

SYSTEMATIC REVIEW OF THE EVIDENCE BASE FOR TREATMENT OF COMMON MENTAL DISORDERS IN SOUTH AFRICA

Debra Kaminer[1], Michael Owen[1,2] and Byron Schwartz[1]

The scarcity of mental health resources in low- and middle-income countries (LMICs) requires the identification of effective interventions that can be taken to scale in a cost-efficient manner. Yet the evidence base for treatment of common mental disorders (CMDs) in LMICs remains limited. As one of the better resourced countries on the African continent, South Africa could potentially play a leading role in developing an African evidence base for mental health care.

This study sought to describe and evaluate the South African evidence base for treating CMDs. A systematic review of randomised controlled trials (RCTs) for depression, substance use and anxiety in the adult South African population from 2000 to mid-2015 was conducted. Eligible studies were assessed for their consistency with recommendations for mental health interventions in LMICs and for methodological and reporting rigour. A total of 16 RCTs satisfied the inclusion criteria, of which eight targeted depression, six targeted substance use and two targeted anxiety symptoms.

There has been a strong trend towards alignment with prevailing recommendations for delivery of mental health interventions in resource-scarce regions. While there are some promising findings with regard to effectiveness of specific interventions, replication, costing and dissemination studies are still required; and there is still an urgent need for treatment studies for anxiety disorders, which are the most common class of CMD in South Africa.

The review also indicates that research design and reporting practices in South African mental health intervention research could be enhanced and recommendations towards this are suggested.

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EVALUATING A TASK SHARED DEPRESSION COUNSELLING INTERVENTION LED BY BEHAVIOUR CHANGE COUNSELLORS: OUTCOME AND PROCESS EVALUATION

One Selohilwe[1], Arvin Bhana[1,2], Lara Fairall[3], Tasneem Kathree[1], Emily Baron[3], Sujit Rathod[4], Ruwayda Petrus[1], Ntokozo Mntambo[1], Crick Lund[3], Inge Petersen[1]

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BACKGROUND:

South Africa is undergoing health transition that is significantly impacted by the rising burden of chronic non-communicable diseases (NCDs) and the transition of HIV/AIDS to become a chronic disease as a result of the expansion of ART. Common mental disorders (CMDs) are often comorbid with HIV and these other NCDs. This comorbidity compromises treatment adherence and consequently threatens the success of the huge investment made in anti-retroviral treatment as well NCD care.

In the context of a 75% treatment gap for CMDs in South Africa, the need for accessible interventions for treatment of comorbid CMDs is highlighted. The clinical, social and economic outcomes of a lay counsellor led task-shared counselling intervention for chronic care patients with comorbid depression in Dr Kenneth Kaunda, North West will be presented and discussed.

A PILOT STUDY OF AN INTERVENTION FOR WOMEN WITH SEXUAL TRAUMA ENTERING HIV CARE

Sikkema, K.J.[1,2], Robertson, C.[2], Ciya, N .[2], Mulawa, M.I.[1], Watt, M.H.[1], Joska, J.A.[2], & the ImpACT Team[1,2]

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OBJECTIVE:

Sexual trauma among HIV-infected women negatively impacts mental health and care engagement. In study phase 1, a coping intervention was developed and culturally adapted based on an evidence based approach to stress and coping among HIV-infected adults. In phase 2, the intervention was pilot tested to reduce traumatic stress and increase retention in care and adherence to antiretroviral treatment (ART). ImpACT (Improving AIDS Care after Trauma) was implemented by a trained and supervised nonspecialist in a public primary care clinic in Cape Town, targeting women during the critical period of ART initiation.

METHOD:

ImpACT, four individual and three group sessions, was evaluated for feasibility and preliminary effectiveness. HIV-infected female patients initiating ART were screened for sexual trauma and enrolled in a pilot trial (n=64). Participants were randomly assigned to a standard-of-care control (SoC: 3 adherence sessions) or the intervention condition (SoC + ImpACT). PTSD (PCL-5) and adherence motivation were assessed at baseline, 3, and 6 months.

RESULTS:

High rates of trauma and abuse were reported: 60% of women reported sexual trauma; 56% of those enrolled reported PTSD. 82% of sample was retained at 3 and/or 6 month follow-up.

Compared to SoC participants at 3 months, ImpACT participants had greater reductions in avoidance and arousal symptoms of PTSD. ImpACT participants also reported greater increases in levels of motivation to adhere to ART. Feedback suggests that individual sessions are feasible and acceptable. All intervention participants reported being satisfied with the intervention and the therapist. Implementation of the group sessions met significant challenges, likely due to privacy concerns and scheduling barriers.

CONCLUSIONS:

Preliminary findings from ImpACT suggest that a brief trauma-focused individual intervention is feasible in the HIV care setting, and has potential to reduce PTSD and improve care engagement.

PSYCHOTHERAPY SYMPOSIUM 2017

THURSDAY 10 AUGUST 2017		
TIME	**TOPIC**	**SPEAKER**
07:30 - 08:30	Registration	
	Chair: Prof. John Joska	
08:30 - 08:45	Welcome	Prof. John Joska
08:45 - 09:15	**Keynote address 1a:** Towards a Mental Health Policy for Counselling and Psychotherapy in Communities	Dr. Tracey Naledi
09:15 - 09:45	**Keynote address 1b:** What is "evidence" in psychotherapy research?	Prof. Crick Lund
09:45 - 10:00	Q & A	
10:00 - 10:30	Coffee/tea	
	Chronic Disease Interventions	
	Chair: Prof. Ashraf Kagee	
10:30 - 10:45	Social, emotional, and economic outcomes of depression treatment with Group Psychotherapy in northern Uganda	Dr. Etheldreda Nakimuli-Mpungu
10:45 - 11:00	Effectiveness of nurse-delivered care for adherence and mood in HIV in South Africa (Ziphamandla): A randomised controlled trial	Dr. Lena Andersen
11:00 - 11:15	Evaluating a task shared depression counselling intervention led by behaviour change counsellors: Outcomes and process evaluation	Ms. One Selohilwe
11:15 - 11:30	Q & A	
11:30 - 11:45	Blended motivational interviewing and problem-solving therapy in low and middle income countries: A transdiagnostic, task-shiftable approach to addressing staff shortages in mental health service delivery	Prof. Katherine Sorsdahl
11:45 - 12:00	Feasibility, acceptability, and initial outcomes of brief mental health counselling provided within chronic disease services at primary care clinics in the Western Cape	Prof. Bronwyn Myers
12:00 - 12:15	IMPACT: A pilot study of an intervention for women with sexual trauma entering HIV care	Prof. Kathleen Sikkema
12:15 - 12:30	Q & A	
12:30 - 13:30	Lunch	
	Maternal Mental Health	
	Chair: Mr. Umesh Bawa	
13:30 - 13:45	Symptoms of depression and anxiety in pregnant women from low socio-economic settings improve after counselling	Dr. Zulfa Abrahams
13:45 - 14:00	Task shifting a screening and problem-solving intervention to treat antenatal symptoms of common mental disorders: Feasibility, acceptability and preliminary responses	Dr. Maxine Spedding
14:00 - 14:15	Africa Focus on Intervention Research for Mental Health (AFFIRM) randomised controlled trial of a task sharing counselling intervention for maternal depression delivered by community health workers in Khayelitsha	Prof. Crick Lund
14:15 - 14:30	Q & A	
14:30 - 15:00	Coffee/tea	
	Child & Adolescent Interventions	
	Chair: Dr. Lena Andersen	
15:00 - 15:15	Preventing child maltreatment and child conduct problems in South Africa: A randomised controlled trial of the Sinovuyo Caring Families Programme	Dr. Inge Wessels
15:15 - 15:30	A task-shifting randomised controlled trial of prolonged exposure treatment and supportive counselling for posttraumatic stress disorder in adolescents	Mr. Jaco Rossouw
15:30 - 15:45	PID-ZA: Findings from a Reflective Parenting Intervention	Ms. Amy Adams Ms. Lameze Abrahams Ms. Juane Voges
15: 45 - 16:00	Q & A	
	Systematic Reviews	
	Chair: Dr. Lena Andersen	
16:00 - 16:15	A systematic review of the evidence base for treatment of common mental disorders in South Africa	Prof. Debbie Kaminer
16:15 - 16:30	Effectiveness of traditional healers in treating mental disorders: A systematic review	Dr. Gareth Nortje
16:30 - 16:45	Burn recovery in children and adolescents: What is the evidence for psychosocial intervention approaches?	Ms. Nancy Hornby
16:45 - 17:00	Synthesis of previous day's findings and concluding remarks	Prof. Ricardo Araya, Prof. John Joska & Prof. Crick Lund

FRIDAY 11 AUGUST 2017		
TIME	**TOPIC**	**SPEAKER**
08:00 - 08:30	Registration	
	Chair: Prof. Crick Lund	
08:30 - 09:15	**Keynote address 2:** Synthesising evidence in global mental health psychotherapy trials	Prof. Ricardo Araya
09:15 - 09:30	Q & A	
	Dissemination and Implementation	
	Chair: Mr Umesh Bawa	
09:30 - 09:45	A case study of lessons learnt from implementing a routine outcome monitoring system for psychotherapy in a South African community clinic	Dr. Jason Bantjes
09: 45 - 10:00	Challenges in disseminating an evidence-based treatment for PTSD	Dr. Anita Padmanabhanunni
10:00 - 10: 15	Q & A	
10:15 - 10:45	Coffee/tea	
10:45 - 11:45	**Panel Discussion: What works: Who, What, Where, How?** Chair: Prof. Ashraf Kagee Panel: Prof. Ricardo Araya, Dr. Tracey Naledi, Prof. Kathy Sikkema, Prof. Crick Lund, Dr. Debbie Kaminer, Ms. Valdi van Reenen	
11:45 - 12:15	Open mic: Delegates to reflect on current state of play and next steps	
12:15 - 12:30	Closing remarks	Prof. John Joska, Dr. Lena Andersen, Mr. Umesh Bawa
12:30 - 13:30	Lunch	

NEW RESEARCH CALLS FOR MORE OPEN TREATMENT DISCUSSIONS BETWEEN PSYCHIATRISTS AND THEIR PATIENTS LIVING WITH SCHIZOPHRENIA

Janssen
PHARMACEUTICAL COMPANIES
OF Johnson&Johnson

BEERSE, BELGIUM, 4 September 2017 – Janssen announces results of pan-European research which shows that a third of psychiatrists (34%) delay conversations about the full range of treatment options with their patients living with schizophrenia. The 'Open Minds' survey, conducted among 347 psychiatrists across eight European countries, also reveals that 22% limit treatment option discussions to avoid upsetting the relationship they have with their patients. This may be because the majority of psychiatrists (80%) say building a strong, trusting relationship with their patients is their key focus.

These new findings when considered alongside previous research[1,2] could explain why many patients living with schizophrenia are not aware of all the treatment options available. In a 2016 survey of 166 people living with schizophrenia, over a quarter (27%) did not think they had been made aware of all options, and a similar percentage (23%) were dissatisfied with their current medication.[3]

The research shows that opportunities exist for both psychiatrists and their patients living with schizophrenia to communicate more openly about treatment options, as on average, both speak for a similar length of time during consultations.

"IT IS VITAL THAT PATIENTS LIVING WITH SCHIZOPHRENIA ARE PROVIDED WITH THE INFORMATION THEY NEED TO OPTIMALLY MANAGE THEIR CONDITION AND HAVE THE BEST CHANCE TO LIVE A FULL LIFE", SAID DR. STEPHAN HERES, SENIOR PSYCHIATRIST AT THE DEPARTMENT OF PSYCHIATRY AND PSYCHOTHERAPY, TECHNICAL UNIVERSITY MUNICH, GERMANY. "THIS INCLUDES BEING INFORMED OF THE DIFFERENT TREATMENT OPTIONS, EACH WITH THEIR RESPECTIVE PROS AND CONS."

HILKKA KARKKAINEN, PRESIDENT OF GLOBAL ALLIANCE OF MENTAL ILLNESS ADVOCACY NETWORKS (GAMIAN)-EUROPE SAID, "THE DIFFICULTY FACED BY MANY PEOPLE LIVING WITH SCHIZOPHRENIA WHEN DISCUSSING THEIR TREATMENT IS EITHER NOT KNOWING OR UNDERSTANDING ALL AVAILABLE OPTIONS. OPEN CONVERSATIONS BETWEEN HEALTHCARE PROFESSIONALS AND THEIR PATIENTS ARE ESSENTIAL TO THE DECISION-MAKING PROCESS."

Importantly, the findings highlight the positive outlook psychiatrists have for the future of their patients living with schizophrenia. The majority (85%) believe those who remain on treatment can maintain functional personal relationships, and 71% believe those on treatment will be able to lead a full life.

'OPEN MINDS'

Janssen has a long heritage in neuroscience and is committed to improving the lives of people living with mental illness. Over 60 years ago, Janssen discovered one of the first treatments for schizophrenia, and continues to invest in expanding the treatment options and supporting the needs of those affected by serious mental illness.

ABOUT THE SURVEY

The 'Open Minds' survey was commissioned by Janssen to explore treatment discussions between psychiatrists and their patients living with schizophrenia.

THE SURVEY ALSO PROVIDES THE CLINICIAN PERSPECTIVE ON PREVIOUS RESEARCH CONDUCTED AMONG PATIENTS AND CARERS, WHICH HIGHLIGHTED THEIR LEVELS OF AWARENESS AND SATISFACTION WITH AVAILABLE TREATMENT OPTIONS.

The survey was conducted by market research agency Cello Health Insights among 347 psychiatrists from France, Germany, Italy, Spain, UK, Hungary, Sweden and Turkey. Those who took part in the online survey had between 3 and 35 years in practice and treated at least 20 people living with schizophrenia each month (at least 10 in Sweden and Hungary).

ABOUT SCHIZOPHRENIA

SCHIZOPHRENIA IS A COMPLEX AND CHRONIC BRAIN DISORDER, IN WHICH SYMPTOMS CAN BE SEVERE AND DISABLING AND CAN AFFECT ALL ASPECTS OF A PERSON'S DAILY LIFE.

It affects people from all countries, socio-economic groups and cultures. Its prevalence is similar around the world - almost one person in every 100 will develop schizophrenia before they reach the age of 60, with men slightly more at risk.[4,5]

There is no single cause of schizophrenia. Different factors acting together are thought to contribute to the development of the illness. Both genetic and environmental factors seem to be important.[6] Symptoms of schizophrenia can include hallucinations, delusions, lack of emotional response, social withdrawal/depression, apathy and a lack of drive or initiative.[4]

Schizophrenia is typically a lifelong condition, but there are treatments that can be beneficial. Clinical guidelines recommend that the optimal treatment package is a combination of antipsychotic medication along with psychotherapy, psycho-education and self-help.[7] Effective treatment may allow people with the condition to enjoy a more fulfilling life, which may include returning to work or study, independent living and social relationships, which in turn can aid their recovery.[8]

ABOUT THE JANSSEN PHARMACEUTICAL COMPANIES

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2. Potkin S, Bera R, Zubek D et al. Patient and prescriber perspectives on long-acting injectable (LAI) antipsychotics and analysis of in-office discussion regarding LAI treatment for schizophrenia. BMC Psychiatry 2013 Oct;13:261.

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Correpsondence: Cristiana Maria Email: cmaria@its.jnj.com

New research calls for more open treatment discussions between psychiatrists and their patients living with schizophrenia

RESULTS OF A 2017 PAN-EUROPEAN SURVEY

Schizophrenia affects approximately 1% of the world's population[1]

Clinical guidelines recommend combination of antipsychotic medication along with psychotherapy, psycho-education and self-help[2]

Effective treatment may allow people living with the condition to enjoy a more fulfilling life[3]

In 2017, Janssen Neuroscience commissioned a pan-European survey to explore treatment discussions between psychiatrists and their patients. The survey was conducted among 347 psychiatrists across 8 countries and provides the clinician perspective on previous research[4,5] conducted among people living with schizophrenia and carers

PSYCHIATRISTS

Treatment conversations

34% **delay conversations** about the full range of treatment options

22% **limit treatment option discussions** to avoid upsetting relationship

80% say **building a strong, trusting relationship** with their patients is their key focus

Future outlook

Both psychiatrists and their patients living with schizophrenia speak for a similar length of time during consultations

Findings highlight their **positive outlook** for the future of their patients living with schizophrenia

85% believe those who remain on treatment can maintain **functional personal relationships**

71% believe those on treatment will be able to **lead a full life**

347 psychiatrists across 8 countries

PEOPLE LIVING WITH SCHIZOPHRENIA

The new findings could explain why many people living with schizophrenia do not feel they are aware of all the treatment options available.

In a 2016 survey of **166 people** with schizophrenia:

23% **were dissatisfied** with their current medication[6]

27% **did not think** they had been made aware of all options[6]

"It is vital that patients living with schizophrenia are provided with the information they need to optimally manage their condition and have the best chance to live a full life. This includes being informed of the different treatment options, each with their respective pros and cons."

Dr. Stephan Heres, Senior Psychiatrist at the Technical University, Munich, Germany

"The difficulty faced by many people living with schizophrenia when discussing their treatment is either not knowing or understanding all available options. Open conversations between healthcare professionals and their patients are essential to the decision-making process."

Hilkka Karkkainen, President of Global Alliance of Mental Illness Advocacy Networks (GAMIAN)-Europe

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PHCB/PSY/0717/0004 August 2017

janssen Neuroscience

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  - The majority of depressed patients report difficulty initiating or maintaing sleep[2]

Trazodone is pharmacologically distinct from SSRI's, and is frequently prescribed to alleviate the sleep-disrupting effects of stimulating antidepressants.[2]

- **Many patients recovering from alcohol or other addictions are prescribed Trazodone because it is without abuse potential[2]**

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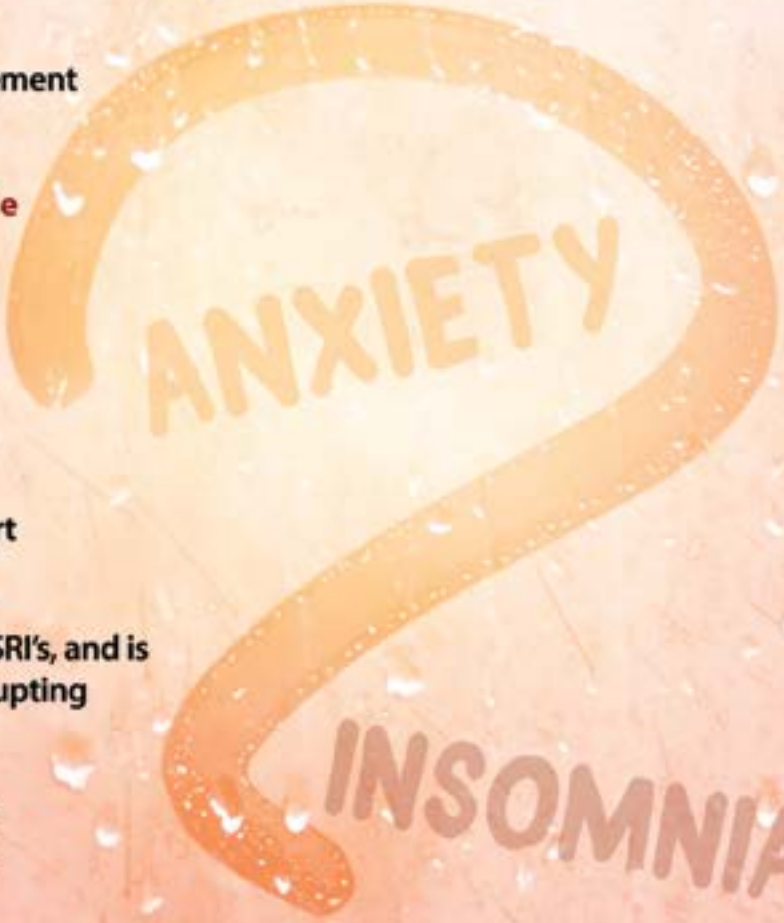

*MDD - Major Depressive Disorder

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Date of publication of promotional item: August 2016
Promotional material reference number: BL0331/08/16

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3. Package insert, published 10 April 2014

PHARMACOLOGICAL CLASSIFICATION
A 1.2 Psychoanaleptics (antidepressants)

SS **BIOTECH Trazodone 50:** Reg. No. 43/1.2/0698
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WPA NEWS

Official Quarterly News Bulletin of WPA

OCTOBER 2017 | WWW.WPANET.ORG

Message from the Secretary General

Roy Abraham Kallivayalil

Dear Colleagues and Friends,

Happy to come back to you again! The biggest WPA event of the triennium, the World Congress of Psychiatry, October 8-12, 2017, is now on our door steps!. The overall theme is ***"Psychiatry of the 21st Century: Context, Controversies and Commitment"****. The opening ceremony is at 5.30 pm on October 8th. Sir Simon Wessely's lecture and the official presentation of the Jean Delay Prize to Jules Angst will take place then and the Bavarian Doctors Orchestra will provide musical entertainment. All congress participants are cordially invited to attend the Opening Ceremony and subsequent networking reception. During the five days of the Congress, there will be 900 sessions, a scientific programme, offering a comprehensive overview of current developments in Psychiatry and mental health. The WPA EC, Council, and Board Meetings will be held on October 8th. The Extraordinary General Assembly will start at the Pullman Hotel at 8.45 am on October 10th. Voting for the EC and Board positions will be held during the Ordinary General Assembly to be held from at 10.45 am. For the first time, we are introducing a WPA owned, user friendly software for the elections. Please visit our newly designed website www.wpanet.org and kindly send us your valuable comments. Our Facebook page is https://www.facebook.com/wpanet/.*

Let me thank WPA President Dinesh Bhugra, President-Elect Helen Herrman, members of the EC, Board, Council and especially Francesca and Pamela at our WPA Secretariat for their help, support and co-operation.

Roy Abraham Kallivayalil
Secretary General
World Psychiatric Association

Message from the President

Dinesh Bhugra

Dear Friends and Colleagues,

As I step down after the 17th World Congress in Berlin next month this is my farewell message to you all. Three years have passed and most of it has been very productive and enjoyable. Indeed, it has been a pleasure and an honour which hopefully has led to major changes in the organisation and for the profession.

Following the successful launch of **Bill of Rights** for Individuals with mental illness and a **Bill of Rights for children and young people** a **Bill of Rights for people with Intellectual Disability** has been developed. Please get your Association/Organisation to support these Bills of Rights. These are available on WPA website.

A survey of discrimination in law in Commonwealth countries showed that there was a significant number of countries which do not have a mental health policy. This was launched on the 3rd World Mind Matters Day on 5th September 2017. Details of the **international discrimination survey** were published in a special issue of *International Review of Psychiatry* volume 28(4).

A WPA Position Statement on **the Roles and Responsibilities of a Psychiatrist in the 21st century** has been approved and is available on the WPA website. A **Position Statement on Wellbeing of Psychiatrists** and a **Statement on Good Psychiatric Practice** are almost ready for launch. I am delighted to announce that over 30 Position statements have been produced in the last Triennium. None of this would have been possible without the support of so many colleagues who worked tirelessly and supportively over the past three years.

WPA-Lancet commission on Psychiatry report is complete. Copies of the report will be available in the World Congress in Berlin in October 2017.

The work on setting up **Diploma in Psychological Medicine in collaboration with University o Melbourne** aimed at psychiatrists continues apace and we hope to launch it later this year. We ar also working on the Diploma for non-psychiatrists

We are continuing to look for examples of **good clinical practice** around the world so that we can learn from each other. Please keep them coming Please check the website regularly and get involved

I would like to take this opportunity to thank you all for your support, assistance and good wishes Thanks are also due to chairs of all Presidentia Task Forces for delivering their reports and recommendations with limited costs to the organisation. It is your support and work behind the scene which has made this triennium so enjoyable. The staff at the Head Office have been unfailingly helpful particularly our Interim CEO. Thanks to the EC, the Council and Board and other colleagues for their hard work and support. Please join me in congratulating Prof. Mario Maj for his stellar contribution to making World Psychiatry number journal in the world.

I very much hope that our paths will cross again and I hope that progress in the field of psychiatry and mental health and well-being shall continue apace.

Best wishes,

Dinesh Bhugra, CBE
President
World Psychiatric Association

TO ALL PSYCHIATRISTS, ASSOCIATIONS AND SOCIETIES OF PSYCHIATRISTS IN WPA ZONE 14

Greetings and hope this finds you all in good health.

David M. Ndetei

We had a most colourful and successful 2017 WPA conference in Berlin, Germany, during which a new Executive committee and Board were elected. Prof. Helen Herrman took over as the President, replacing Dinesh Bhugra whose term had just ended after serving the Association with distinction. Prof. Afzal Javed was elected as the President Elect. All the Council Members (Past Presidents) were also in attendance and were publically recognized and honoured, one by one, by Prof. Bhugra. Four of our members - Dr. Mvuyiso Talatala (South Africa), Prof. Bernard van Rensburg (South Africa), Dr. Ian Westermore (South Africa) and myself (Kenya) were honoured by the President as Honorary Members of WPA for various contributions. They will be receiving their certificates.

I was honoured with re-election as your Representative to the WPA Board.

I WOULD LIKE TO THANK ALL THE COUNTRY ASSOCIATIONS THAT NOMINATED AND SUPPORTED ME WHILE AT THE SAME TIME I ACKNOWLEDGE THAT I REPRESENT ALL THE ASSOCIATIONS OF ZONE 14.

We should join hands as brothers and sisters and collectively articulate the concerns on Mental Health issues in Zone 14. The voice of every association, from the smallest to the largest should be heard by WPA through the official channels.

Please keep me posted of your activities and concerns as members of WPA. There is no small news nor a concern that does not matter. I will synthesize them and forward them as a collective voice of the Zone. But make sure you also pay directly to WPA secretariat your annual subscriptions.

Secondly, I urge you to continue, as you have been doing at the very minimum with country level annual scientific conferences. I will be happy to join you. These annual meetings should be in addition to other activities. Please give me reports of all your activities for synthesis and onward transmission to WPA secretariat.

DURING MY LAST TERM I CAME TO APPRECIATE THE UNIQUE DIFFICULTIES WE FACE AS ZONE 14 – MAINLY LANGUAGE ISSUES DEPENDING ON PAST COLONIZATION, GEOGRAPHICAL DIVERSITY WITH COUNTRIES THAT ARE ISOLATED ESPECIALLY SOME ISLANDS IN THE INDIAN OCEAN AND VERY FEW PSYCHIATRISTS IN SOME OF THE COUNTRIES, AND SOME COUNTRIES THAT ARE STILL COLONIES AND ARE TECHNICALLY MEMBERS OF EUROPEAN BASED ASSOCIATIONS.

We can overcome these various barriers through modern communication technology – emails, Skype, etc. My office has a desk to facilitate these. Feel free to write to me – either in English, Portuguese or French – whatever you are most comfortable with. I am sure there is enough expertise and goodwill in the Zone 14 to help us overcome these language barriers.

I also want to encourage those countries that do not have associations to kindly make all efforts to form theirs and let me know if you experience any problems that WPA could be of assistance.

The next WPA conference will be in Mexico City next year (2018) – details to follow. Let as many of you as possible make efforts to attend, make presentations, hold symposia etc about what is going on in your respective countries.

If you know any psychiatrist in Zone 14 that is not on this list, please forward this letter to them and copy (cc) me in.

With very warm regards,

Yours faithfully,

David M. Ndetei
WPA Zone 14 Representative
Correspondence: dmndetei@amhf.or.ke

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WPA XVII WORLD CONGRESS OF PSYCHIATRY BERLIN 2017

PUBLICATIONS SYMPOSIUM, 9TH OCTOBER 2017

Christopher Paul Szabo

The symposium addressed the issue of publishing in low resource countries, and was chaired by Christopher Paul Szabo (South Africa), co-chaired by Prabha Chandra (India) and featured 4 speakers: Peter Tyrer (Emeritus Professor, Imperial College, UK), Dusica Lecic-Tosevski (Professor of Psychiatry, Belgrade University and Member of the Serbian Academy of Sciences and Arts, Serbia), Joao Mauricio Castaldelli-Maia (President of the ABC Centre for Mental Health Studies, Santo Andre, SPe, Brazil) and Reinhard Heun (Professor of Psychiatry, Royal Derby Hospital, UK).

Peter Tyrer presented work undertaken in an attempt to see whether email assistance helps authors whose papers have been rejected without review by the British Journal of Psychiatry (BJPsych), to publish subsequently.

Approximately 40% of manuscripts submitted are rejected without review. A disproportionate number are from Low and Middle Income Countries (LMICs). A randomized control trial (RCT) was undertaken.

Three groups were analysed - randomisation but no further action (no email support), randomisation plus expert feedback (email support), refusal to be randomised. One of the biggest problems was that the overwhelming majority were not interested in being randomized into the study.

Of interest is that in following up it was noted that whether authors agreed to be randomized into the study, there was no significant difference between groups (feedback/no feedback/not allocated) in terms of the primary putcome. One paper in the RCT (i.e. <1%) was published in a journal with a higher impact factor than the BJPsych. Of note was that amongst the countries represented in the sample, publications from China were in journals with the highest impact factors.

Christopher Paul Szabo

Dusica Lecic-Tosevski spoke about the "publish or perish" credo and the pressure to publish as a phenomenon that impacts not just developed but also developing world settings. Publication record impacts on university rankings, staff appointments, and ultimately personal and institutional funding. From being an option, publication is now an obligation. Language i.e. English is a major obstacle to publication, beyond issues of resources (infrastructure/time/costs). A specific issue is cost, not only in terms of access to published material but also in relation to cost to author/s of publishing (with lack of research grants).

Joao Mauricio Castaldelli-Maia spoke about gaps in randomised control trials having conducted a bibliometric study (Pubmed database) to review such gaps. Using ICD-10 F codes over the last 20 years it was established that there was an inclination to research specific diagnostic entities within each group of F codes i.e. dementia, depression , insomnia and schizophrenia with research related to the mood disorders group dominating with more than 1000 studies.

SPECIFIC GAPS WERE IDENTIFIED FOR RESEARCH RELATED TO PERSONALITY DISORDERS AND MENTAL RETARDATION – THE APPARENT "FORGOTTEN GROUPS". IN ADDITION, WITHIN EACH GROUP, SOME "FORGOTTEN DISORDERS" CAME UP, SUCH AS ORGANIC INDUCED, ACUTE PSYCHOSIS, DYSTHYMIA, CYCLOTHYMIA, ACUTE STRESS, ADJUSTMENT, DISSOCIATIVE, SOMATIZATION, HYPOCHONDRIA, PSYCHOGENIC IMPOTENCE AND ANORGASMIA, PUERPERAL PSYCHOSIS, IMPULSE AND GENDER IDENTITY DISORDERS.

The final presentation was by **Reinhard Heun** who spoke about how to write a paper, proposing that it should adopt a hypothesis based approach. In making such a proposal it was clearly illustrated how this approach influences the structure of a paper, and shapes content. Ultimately the issue of relevance both in terms of the original hypothesis, the results of the study as well as implications for future study - emanating from the data - was highlighted.

Arising from the presentations, audience discussion highlighted some ways of overcoming the problem of low levels of publications from LMICs in high impact journals, collaborative research between LMICs and High Income Countries (HIC), research in areas that are more well developed in LMICs e.g. primary care and somatization (which may not be possible in HIC), publishing in one's own regional journals and mentoring and feedback by editors.

This was the final work of the Operational Committee for Publications (noting the absence of Alfredo Cia) who served under Michelle Riba as Secretary for Scientific Publications.

Photo from Left to Right:
Joao Mauricio Castaldelli-Maia, Peter Tyrer, Reinhard Heun, Prabha Chandra, Christopher Paul Szabo, Dusica Lecic-Tosevski

Christopher Paul Szabo is Professor and Academic Head, Department of Psychiatry, University of the Witwatersrand, Johannesburg, South Africa and was a member of the WPA Operational Committee on Publications at the time of the symposium. **Correspondence: Christopher.szabo@wits.ac.za**

ADVANCED PRACTICUM IN RATIONAL EMOTIVE AND COGNITIVE

Behaviour Therapy (Part 2) – Albert Ellis Institute- Cape Town (2017)

Jasmin Kooverjee

BACKGROUND

The training offered by the Centre of Cognitive Training (CCT) is held in association with the Albert Ellis Institute of New York. The 3 days practicum is aligned to match the training offered in New York at the same time. Bradley Drake and Jaco Rossouw are South Africa's only 2 Associate Fellow and Certified Supervisor of the Institute hence they bring the course at an affordable price and location for CBT inspired practitioners. Kirsten Doyle, a Clinical Director at the Albert Ellis Institute joins the training for the 3 days in the beautiful setting of Cape Town.

PRIMARY PRACTICUM

Before partaking in the Advanced course you have to pass the Primary Practicum which is held the year before. On the registration form one of the questions is the years of experience one has in CBT. In 2016, when I participated in the Primary Practicum, I was proud to say that I practised CBT for the last 9 years however the Course soon had me wishing that I stated 0 years of experience as the training brought out every blind spot and lack of understanding of the paradigm that one has. Each day of the Primary Practicum started at 8am with 3 hours of lectures and then followed by 6-7 hours of practical role plays. Topics for the Primary practicum covered an introduction to REBT; the clinical interventions and strategies; conceptualisation of emotions; errors in REBT and finally role plays.

Each role play made each one of us feel as if we should sink further and further into our seats and even though one became more insecure about

Jasmin Kooverjee

one's skills, the course still remained enjoyable. The Primary course ended with a 1 hour examination, that with growing anxiety about one's skills, made the exam more overwhelming than it should have been. The day of the exam, one would hear many whispers in the corridor about how embarrassing it would be if one failed the exam even though your current Business card stated CBT practitioner and how would you face your client. Everyone had their books open, cramming the 3 day information before we started.

Thoughts racing, heart rate increasing and sweaty palms; all one could do is actually use the tools taught in the 3 days that you should use with your patients. So with breathing deeply, constant rephrased thoughts and walking into the examination room with one thought; "I've done this for 9 years. I prefer to pass this exam but if I don't then this is not a catastrophe"; made the process manageable.

LEAVING THE PRIMARY COURSE, I LEFT WITH A SENSE OF GRATITUDE FOR GAPS OF KNOWLEDGE BEING FILLED, THE HUMBLENESS OF KNOWING THAT THIS PARADIGM HAS SO MUCH MORE TO OFFER THAN WHAT WE MAKE OTHERS AWARE OF AND DEFINITELY MORE DETERMINED TO USE THESE SKILLS THAT I LEARNT.

COGNITIVE BEHAVIOUR THERAPY

"How much do I really know?"

ADVANCED PRACTICUM

As I prepared to start the Advanced Practicum, the all too familiar anxiety of; "how much do I really know ?"; "Have I progressed and practiced my new skills enough over the last year?" and "is there another exam?"; started to intrude my cognitive space. Quickly I contained those anxieties as I looked for the evidence that I did know what I was doing.

I KNEW HOW TO GET MY PATIENTS TO ACKNOWLEDGE THEIR TRIGGERS (A); LINK THAT TO THEIR IRRATIONAL BELIEFS (B) AND TO IDENTIFY THE UNHELPFUL CONSEQUENCES OF THAT BELIEF (C).

Changing the starting statement of my sessions to "What would you like to work on today?", seemed to significantly shift my patients to focus on their aim more so than they used to. Feeling more confident, I entered the venue knowing that these 3 days would be another massive learning curve and definitely a positive one. Seeing the group for the Primary Practicum 'freaking out' about learning of their exam felt somehow reassuring that I wasn't in that space anymore.

The Advanced Practicum (as per the CCT website) focused on:

- Comprehensive strategies for challenging clients' dysfunctional thinking and creating new rational philosophies.
- Developing case conceptualizations of REBT and CBT for numerous clinical disorders.
- Integrating affective and behavioural interventions into each session of therapy.
- Understanding the theory, research, and clinical intervention on self-schemas and self-worth.

Ironically, knowing there was no exam, offered a free cognitive space just to absorb and learn these new strategies. Starting the day with the role plays felt much easier but I had to wonder whether it was the new structure of the day or whether it was actually because I used the tools in my own sessions with patients over the last year. Narcissistically, my mind concluded it was the latter reason.

AS THE DAYS PROGRESSED, THE LECTURES WERE MORE ENLIGHTENING; THE ROLE PLAYS WERE MORE WELCOMED AND ONE COULD ONLY ADMIRE THE SKILL AT WHICH THE 3 FACILITATORS MANAGED A 'CLIENT IN THE ROOM'. EVEN THOUGH EXHAUSTING, AS IT WAS 11 HOUR DAYS, I WAS SO GRATEFUL FOR BEING OFFERED THE OPPORTUNITY TO ATTEND THIS COURSE.

There is one more step of the training. One could opt to continue the process of becoming an Associate Fellow of the Albert Ellis Institute (NY). You have to have supervision with a certified supervisor and submit three 15min sessions. Thereafter you have submit full 40 minute sessions and submit one to be evaluated and examined by the Institute.

Our group was so motivated, as the requirements sounded simple enough and our enjoyment of the course left us with a feeling of determination to have more REBT/CBT practitioners accredited in SA. Whatsapp support groups were created and each of us was determined to follow the next step.

As I sit writing this, I think that somehow one needs to find a way to maintain that determination that one felt on the day we left. Life and schedules seem to have gotten in the way and the Whatsapp group is even quiet. Maybe more contact or communication with and from the facilitators? But, all these are external 'excuses'. "If one wants it, one has to find a way to do it. Our thoughts and behaviour are solely our own."

To the Finance committee of the Department of Psychiatry at the University of the Witwatersrand: I am so appreciative and honoured by your contribution towards allowing me to attend this course. It has been such a learning curve and I would definitely recommend it for any REBT/CBT inspired practitioner.

Jasmin Kooverjee is the Prinicipal Psychologist in the Department of Psychiatry at Chris Hani Baragwanath Academic Hospital and is jointly appointed in the Department of Psychiatry, University of the Witwatersrand, Johannesburg, South Africa.
Correspondence: Jasmin.Kooverjee@gauteng.gov.za

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References: 1. Probyn MJ. Some drugs more equal than others: pseudo-generics and commercial practice. Aust Health Rev 2004;28(2):207-217 [cited15 June 2018] Available from: http://www.publish.csiro.au/?act=view_file&file_id=AH040207.pdf. 2. DOH Medicine Price Registry. Database of medicine prices [17th May 2017 [cited 12 July 2017]. Available from: http://www.mpr.gov.za.

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11726

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REALIZING THE VISION FOR GLOBAL MENTAL HEALTH THROUGH PRIMARY CARE TRANSFORMATION

Sumaya Laher

Earlier this year, SADAG in partnership with the Psychological Society of South Africa (PsySSA) and the Wits Psychology Department hosted a lunchtime address by Prof Gabriel Ivbijaro, President of the World Federation for Mental Health.

Prof Ivbijaro argued in his talk that there has been a systematic failure of the health care system in preventing, identifying and treating mental health conditions, partly due to mental health stigma, poor training and a lack of evidence for policy makers to fund mental health.

His address focussed on mental health as an integral and essential component of general health, human resources and social care in the context of the predictions of the global burden of disease to 2030 and the role of primary care to provide a framework for collaborative and integrated care.

Prof Gabriel Ivbijaro

USING THE LITERATURE AND PERSONAL EXPERIENCE PROF IVBIJARO HIGHLIGHTED THE FOLLOWING:

- Why we need to transform primary care mental health
- Demonstrate the effectiveness of primary care mental health
- Describe the key ingredients for success
- The need to invest in an enhanced primary care workforce
- How lessons learned can be generalised to South Africa

Prof Ivbijaro's presentation can be accessed at:
http://www.psyssa.com/wp-content/uploads/2017/07/Ivbijaro_SADAG PrimaryCareTransformation_14-06-2017.pdf

Sumaya Laher is an Associate Professor – Psychology, School of Human & Community Development University of the Witwatersrand,Johannesburg, South Africa. **Correspondence: sumaya.laher@wits.ac.za**

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info4africa's Director, Debbie Heustice says, *"Our info4africa service finder is free, user friendly and uses very little data. We have created a range of ways to access our national service finder database so that people can find help when and where they need it most. We'd like to encourage all health professionals to add their details to the info4africa database. Membership is free."*

info4africa's Service Finder is available as follows:

- www.info4africa.org.za
- On basic phones call *120*448#
  and follow the menu prompts
- "info4africa" Facebook Messenger
- Mobile phone app: WeChat or Google PlayStore
- SMS 45080 / 071 624 2255
- Email: community@info4africa.org.za

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References:
1. Efegen XR package insert, Ranbaxy (S.A.) (Pty) Ltd. (July 2010)

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DEPARTMENTS OF PSYCHIATRY
UNIVERSITY OF THE WITWATERSRAND

UNIVERSITY OF THE WITWATERSRAND 29TH ANNUAL PSYCHIATRY RESEARCH DAY

On the 21st of June 2017, the Department of psychiatry at Univer-sity of the Witwatersrand, hosted its 29th annual Research Day at the Sunnyside Park Hotel in Johannesburg. Associate Professor Janse Van Rensburg was the over-seer of the Registrars in their second year, as they were organising the event. The aim of this event was to empower all stakeholders by sharing new information amongst those present.

Professor Charles Feldman was the keynote speaker for the day and he presented on "Breathing Life into Medicine: Research in a Clinical Environment" which was a very fascinating topic. Charles Feldman is the Professor of Pulmonology and Chief Physician at the Charlotte Maxeke Johannes-burg Academic Hospital and Faculty of Health Sciences, University of Witwatersrand. He obtained his undergraduate degree from the University of Witwatersrand in 1975, and successively his PhD in 1991 and DSc in 2009.
The attendees participated and showed great interest towards the presentations. Of all the topics presented, Dr. Thuli Mdaka's topic which was "Long term outcomes of psychiatric patients initiated on antiretroviral therapy (ART) at Luthando clinic in 2008 – 2010" was the winning topic. Dr Nel and Dr. Jonsson supervised Dr Thuli Mdaka's research. SASOP sponsored the delightful prize that was awarded to the winner.

Keynote speaker, Prof Charles Feldman

Prof.Christopher Szabo (Right) HOD congratulating one of the committee members Dr Jess Taylor

Adjudicators of the day: Prof.'s Gill Nelson and Geoff Candy

Chairperson of Research Committee: Dr. Phil Pitjeng

OPENING - PROF SZABO	
Prof Charles Feldman	KEY NOTE - BREATHING LIFE INTO MEDICINE: RESEARCH IN A CLINICAL ENVIRONMENT
NAME	TOPIC
Sapinoso R	Internalized Stigma Among Psychiatric Outpatients
Anic A	Prevalence and patterns of substance use amongst psychiatric inpatients at Helen Joseph Hospital
Eklektos N	An assessment of childhood trauma in a group of state patients admitted to Sterkfontein Hospital
Galesitoe L	Retrospective record review of adolescents admitted to an inpatient psychiatric unit
Lowton K	Assessing the clinical utility of the severity dependence scale (SDS) for benzodiazepine use disorder at a Johannesburg outpatient psychiatric clinic
Maisto A	Screening for antenatal depression in women attending the CHBAH antenatal clinic
Mhlane T	A psychosocial profile of children referred toSterkfontein Hospital for assessment of criminal responsibility under the Child Justice Act (75 of 2008)
Tlolane T	Clinical profile, service utilization and follow-up of patients attending Za-mani Dual Diagnosis Clinic
TEA	
Chawane N	A record review of the profiles of alleged sex offenders and outcomes of their observations in a forensic psychiatric unit
Govender M	A review of individuals charged with common assault and assault with intent to do grievous bodily harm, referred for forensic psychiatric observation
Mdaka T	Long term outcomes of psychiatric patients initiated on anti-retroviral therapy (ART) at Luthando clinic in 2008-2010
Tonyane G	Treatment-resistant schizophrenia at Chris Hani Baragwanath Academic Hospital psychiatry adult outpatient clinic
Letlotlo B	Neuro-imaging studies in psychiatry in-patients at the Charlotte Maxeke Johannesburg Academic Hospital
Prize giving and closure	
LUNCH	

ART EXHIBITION

Prof. Ugash Subramaney was one of the featured artists at the 42nd annual art exhibition of the Health Professionals Art Group which took place at the Adler Museum in the Faculty of Health Sciences at Wits on the 15th August 2017.

Works by Ugash Subramaney

Bernard Levinson & Ugash Subramaney

FORENSIC PSYCHIATRY - SUBSPECIALIST QUALIFICATION

Dr Naseema Cassimjee passed the first ever certificate in Forensic Psychiatry exams in South Africa. The exams were hosted at Sterkfontein Hospital, under the auspices of the College of Psychiatrists (Colleges of Medicine of South Africa)

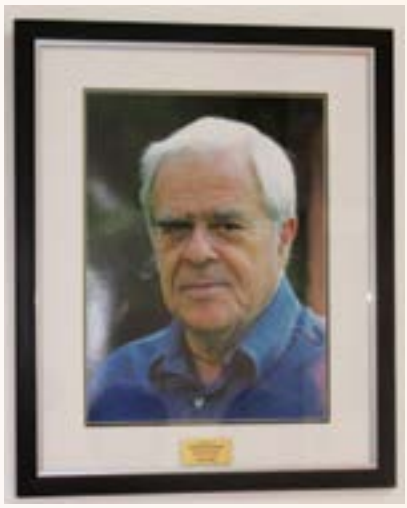
From L-R: Mo Nagdee, Naseema Cassimjee, Tuviah Zabow, Ugash Subramaney, Funeka Sokudela, Sean Kaliski

RESEARCH AND LEARNING CENTRE AT STERKFONTEIN HOSPITAL

The opening of the new Research and Learning Centre at Sterkfontein Hospital took place on Wednesday the 27th September 2017. The audience were welcomed by Prof. Ugash Subramaney, Head of Clinical Department at the Hospital.

The guest speaker was Prof. Lee Berger (Research Professor in Human Evolution and the Public Understanding of Science Evolutionary Studies Institute, University of the Witwatersrand, Johannesburg, South Africa and Explorer-in-Residence The National Geographic Society Washington D.C, United States of America). Dr. Ralf Brummerhoff, a psychiatrist at Sterkfontein Hospital, gave a presentation on the history of Sterkfontein Hospital.

The centre was then formally opened by Prof. M. Lukhele (Head of School – Faculty of Health Sciences) and Mr. J. Mapunya (CEO- Sterkfontein Hospital). It is anticipated that the Centre will be named after Dr Mike Ewart Smith. The event was sponsored by Astra Zeneca Pharmaceuticals (Pty) Ltd – and sanofi-aventis South Africa (Pty) ltd.



Mike Ewart Smith

Opening of Centre

L-R : Lee Berger, Ugash Subramaney, Christopher Paul Szabo

SERVICE EXCELLENCE AWARD AND HERITAGE CELEBRATION AT TARA HOSPITAL

GAUTENG PROVINCE

'CELEBRATING EXCELLENCE IN THE WORKPLACE'

On the 29th of September 2017, Tara Hospital hosted the Service Excellence Awards and Heritage Day Ceremony. Staff members gathered at the hospital recreational hall dressed in traditional attire; under the theme "Excellence in the workplace". Ms. Lebo Mkhethoni outlined the purpose of celebrating Heritage Day as a celebration of South Africa's "rich, proud and diverse heritage". She said that although South Africans speak different languages, practice different beliefs and engage in different cultural practices, we are bound by a common African heritage.

The purpose of the event is to recognize and reward staff members who go the extra mile in contributing to the overall success of Tara Hospital. It recognizes individuals who promote the six ministerial priorities and the Batho Pele principles that guide our service to the public. Further the awards aim to acknowledge and uphold the vision and the mission of the hospital which is to provide quality care to our patients and to motivate, uplift and improve the morale of our staff members.

Mr Siphile Buthelezi; Director of the ButheleziVilakazi Attorneys addressed staff members during his motivational talk. His inspiring talk was about his life as a taxi driver before obtaining his LLB degree which he graduated with distinction.

Many employees were awarded for their outstanding performance in ensuring that the service we offer to our patients is excellent. The Employee of the year was awarded to Mr. Ronald Makamu, an employee who has portrayed a positive attitude towards his work, and a striving for excellence. Mr. Ronald Makamu is an individual who goes beyond the call of duty and is always available when needed. Before announcing the winner, the CEO mentioned that all the nominees for the CEO's award of 'employee of the year', were winners. Ward 4&5 and the Property Caretakers were awarded the best Clinical Unit in Cleanliness, and the Best Improved Team respectively.

The Bapedi, Vatsonga and Basotho dancers performed their traditional dances on stage. This was to encourage the staff to celebrate not only their own cultural traditions, but also the diversity of cultures, beliefs and traditions that make up our community.

With the contribution of one of our neighbours Mr De- Roos; Old Mutual, the Saxon Hotel, Nchama Construction, and Mfanyana Security, the event was a great success. Thank you from the Tara Team.

Article by: V. M.
Former Communications Officer - Tara Hospital
Correspondence: no longer available

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Edited by: Mr Jonathan Percale,
Psychology Head of Department

NURSING CATEGORY	ADMINISTRATION CATEGORY	SUPPORT CATEGORY	CLEANING CATEGORY	CLINICAL CATEGORY
3rd prize - Fortunate Nkosi 2nd prize - Keletso Mati 1st prize - Buyi Ndlovu	3rd Prize - Synesta M khondelela 2nd Prize -Tebogo Nkala Molepo 1st Prize - Mbuyiseli Sonjani	3rd prize - Faezz Cassim 2nd prize - Eunice Hlongwane 1st Prize - Ronald Makamu	3rd Prize -Thembi Hlongwane 2nd Prize -Joyce Kubjane 1st Prize -Dinah Shilange	1st prize - Belinda Marais

BEST CLINICAL UNIT IN CLEANLINESS	BEST IMPROVED TEAM	BEST MANAGER	EMPLOYEE OF THE YEAR
Ward 4/5	Property Caretakers	Mary Mosima	Ronald Makamu

UNIVERSITY OF CAPE TOWN

NEW HONORARY SENIOR LECTURER IN THE DIVISION OF CHILD & ADOLESCENT PSYCHIATRY AT THE UNIVERSITY OF CAPE TOWN BRINGS HOPE FOR AUTISM INTERVENTIONS IN AFRICA

Dr Lauren Franz

We are delighted to announce the appointment of Dr Lauren Franz, from Duke University in the USA, as Honorary Senior Lecturer in the Department of Psychiatry and Mental Health at UCT.

Lauren was born in South Africa and specialised in Medicine training in Public Health, Psychiatry, Child & Adolescent Psychiatry and Global Health. She is now a Child and Adolescent Psychiatrist and Assistant Professor of Psychiatry and Global Health at Duke University. Dr Franz's research focuses on improving access to evidence-based treatment for neurodevelopmental disorders, including autism spectrum disorders, in sub-Saharan Africa and other low-resource settings.

FIRST REGIONAL IMFAR IN AFRICA

Above: Prof Petrus de Vries and his research team

From 7-9 September 2017 a unique congress was held at Spier Wine Estate in Stellenbosch. The South African Association for Child & Adolescent Psychiatrists and Allied Professions (SA-ACAPAP) joined forces with the International Society for Autism Research (INSAR) and the African Association of Child & Adolescent Mental Health (AACAMH) to host an Africa Regional IMFAR (International Meeting for Autism Research) and African Child & Adolescent Mental Health Congress.

The meeting was attended by over 300 participants from more than 25 mainly African countries. The meeting included pre-congress workshops, symposia, oral presentations and a very lively poster presentation session. The main funders of the event was INSAR, Autism Speaks and the Duke Global Health Institute.

MENTAL ILLNESS AN INCREASINGLY UNBEARABLE BURDEN FOR SOUTH AFRICAN ECONOMY

In anticipation of World Mental Health Day (WMHD) on 10 October 2017, the Alan J Flisher Centre for Public Mental Health hosted a roundtable discussion on Economy, Equality & Access to Mental Health Services at the Baxter's Masambe Theatre in Cape Town on the 3rd. Chaired by the Centre's Co-director, Prof Ashraf Kagee from Stellenbosch University, the presentations and lively discussions touched on many aspects related to the need for sustainable solutions to South Africa's mental health treatment gap. Addressing the international WMHD theme, the Centre's other Co-director, Prof Katherine Sorsdahl from the University of Cape Town, spoke about mental health in the workplace.

Also from the Centre, Ms Sumaiyah Docrat, in her presentation made an economic case for investing in mental health in South Africa. Mrs Ingrid Daniels, the Director of Cape Mental Health, continued the discussion by speaking on the consequences of an event like the Life Esidimeni tragedy. Other presenters on the day included Prof Petrus de Vries, Professor of Child & Adolescent Psychiatry at the University of Cape Town, Dr Simone Honikman and Charlotte Mande Ilunga from the Perinatal Mental Health Project, Dr Jo Hart and Dr Lucie Byrne-Davis from the University of Manchester and Prof Lou-Marie Kruger from the University of Stellenbosch.

Discussions forthcoming from the event shows a desperate need for in-depth investment by the South African government into sustainable mental healthcare.

To access recordings of all the presentations as well as the PowerPoint slides, please visit the vent website at **www.cpmh.org.za/wmhd.**

SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY

AWARD ETHEL THEKISO

2017 BIOLOGICAL PSYCHIATRY CONGRESS

14 – 17 September 2017
Lord Charles Hotel, Somerset-West
Western Cape, South Africa
www.biopsychsa.co.za

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For Best Registrar Presentation

"Prevalence of Clinical features of Depression in adult patients receiving antiretroviral treatment at the Dr George Mukhari Academic Hospital Tshepang HIV Clinic"

at

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Lord Charles Hotel, Somerset West
14 – 17 September 2017

Prof Soraya Seedat

Stellenbosch University, South Africa
Chairperson: Organising Committee
Biological Psychiatry Special Interest Group
South African Society of Psychiatrists (SASOP)

Ethel Thekiso

BIOLOGICAL PSYCHIATRY CONGRESS HIGHLIGHTS

Sian Hemmings

The Biological Psychiatry Congress, held between September 14-17 at the Lord Charles Hotel in Cape Town, was attended by 547 delegates (including 239 psychiatrists and 59 registrars).

Two highlights of the Congress were the five Pre-Congress Workshops and the Southern African Neuroscience Society (SANS) Symposium, the former attended by a record 177 delegates:

1. THE PRE-CONGRESS WORKSHOPS

The pre-congress workshops were launched on Thursday 14 September 2017 and followed the theme of the Biological Psychiatry Congress 2017 – i.e. Risk and Resilience in Mental Health: Improving life through Science – closely.

THE VERY FIRST SESSION OF THE DAY WITH THE ENTICING TITLE "MOLECULAR DETECTIVES: UNCOVER THE MOLECULAR AND CELLULAR PATHWAYS INVOLVED IN NOVEL TREATMENT STRATEGIES" SET THE TONE FOR A HIGH LEVEL SCIENTIFIC OFFERING.

This workshop was presented by the special interest group for Cellular and Molecular Psychiatry. The first presentation focused on functional medicine and DNA coaching, and lay the foundation for this interesting session. The basics of molecular biology was revisited, with a focus on how available technologies can be used in functional medicine. Subsequently, there was a talk on how mAbs (monoclonal antibodies) can be used as biological traps to eliminate circulating pro-inflammatory mediators. This was particularly interesting in light of more recent research illustrating that in most psychiatric disorders, the immune system is dysregulated, with high levels of pro-inflammatory molecules.

Sian Hemmings

Data showed that a monoclonal TNF-α antibody was used as an effective treatment for major depressive disorder, since inhibition of TNF-α down-regulated the inflammatory response. Therefore, it was concluded that such therapies are not only effective in the treatment of inflammatory disorders, such as rheumatoid arthritis, but hold great potential for numerous psychiatric disorders.

THIS WORKSHOP ALSO INCLUDED A PRESENTATION ON THE MORE UNKNOWN TOPIC OF THE SO-CALLED "DARK GENOME", WHICH INCLUDES FACTORS SUCH AS THE VAST NUMBER OF NON-CODING RNAS.

Originally it was believed that non-coding RNAs had limited to no function, however, research has since shown that they have numerous functions, especially in the regulation of gene and protein expression. In addition to non-coding RNAs, the audience was

WORKSHOP

reminded that genetic investigations should ideally be accompanied by proteomic investigations, as that might shed more light on the underlying molecular mechanisms involved in psychiatric disorders. The final presentation focused on the actions of lithium and lamotrigine, especially the molecular pathways involved in the immunological responses. The clinical utility of specific genes, such as the methylenetetrahydrofolate reductase gene (MTHFR) was also covered.

IN CONCLUSION, THIS WORKSHOP PROVIDED A THOROUGH OVERVIEW OF THE MOLECULAR FACTORS AND PATHWAYS THAT ARE IMPORTANT IN MOLECULAR PSYCHIATRIC RESEARCH.

During one of the parallel workshop sessions in the afternoon, Dr Simon Whitesman, Director and Chairperson of the Institute for Mindfulness South Africa (IMISA), delivered a refreshing take on the 'what' and 'how' of mindfulness. Dr Whitesman practices medical psychotherapy at Christiaan Barnard Memorial Hospital in Cape Town and also coordinates the postgraduate certificate training in Mindfulness-Based Interventions at Stellenbosch University's Faculty of Medicine and Health Sciences. Internationally, research on the effectiveness of Mindfulness-Based Interventions (MBIs) in the area of mental health is growing rapidly.

THE AUDIENCE WAS INTRODUCED TO THE CONCEPT OF MINDFULNESS, ITS ROOTS AND CURRENT RELEVANCE IN PREVENTING AND TREATING PSYCHIATRIC CONDITIONS, ESPECIALLY THOSE RELATED TO STRESS, MOOD AND ANXIETY.

A few role-playing scenarios and videos clearly showed that, even in a room of researchers, scientists and academics, most are not as aware or present as we expected (or hoped). This interactive and engaging session was complimented by Whitesman's understanding and passion for the topic, which kept the audience hooked and left wanting for more.

A workshop on medically unexplained symptoms and chronic pain was presented by a team including staff from Stellenbosch University and the University of Cape Town.

THE FOCUS OF THE WORKSHOP WAS ON DIAGNOSIS AND TREATMENT OF SOMATIC SYMPTOM DISORDERS, CONVERSION DISORDERS AND CHRONIC PAIN.

The presentations challenged participants to think more critically about mind-body dualism and the need for interdisciplinary approaches to dealing with these conditions. One of the key messages of the workshop was that there is clear value in considering biological mechanisms alongside psychological, inter-personal and socio-economic factors, in both the aetiology and management of somatic symptoms and conversion disorders.

It was clear from the richness of the case material presented and the level of discussion among participants, that this is an area of clinical practice which is challenging. Given the prevalence of somatic symptom complaints and recent advances that have been made in this area, there would seem to be a need for more professional development and training, particularly to equip those working in primary health care settings to effectively assess and manage patients whose physical symptoms cannot be adequately accounted for using bio-medical explanations.

ANOTHER PRE-CONGRESS WORKSHOP HIGHLIGHTED AND DEBATED THE POTENTIAL BENEFITS AND ADVERSE CONSEQUENCES ASSOCIATED WITH CANNABIS USE IN SOUTH AFRICA.

Presenters covered a number of topics relevant to mental health professionals around cannabis use and misuse. Common themes included the global prevalence of cannabis use and cannabis use disorders and the impact that changing policy regulations has had on the prevalence of cannabis related problems; the context of legalization of cannabis use (who can use it and where it can be used without legal repercussions) in South Africa; the negative consequences associated with cannabis misuse for vulnerable populations (adolescents and patients with severe mental illness); and the potential medical benefits of cannabis, particularly for the management of chronic pain.

In addition, the importance of additional research and appropriately designed studies emerged as a theme, both in assessing the relationship between cannabis use and co-occurring mental health issues, but also when evaluating the use of cannabis use for medicinal purposes such as for pain relief.

The conclusion was that more evidence is necessary before various cannabis ingredients such as CBD and THC can be unequivocally identified as having medicinal benefits through randomized controlled trials, the gold standard of research design.

AND FINALLY, A WORKSHOP WITH PHARMACOTHERAPY UPDATES PROVED TO BE ONE OF THE WELL-ATTENDED SESSIONS OF CONGRESS.

All of the presenters, who were affiliated with either Stellenbosch University or Pretoria, not only focused on the latest available information on diagnosis and treatment of a number of conditions such as psychotic disorders, trauma and stress related conditions and Alzheimer's disease, but also included several examples of how this would tie in with the theme of prevention, risk and resilience.

A comprehensive review of new developments in diagnosis and treatment of schizophrenia and first episode psychosis in children and adolescents was followed by a lecture on the latest pharmacotherapy guidelines for trauma and stress related disorders.

A pharmacological angle provided insights into drug-drug interactions, and what the core knowledge of the psychiatrist should be in this regard. Forensics was also brought into the discussion with a presentation that addressed the question on what we can learn from pharmacotherapy in forensic psychiatric practice.

AND FINALLY, THE WORKSHOP ALSO INCLUDED A PRESENTATION FOCUSED ON NEW DEVELOPMENTS IN THE TREATMENT OF ALZHEIMER'S DISEASE. IN SUMMARY, THIS WORKSHOP WITH ITS WIDE VARIETY OF TOPICS SHARED ONE CORE CHARACTERISTIC: CUTTING EDGE DATA ON PHARMACOTHERAPY AND RELATED ISSUES IN THE FIELD OF PSYCHIATRY AND MENTAL HEALTH.

2. THE SANS SYMPOSIUM

THE SANS SYMPOSIUM WAS HELD ON SATURDAY 16 SEPTEMBER. A VARIETY OF TOPICS, RELATING TO BASIC NEUROSCIENCE AND GENETICS RESEARCH IN AFRICA, WAS PRESENTED BY YOUNG RESEARCHERS FROM STELLENBOSCH UNIVERSITY, UCT, UKZN AND WITS.

THERE WERE TWO PLENARY SPEAKERS, DR JOE RAIMONDO FROM UCT STARTED THE SANS SYMPOSIUM OFF WITH A VERY WELL-ATTENDED PLENARY LECTURE ENTITLED "GABAERGIC TRANSMISSION IN EPILEPTIC SEIZURES: A GOODIE TURNED BAD?". PROF JOAN KAUFMANN, FROM THE SCHOOL OF PUBLIC HEALTH AT JOHNS HOPKINS UNIVERSITY, ENDED THE FIRST SESSION OFF WITH HER PLENARY LECTURE ENTITLED "PROMOTING RESILIENCE IN MALTREATED CHILDREN".

THIS YEAR REPRESENTED THE FIRST TIME THAT WE HELD A PSYCHIATRIC GENETICS SYMPOSIUM AS PART OF THE SANS SYMPOSIUM. THIS WAS A WELL-ATTENDED SYMPOSIUM FOCUSING ON PSYCHIATRIC GENETICS IN AFRICA. PRESENTATIONS BY EXPERTS FOCUSED ON METHODOLOGIES CRUCIAL TO THE FIELD OF PSYCHIATRIC GENETICS, SUCH AS STATISTICAL AND BIOINFORMATICS METHODOLOGY (DR CHIMUSA, UCT), AND GENETICS AND EPIGENETICS IN PSYCHIATRIC GENETIC RESEARCH (PROFS SCHULZE (LUDWIG MAXIMILLIAN UNIVERSITY, GERMANY), HEMMINGS (STELLENBOSCH UNIVERSITY)). IN ADDITION, A PRESENTATION ON TIPS FOR SUCCESSFUL GRANT WRITING WAS ALSO INCLUDED (PROF KUIVANIEMI, STELLENBOSCH UNIVERSITY). THE PSYCHIATRIC GENETICS SYMPOSIUM CONCLUDED WITH A "QUESTIONS FOR THE EXPERTS" SESSION, WHICH GENERATED SOME INSIGHTFUL AND OFTEN LIVELY INTERACTION AND DISCUSSION.

Sian Hemmings, is a Professor in the Department of Psychiatry, Stellenbosch University. She heads the Psychiatric Genetics research group. She obtained her MSc and PhD from Stellenbosch University, and has been involved in psychiatric research for the past 15 years. Her research interests include investigating the molecular aetiology of PTSD and stress-related disorders, by conducting genetic, epigenetic, transciptomic and microbiomic studies. She also works on fetal alcohol spectrum disorders (FASD). **Correspondence: smjh@sun.ac.za**

The Imizama Yethu dance group at the Congress Dinner

Prof Soraya Seedat announcing prize winners at the Congress Dinner.

Dr Alison Bentley: "The Role of Melatonin in Treating Insomnia" Talk

UPA & AFCNP 2017 JOINT SCIENTIFIC CONFERENCE

18 -19th JULY, SILVER SPRINGS HOTEL, KAMPALA

DICKENS AKENA

The Uganda Psychiatry Association and African College of Neuropsychopharmacology (AfCNP) joint scientific conference took place in Uganda, at the Silver Springs on 18th and 19th July 2017, and was attended by over 200 delegates.

The conference was convened by Dr Dickens Akena, a Psychiatrist at Makerere University in Uganda, and supported by the Stanley Centre for Psychiatric Research at the BROAD institute of MIT and Harvard, the Lundbeck International Neuroscience foundation, Phillips Pharmaceuticals Uganda, Makerere University Department of Psychiatry, The Department of Psychiatry and Mental Health at the University of Cape Town, and Uganda.

The local organizing committee was comprised of Drs Noeline Nakasujja, Catherine Abbo, Emmanuel Mwesiga (from Makerere University), and Drs Brian Mutamba, and Dr Sylvia Nshemereirwe from Butabika Hospital. The international faculty included Prof Dan Stein (University of Cape Town), Prof Joseph Zohar (Tel Aviv University), Prof Karestan Koenen (Harvard TH Chan School of Public Health), Prof David Baldwin (University of Southampton), and Prof Bonginkosi Chiliza (University of KwaZulu Natal).

There were a total of 29 lectures, 4 break away symposia and two key note lectures.There were separate meetings for the AfCNP, African Psychiatry Association (APAP), Neuro-GAP, and the Young Psychiatrists of East and Central Africa (EAYPTA).

The key note addresses were delivered by a). Prof Seggane Musisi who gave a talk about ` Mental Health in Africa, the past, present and future, challenges and opportunities' and b). Prof Dan J Stein's talk, entitled `DSM-5 vs ICD-11 vs RDoc: An Integrative Perspective'.

Dickens Akena

ACTIVITIES OF DAY 1: 18TH JULY 2017

1. THE AFCNP LECTURE SERIES

a). Prof Joseph Zohar, introduced the Neuroscience based nomenclature and gave a live demonstration of the NbN app. The application, which can be downloaded from Google Play and iTunes App Store, provides a succinct account of the available medications used in the treatment of common mental illnesses. Prof Zohar donated 100 books that contain information found in the application to the conference attendees.

b). Prof David Baldwin, gave a lecture about antidepressants and sexual dysfunction. He emphasized the need to assess for the common but often neglected sexual dysfunction in patients with depression. Prof Baldwin provided a detailed account of available antidepressants and the rationale for choosing each, taking into consideration the sexual side effects (and how they can be treated)

c). Prof Bonga Chiliza gave an update lecture about Psychosis treatment options. This talk centred on the indications of antipsychotics, their mechanisms of actions, and side effect profiles

29 LECTURES 4 BREAK AWAY SYMPOSIA

d). Dr Gerhad Grobler gave an update lecture about cognition and sleep problems in Bipolar Disorder. Dr Grobler emphasized the need to assess for sleep and cognitive problems in patients with Bipolar Illness and how these can be addressed.

2. THE NEUROPSYCHIATRIC GENETICS IN AFRICAN POPULATIONS (NEURO-GAP-P) – PSYCHOSIS LECTURE SERIES

a). Prof Karestan Koenen lectured about the role of genetics in psychopharmacology, heredity of psychiatric disorders and the need to explore the genetics of psychiatric disorders in Africa. Prof Koenen stated that Africa is lagging behind in the field of genetics and mental health, yet it has the highest genetic diversity. The Neuro-GAP project which is led by Prof Koenen seeks to answer a number of questions in this regard.

b). Prof Lori Chibnik lectured about the Global Initiative for Neuropsychiatric Genetics Education in Research (GINGER) program, which is a capacity building initiative for scholars from resource limited settings. The GINGER program is complimentary to the Neuro-GAP; both are funded by the Stanley Centre

c). Dr Jantina de Vries talked about 'Ethical Considerations in Genomics Research in Africa: evolving considerations of informed consent'. Dr de Vries' talk centred around the importance of having robust mechanisms in place to protect the rights of mentally ill patients who are involved in genetics research.

d). Prof Zukiswa Zingela lectured about the challenges of conducting neurogenetic research in under resourced areas. Top of her agenda was the limited resources needed to conduct such high calibre research that is a necessity in Africa.

3. THE IMPLEMENTATION SCIENCE LECTURES (BREAK AWAY SESSION 9-11) WERE DELIVERED BY

a). Dr Brian Mutamba (Service user involvement in mental health care, successes, challenges and opportunities: brain gain in Uganda,)

b). Dr David Basangwa (practicing mental health in low resource setting) and

c). Dr Fred Kigozi (Development and implementation of a district level mental health care plan Kamuli district – Uganda).

4. THE CHILD AND ADOLESCENT PSYCHIATRY LECTURES (BREAK AWAY SESSION 14-17) WERE DELIVERED BY

a). Dr Justine Namuli (Knowledge about childhood autism and challenges in management among health care providers in Mulago and Butabika), b). Dr Christy Denckla (clinical features of an autism cohort in Nairobi, Kenya), and c). Prof Charles Newton (psychiatric comorbidity of epilepsy in Africa).

Official Opening ceremony: The conference was officially opened by Prof Sam Maling, Dean, Faculty of Medicine, Mbarara University of Science and Technology.

DAY 2: 19TH JULY 2017.

The first activity of the day was the East African Young Psychiatrists and Trainees Association (EAYPTA) symposia. The 40 members of the EAYPTA shared their experiences under the mentorship of Prof Dan Stein, Prof Eugene Kinyanda and Dr Noeline Nakasujja.

The keynote speech was given by Prof Dan Stein who talked about the DSM-5 vs ICD-11 vs RDoC, highlighting some of the historical aspects of classification systems, their strengths and weaknesses. Prof Stein noted that mental health nosologies have become, and will only become better with time.

1. THE FORENSIC PSYCHIATRY AND SPECIAL POPULATION LECTURE SERIES WAS CHAIRED BY DR JANET NAKIGUDDE AND DELIVERED BY

a). Prof Solly Rataemane (Adult ADHD),

b). Prof Emilio Ovuga (Decriminalization of suicide in Uganda),

c) Lt Denis Koire of the Uganda People's Defence Forces(mental health in the Uganda Military), and d) Assistant Commissioner of Police, Dr Emmanuel Nuwamanya (Mental Health and Police Work, the Ugandan perspective).

TWO KEY NOTE LECTURES

Delegates

2. THE VULNERABLE POPULATIONS LECTURE SERIES WAS CHAIRED BY PROF ZINGELA AND DELIVERED BY

a). Dr Noeline Nakasujja(Cognitive deficits among the elderly in SSA),

b). Dr Paul Bangirana (the patterns and long-term neuropsychological outcomes of traumatic brain injury (TBI) in Uganda).

c). Dr Scholastic Ashaba(bullying and depression among adolescents in Uganda), Dr. Janet Nakigudde ('Perceptions and practices of mental health researchers regarding ethical considerations in research involving mental health participants in a low resource setting').

3. IMPLEMENTATION SCIENCE SYMPOSIA WAS CHAIRED BY DR BRIAN MUTAMBA AND DELIVERED BY

a). Mr David Kyaligoza (The role of psychiatric nurses in delivery of mental health services in Uganda),

b). Mr Emmanuel Ngabirano (improvement of access to mental ealth services among refugees: the experience of TPO),

c). Prof Eugene Kinyanda (integrating the management of depression in routine HIV care in Uganda: Introducing the HIV+D Trial),

d). Prof Atwoli Lukoye (building capacity for mental health research in SSA)

4. CLOSING CEREMONY:

Dr Akena thanked participants and wished them safe journey back home.
Dr David Basangwa closed the conference.

Dickens H Akena is a Psychiatrist and Lecturer, Department of Psychiatry, Makerere University College of Health Sciences, Kampala, Uganda. **Correspondence: akenadickens@yahoo.co.uk**

ELECTION RESULTS

COLLEGE OF PSYCHIATRISTS
TRIENNIUM 2017 - 2020

The Council will be empowered to co-opt additional persons if deemed necessary to improve representation on a geographic or demographic basis, or to ensure university representation.

PRESIDENT	Prof S Seedat
SECRETARY	Dr S Ramlall

REPRESENTATIVES ON SENATE:

Prof S Seedat

Dr B Chiliza

OTHER MEMBERS OF COUNCIL:

Prof A B-R Janse van Resnburg

Prof J A Joska

Dr K-A Louw

Prof U Subramaney

Dr M Talatala

WHAT SKILLS DO WE NEED TO PROVIDE MENTAL HEALTHCARE IN SOUTH AFRICA?

PROVIDER CORE COMPETENCIES FOR IMPROVED MENTAL HEALTH CARE USING A TASK-SHARING APPROACH: A CONSENSUS STUDY

The Academy of Science of South Africa (ASSAf) is conducting a consensus study on **Provider Core Competencies for Improved Mental Healthcare of the Nation.** We would like to take this opportunity to inform you about the study and to obtain your inputs. The inputs received are hoped to strengthen the study and make it more relevant for the country (including policymakers).

This study aims to:

1. Reflect on the human resource mix and the skills required to implement the National Mental Health Policy Framework and Strategic Plan (2013-2020) along the continuum of care from health promotion and prevention to treatment, rehabilitation and recovery.

2. Provide baseline data on the status of education and training in Mental, Neurological and Substance use (MNS) disorders provided to cadres who form the human resource mix for the delivery of integrated care within a task sharing model.

3. Provide recommendations on the competencies which this human resource mix should acquire through their education and training to ensure the provision of integrated services for MNS disorders.

The panel for this study is chaired by Prof Rita Thom (Wits University) and the other panel members are: Dr Robin Allen (DoH - WP), Prof Eve Duncan (UCT), Prof Gayle Langley, Ms Bharti Patel (SAFMH), Prof Crick Lund (UCT), Prof Bronwyn Myers (MRC), Prof Solomon Rataemane (SMU) and Prof Inge Petersen (UKZN).

ASSAf
ACADEMY OF SCIENCE OF SOUTH AFRICA

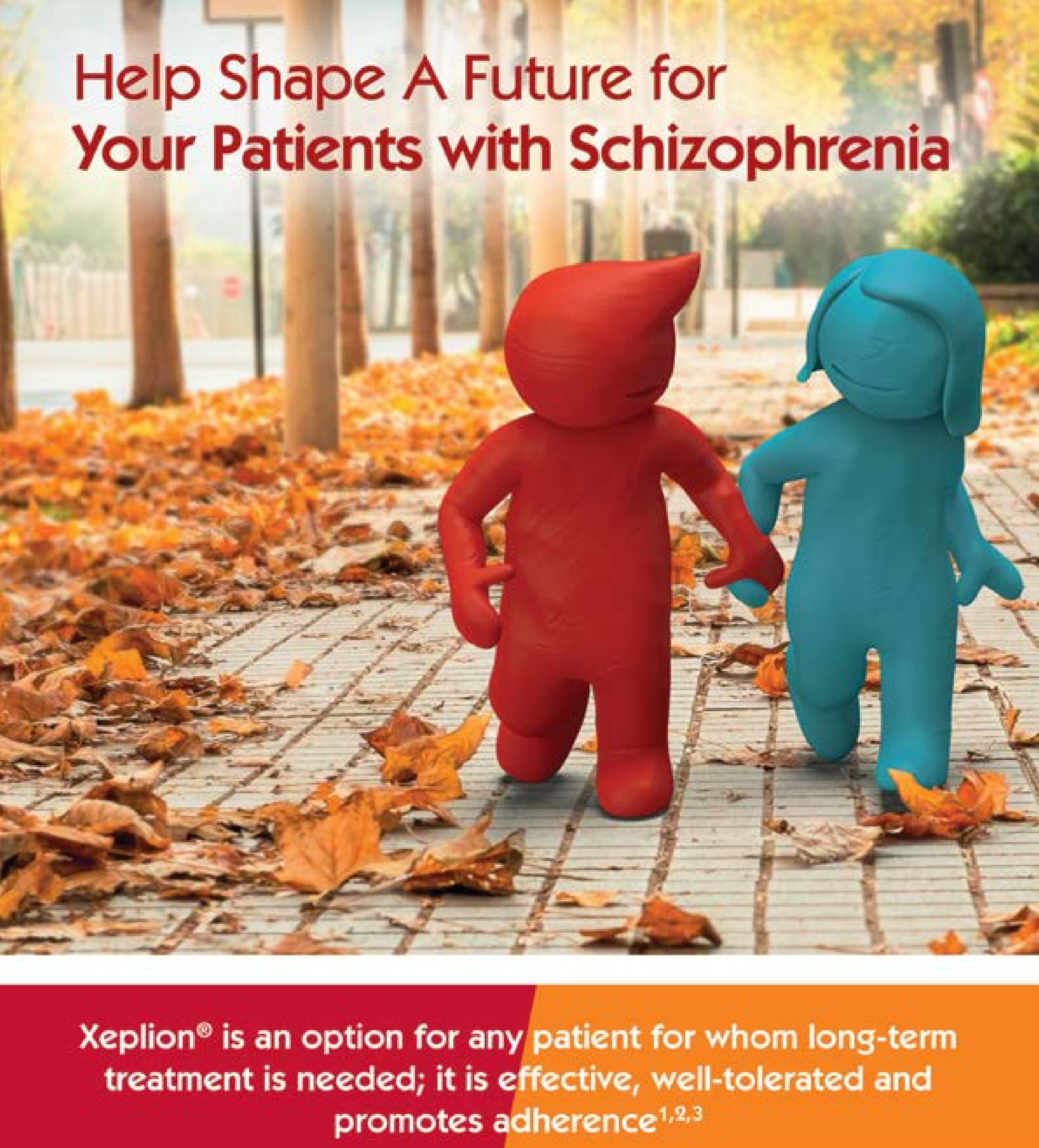
AN ELECTRONIC SURVEY IS CURRENTLY BEING DISTRIBUTED TO SERVICE PROVIDERS, EDUCATORS AND SERVICE USERS. PLEASE NOTE THAT YOU CAN COMPLETE THE SURVEY BOTH AS A SERVICE PROVIDER AND AS AN EDUCATOR IF YOU FULFILL BOTH ROLES.

The survey can be accessed on the ASSAf website **(http://www.assaf.org.za)** If you are not able to access the survey by the end of November,and would like to participate, please contact Khutso Phalane **(khutso@assaf.org.za)**or Ashley Govender **(Ashley@telkomsa.net)**.

If you would like to learn more about the study, or would like to contribute in any other way, please let us know.
I look forward to your inputs.

Yours sincerely,

Rita Thom
Panel Chairperson of the ASSAf Consensus Study
rita.thom@wits.ac.za



NATIONAL PUBLIC MENTAL HEATLH FORUM FOR REGISTRARS

Mohamed Faadiel Williams

SEPTEMBER 2017

The second National Registrar Public Mental Health Forum took place on the 14th of September 2017 at the Lord Charles Hotel in Somerset West.

It was hosted by the Division of Public Mental Health (DPMH). The DPMH originates from the University of Cape Town. It has in recent times, enjoyed input from the University of Stellenbosch as well. The plan is to further strengthen cross university collaboration.

The DPMH works in collaboration with the Alan Flisher Centre for Public Mental Health (www.cpmh.org.za) which is a cross university centre involved in several exciting multinational projects and houses our academic programmes e.g. MPhils and PhDs. The DPMH is the more operationally and clinically based arm. The DPMH also produces academic outputs, most notably post and undergraduate teaching and training. A full registrar syllabus has been developed over the last decade or so.

THE FORUM WAS FUNDED BY SANOFI, THE COLLEGE OF MEDICINE OF SOUTH AFRICA AND THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS. IT WAS INITIATED BY PROF. C SZABO AND CONVENED AND ORGANIZED BY DR. MF WILLIAMS.

The forum was held on the same weekend and at the same venue as the Biological Psychiatry Conference. This was strategically suggested by Prof. S Seedat in order to attract more registrars to both events. The forum was then nestled into the morning session prior to the commencement of the conference.

Mohamed Faadiel Williams

Each psychiatric department was asked to nominate 3 registrars who were preparing to sit their final exams. 28 registrars attended from 8 psychiatric departments. There was a total of 37 attendees (including the lecturers and some sponsors).

The forum compromised content deemed important for the College Part II Exams. Three lecturers made specific reference to examples of past questions set on their respective topics. There was a fair amount of interaction in the lectures. Given the time constraints, however, lectures had to be largely didactic and limited to 30 minutes each. It was decided to deliver 'bite-sized' lectures in order for registrars to get a fuller sense of the wide array of topics in the field.

The lecture topics included:

- Introduction to Public Mental Health (Prof. C Lund)
- Interventions to Prevent Mental Disorders (Prof. S Seedat)
- Stigma and labelling theory (Dr. MF Williams)
- Assertive Community Treatment (Dr. Q Cossie)
- Mental Health Economics (Dr. R Allen)
- Recovery (Dr. J Parker)

ANONYMOUS FEEDBACK COLLECTED WAS GLOWINGLY POSITIVE (N=11):

- The general quality of the lectures was very well received. 8 registrars thought it was "excellent" (score of 5/5); 2 registrars thought it was "good" (score of 4/5) whilst 1 registrar was arguably free thinking and created his/her own score of 4.5/5. Average score was 4.5/5.
- The general usefulness of the forum was also well received: 9 registrars gave it a score of 5/5 and 2 registrars scored it 4/5. Average score was 4.81/5.
- All 11 surveyed registrars wanted more such forums in the future.

When asked for further comments: several registrars responded with 1 word answers: "Inspiring", "Exciting", "Motivating" and "Excellent!!!". Others provided longer inputs: one registrar wrote: "I found this talk so inspiring. It is easy, in our setting, to feel disheartened. I felt inspired that merely changing our attitude can affect stigma and provide hope to patients by encouraging them to be 'in recovery'. It is inspiring to realize how we can influence policy and public health." Two registrars noted that these topics were not specifically covered in their syllabus. One registrar commented that he/she "would have liked the lectures to be longer" whilst another registrar particularly enjoyed the brevity of the lectures. Another registrar also asked us to fulfil our promise to disseminate the lectures electronically as it was "valuable" and reported that this promise had been often reneged on at other events. Whilst a final comment was: "I like your passion for the people".

Our warmest thanks to all our sponsors, lecturers and aides for what was a reportedly well-received and highly successful forum. A special word of appreciation to Prof. C Szabo for initiating this forum and graciously entrusting it to the Division of Public Mental Health. A gargantuan thank you to Prof. S Seedat for her invaluable assistance and advice in setting up this event. Thanks to Sonja du Plessis from Londocor for the efficient event co-ordination and logistics.

Our hope with this forum is that it will further empower the activism and leadership of our soon-to-be fellow Fellows in this enterprise of ours. Our enterprise should be/is one of excellent, evidence based mental healthcare provision with the broader imperatives of nation-building and sterling service to humanity.

We would like to make this a more regular feature. Preliminary talks with our sponsors in this regard have already begun…

ALUTA CONTINUA, AMANDLA AWETHU.

Mohammed Faadiel Williams is a psychiatrist and The Chair of the Division of Public Mental Health, Department of Psychiatry and Mental Health, University of Cape Town; Consultant Psychiatrist, Lentegeur Hospital; Owner of Serenity Clinic and philanthropist.
Correspondence: drmfwilliams@gmail.com

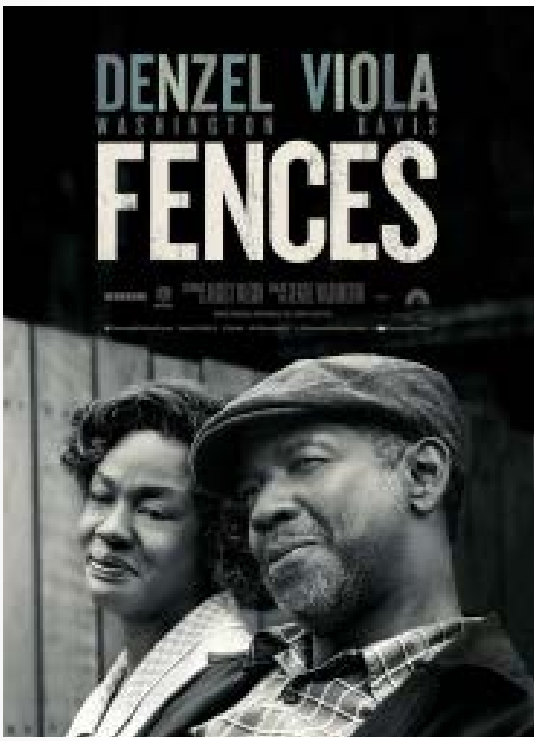
FENCES

A film review by Franco P. Visser

A Paramount Pictures /
Bron Creative / Marco Media Presentation
Scott Rudin Producer
Denzel Washington Director

There comes a time in people's lives when they start building fences – fences around them, fences around others, "fences to keep people in and fences to keep people out". Whether it be due to our experiences, our interaction with others, or due to something in our past, we build fences mainly in order to protect our sense of security and existence.

Let's face it – the world is most certainly becoming more challenging every day, and fences are sometimes borne out of necessity for self-preservation. Sometimes though our fences can become so constricting to the point of suffocation, not only for others in our lives but for us too. Room to breathe becomes scarce and we end up pushing others away in the process.



Fences, the film that I have chosen for this issue is a 2016 Paramount Pictures release that received four Oscar nominations, one of which Viola Davis won (Best Supporting Actress) for her portrayal of Rose Maxon, the wife of Troy Maxon (played by Denzel Washington).

Troy is a man with a very difficult past and an even more difficult personality and outlook on life. Troy comes from a very troubled background that saw him doing prison time for robbery and murder. He was a gifted baseball player, playing for the then so-called 'Negro Leagues' although Troy never made it to the Major Leagues.

Troy's abusive childhood, his imprisonment and the fact that he did not make it to Major Leagues became in essence the foundation for his very difficult character. Naturally, this spells disaster for his home life and the people in it.


Franco P. Visser

Troy's eldest son from a previous relationship, Lyons (played by Russell Hornsby), is a gifted musician who only visits his father on paydays in order to borrow money from him. Troy does not support Lyons' musical abilities and he never once visits Lyon at the club where he is playing. Troy insists that Lyons should find himself a 'real' job and their relationship inevitably suffers because of Troy's stance towards him.

Rose and Troy also have a son of their own, Cory (played by Jovan Adepo) who is showing remarkable talent as a football player. Again, Troy does not support this, also insisting that Cory finds himself a 'real' job. It is not difficult for the viewer to see how Troy's behaviour and stifled interpersonal relationships suffocates those around him.

Troy also has to fight his own demons albeit unsuccessfully due to his inability to allow others into his world and his emotional processes.

Troy's motto seems to be "a man's gotta do what is right for him" and this clearly excludes the needs and desires of his wife and two sons. The plot becomes even more complicated when Troy comes home one day and tells Rose that he has fathered a child with another woman. This news naturally breaks Rose's heart, and whilst she continues to care for herself, Troy and Cory, she is emotionally and physically not available for Troy anymore.

FENCES

Late one night the telephone rings and Rose gets up to answer it. Troy's baby was born, although the mother of the child died during the birth process. Troy brings the baby girl home and asks Rose to care for the baby which she ends up doing, although she tells Troy that she will do everything for her family including caring for his daughter, but that he was now a 'womanless man' due to his indiscretions.

To add to the already heavy and difficult dynamics that play out between Troy and his family members, Troy has a younger brother Gabriel (played by Mykelti Williamson) who sustained a severe head injury during World War II. Troy used Gabriel's money that he received from the U.S. government to buy a house for himself and his family.

Gabriel used to live with Troy, although he moved out into a rented room somewhere else in the neighbourhood. Gabriel has an affinity for collecting trumpets in addition to a very strong religious fixation, something that he and his brother share on some level. Troy survived a serious bout of pneumonia whilst he was a child, and he firmly believed that he had it out in a fistfight with the 'Grim Reaper'. He also believes that the 'Grim Reaper' told him that he will return for a 'rematch' of sorts.

Set in Pittsburgh in the 1950s, Fences is a complicated yet brilliantly observed period drama that is an emotional rollercoaster ride from beginning to end. I have never viewed a complicated and intense story like this before suffice to say that this movie is worth viewing despite the heavy emotionality contained in it.

FENCES IS A MOVIE THAT MAKES YOU, AS THE VIEWER, AWARE OF YOUR OWN 'FENCES', BELIEFS, PREJUDICES, FIXATIONS AND TROUBLE SPOTS IN YOUR LIFE. BUILDING FENCES AROUND YOU IS ONE THING, BUT MAYBE THE CHALLENGE IS TO KNOW WHEN TO START BREAKING THEM DOWN IN ORDER TO ALLOW LIGHT AND OTHERS BACK INTO YOUR LIFE. UNTIL NEXT TIME, ENJOY THE MOVIE!

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

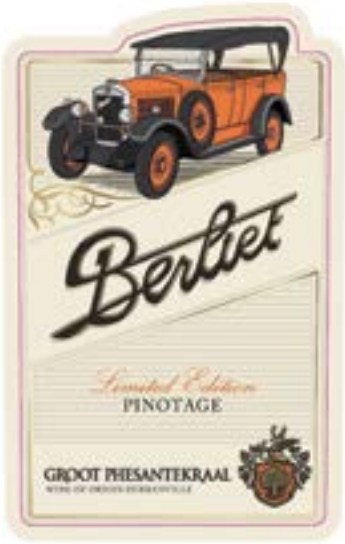
DURBANVILLE GEM DISCOVERY

David Swingler

When 'i' becomes 'e', 's' out of 'zee', and two become one…

And thus, Phizante Kraal becomes Groot Phesantekraal!

Shrew… OK, let me take you through this. One of Durbanville's oldest farms that is now Groot Phesantekraal, was allocated by Cape Governor Simon van der Stel to Captain Olof Bergh in 1698. (His name lives on as one of the Cape's rare aged brandies produced by the multi-level solera system.)



The current Brink Family lineage commenced here when Arend Brink bought the land from the Louws – ubiquitous in the valley – in 1897. It was deployed to mixed grain and livestock farming until the current, fourth generation custodians André and Ronelle Brink planted 50 ha (of the 840 ha expanse) to vines in 1996. The property was both historically and colloquially also known as 'Phizante Kraal', which was the moniker they chose to launch their own, private-label bottling of wine from just ten tons of grapes, in 2005.

But wait! The producer registration at the regulatory South African Wine Information and Systems (SAWIS) is 'Groot Phesantekraal', not the bottle-borne 'Phizante Kraal'. And so, to align history, registration and commerce, the range is being refreshed and rebranded as Groot Phesantekraal.

David Swingler

It's not all just wine, of course. Sure, there is a both a tasting room which walls are stacked with apothecary glass bottles housing a vast selection of herbs, spices and teas, and a grassed outdoor terrace where the wines can be sampled with the majestic views of the valley tossed in for free. Or indeed, the original chicken coop (refurbished…) adjacent, where private tastings are held.

There is also a singular restaurant – 'elegantly rustic' is how the Brinks like to describe it – in the original stable dating back to 1767; think white-washed walls, original stone floors, open-beam thatched roof, and the original feeding troughs. Culinary appointments are, however, modern!

The Restaurant's unique selling point is Saturday Brunch, being the only wine farm in the valley offering one. The small but eclectic menu changes with the seasons as much of the produce is sourced on the farm. Salmon with scrambled eggs, pickled red onion, crème fraiche, avocado puree & Parmesan has featured, along with Chorizo & Bean Stew with poached eggs and Pork Belly with pumpkin rosti for sturdier appetites.

Groot Phesantekraal

Groot Phesantekraal Blanc de Blanc 2015

André and Ronelle Brink with Etienne Louw

Groot Phesantekraal restaurant

Pork Belly

Tasting Room

Breakfast Tuesday to Friday headlines 'The Full Farmer', and has included Sweet Corn flake brioche French Toast with peanut butter cream, caramelized banana, nut brittle, a drizzle of honey and salted caramel – add bacon if you choose – as well as Caramelised Onion and Cheese Tart. Examples of lunch service are Pumpkin Gnocchi accompanying garlic-&-thyme pan-seared thin Kudu loin served medium rare with sesame-dressed burned cabbage, baby spinach & orange jam in attendance. There's also sirloin steak, lamb curry and other plates for simpler tastes.

While vines were planted on the property as early as the Eighteenth Century, modern day winemaking here was courtesy of Brink family friend, Thys Louw of Diemersdal Estate, Latterly, Altydgedacht's Etienne Louw has taking over capturing the essence of the grape in a glass.

The new bottled-fermented bubbly, 2015 Blanc de Blanc, has a languid bead and deeply satisfying biscuit notes with a refreshing elegance from the all-Chardonnay grape origins. Durbanville is nothing if not Sauvignon Blanc country and the 2017 Groot Phesantekraal garnered a Veritas Double Gold Medal and Top 10 status at the FNB Top 10 Sauvignon Blanc Awards – the fourth time that the 'Savvy' placed in the Top 20, and the second time in the Top 10.

A personal favourite is the 2017 Chenin Blanc eked from 55-year-old bush vines, more so that it's generous stone-fruit & pear flesh tucked up in a lip-smackingly fresh finish is on offer for R50 a bottle on site. Red wines include a respectable Cabernet Sauvignon, a redoubtable Shiraz, and a new Pinotage 'Berliet' that will thrill lovers of our very own grape.

Just twenty minutes from Cape Town, Groot Phesantekraal lies within the Tygerberg Hills, which used to be a specific 'District' of the Coastal Region of the Wine of Origin system. No more. After repeals – including 'Cape Peninsula' – earlier this year, a 'Cape Town' District was introduced. It is comprised of Constantia, Hout Bay, Durbanville and Philadelphia. Expect to see it more often on bottles, being a hit with tourists! (Durbanville grown and made wines can now be labelled any of Wine of Origin Coastal (non-descript), Cape Town (attractive) or Durbanville (for the purists).)

By the way, when heading out to Groot Phesantekraal, be sure to turn right into Wellington Road (a continuation of R302) off Durban Road (R302 off the N1 north), otherwise you could be heading further north, away from this action, on Vissershok or Koeberg Roads. The city is quickly behind you…

GROOT PHESANTEKRAAL
Tasting Room: wines@phesantekraal.co.za
Restaurant: venue@phesantekraal.co.za Tel: 021 825 0060
Groot Phesantekraal Farm Klipheuwel Way (R302)

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

A MEANINGFUL MEAL OF PSYCHIATRIC AND PSYCHOLOGICAL INFORMATION

Chef: Ethelwyn Rebelo

What follows is a menu to prepare you for the holidays.

As an hors d'oeuvre, an interesting dish is offered of how ergotism inspired some great European Renaissance painters in their depiction of a religious figure known as St Anthony. The latter died as a result of this poison, with the terrible hallucinations of fire it evokes.

The main course consists of some exciting news relating to drawing people out of a vegetative state by means of vagal nerve stimulation.

As a refresher, there is some research which concludes that young people with Bipolar Mood Disorder do not decline cognitively and that the lowest functioning of these are likely to benefit from cognitive remediation and medication.

When better to indulge on desserts than the holidays? One can always lie in bed afterwards. Hence some notes on Freud's use of the couch in therapy are presented. This is accompanied by an account of the growing popularity of text therapy; the use of Ecstasy in treating people with Post-Traumatic Stress Disorder; and a sweet and sour pudding on women's motivations for sex.

Finally, there is an extraordinary little `piece de resistance', included to keep your spirits high. It is best enjoyed with a pinch of salt.

HORS D'OEUVRE

THE INFLUENCE OF A LITTLE KNOWN HALLUCINOGEN ON RENNAISSANCE PAINTING

Ethelwyn Rebelo

Ergotism is contracted by ingesting the ergot fungus which appears in cereal grains, most commonly rye. It then produces nausea, depression, agitation, insomnia, a delusion that includes feelings of self-accusation or mysticism, and hallucinations that commonly include animals and fire.

During the European Renaissance, these symptoms were difficult to distinguish from the Bubonic Plague and episodes often resulted in the amputation of limbs due to gangrene or ended in death.

Paintings of St Anthony, who was said to have been tempted by the devil with jewels and seductive women, have often been influenced by the effects of Ergotism in their depictions. Examples of these artists include Pieter Bruegel the Elder, Jan Mandijn, Nikolaus Hagenauer and Mathias Grunewald.

Examining the imagery in Hieronymus Bosch's painting, specifically the Anthony Triptych, fires are revealed as raging in the background. Fires are found in many of Bosch's painting and in the work of other artists depicting St Anthony. One of a pair of Magi in the centre panel has wide eyes and perhaps intentionally diluted pupils. In the centre panel, Anthony looks like a strung out Dead Head at the end of a two day acid trip.

In 1928, Albert Hoffmann, a Swiss Chemist searching for a pharmaceutical for postpartum bleeding by making use of ergot fungi, accidentally sythesized the psychedelic drug, LSD-25.

MAIN COURSE

THE EXCITED VAGAL NERVE

By making use of a pioneering therapy which stimulates the vagus nerve, Corazzol, Lio and Lefevre et al (2017) managed to draw a 35 year old man out of a vegetative state. This person had sustained brain injuries in a car accident some fifteen years earlier. In surgery lasting about twenty minutes, an implant was inserted around the vagus nerve in his neck.

After a month of vagal stimulation, his attention, movements and brain activity improved and he obtained a state of minimal consciousness. He began to respond to simple requests such as being asked to turn his head; he was able to stay awake while being read a story; and his eyes opened wide in surprise when the examiner suddenly moved her face close to his. While still paralyzed and unable to speak, he has become more aware and responsive.

The researchers note that recordings of his brain activity have revealed signs of increased electrical communication, both between brain regions, as well as in those areas linked to movement, sensation and awareness. It is hoped that the same technique will produce greater success when applied to patients with less serious brain damage or to those whose brain stem has been injured but whose cortex remains intact.

HEMINGWAY'S CHRONIC TRAUMATIC ENCEPHALOPATHY

In the Psychiatric Times, Sydney Smith (2017) interviewed the author of a new biography of Ernest Hemingway.

In his book, titled `Hemingway's Brain', Andrew Farah (see ingredients) explains that there is a great deal of evidence that the writer was primarily a victim, not of Bipolar Mood Disorder as has been commonly believed, but of chronic traumatic encephalopathy as a result of the numerous serious concussions he sustained throughout his life, together with his alcoholism, untreated diabetes and hypertension. Farah notes that while he was prone to depression when he felt he could not work as a result of his injuries and mental difficulties, he never had a truly manic episode.

He points out that the etiology of his symptoms have to be greatly rooted in his many head injuries and their cognitive implications. In addition to boxing and playing rugby, during World War I a trench mortar bomb lit a short distance away from Hemingway, blew him several feet and covered him with earth. In Paris in 1928, after coming home late from partying with friends, he attempted to pull the cord of a commode and accidentally grabbed a wire attached to a cracked skylight, causing it to fall on to the left frontal region of his head.

These incidents were followed by a fall from the fly-bridge of a fishing boat; a serious car accident in London during the blitz, as a result of which he required 57 stitches to the frontal area of his head; three more concussions during World War II; another motor vehicle accident in Cuba and two plane crashes in Africa during a 1954 Safari.

After the second crash his cognitive decline was apparent to most people and he was evidently suffering from CTE, a mixed dementia and depression. In order to treat the latter, ECT was administered to him. This caused him to decline even further so that he ended up committing suicide.

Farah notes that patients who decline after ECT often have an undiagnosed organic brain disease, which he argues was the case with Ernest Hemingway, considered by many to have been among America's finest novelists.

REFRESHER

NO COGNITIVE DECLINE IN BIPOLAR YOUTH

There have been relatively few studies investigating the trajectory of cognitive functioning in young people with Bipolar Disorder. It has emerged in a recent study exploring cognitive decline over time in these individuals that their intellectual functioning does not deteriorate (Frias, Dickstein & Merranko et al, 2017).

The findings of the authors were based on their assessment of 135 participants on the Cambridge Neuropsychological Test. These assessments were carried out on three occasions over two and a half years. They concluded also that cognitive remediation and pharmacological treatment could improve the performances of low functioning young people.

This was the group who exhibited a greater prevalence of Attention Deficit Hyperactivity Disorder and had suffered for longer periods from manic and depressive symptoms. As a consequence they functioned in a persistently impoverished fashion on measures of global, social and academic functioning.

DESSERT

FREUD'S COUCH

Have you ever wondered why Freud's patients were required to lie on a couch rather than an armchair? In his 1913 essay `On Beginning the Treatment' (see ingredients) the father of psychoanalysis explained that its historical basis was a remnant of the hypnotic method. He had however retained its use in order to help with isolating the transference. In a book on the history of the analytic couch, Kravis (2017) traces the tradition of recumbent speech back to several places. For example, in ancient Greece, upper-class males reclined on couches at the symposium as they discussed philosophy and drank wine. Lying down to obtain knowledge and inspiration also has roots in the Greek practice of `incubation' which involved sleeping in a temple in the hope of receiving a divine visitation in a dream. There are other precursors to the development of the couch as an icon of self-knowledge, self-reflection and healing - all of which Kravis explores in his text. Freud, it should be noted, also confessed that he had a personal motive for making use of a couch. He could not put up with being stared at by people for hours each day.

THE RISE OF TEXT THERAPY

If you have been wondering about what the renowned existentialist psychotherapist and writer, Irvin Yalom, has been up to of late, the answer may surprise you. In addition to working on his memoir, `Becoming Myself', he is acting as an adviser to Talkspace. This is a mobile online therapy platform in which, for a small fee, users are matched with licensed therapists. Therapy sessions are then carried out by means of texting. Since November 2016, Talkspace's user base has grown by 70% more than was initially projected. Lyford (2017) who writes about the phenomenon in a column for the Psychotherapy Networker, quotes Yalom's initial response to the idea. He thought it a distortion, a dehumanization and a parody of the therapy process. After being asked to supervise the therapists on the application and observing its workings, he noted with surprise that

even after clients were offered the opportunity to meet their therapist via live videoconferencing and to leave voice messages for them, most preferred texting and declined other forms of contact. According to Lyford, Yalom noted that although it is not the same therapy as that offered in face-to-face encounters, it still has value. For example if clients have a panic attack in the middle of the night, they can text their therapist. While the therapist may not read the text for hours, it is still a form of immediate contact. Furthermore, he points out that clients can easily review their entire therapy, word for word, and in this way gauge how much progress has been made.

The issue of the strengths and weaknesses of text therapy and it's role in supplying mental health care is still very much debated. There are signs, however, that while it may still evolve in different ways, it is here to stay. Perhaps Freud would have approved. It offers another opportunity, if you so choose, to avoid seeing the faces of those talking to you.

USING MDMA

The old man might have been truly excited by this latest frontier in the treatment of trauma. In a recent article in the Psychotherapy Networker, Howes (2017) a clinical professor at Fuller Graduate School of Psychology in Pasadena, California, interviewed Michael Mithoefer. The latter is a clinical faculty member at the Medical University of South Carolina and he is developing an experimental trauma treatment utilizing psychotherapy and MDMA (3,4-methylenedioxy-methamphetamine). The drug causes a release of serotonin, dopamine and norepinephrine. It also raises the levels of various hormones, including oxytocin.

The treatment proceeds as follows. First, participants who suffer from PTSD (and have not responded to prior treatment) are screened so that those with serious medical problems are excluded. An independent rater measures their levels of trauma on the Clinician Administered PTSD Scale (CAPS). They are then divided into an experimental group, who will receive MDMA, and a control group who will receive a placebo. Both groups then undergo three preparatory therapy sessions which last eight hours. After the experimental group have been given the MDMA, they are encouraged to focus inwardly. Depending on what issues emerge, therapists work non-directively, making use of both psychodynamic and cognitive-behavioural perspectives and interventions. After the session they sleep in the clinic with a night attendant and before leaving the following morning, they meet with their therapist for a further hour and a half.

Participants receive three MDMA sessions with monthly intervals and after each one they talk to their therapist over the phone for a week. They also meet with their therapist for two ninety-minute integration sessions before their next interventions with MDMA.

Assessing their results on the CAPS, Mithoefer and his fellow researchers have found that their experimental groups have tended to drop 55 points on the CAP, in comparison to the control group which drops 22 points. When members of the control group switch over into the next experimental group, they tend to drop a further thirty points or so.

Mithoefer explains that the reason MDMA is useful is because it decreases activity in the amygdala and increases activity in the prefrontal cortex. People with Post-Traumatic Stress Disorder tend to suffer from increased activity in the amygdala and decreased activity in the prefrontal cortex. The drug therefore gives people more time in an optimal arousal zone in which the brain is alert but not threatened. Hence they are neither dissociated from their emotions nor overwhelmed by them.

HOT DRINK

WOMEN'S MOTIVATIONS FOR SEX

In an analysis of women's motivations for sex, Carvalheira, Brotto and Leal (2010) explored women's motivations to engage in sex; the frequency of sexual fantasies; sexual arousal; and the association between relationship duration and these variables. They developed a questionnaire which they administered to 3687 women.

Their findings indicated that, after controlling for age, relationship duration was negatively correlated with frequency of initiating sex; women's satisfaction with their own sexuality and sexual satisfaction with their partners. The authors concluded that their results showed that there was a diversity in women's motivations for sex and there is evidence that responsive desire occurs in women with and without arousal difficulties.

They recommended that relationship duration. as well as the adequacy of partner sexual stimulation be recognized in future diagnostic frameworks of dysfunction - a piece of advice which appears not to have been heeded by those who constructed DSM 5.

EARLY MORNING HAPPINESS

In an article on morning erections, Youn (2017), a researcher from a university in Korea, points out that penile erections have generally been considered to be an epiphenomenon of REM sleep-related physiological changes for healthy men. He then goes on to question whether this aspect of sexual functioning may have evolved to ensure procreation and recreation in times of stress.

He explains that when men are under great psychological strain they often find it difficult to obtain and maintain an erection. They therefore may suffer from the loss of an erection as well as possibly from premature ejaculation. It would seem that if part of this psychological strain is linked to relationship problems with their partners, then on top of everything, they may fear initiating sex in case they get rejected. Youn states that when it is considered that women also experience clitoral enlargement during REM sleep, then one can deduce that they too are ready for sex at this time. Furthermore, given that they are semi-awake, they are less likely to resist their partner, even if they are uncomfortable with him. The solution to the sad couples' problems is, in Youn's opinion, for the man to go ahead, take advantage of biology, and have sex with his partner at this time.

He indicates that Korean couples apparently tend to believe that relationship problems can be solved with sex. While researching couples who were no longer sleeping together as a result of conflict, Youn says that he has met many women who, despite their relationship difficulties, had not rejected their husbands who came to their bed with penile erections while they were sleeping.

Youn thus concludes that sexual encounters as a result of REM sleep-related erections serve a palliative function and, he implies, a powerful couples therapy technique.

Just how much faith one can attach to his advice is, however, a matter for caution, particularly as he does not mention how many women he interviewed or how they were sampled. It is strongly advised that South African men reading this study discuss the issue with their partners first before becoming too inspired by its conclusions.

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CONSULTATIVE FORUM WITH SOUTHERN AFRICAN PSYCHIATRISTS

Mvuyiso Talatala

As part of the Dr Reddy's academic weekend held at the Mount Nelson Hotel, Cape Town, 10th June 2017, a consultative forum with Southern African psychiatrists was held.

In attendance were: Dr Samuel Likindikoki (Tanzania), Dr Frank Masao (Tanzania; Chair Mental Health Association of Tanzania), Dr Violet Mwanjali (Swaziland), Dr Francis Simenda (Zambia; ZPA President), Dr Lídia Gouveia (Mozambique; MPA President), Dr Wilza Gumo (Mozambique), Dr Hilen Ndjaba (Namibia), Dr Belinda Bruwer (Namibia), Dr Simon Kahonge (Kenya; Kenyan PA President), Prof Solomon Teferra (Ethiopia; Ethiopian PA President), Dr Munyaradzi Madhombiro (Zimbabwe; Chair Zimbabwean College of Psychiatry), Dr Keneilwa Molebatsi (Botswana), Dr Angel Chirwa (Zambia), as well as members of the South African Society of Psychiatrists' Board: Dr Talatala, Prof. Janse van Rensburg, Prof. Chiliza, Drs Seape, Robertson, Chetty, Lachman, Rama, Naicker, Seshoka, Johnson, Melapi, Vahed, Modisane, Narsi, Mpinda, Sibandze, Agambaram, Mashapu, Reddy, Zingela.

DR REDDY'S ACADEMIC WEEKEND

A Position statement on: **"A continental alliance for integrated mental health care in Southern Africa."** was developed[1], cognizant of the WHO "Global Mental Health Action Plan 2013-2020", with its main components:

(1) Leadership and governance

(2) Health and social services

(3) Prevention and promotion

(4) Information, evidence and research

as well as those of:

(1) The African Association of Psychiatrists' vision, mission and objectives;

(2) individual associations of psychiatry in individual countries

(3) the recommendations and position statement[1] of the WPA-WHO African Forum on "Continental Alliance for Integrated Mental Health Care in Africa"

(4) the objectives of the African Mental Health Institute with regards to collaborative research

The attendees of this consultative meeting agreed to collaboratively work in terms of including and strengthening psychiatric and mental health (1) service delivery, (2) training and (3) research in our respective countries, as well as building alliances with the different role players involved, including other professional societies involved in mental health, users of services and their families, mental health advocacy groups, the media, different levels of government, as well as private service providers.

OUR SHORT-TERM GOALS IN THIS REGARD INCLUDE:

- to establish organised societies in Namibia and Tanzania
- to pursue a follow-up meeting annually, 2018
- to extend the international membership of SASOP, KPA and EPA to psychiatrists from Lesotho, Zimbabwe, Swaziland and Rwanda,
- to establish a "Southern African Subcontinental Committee" – WPA Zone 14 Eastern and Southern Africa; AAPAP Chair, Secretary, Treasurer
- to promote and strengthen rights of providers and users, as well as advocate for and promote the place and priority of Psychiatry
- promote and strengthen training of registrars in respective countries
- to promote research collaboration
- to develop a website and a communication structure

1 ***Position statement on: "A continental alliance for integrated mental health care in Africa."***

In order to achieve the communicated vision, objectives and targets for achieving the potential of mental health for all and integrated mental health care in Africa, we will need to work together with collective strength and active collaboration.

Such an alliance for integrated mental health care in Africa, with emphasis on public mental health includes: individual and collective psychiatrists; as well as all members of the multidisciplinary mental health team (psychologists, nurses, social workers, occupational therapists); other health professionals in primary and specialist health care; community mental health workers and self-help resources; our patients or service users and their families; the public at large through the media; training institutions; as well as governments' Ministries of Health and private service providers of mental health care services.

While different countries and groups may have different entry points, strengthening of this alliance must be sought within countries nationally, provincially and locally, but also on subcontinental and continental levels.

Mvuyiso Talatala is a specialist Psychiatrist: Dr SK Matseke Memorial Hospital, Soweto, an Honorary Lecturer, Department of Psychiatry, University of Witwatersrand, Johannesburg and Past President: South African Society of Psychiatrists. **Correspondence: mvuyiso@talatala.co.za**

headline
NOVEMBER 2017
OFFICIAL NEWSLETTER OF THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS (SASOP)

SASOP: THE ALTERNATIVE SOLUTION

1.FROM THE EDITOR


Ian Westmore

Over the last quarter, SASOP members have been rather busy, not only delivering the much-needed clinical work in both the state and private sectors, but also in dealing with issues of the professional body and the communities that we serve.

In this issue of Headline, we report on some of these activities, most notably the Biological Psychiatry Congress that was held in September. Note that some important decisions were made regarding the funding of the SAJP, and also the membership fees. It has been a busy time for our President, who is now halfway through his term of office (see below).

The vocational groups have been busy too, with the PubSec meeting in June in Cape Town, and the PsychMG meeting in August at Zimbali in KZN. Also, in October, which was Mental Health Awareness month, several members were involved in activities in the media and elsewhere, promoting knowledge specifically regarding mental health in the workplace.

As 2017 winds down, may I take this opportunity to wish all our SASOP members a relaxing and peaceful festive season.

Dr. Ian Westmore (Editor)
NOVEMBER 2017

2.FROM THE PRESIDENT

Since our last communication in August, PsychMG had a very successful weekend meeting from 11-13 August 2017. This was also an opportunity to introduce new initiatives for revisiting public-private alliances through which to promote access to appropriate psychiatric and mental health care in South Africa.

BOTH THE PSYCHMG AND SASOP BOARDS AGREED TO FORM A SASOP PUBSEC-PSYCHMG WORKING GROUP (SASOP PP-WG) TO INVESTIGATE THE MOST APPROPRIATE APPROACH TO CONSOLIDATE THESE PARALLEL EFFORTS AND TO EXPLORE HOW THE TWO SASOP VOCATIONAL GROUPS SHOULD BE MUTUALLY SUPPORTIVE IN TERMS OF E.G. THE AVAILABLE MEDICATION, GROUPING AND COSTING OF SERVICES AND REMUNERATIONS OF PRACTITIONERS.

We have also experienced a very successful biennial Biological Congress from 14-17 September 2017, at the Lord Charles Hotel in Somerset West, convened by Prof Soraya Seedat and the Biological Interest Group's organizing committee.

In addition to an excellent academic program, we also had a chance to conduct the required business meetings, including the SASOP annual general meeting.

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

A full report on this AGM will be forwarded to all members shortly, but reporting to members was done on: the conclusion of the WPA 2016 congress in Cape Town; the aftermath of the Life Esidimeni incident and Health Ombud's report; the status of the SAJP; SASOP's ongoing communication activities; advocacy meetings with national and provincial decision makers; SASOP Board's strategic objectives for the current term; as well as other business and CPD meetings during the past year.

DURING THE FIRST PART OF OCTOBER, FROM THE 8TH TO 12TH, SOME SOUTH AFRICANS WERE ALSO ATTENDING THE WPA'S TRIENNIAL WORLD PSYCHIATRIC CONGRESS IN BERLIN.

THIS MEETING HAD REPORTEDLY MORE THAN 10,000 DELEGATES AND ALSO PROVIDED THE OCCASION FOR THE HANDOVER OF TERM OF OFFICE TO THE NEW WPA EXECUTIVE COMMITTEE FOR 2017-2020, WHICH INCLUDES:

PROF HELEN HERRMAN
(President);

DR AFZAL JAVED
(President-Elect);

DR ROY KALLIVAYALIL
(Secretary General);

PROF MASA TAKEDA
(Secretary For Scientific Meetings)

And Newly Elected
PROF THOMAS SCHULZE
(Secretary For Scientific Sections)

And PROF MICHEL BOTBOL
(Secretary For Scientific Publications).

Looking ahead, the year seems to speed to a close with the clinical exams looming for invited FCPsych Part II candidates, as well as the rest of the academic sector. While the local organizing committee from the Free State Subgroup has already made important inroads with the planning of the 2018 SASOP National Congress. This meeting will be held in Pretoria from 21 to 24 September 2018 at the CSIR Conference Centre, with the assistance of Londocor.

With best regards

Prof Bernard Janse van Rensburg

3. FROM THE HON SECRETARY
DR ANUSCHA LACHMAN

SUMMARY OF SASOP AGM HELD AT THE LORD CHARLES HOTEL DURING THE BIOLOGICAL PSYCHIATRY CONGRESS, 16 SEPTEMBER 2017

The following is a brief executive summary of the reports and feedback from the national BoD of SASOP that were tabled at the national SASOP AGM held on the 16 September 2017. The detailed reports will be circulated and distributed to all registered SASOP members and subgroups.

SASOP PRESIDENT'S REPORT 2017

- The executive Summary of the Final Report on the WPA International Congress in Cape Town, 18-22 November 2016 was presented with the final audit results and the discussion around the merits and challenges around hosting a similar congress in future.

- This also included the President's Newsletters to members.

SASOP PUBLIC SECTOR GROUP CONVENOR'S REPORT 2017

- The focus was the SASOP Press Release on

28th June 2017, which highlighted the current unacceptable state of public mental health services in South Africa. Additional feedback on the updated coverage report and the Life Esidemeni Tragedy was reported on.

PsychMG Chair's Report 2017 was tabled, but this was discussed in detail at the PsychMG weekend at Zimbali in August 2017.

SASOP Honorary Treasurer's Report 2017 included the current state of the Professional Development Fund, the consideration of fundraising from alternative sources and an update on the current financial standing of SASOP National.

SASOP Honorary Secretary's Report 2017 included the review of the current service providers including the web service providers, and the digital platform, as well as introduction of the new SASOP WEBMASTER – Dr Neil Yorke.

Healthman presentation of all financial matters, including proposed provisional budget (2018-2023)

The following decisions were proposed and ratified at this AGM:

(1) Adoption of AGM Minutes of 20th November 2016.
(2) Adoption of audited financial statements 2016 (Jan - Dec 2016).
(3) Approval of the creation of a SAJP fund and member contribution per month for 2018 (Full member R77.60; Associate R38.80 and Registrar/ Pensioner R19.40)
(4) Approval of a 10% increase of annual membership fees for 2018 (Full member R3750.00; Associate R1875.00 and Registrar/Pensioner R950.00).
(5) Appointment of auditors, Integritas Auditors.

4. SASOP PUBLIC SECTOR PSYCHIATRISTS (PUBSEC) REPORT

DR LESLEY ROBERTSON (NATIONAL CONVENER)

The following report was submitted by Dr Robertson to the SASOP AGM on 16th September 2017 during the Biological Psychiatry Congress, and reflects on the activities of this vocational group from April 2016:

4.1 TIMELINE OF ACTIVITIES

April 2016 - Dr Reddy's meeting in Swakopmund

- Focus: understanding NHI and preparation of response to White paper.

May 2016 – SASOP response to NHI submitted to National Department of Health (NDoH)

- Strengths:
  - Built on the submission on the Green Paper
  - Fulfilled our societal role – our social contract
  - Increased solidarity with colleagues e.g. PsySSA
  - Helped place psychiatry and mental health on the NHI agenda
- Weaknesses:
  - Did not critique the financing and governance of NHI
  - Poor ability to represent the whole of SASOP – focussed on public health sector. However, it did refer to private sector considerations being submitted together with SAPPF.

September 2016 – In Gauteng, 36 deaths amongst patients transferred from Life Esidimeni became public knowledge via the parliamentary legislature.

- Five SASOP members were appointed to the expert panel for the investigation into the circumstances of the deaths by the Health Ombudsman: Bernard Janse van Rensburg, Dan Mkize, Thabo Rangaka, Lesley Robertson and Sebolelo Seape
- 1st February 2017 – Ombudsman for Health released his report resulting in the following activities:
  - February 2017 – National Department of Health appointed task teams to evaluate the situation. SASOP members on these teams: Gerhard Grobler, Bernard Janse van Rensburg and Lesley Robertson.
  - March 2017 – National Institute for Communicable Diseases was tasked with guiding the verification process of all patients transferred and the relocation project
  - All patients accounted for by end of May 2017
  - Data verification team set up within Gauteng DoH – ongoing monitoring
  - Forensic investigations by SAPS and Special Investigations Unit commenced.
- South African Human Rights Commission was tasked with monitoring human rights violations of people with mental illness nationally – ongoing.

May – June 2017 – NDoH sent teams to all provincial departments of health to assess policy implementation. SASOP members involved – Solly Rataemane, Lesley Robertson and Zuki Zingela. A full report is to be made available by the NDoH.

June 2017 – Dr Reddy's meeting in Cape Town

- Focus: Regional feedback from subgroups and development of a position statement on structure and HR for community based psychiatry.

June 2017 – Section 11 Committee established by the South African Human Rights Commission in preparation for a National Hearing on the Status of

Mental Health Care which is to occur later this year. Bernard Janse van Rensburg and Lesley Robertson are on this committee.

June 2017 – Release of media statement on public sector psychiatric services derived from the regional feedback given at the Dr Reddy's conference. Immediate reaction from the Minister was strongly negative and disputed the facts of the statement. However, no other negative comments were received from any government department. The Mpumulanga and Eastern Cape DoH responded positively to meeting requests sent by the SASOP president subsequent to the media statement; Bernard Janse van Rensburg and Mvuyiso Talatala met with the Mpumulanga MEC and HOD on the 7th September and a meeting with the Eastern Cape has been scheduled for the 3rd October. (Overall publicity coverage of the media statement was valued at over R3 million).

August 2017 – Nominations were submitted for NHI Committees: Mvuyiso Talatala for the Benefits Committee, and Nkokone Tema for the Health Technology Assessment Committee.

September 2017 – A position statement re HR proposal for general hospital psychiatric units and community based psychiatric services was posted on the website and submitted to NDoH. (Will be available for subgroups to send to their provincial DoHs).

4.2 General

The SASOP presence as an advocacy group for public sector mental health care has strengthened. Amongst members, a growing sense of unity and activism is evident, both at the Dr Reddy's congress and in the rallying responses of the subgroup members to the issues surrounding the media statement.

Regular meetings between SASOP and provincial health structures are now held in:

- Eastern Cape – with the Directorate of Mental Health; (HOD when possible).
- KwaZulu Natal – with the Directorate of Mental Health; Chief Director of Non-Communicable Diseases; (HOD when possible). A Provincial Advisory Committee was established previously and is now chaired by Bonga Chiliza. Public awareness work with a Mental Health awareness walk in October, organised by Suvira Ramlall, is ongoing.
- Gauteng – with the Directorate of Mental Health. There has been no meeting as yet with the new MEC for Health

The focus for next year is to:

- Strengthen the relationship with government health departments not only through regular meetings, but also through the delivery of a consistent and evidence based message regarding mental health care.
- To improve our public mental health knowledge in the South African context, so that advocacy is based on academic argument and is not all rhetoric. This will require more collaborative research and sharing of information to generate the evidence required.
- Improve reporting on, and tracking of human rights violations of people with mental illness and to liaise with review boards and human rights organisations within each province.
- Have a continued presence on government health and related committees:
  - NEMLC – Gerhard Grobler on TQEML and Lesley Robertson on Hospital Adult Standard Treatment Guidelines
  - NHI – depending on appointments by NDoH
  - SAHRC – Section 11 Committee for National Hearing

5. PSYCHMG REPORT DR SEBOLELO SEAPE

A year has gone past since the 2016 annual AGM. I hope it has been a good year that has brought joy, peace and fulfilment. Please receive the state of our organisation.

5.1. PsychMg Membership

There has been a slow growth in our membership. PsychMg at present has 239 members, coming from the following membership categories:

- Full member: Limited Private Practice 22
- Full member: Very Limited Private Practice / Public Sector 5
- Full member: Full Private Practice 210
- Full member: Full State 1
- Honorary member: 1

PsychMg membership automatically confers to the members, the following additional membership:

- South African Society of Psychiatrists (SASOP)
- Biological Psychiatry Special Interest Group
- World Federation of Societies of Biological Psychiatry (WFSBP)
- World Psychiatric Association (WPA)
- South African Private Practitioners Forum (SAPPF)

5.2 Financials

The finance of PsychMg is administered by Healthman, led and guided by Mr Peet Kotzé. The finances of PsychMg is in good standing and the full and detailed Annual Financial Statements are available.

5.3 Leadership

The present Directors have all indicated their availability to continue serving as directors. These individuals dedicate a large number of their billable hours to the service of PsychMg, for which we should

all be grateful. Thank you, ladies and gentlemen! PsychMg recognizes the need for new and younger directors to be inducted into the organisation. A few individuals have been identified. We are pleased to announce that Dr Mpho Dianah Mhlongo and Dr Madumetya Amos Poto have accepted the nominations to serve on the PsychMg Board of Directors. All these directors were duly elected at the AGM on 12 August 2017.

The leadership of PsychMg for the next term is as follows:

- Dr Sebolelo Seape, Chairperson
- Dr Kali Tricoridis, Vice-Chairperson
- Dr Lerato Dikobe
- Dr Mhpo Mhlongo
- Dr Madmetya Poto
- Dr Thabo Rangaka
- Dr Shaquir Salduker
- Dr Renata Schoeman
- Dr Mvuyiso Talatala
- Dr Ian Westmore
- Dr Eugene Allers is an external consultant and not a Director of PsychMg.

5.4 Communication

The board would like to encourage members to read the numerous communications that are sent to PsychMg members on a regular basis. The board also invites members to engage with leadership (and other members) on any topic. As of October 2016, the board contracted Jigsaw Public Relations to publish articles in various newspapers, every two months, as a means to educate and empower the lay public on psychiatric topics. The topics are chosen by the board, as topical items, or to fit in with the Mental Health calendar. The board members have to prepare the content of these topics and send it to Jigsaw who then prepares it for publication. This generates a lot of interest from many other newspapers and radio stations and the author has to be available for interviews.

The following topics have been chosen for the next few months:

- August spokesperson: Dr Kali Tricoridis: Pain
- October spokesperson: Dr Allers: Substance Abuse
- December spokesperson: Dr Thabo Rangaka: The Elderly
- February spokesperson: Dr Schoeman: Stress and Burn-Out

5.5 Events

The annual **PsychMg Scientific & Business Weekend** took place on 11 - 13 August 2017 at Zimbali, KZN. The weekend was fully booked and very well attended. HealthMan has done a sterling job to accommodate everyone and plan the event, with the help and guidance of our generous sponsor, Aspen Pharmacare. Feedback from the delegates indicates that this event was very successful and informative. The **Sanofi Zentiva Psychiatry in Focus Weekend** was a great success in February. Much gratitude to Sanofi Zentiva for his event! **The Dr Reddy's SASOP PubSec Weekend** was another successful event which helped to foster close working relations between the public sector and the private sector, in keeping with SASOP Past-President, Dr Mvuyiso Talatala `s mandate. Thank you to Dr Reddy's. **The Registrar Finishing School** is another important event on our calendar. This is a SASOP / PsychMg, Adcock Ingram and Lundbeck project that has proved invaluable to registrars who are about to join the ranks. The event will be on the 17 - 18 November 2017, under the leadership of Dr Ian Westmore.

5.6 Projects

Hospital Validation Project

The Hospital Validation Project is on hold at the moment as we first need to secure funding. We need to get all medical schemes to participate in this project. PsychMg is working on a marketing strategy and the budget to roll this out. The validation project will extend to the Day Clinics as well as Rehab Centres.

Hospital Admission Criteria

There has been ongoing dissatisfaction amongst members with regard to the usage of the available beds in the different provinces. The Board of PsychMg has suggested that there should be a "bosberaad" to discuss hospital admission criteria, which should then be adhered to on admitting patients to hospital. Members are welcome to send their suggestions with regard to the above.

5.7 Medical Schemes Liaison

- The PsychMg board of directors continuously engage with various funders on private practice matters.
- Discovery Health. There has been serious engagement with this scheme which was spurred on by forensic engagements. There have been discrepancies with regard to the use of certain psychotherapy codes and time spent with patients.
- GEMS remains a difficult area. The board wrote to the CEO of GEMS, raising our concerns with the service our members are receiving from GEMS. The contact numbers and email addresses for queries will be sent out to members.
- There has been disconcerting news from other schemes, some of which include: one patient contact per day, i.e. only 1 member of the MDT can see a patient. The board has engaged with these schemes and plans to meet with them to discuss the issues.

5.8 Forensic Investigations

Various administrators and schemes are taking psychiatrists to task regarding up-coding, time spent with patients and the incorrect application of the codes. We urge our members to code correctly and reasonably; to keep proper records of locums, on call duties and daily time sheets. This can come in handy when investigated. Should you need PsychMg to assist, you are welcome to contact us. We also advise that members should keep accurate time records of each session with every patient.

5.9 Psychiatric Coding

The industry is moving towards aligning all coding with international coding systems, e.g. The AMA CPT Coding system and others. It is to this end that PsychMG and HealthMan are currently reviewing the psychiatry codes in conjunction with SAMA, Discovery and coding specialists in the country. Other medical administrators will also be involved in the process going forward. An initial framework of the CPT crosswalk to current South African psychiatry coding was presented at the PsychMg Scientific & Business weekend. Unfortunately, this presentation was misunderstood to be the final draft from PsychMg, but it is not. The intention was simply to start the consultative process with psychiatrists and to inform members of the challenges ahead. Please be assured that this is only the start of a process which may take 18 – 24 months or even longer, to complete. The project must be done on a cost neutral basis across the discipline and an impact study must be done in order to establish how this will impact on individual practices. Independent actuaries will do the work for PsychMG and HealthMan will review it. Further consultation will take place with psychiatrists and all efforts will be made to ensure proper due diligence before final decisions are taken and a new coding system is implemented.

5.10 Other engagements

The CMS has initiated a project to review PMBs. This is a massive project. PsychMg is represented by Dr Talatala, Dr Allers and other members of the board. I wish to thank the board members for the work they put into PsychMg. More gratitude to HealthMan for the work and time they dedicate to PsychMg. We would not be able to function without them.

6. From the Subgroups:

6.1 Northern Subgroup
(Dr P Malherbe reported on behalf of the chairperson, Dr C Kotzé)

The executive committee

Dr C Kotzé (Chairperson) Dr P Malherbe (Secretary) Dr RA van Schoor (Treasurer) Dr M Rademeyer (Private Practice representative) Dr H Eksteen (UP registrar representative) Dr Muluvhu (SMU registrar representative).

Activities of the subgroup

The first CME meeting was held at Zest Bistro restaurant on 30 March 2017. Prof Manfred Böhmer did a presentation entitled: "Management of personality disorders by the general psychiatrist, with the focus on borderline personality disorder". The event was sponsored by Servier and was well attended.

On 8 July 2017 the subgroup hosted the annual mini-symposium at the CSIR in Pretoria. We received 173 registrations and it was well supported by sponsors. Prof Bernard Janse van Rensburg who also attended, opened the event.

The theme was "Neuropsychiatry" and we had 6 speakers, including 3 SASOP members, Dr Anersha Pillay, Dr Lennart Eriksson and Dr Gian Lippi, 2 neurologists and a clinical psychologist. The feedback was very positive and a report will be written for publication in South African Psychiatry.

The AGM combined with a CME presentation will be held at Denmar Hospital on 4 November 2017. Dr Maaroganye, psychiatrist, will be presenting on "HIV and psychiatry".

Finances

The subgroup is currently financially quite strong and sponsored two registrars to the Biological Psychiatry Congress in September 2017. We are also looking into the possibility of offering research grants. In 2016, the subgroup offered R7000.00 sponsorship to a senior registrar from UP and from SMU, who were SASOP members to attend the WPA in Cape Town. The subgroup offered R10 000.00 sponsorship, if the registrar presented at the conference.

The financial management remains a challenge and Dr van Schoor has been sending monthly statements to HealthMan, but no feedback about an annual audit or tax submissions has been received. As stated in our previous reports, the subgroup would still prefer to relinquish control of the finances to the central governance of SASOP.

Executive committee participation

The current committee has been serving for a longer than usual term as there is no interest among members to become involved in the subgroup management. Two previous AGMs were too poorly attended to form a quorum for the election of a new executive committee.

We as executive committee members approach

SASOP members with whom we are acquainted to assist in projects -- this may create the impression of a lack of transparency, which is not our intention. We look to the SASOP national committee to offer guidance in this matter.

7. Special Interest Groups (SIGs)

Biological Special Interest Group: The Biological Psychiatry Congress 2017 held from 14-17 September at the Lord Charles Hotel, Somerset West, Cape Town.

(Report compiled by Dr Leigh vd Heuvel).

THE THEME OF THIS YEAR'S BIOLOGICAL PSYCHIATRY CONGRESS (BPC) WAS 'RISK AND RESILIENCE IN MENTAL HEALTH: IMPROVING LIFE THROUGH SCIENCE' AND THIS THEME WAS WELL REPRESENTED IN THE VARIOUS PRESENTATIONS. PRIOR TO THE OFFICIAL OPENING OF THE CONGRESS, THE PRE-CONGRESS WORKSHOPS PRESENTED ON SUBJECTS APPEALING TO VARIED INTERESTS, INCLUDING MOLECULAR PSYCHIATRY, PSYCHOPHARMACOLOGY, CANNABIS AND MENTAL HEALTH, MINDFULNESS AND MEDICALLY UNEXPLAINED SYMPTOMS. THE WORKSHOPS WERE ATTENDED BY A TOTAL OF 177 PARTICIPANTS.

Following the workshops the conference was opened by Prof Soraya Seedat, and Prof Bernard Janse van Rensburg delivered the presidential address. The keynote opening address on neuropsychiatry and resilience was delivered by Prof Gregory Fricchione via a video link from Massachusetts General Hospital in the United States. Despite some technical difficulties, Prof Fricchione provided an in-depth exploration linking basic science regarding stressful separation challenges to a clinical stress management and resilience training program instituted to enhance coping and resilience in their setting. This was followed by a cocktail function where colleagues from all over the country could connect with each other.

The first full day of the congress commenced with further presentations related to risk and resilience. Prof Marit Sibrandij, an invited speaker from the Frije Institute in Amsterdam, presented innovations related to PTSD prevention followed by a critical panel discussion on whether mental illness could actually be prevented. Further sessions throughout the day involved diverse topics including HIV psychiatry, women's mental health, addictions, psychosis and more on vulnerability and resilience. On the Friday the first neuropsychiatry sub speciality symposium was also held.

The second day of the congress comprised a full program with parallel symposia for the South African Neuroscience Society, including a psychiatric genetics symposium. Similar to the first day, the program commenced with presentations related to childhood trauma and disease risk by Dr Joan Kaufmann and Prof Helen Fisher. Further sessions during the day were related to ethical matters related to psychiatry, service planning, neurodevelopmental disorders and genomics. There was also an opportunity for questions and interactions with the poster authors at the poster session held during the lunch break.

As per usual, the congress provided opportunities for the various special interest groups to meet, including the SASOP AGM. At the AGM Prof Janse van Rensburg provided feedback on the WPA congress and how it impacted the budget, as well as the current situation concerning the South African Journal of Psychiatry (SAJP) and developments surrounding the Life Esidimeni case.

After two full days of academic presentations the congress dinner provided a welcome reprieve for many. The dinner's theme was 'around the world' and guests could choose between various dishes representing different countries. The theme of resilience was further reflected by the opening entertainment with a lively performance by the Imizama Yethu dance group.

After a welcome by Dr Anusha Lachman, Prof Seedat handed out the awards for outstanding presentations at the congress. Guests could then relax and socialise whilst the band Tucan Tucan played jazz in the background.

The final day of the congress was initiated with presentations related to schizophrenia neuroimaging biomarkers by Prof Paula Dazzan and Prof Robin Emsley. The final session involved a thought-provoking debate on whether antisocial personality disorder should be treated with proponents Dr Indhrin Chetty and Prof Sean Kaliski.

THE CONGRESS WAS ATTENDED BY A TOTAL OF 422 DELEGATES, INCLUDING PSYCHIATRISTS, REGISTRARS, PSYCHOLOGISTS, NEUROSCIENTISTS AND OTHER HEALTH CARE PROFESSIONALS. AMONG THE DELEGATES WERE ALSO NINE COMPETITIVE TRAVEL GRANT RECIPIENTS FROM OTHER AFRICAN COUNTRIES.

AWARDS

Best Registrar Presentation
(Dr Ethel Thekiso)

Best Oral Presentation
(Prof Zukiswa Zingela)

Best Early Career Oral Presentation
(Dr Anusha Lachman)

Best Poster Presentation
(Dr Kwavena Kusi-Mensah)

MS Bell Award - Best Oral Presentation
(Dr Graham Michie)

MS Bell award -
Best Poster Presentation
(Dr Ani Anic)

SANS Best Poster Presentation
(Jaqueline Womersley)

SANS Best Oral Presentation
(Paula Herron Award)
1st prize - Dr Toni-Lee Sterley

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References: **1.** Clark BG, Jue SG, Dawson GW, Ward A. Loprazolam – A Preliminary Review of its Pharmacodynamic and Pharmacokinetic Properties and Therapeutic Efficacy in Insomnia. *Drugs*. 1986;31(6):500-516. **2.** Dormonoct® 2 mg Package Insert. 04.10.1983. **3.** Saletu MR, Silverstone T. The clinical and psychometric evaluation of a new hypnotic drug, loprazolam, in general practice. *Curr Med Res Opin*. 1983;8(5):368-374. **4.** McInnes GT, Bunting EA, Ings RMJ, Robinson J, Ankier SI. Pharmacokinetics and pharmacodynamics following single and repeated nightly administrations of loprazolam, a new benzodiazepine hypnotic. *Br J Clin Pharmac*. 1985;19:649-656. **5.** Botter PA. A Comparative Double-blind Study of Loprazolam, 1 mg and 2 mg, Versus Placebo in Anxiety-induced Insomnia. *Curr Med Res Opin*. 1983;8(8):626-630.

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