

SOUTH AFRICAN PSYCHIATRY

ISSN 2409-5699

ABOUT the discipline FOR the discipline

issue 9 • november 2016

AN ARTIST,
STATISTICS &
MENTAL ILLNESS

SOCIAL
RESPONSIBILITY
AND SOCIAL
JUSTICE

PSYCHOTHERAPY
TRAINING
FOR PSYCHIATRISTS IN SA

ANGUISHED
CHILDREN



PUBLISHED IN ASSOCIATION WITH THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

Cover Artwork Title: *Liberty Battson, January .co.za 2016*

THE DELUSION OF
INDEPENDENCE

www.southafricanpsychiatry.co.za



Sleep a full night, **Live** a full day.

Stilnox® MR offers your patients:

- Rapid Sleep Onset¹
- Sustained Delivery for Sleep Maintenance²
- Improved Sleep Quality³
- Attentive and Alert the next day⁴
- Improved Daily Functioning⁴ and Work Performance⁵



SANOFI 

References: 1. Moein MD and Ploeker G.L. Zolpidem Extended-Release. *CNS Drugs*. 2006;20(5):419-426. 2. Wainling E, McDougall S, Andre F, Blanchette G and Dubruc C. Pharmacokinetic profile of a new modified release formulation of zolpidem designed to improve sleep maintenance. *Fundamental & Clinical Pharmacology* 2006. 3. Monti JM, Spence DW, Pand-Perumal SR, Langer SZ, Hardeland R. Pharmacotherapy of Insomnia: Focus on Zolpidem Extended Release. *Clinical Medicine: Therapeutics*. 2009;1:123-140. 4. Krystal AD, Erman M, Zinnit GK, Soubriere C, Roth T. Long-Term Efficacy and Safety of Zolpidem Extended-Release 12.5 mg Administered 3 to 7 Nights Per Week for 24 Weeks, in Patients With Chronic Primary Insomnia: A 6-Month, Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, Multicenter Study. *SLEEP* 2008;31(1):79-90. 5. Erman M, Guiraud A, Josh VN, Lerner D. Zolpidem ex-extended-release 12.5 mg associated with improvements in work performance in a 6-month randomized, placebo-controlled trial. *SLEEP* 2008;31(10):1371-1378.

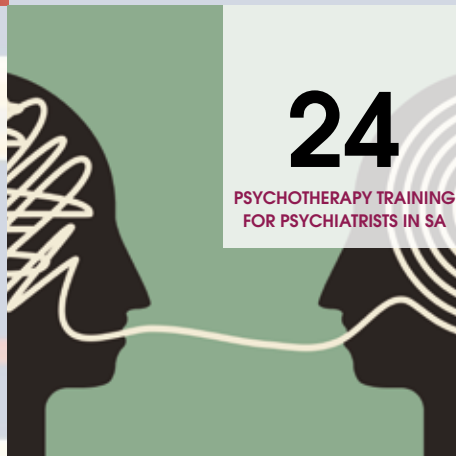
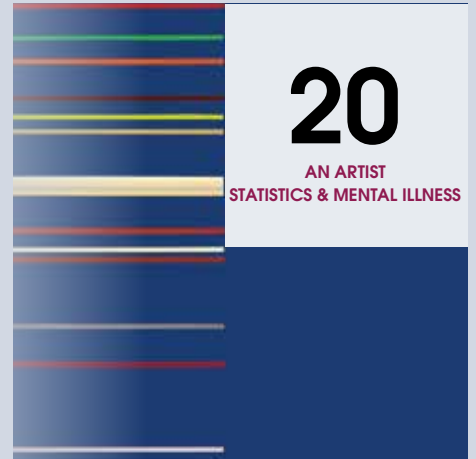
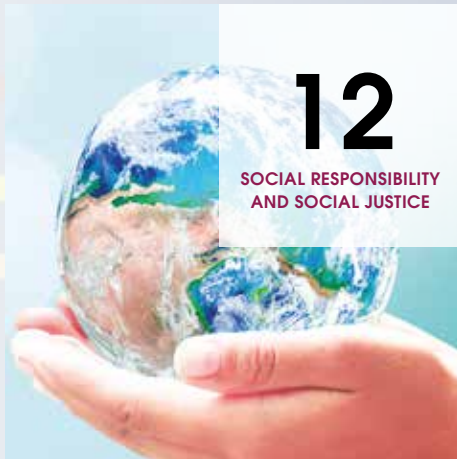
For full prescribing information refer to the package insert approved by the medicines regulatory authority.

SCHEDULING STATUS: S5 **PROPRIETARY NAME (AND DOSAGE FORM):** STILNOX® MR 12.5 (Modified Release Tablet). **COMPOSITION:** STILNOX® MR 12.5. Each tablet contains zolpidem tartrate 12.5 mg. **PHARMACOLOGICAL CLASSIFICATION:** A 2.2. Sedatives, hypnotics. **REGISTRATION NUMBERS:** STILNOX® MR 12.5: A40/2/2/0441. **NAME AND ADDRESS OF THE HOLDER OF THE CERTIFICATE OF REGISTRATION:** sanofi-aventis south africa (pty) ltd., Reg. No. 1999/010381/07, 2 Bond Street, MIDRAND, 1685, South Africa. Tel + 27 (0)11 256 3700. Fax +27 (0)11 256 3707. www.sanofi-aventis.com

ZASTMR.15.01.02

STILNOX® MR
ZOLPIDEM TARTRATE

Features



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

SOUTH AFRICAN PSYCHIATRY NOVEMBER 2016

- 5 FROM THE EDITOR
- 8 WPA IC 2016 - **OVERVIEW**
- 12 **SOCIAL RESPONSIBILITY** AND SOCIAL JUSTICE
- 18 **WPA** POSITION STATEMENT
- 20 **AN ARTIST** STATISTICS & MENTAL ILLNESS
- 24 **PSYCHOTHERAPY** TRAINING FOR PSYCHIATRISTS IN SA
- 28 **THE DELUSION OF INDEPENDENCE:** A REFLECTIVE ESSAY
- 34 **ANGUISHED** CHILDREN
- 38 **DEPARTMENT** NEWS
- 44 **UKHANYO** CENTRE
- 50 **CIVIL FORENSIC** PSYCHIATRY
- 54 **WHATS NEW IN** SUBSTANCE ABUSE DISORDERS
- 56 **CONSULTATIVE WORKSHOP** ON THE PUBLIC HEALTH
DIMENSIONS OF NARCOTIC AND PSYCHOTROPIC
SUBSTANCES ABUSE PROBLEM
- 58 **2ND AFRICAN COLLEGE OF** NEUROPSYCHOPHARMACOLOGY
- 62 **ADULT ADHD** WORKSHOP
- 64 **MENTAL HEALTH** AT THE RURAL HEALTH CONFERENCE
- 68 **WINE FORUM:** THE LANGUAGE OF WINE
- 70 **MOVIE REVIEW:** ME BEFORE YOU
- 71 **SASOP** HEADLINE

* PLEASE NOTE: Each item is available as full text electronically and as an individual pdf (if one clicks on the item in the contents page) online.

Disclaimer: No responsibility will be accepted for any statement made or opinion expressed in the publication. Consequently, nobody connected with the publication including directors, employees or editorial team will be held liable for any opinion, loss or damage sustained by a reader as a result of an action or reliance upon any statement or opinion expressed.

© South African Psychiatry This magazine is copyright under the Berne Convention. In terms of the South African Copyright Act No. 98 of 1978, no part of this magazine may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording or by any information storage and retrieval system, without the permission of the publisher and, if applicable, the author.

COVER PHOTOGRAPH: Shutterstock Image

Design and layout: The Source • Printers: Lloyd-Gray Digital.

Dear Reader,

the final issue of 2016 has arrived and has done so on a most auspicious occasion – the World Psychiatric Association International Congress 2016. Congratulations to all involved in ensuring that this landmark event is taking place in South Africa. Any doubts about taking on such a major project, and I was concerned, have been dispelled.



It is a great privilege to have the WPA President, Dinesh Bhugra CBE, contribute a *Feature* piece for this issue. It is anticipated that a range of content from the Congress will feature in future issues during 2017. Beyond the aforementioned *Feature* we have several others covering a range of topics with 2 very powerful reflective pieces (Singh; Naidu) as well as one on art and mental illness that has contributed the cover image for the current issue (Grobler) with the 5th *Feature* related to an area of importance to specialist training i.e. psychotherapy (Bohmer). The *Department News* section highlights events in Departments around the country, but most impressive are the number of *Reports* that really give a sense of a vibrant discipline. Amidst turmoil on campuses nationwide, the endeavours within our discipline provide an important positive counter balance.

I recently reviewed the publication's Google analytics which provide some indication of trends regarding electronic access of content. Very pleasing was the observation that our South African viewership is steadily increasing as a percentage of total viewership having increased from 10.05% of total during 2014-2015 to 40.88% during 2015-2016, with return viewers increasing from 5% during 2014-2015 to 23.9% during 2015-2016. It seems that we are increasingly reaching our primary audience, electronically, with more folk returning to view content. These are encouraging signs of a publication that is maturing.

Following on from the *Dear Reader* column in the August 2016 issue, invitations to contribute the literature review content of successfully examined research reports contributing to MMedS were forwarded to all Departmental Heads. The *Instructions to Authors* have been amended accordingly, and I await such contributions.

I would like to thank all of the contributors who have made the issues of 2016 what they were, as well as industry for their ongoing support. I trust you will enjoy this issue and I look forward to seeing you again in 2017!

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

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

Dan Stein – *Head, Department of Psychiatry and Mental Health, University of Cape Town*

Solly Rataemane – *Head, Department of Psychiatry, Sefako Makgatho Health Sciences University*

Louw Roos – *Head, Department of Psychiatry, University of Pretoria*

Janus Pretorius – *Head, Department of Psychiatry, University of Free State*

Zuki Zingela – *Head, Department of Psychiatry, Walter Sisulu University*

Mvuyiso Talatala – *President, South African Society of Psychiatrists*

Bernard Janse van Rensburg – *President Elect, South African Society of Psychiatrists*

Headline Editor: Ian Westmore

Acknowledgement: *Thanks to Lisa Selwood for assistance with proof reading*

Advertising: The Source Public Relations, Pharmapreneurs

Design and Layout: Michelle Haskins, **Printer:** Lloyd-Gray Digital

Web: www.southafricanpsychiatry.co.za

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

South African Psychiatry is published quarterly by The Source Public Relations Group.
Its mission is to communicate the latest news and developments in the area of South African Psychiatry.

"The views expressed in individual articles are the personal views of the authors and are not necessarily shared by the editor, advisory board, advertisers or the publisher."

Fast growing CNS portfolio.¹

ZOXADON

RISPERIDONE 0,5 mg; 1 mg; 2 mg; 3 mg; 4 mg



SA'S RISPERIDONE
MARKET LEADER²

**Dyna
Levetiracetam**
LEVETIRACETAM 250 mg | 500 mg | 750 mg



SAFELY AND
EFFECTIVELY
REDUCES SEIZURE
FREQUENCY³

Dyna Sertraline
SERTRALINE 50 / 100



A CLEAR
BLUE SKY

**Dyna-
Lamotrigine**
LAMOTRIGINE
25 mg, 50 mg, 100 mg, 200 mg



LIVE
LIFE
FREEDOM

zytomil
ESCITALOPRAM 10 mg | 20 mg



FAST-ACTING
ANTIDEPRESSANT³

serrapress
PAROXETINE 20 mg



OPEN THEIR EYES
TO FACE THE
COLOUR
OF LIFE

For further product information contact
PHARMA DYNAMICS P O Box 30958 Tokai, Cape Town 7966
Tel 021 707 7000 Fax 021 701 5898

Email info@pharmadynamics.co.za CUSTOMER CARE LINE 0860 PHARMA (742 762) www.pharmadynamics.co.za

ZYTOMIL 10 mg. Each coated tablet contains 10 mg escitalopram. Reg. No.: RSA S5/A42/1.2/0912 NAM NS3 10/1.2/0479. **ZYTOMIL 20 mg.** Each coated tablet contains 20 mg escitalopram. Reg. No.: RSA S5/A42/1.2/0914 NAM NS3 10/1.2/0481. **ZOXADON 0,5 mg.** Each tablet contains 0,5 mg risperidone. Reg. No.: RSA S5/A41/2.6.5/0468 NAM NS3 10/2.6.5/0021. **ZOXADON 1 mg.** Each tablet contains 1 mg risperidone. Reg. No.: RSA S5/A41/2.6.5/0445 NAM NS3 10/2.6.5/0022. **ZOXADON 2 mg.** Each tablet contains 2 mg risperidone. Reg. No.: RSA S5/A41/2.6.5/0446 NAM NS3 10/2.6.5/0023. **ZOXADON 3 mg.** Each tablet contains 3 mg risperidone. Reg. No.: RSA S5/A41/2.6.5/0469 NAM NS3 10/2.6.5/0024. **ZOXADON 4 mg.** Each tablet contains 4 mg risperidone. Reg. No.: RSA S5/A41/2.6.5/0470 NAM NS3 10/2.6.5/0025. **SERRAPRESS 20 mg.** Each tablet contains paroxetine hydrochloride equivalent to 20 mg paroxetine. Reg. No.: RSA S5/A38/1.2/0069 NAM NS3 08/1.2/0101. **DYNA-LAMOTRIGINE 25 mg.** Each tablet contains 25 mg lamotrigine. Reg. No.: RSA S3/A40/2.5/0173 NAM NS2 08/2.5/0177. **DYNA-LAMOTRIGINE 50 mg.** Each tablet contains 50 mg lamotrigine. Reg. No.: RSA S3/A40/2.5/0169 NAM NS2 08/2.5/0178. **DYNA-LAMOTRIGINE 100 mg.** Each tablet contains 100 mg lamotrigine. Reg. No.: RSA S3/A40/2.5/0166 NAM NS2 08/2.5/0179. **DYNA-LAMOTRIGINE 200 mg.** Each tablet contains 200 mg lamotrigine. Reg. No.: RSA S3/A40/2.5/0167 NAM NS2 08/2.5/0180. **DYNA SERTRALINE 50.** Each film coated tablet contains 50 mg sertraline. Reg. No.: RSA S5/A43/1.2/0339 NAM NS3 14/1.2/0627. **DYNA SERTRALINE 100.** Each film coated tablet contains 100 mg sertraline. Reg. No.: RSA S5/A43/1.2/0340 NAM NS3 14/1.2/0628. For full prescribing information, refer to the package insert approved by the Medicines Control Council. 1) IMS Data, March 2016. 2) Tellez-Zenteno JF. Conclusions of the available Meta-Analysis Exploring the Efficacy of Levetiracetam. Canadian Journal of Neurological Sciences. 2011;38:388-389. 3) Kasper S, et al. Onset of action of escitalopram compared with other antidepressants: results of a pooled analysis. International Clinical Psychopharmacology. 2006;21:105-110. GNSRB250/05/2016.

WPA INTERNATIONAL CONGRESS CAPE TOWN, 18-22 NOVEMBER 2016

CONTACT

Please visit the website:
www.wpacapetown2016.org.za

Chair WPA2016 Local Organizing Committee

Bernard Janse van Rensburg (bernard.sasop@mweb.co.za)

Associate Professor Department of Psychiatry, University of Witwatersrand, Johannesburg

Chair Local Organizing Committee WPA International Congress in Cape Town 2016

President-Elect South African Society of Psychiatrists (SASOP) 2014-2016

C/O Healthman, Unit 16 Office Park, 203 Beyers Naude Drive, Northcliff, Johannesburg, South Africa

Email: bernard.sasop@mweb.co.za • Telephone/Fax +27 11 489 0620 • Cell: +27 82 807 8103

www.wpacapetown2016.org.za

WPA2016 Conference Organisers - Scatterlings Conference & Events

Head of Operations: Charlene Jansen (charlene@soafrica.com)

Abstract Speaker Coordinator: Simone Solomons (simone@soafrica.com)

Exhibition and Sponsorship: Brenda Outhet (brenda@soafrica.com)

International Delegate Registrations: Carina du Plessis (carina@soafrica.com)

South African Delegates Registrations: Stephanie de Boer (Stephanie@soafrica.com)

Keynote/Invited Speakers Coordinator: Charné Millet-Clay (charne@soafrica.com)

WPA2016 Sponsors

Platinum Sponsor

Dr.Reddy's 

 National
Research
Foundation

Gold Sponsor



Silver Sponsors

janssen 

 SERVIER

For more information, please visit the congress website

www.wpacapetown2016.org.za

WPA INTERNATIONAL CONGRESS

CAPE TOWN, 18-22 NOVEMBER 2016

“Transformation also includes reconciliation and creating a nation united in the rich diversity of communities previously forced apart.”¹



The **World Psychiatric Association (WPA)** and the **South African Society of Psychiatrists (SASOP)** are co-hosting the **World Psychiatric Association International Congress in Cape Town (WPA2016)** from **18 to 22 November 2016**, at the **Cape Town International Convention Centre (CTICC)**. This will be the biggest meeting of its kind held in South Africa and Africa to date, hoping to attract more than 2000 psychiatrists from across the world (www.wpacapetown2016.org.za).

Contemplating a possible theme for this meeting at the time, incidentally co-occurred with the death and funeral of **Nelson Mandela** in December 2013 - an experience which left many with a fairly general sense that reconciliation, **transformation and integration** of our communities and of our clinical practice, may not have been completed or, in some instances, not even undertaken yet. To the extent, that the question was asked, what are even psychiatrists' role in terms of this "unfinished business"? The congress theme has therefore been identified to be: **“Psychiatry: Integrative Care for the Community”**.

The congress program includes individual lectures and symposia on the different components of psychiatric practice to be integrated, such as: **neuroscience, psychotherapy, social involvement, and the cultural-religious-spiritual contexts** in which clinical problems present; as well as the systems and networking required to provide **different levels of services in a multi-sectoral environment**. The meeting will also explore concepts, controversies and consequences of Psychiatry's responsibility and accountability to society in terms of its scope of practice and of what can be considered as **Psychiatry's and psychiatrists' social contract**.

PSYCHIATRY'S AND PSYCHIATRISTS' SOCIAL CONTRACT

The concept of a **“social contract”** is generally used in a political science context, referring to the relationship between the state and its citizens, and the obligations that both parties may have in their relationship. Applying it to the area of professional medical associations, was further developed through the work of **Bhugra, Cruess** and others, who suggested that Medicine's and Psychiatry's relationship with society should be seen as a contract,^{2,3} and includes notions of a mutual agreement, a compact, and a “memorandum of agreement” (albeit often mostly unwritten), in which the scope, principles, quality and outcome of such an agreement are specified.²

Psychiatry's and psychiatrists' social contract is therefore all about **professionalism** and engaging with members to ensure the quality of care in their practice, but also with the other **stake holders groups** in this relationship, including: the **users** of psychiatric services, families and mental health advocacy groups; the **public at large** and the media; public and private **managers and funders** of psychiatric services; different **medical regulatory bodies and training facilities**; as well as the **other professional groups** involved in mental health, such as nurses, psychologists, social workers and occupational therapists - the other members of the interdisciplinary mental health care team.

In this relationship with psychiatrists as a professional group, **Society** expects services by competent, moral, accountable and transparent professionals,

as well as objective advice and altruistic service. The **Professional Group** provides clinical services while regarding patients' interests even above their own; assures competence of practicing members; demonstrates probity, morality and integrity; addresses issues of societal concern, while being devoted to the public good and being accountable to their patients and the public. In turn, **Society** provides the professional group the opportunity of autonomy of practice; allows them to have the monopoly of use of their knowledge-base and the privilege of self-regulation; as well as financial and non-financial rewards. In turn **Psychiatry** could expect trust, autonomy and self-regulation as a profession, also to be adequately funded in value-driven health systems, as well as to participate in public policy in their area of expertise and having a shared responsibility for health and mental health.⁴

CONGRESS PROGRAM

More than 760 submissions have been received for presentation at the congress. From these, 121 symposia and about 40 oral presentations session have been scheduled over the three-and-a-half days, in more than 20 parallel venues across the CTICC. For the full program, please visit the congress website: <http://www.wpacapetown2016.org.za/index.php/theme/detailed-programme-main>

The program includes pre-congress lectures in Johannesburg and Cape Town, 11 pre-congress workshops, lectures (9 key-note, 25 invited and 36 parallel), 121 symposia (regular, sectional, zonal and workshops), 37 oral presentation sessions, 176 poster presentations.

Pre-congress lectures – Professors Andreas Meyer-Lindenberg and Wolfgang Gaebel will be conducting visiting lectures at the Departments of Psychiatry at the University of the Witwatersrand and Stellenbosch University on the 16th and 17th November.

Pre-congress workshops – These workshops on Friday the 18th November cover a range of topics, including an update for general practitioners on depression, anxiety and bipolar disorders:

PRESENTERS	PRE-CONGRESS WORKSHOPS 17 November; CTICC Cape Town
Bhugra, Dinesh (WPA); Saxena, Shekhar (WHO)	AFRICAN FORUM: Continental Alliance for Integrated Mental Health Care in Africa
Sharma, Avdesh & Sharma, Sujatha (India)	PCW1. "Mind Your Mind": Interface of Media and Mental Health
Grobler, Christoffel Prof (South Africa)	PCW2. Conducting Psychiatric Impairment Assessments
Lewis-Fernandez Roberto, Prof (USA)	PCW3. Cultural Competency in Psychiatric Practice
Konrad, Norbert Prof (Germany)	PCW4. Forensic Psychiatry: Prison Mental Health
Berk, Michael Prof (Australia)	PCW5. "Can we prevent depression?"
Tyrer, Peter & Tyrer Helen (UK)	PCW6. The Psychotherapy of Anxiety and Somatoform Disorders
Korb, Frans (South Africa)	PCW7. Designing and Managing a Hospital-based Group Therapy Program
Allers, Eugene et al (South Africa)	PCW8. General Practitioner Update on Primary Care for Major Depression, Bipolar Disorder and Anxiety Disorders
Robertson, Michael (Australia)	PCW9. Qualitative Research Methods in Mental Health
Asmal, Laila (South Africa)	PCW10. A Practical Approach to Neurocognitive Disorders
Mohammed, Irfan (Pakistan)	PCW11. Publication Ethics: Issues and Challenges to authors, editors and educators

Key-note lectures – A range of lectures are also scheduled, either as plenary or parallel events, including the following key-notes:

- **Prof Dinesh Bhugra**, CBE (WPA President; Professor of Mental Health and Cultural Diversity, Institute of Psychiatry, King's College London, **UK**):
"Psychiatry's and Psychiatrists' Social Contract: A WPA Institutional Program."
- **Prof Sean Hill** (Co-Director of the Blue Brain Project and Co-Director of Neuro-informatics in the European Union funded Human Brain Project (HBP) at the École Polytechnique Fédérale de Lausanne (EPFL), **Switzerland**):
"The Blue Brain Project: An approach to Integrative Neuroscience."
- **Prof Vikram Patel** (Professor of International Mental Health and Senior Research Fellow Wellcome Trust, **India**):
"Psychological treatments for the world: Lessons from Premium."
- **Prof Andreas Meyer-Lindenberg** (Director and CEO of the Zentralinstitut für Seelische Gesundheit in Mannheim, **Germany**):
Translational neurogenetics of psychiatric disorders."
- **Prof Wolfgang Gaebel** (President of the European Psychiatric Association; Director of the Department of Psychiatry and Psychotherapy at the Heinrich Heine University, Duesseldorf, **Germany**):
"Towards Community-Based Integrative Treatment & Mental Health Care: From Guidance to Implementation."
- **Prof Sir Simon Wessely, KBE** (President of the Royal College of Psychiatrists; Professor and Head of the Department of Psychological Medicine, **UK**):
"Picking up the pieces: what psychiatry should and should not do after armed conflicts."
- **Prof Maria Oquendo** (President of the American Psychiatric Association, Professor of Psychiatry and Vice-Chair at Columbia University and New York State Psychiatric Institute **USA**):
"Suicide Prevention and Promotion of Women's Mental Health."
- **Prof Helen Herrman** (WPA President-Elect; Professor of Psychiatry in the Centre for Youth Mental Health, University of Melbourne, **Australia**):
"Integrative mental health care across the lifespan: Engaging with Social Determinants."
- **Dr Saxena Shekhar** (Director: Department of Mental Health and Substance Abuse World Health Organization, Geneva, **Switzerland**):
"Implementing WHO Care Programs for Mental, Psychiatric and Substance Use Disorders in Africa."

Social program and special events

- The following special events are also part of the program:

- **Thursday 17th November 2016 (16h00 - 18h00)**
- 125th Year Celebration of Valkenberg Psychiatric Hospital
- **Friday, 18 November 2016 (17h00 - 21h30)**
- Conference Opening and Welcome Cocktail
- **Saturday, 19 November 2016 (14h30 - 19h00)**
Iziko Slave Museum History Symposium and Tour
- **Saturday 19 November 2016 (19h00 - 21h30)**
- WPAIC Gala Concert, Cape Town City Hall: Cape Town Philharmonic Orchestra performing Beethoven's 9th Symphony
<http://www.cpo.org.za/2016/06/30/ode-to-joy/>
- **Sunday 20th November 2016 (19h00 - 22h00)**
- SASOP Presidential Dinner
- **Monday, 21 November 2016 (19h00 - 22h00)**
- WPAIC Congress Gala Dinner
- **Tuesday, 22 November 2016 (11h30 - 12h00)**
- Congress Closing

CONGRESS OPENING

An opening presentation/production has been prepared by the Arts Subcommittee of the Local Organizing Committee, in collaboration with local Cape Town artists. Following the opening addresses of officials, this presentation will have its own significant entertainment value and will include a number of musicians and a group of youth dancers. These dancers from Khayelitsha represent an existing community arts project and personify an example of how wider social involvement aimed at mental health promotion can practically be achieved through creative projects.

To emphasize the theme of the congress - "Psychiatry - Integrative Care for the Community", the presentation will be consolidated by short narrative on the integration of fragmented components and people, with poem readings by a prominent Cape Town poet, as well as a local psychiatrist.

ENGAGEMENT THROUGH ARTS PROJECTS

Apart from active engagement with the users of psychiatric services about clinical and service matters, engagement with the **public at large** about mental health care issues generally is also included in the activities of Psychiatry's Social Contract. Finding effective ways of establishing a context and opportunity for such engagement with the public in different regions and nationally, does propose some challenges.

However, being involved in the development of **community art, music and drama projects**, has been identified as one possible vehicle through which to effectively achieve these objectives.

When planning the content and activities of the WPA2016, it became apparent that specific opportunities to engage with the local public and communities of Cape Town and the Western Cape should also be actively pursued. Collaborating with the **Cape Town Philharmonic Orchestra (CPO)** to perform one of the concerts during their 2016 Summer Season in November, proved to be one such opportunity.

The inclusion of **Ludwig von Beethoven's Symphony No. 9 in D minor, Opus 125 ("Choral Symphony")** in the program of this first concert of the **CPO's 2016 Summer Season**, has been chosen with consideration of the theme of the congress: **"Psychiatry: Integrative Care for the Community"**. It was considered in context of the overall objective of the WPA2016 meeting, which is an increased awareness of, and commitment to its social contract with the community, by the professional fraternity of psychiatrists in South Africa, as well as by psychiatrists internationally. This may be a renewed commitment or a realization of it for the first time, and alludes to individual and collective professionals involving themselves more consciously with social issues important to the community and seeking alliances with stake holders towards the achievement of better mental health and the prevention of psychiatric problems and disability.

Other opportunities to engage with the local public during the course of the congress include for e.g. two productions directed and produced by local psychiatrists: **"Madness: Songs of Hope and Despair"** (a mixed media production using music, graphic animation, dance and spoken word, directed by **Dr Sean Baumann** and artwork by **Fiona Moodie**) and a monodrama/short opera: **"Shirt of Fire"**, by **Dr Pieter L. Cilliers**. These two works will be performed as part of the congress's scientific program during the two lunch hours on Sunday and Monday, which will be repeated in the evenings for the public to attend as well.

You might think
that your patient's
depression is better...



...until you open the fridge

Lundbeck



Brintellix[®]
vortioxetine
10 mg once daily

Take care of *more than mood*

Lundbeck South Africa (Pty) Ltd. Units 9, 13 and 14, Blueberry Office Park,
Apple Street, Randpark Ridge Extension 114. Tel: +27 11 699 1600

[S5] Brintellix 10 mg film-coated tablets. Each tablet contains vortioxetine hydrobromide equivalent to 10 mg vortioxetine.
Reg No. 48/1 2/0430 Namibia: NS 3:15/1.2/0071 Botswana: S2: BOT 1502705 MO 01/16

SOCIAL RESPONSIBILITY AND SOCIAL JUSTICE IN THE CONTEXT OF SOCIAL DISCRIMINATION

Dinesh Bhugra CBE

In most cultures over the centuries, individuals with mental illness have been discriminated against and stigmatised.

These responses have meant that in many cultures individuals with mental illness are treated as second class citizens with limited or no rights to participate actively in society. There is no doubt that reasons for stigma and discrimination and responses to these negative attitudes are many and are strongly affected by cultures and societies. Social discrimination often appears in response to race, ethnicity, religion, gender or sexual orientation. However, individuals with mental illness appear to face higher levels of discrimination, stigma and prejudice. Stigma towards individuals with mental illness reflects negative attitudes and behaviour associated with lack of knowledge about the psychiatric conditions. Stigma may also reflect that people may feel threatened by unknown aspects of the illness and behaviours of individuals with mental illness.

It must be recognised that stigma plays a role in formulating the identity of the individual who is acting in creating stigma. French philosopher Roland Barthes argued that the creation of 'the other' is important in confirming one's own identity in the way that one is male in response to someone else being female. One person is heterosexual because someone else is homosexual thus validating their own sexual identity. These stigmatising attitudes are also related to negative attitudes of the majority towards the minority be they sexual or religious or have mental illness. A majority in the community may also have the power which they may choose to withhold from minority individuals. Thus stigma may lead to attitudes of discrimination.

Discrimination is based on the distinction between people on the basis of their physical disability, gender, sexual orientation, age, religion etc. Such discrimination and distinction may lead to creating levels of inequality. These levels of inequality then go on to affect social functioning of individuals who are being discriminated against. Several forms of discrimination against people with mental illness can be identified. These include social, economic,



Dinesh Bhugra CBE

personal or political discrimination. It can be argued that historically all civic movements for empowering vulnerable groups (by virtue of their age, race, religion, ethnicity, sexual orientation) have brought about equality by demanding and pushing for elimination of discrimination rather than by relying simply on the reduction of negative attitudes and resulting behaviours. Discrimination can be eliminated through legal challenges and legal changes as has been demonstrated in many countries in response to gender based or sexual minority rights.

HOWEVER, IT IS CLEAR THAT STIGMA PLAYS A MAJOR ROLE IN MAINTAINING ONE'S IDENTITY IN COMPARISON AND CONNECTION WITH THE 'OTHER'. EDUCATIONAL PROGRAMMES WHICH HELP TO REDUCE STIGMA HAVE BEEN SHOWN TO CHANGE ATTITUDES IN A POSITIVE DIRECTION BUT OFTEN NOT THE ACTUAL NEGATIVE BEHAVIOURS.

Therefore, the key challenges for clinicians and policy makers alike are to explore the possibilities of eliminating discrimination against people with mental illness. Another reason for trying to tackle discrimination, its type and levels, is that these can be measured, recorded and reported on directly, which means that it will be possible to challenge these levels and thereafter eliminate it.



SOCIAL RESPONSIBILITY

Non-discrimination towards minority groups is at the heart of international human rights law. These are enshrined in all United Nations human rights conventions. The elimination of discrimination against vulnerable groups deserves immediate response and action at multiple levels. These should not have to rely on resources but on well-argued and well-settled principles in international human rights.

SOCIAL JUSTICE GOES BEYOND THE GENERALLY HELD (OFTEN ERRONEOUS) VIEW OF IT AS THAT OF A LIBERAL DEMOCRATIC POLITICAL REGIME ENSURING THAT ITS CITIZENS' BASIC NEEDS FOR PRIMARY GOODS ARE MET AS WELL AS THAT CITIZENS HAVE THE MEANS TO MAKE EFFECTIVE USE OF THEIR LIBERTIES AND OPPORTUNITIES. AN IMPORTANT PRINCIPLE IS THAT OF MAKING SURE THAT CITIZENS HAVE A FAIR EQUALITY OF OPPORTUNITY WHICH OFTEN DOES NOT APPLY TO INDIVIDUALS WITH MENTAL ILLNESS FOR A NUMBER OF REASONS. IT IS IMPORTANT TO NOTE THAT PRINCIPLES OF SOCIAL JUSTICE RELY ON STRENGTHENING SOCIAL INSTITUTIONS. SOCIAL JUSTICE MAY BE EQUATED WITH ECONOMIC JUSTICE, ANOTHER AREA IN WHICH INDIVIDUALS WITH MENTAL ILLNESS TEND TO LOSE OUT.

Social justice especially when applied to individuals who have mental illness relies on the key question of what members of society owe each other in the promotion and protection of health. Three subsidiary questions raised are whether health should be seen as special. Also if and when health inequalities are unjust; and finally how in the face of finite resources, infinite demands are met irrespective of the health care systems in a fair and just way. Planning and delivery of healthcare must ensure that all members of the society have the capability of being healthy so that they are in a state of reaching their full potential and through being healthy they can provide distinct contributions to the society through equality of opportunity. Healthcare carries with it, special moral importance because it helps to preserve status of all members of a group as fully functioning citizens of the society. Unlike food or shelter, healthcare needs may be disproportionate depending upon a number of factors, thereby creating an inherent inequality and discrimination.

Social determinants influence mental health as well as physical health. It is therefore entirely acceptable that social inequalities, which are becoming increasingly evident in many advancing countries, are tackled. However, more significantly, in order to ensure greater social justice to health outcomes no matter where in the world, the focus on delivery of social justice needs to be co-ordinated bringing together traditional health sectors as well as allopathic healthcare systems along with education, employment and the criminal justice system. Social institutions, whether these are schools, universities, courts or others, must be strengthened so that social justice can be delivered. The health care system is often itself is institutional and bound by institutional cultures and norms and therefore must be prepared to deliver social justice not only by providing appropriate and easily accessible healthcare, but also through commitment to health promotion and prevention of mental illness.

A capability to be healthy is at the core of this social justice so that individuals can look after their health whereas the institutions can help ascertain health and social inequalities with ethical commitment. It is worth emphasising that the core of social justice in health has ethical and moral frameworks. The balance between societal responsibility as represented by the government and individual responsibility as embedded in an individual's choice and responsibility for their own health and capabilities, is crucial. Social justice carries, embedded within it, concepts of human rights. Social justice focuses on strengthening and supporting institutions which can then eliminate social discrimination, especially against individuals with mental illness.

DISCRIMINATION CAN BE REDUCED THROUGH LEGAL LEGISLATIVE FRAMEWORKS AND APPROPRIATE POLICY INITIATIVES. GOVERNMENTS IN GENERAL AND OCCASIONALLY INDIVIDUALS CAN USE THE LEGAL FRAMEWORK TO CHALLENGE DISCRIMINATORY PRACTICES AND TAKE SUITABLE APPROPRIATE ACTION. THE LAWS WHICH FOSTER DISCRIMINATION - SUCH AS LACK OF RIGHTS TO INHERIT PROPERTY OR TO ADOPT CHILDREN - COMMUNICATE TO THE LARGER COMMUNITY THAT SUCH BLATANT DISCRIMINATORY PRACTICES ALSO CONTRIBUTE TO A LEVEL OF INEQUITY IN FUNDING FOR SERVICES AS WELL AS FOR RESEARCH INTO MENTAL ILLNESS.

Recent studies by the World Psychiatric Association (WPA) have highlighted hideous levels of discrimination against individuals with mental illness. There is no reason why such individuals should not have the same equitable rights as other members of society. Other discriminatory practices – for example, lack of housing, employment and educational opportunities – need to be challenged. Member associations of the WPA have to take on this responsibility and work as advocates with partner organisations in order to challenge and alter these discriminatory powers. Mental health professionals have a moral duty to advocate for principles of non-discrimination and to convince policy makers of their urgent obligation to repeal any laws which foster discrimination against individuals with mental illness.

Social responsibility for change and elimination of discrimination should be seen at four levels: individual, community, national or regional and international. At an *individual* level, social justice needs advocacy, clear identification of prejudices and education in order to change attitudes towards individuals with mental illness and, consequently changes in behaviour. At the *community* or familial or kinship level, social justice is about ensuring that individuals and their immediate environment have the power to ensure that the group has the capability to be healthy and to understand what is missing. At a *national* level, social justice means strengthening and empowering institutions, be they schools, healthcare systems, the judiciary, ministries or other stakeholders. At the *international* or global level, institutions such as the WPA have a major social responsibility to persuade global organisations such as the United Nations to deliver social justice and eliminate social discrimination against individuals with mental illness.

Social justice and social discrimination go hand in hand. Social discrimination can be measured in several spheres, from personal to political ones. There is widespread discrimination in not giving proper habilitation to individuals with mental illness and not to give them voting rights, which means that they cannot stand for elections and therefore are excluded from participating actively in the political democratic process.

One of the major challenges in understanding discrimination lies in the number of terms that are used in laws around the world to describe mental illness. These include: mental illness, mental disorder, mental derangement, medically certified insane or medically proven total mental incapacity, mental incompetence, insanity, lost his mind, demented, seriously weakened mental state, mentally deficient, insane or imbecile, certified to be insane and mental ineptitude. As these terms are often not described how these are understood or interpreted is left to the person using them. As the procedure for how a person

is judged to have a mental health problem is not laid down in law inevitably this leads to de jure and de facto discrimination. Thus the psychiatric profession has a moral and ethical responsibility to get our house in order and be clear as to what terms are used and what they mean. The psychiatric profession therefore, in discussions with the society it serves through the social contract and working with legal profession as well as other stakeholders must agree on definitions of terms so that they can be applied universally. The terms must be non-discriminatory.

A FIRST STEP IS FOR NATIONAL PSYCHIATRY ASSOCIATIONS TO EXPLORE PSYCHIATRY'S CONTRACT WITH REPRESENTATIVE POLICY MAKERS, STAKEHOLDERS, PATIENTS, PATIENT CARERS AND FAMILIES AND OTHER PROFESSIONAL AND NON-PROFESSIONAL GROUPS. PSYCHIATRY NEEDS TO EXPLORE SOCIAL EXPECTATIONS IN SUCH A CONTRACT WHICH IS OFTEN IMPLICIT AND NOT EXPLICIT.

The chief aim of exploring such an implicit contract is to ensure that both parties are aware of what is needed and what is required in terms of responsibility on each side. Psychiatry's contract is also about adequate and indeed equitable funding for delivery of services as well as research. Recruitment and retention into psychiatry are very poor in many countries around the world. This is often due to low status but also discrimination and stigma against mental health professionals.

Each national association needs to take on the responsibility of clarifying the nature of the said contract including funding and remuneration. The multi-dimensional nature of a profession which is in transition needs to be explained better. The ongoing bitter, reductionist, internal battles between biological psychiatrists and social psychiatrists contribute to stigma and discrimination against psychiatrists and psychiatry.

As part of the social contract between the society and psychiatrists it is evident that public/society expect psychiatrists to be healers, competent doctors, altruistic, moral, honest, trustworthy individuals who will treat mental illness, promote mental health and will also be a source of objective advice. In return, psychiatry and psychiatrists expect from patients and public a degree of trust, autonomy, a role in public policy, advocacy and financial as well as non-financial rewards. Psychiatry and psychiatrists expect that the society will provide sufficient resources, autonomy to the profession and a value laden equitable healthcare system. In return, the society has the expectations that psychiatrists, like other doctors, will be competent, moral, honest, accountable productive and transparent, with clear objective



SOCIAL RESPONSIBILITY

advice. The public expects from the State a quality healthcare system which is accessible, affordable, equitable and adequately resourced, funded and accountable.

The State in turn expects from the public appropriate use of resources, taking some responsibility for their own health. Psychiatrists as doctors also have a clear role, not only as healthcare professionals but also as members of the public, who with their specialist skills can, and indeed must, act as advocates for the healthcare system as well as for their patients. The second key step is to create a Bill of Rights for individuals with mental illness which advocates not only for the elimination of discrimination but also encourages governments to give rights to patients which ensure their engagement and betterment on

a number of levels. WPA has created this and to date 30 organisations worldwide have signed up to it.

The third immediate step is to share and learn from examples of good clinical practice through exchanging information about minimum standards of care and services. WPA has made a start on this but it is imperative that national associations take ownership of these steps and work towards improving resources and services so that our patients get the best services and not only get better but also stay better.

The WPA (World Psychiatric Association) calls for urgent elimination of discrimination and discriminatory practices against people with mental illness.

Dinesh Bhugra is the current President of the World Psychiatric Association. He is a Professor of Mental Health and Diversity at the Institute of Psychiatry at King's College London as well as an Honorary Consultant Psychiatrist at the South London and Maudsley NHS Foundation Trust and past President of the Royal College of Psychiatrists. He was awarded a CBE – Commander of the Order of the British Empire – in recognition of outstanding work in his field. **Correspondence:** dinesh.bhugra@kcl.ac.uk

WORLD PSYCHIATRIC ASSOCIATION
الجمعية العالمية للطب النفسي
世界精神病学协会
ASSOCIATION MONDIALE DE PSYCHIATRIE
WELTVERBAND FÜR PSYCHIATRIE
ASSOCIAÇÃO MUNDIAL DE PSIQUIATRIA
ВСЕМИРНАЯ ПСИХИАТРИЧЕСКАЯ АССОЦИАЦИЯ
ASOCIACIÓN MUNDIAL DE PSIQUIATRÍA



WPA NEWS

Official Quarterly News Bulletin of WPA

SEPTEMBER 2016

| WWW.WPANET.ORG

Message from the Secretary General



Roy Abraham Kallivayalil

Dear Colleagues and Friends,

Hearty greetings to you! We are very happy WPA remains very active and in constant contact with our Member Societies all over the world. One of the important events was the

meeting of the Executive Committee at the WPA Secretariat, Geneva on July 17-18, 2016. A host of issues concerning Psychiatry and mental health were discussed. Besides, the WPA Planning Committee met at the same venue on July 16-17 and discussed the amendments to the Statutes and Bye-Laws. These meetings had a special significance, as we were meeting at our Secretariat for the first time, during this triennium.

We are looking forward to the WPA International Congress, Cape Town November 18-22, 2016. Theme: "Psychiatry: Integrative Care for the Community". Psychiatry's and Psychiatrists' Social Contract, The Blue Brain Project, Translational neurogenetics of psychiatric disorders, Integrative mental health care across the lifespan: Engaging with Social Determinants and Implementing WHO Care Programs for Mental, Psychiatric and Substance Use Disorders in Africa are some of the topics for Plenary Lectures. More information at www.wpacapetown2016.org.za. Hearty congratulations to the South African Society of Psychiatrists, Dr. Bernard van Rensburg and their dedicated team for their excellent work. Let us all strive to make this a great Congress!

Our newly designed website www.wpanet.org is very attractive and informative. Please visit and send us your valuable comments. We thank WPA President Dinesh Bhugra and the EC for their support and guidance.

Thanking you,

Roy Abraham Kallivayalil
Secretary General
World Psychiatric Association

Message from the President



Dinesh Bhugra

The Second World Mind Matters Day approaches. This year we aim to launch our findings from a global survey from 193 countries on discrimination against persons with mental illness. The levels of discrimination are horrendous across the globe. Nearly one third countries do not allow people with mental illness to get married. Fewer countries provide supported employment or right to vote. WPA has produced a Bill of Rights which is obtainable from the Head office. Please read and sign your support.

WPA-Lancet commission on Psychiatry has completed its data analysis and six writing groups



Gimmelwald is a beautiful mountain village located in the Bernese Highlands region of Switzerland. It is best known for the great cheese, farming and tourism. It is a perfect place for Alp-holics because it offers incredible views with majestic cliffs, colourful mountains and impressive peaks. Aside from the picturesque surroundings, the travellers are drawn by the peaceful setting and quiet laid-back attitude.

have been set to explore and discuss these findings. First draft of the report will be ready by end of September and full report will be published by Lancet Psychiatry early next year. 2016-2017 is the year of WPA campaigning for Social Justice for persons with mental illness. We are developing Bill of Rights for Children and young people and on Rights of those with intellectual disability.

Several Position Statements have been launched including the mental health of migrants, refugees and asylum seekers; LGBT individuals and reasons to be a psychiatrist. World Psychiatry in the very near future will be bringing these out, please look out for them.

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

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

WPA has an International Congress in Cape Town from 18-22 November. Please put the dates in your diary. This will be an exciting conference with eminent speakers and range of symposia and workshops. I look forward to seeing you at the conference and hearing your thoughts.

Please check the website regularly and get involved.

Dinesh Bhugra, CBE
President
World Psychiatric Association

WPA NEWS

SEPTEMBER 2016



CHERRYMED

Enterprises (Pty) Ltd 2016/000933/07

SOLE DISTRIBUTOR OF

Thymatron® System IV

The smart choice for all your ECT needs



"Thymatron® System IV:

The most advanced ECT device technically and operationally, with demonstrated superior safety and clinical effectiveness."

"Thymatron® Why Trust Anything Less?"

Contact Us: admin@cherryred.co.za

Colleen - 082 800 9717 - colleenc@cherryred.co.za

PSYCHIATRIST POSITION AVAILABLE

LOCATED IN UNDERBERG, IN THE BEAUTIFUL SOUTHERN DRakensBERG, RIVERVIEW MANOR IS A PRIVATE SPECIALIST CLINIC WITH A DIFFERENCE.

THE CLINIC AND ITS SURROUNDS OFFER AN ENVIRONMENT THAT RESONATES WITH HEALING AND RECOVERY.

OUR CLIENTS ENJOY THE ANONYMITY AND SAFETY THAT UNDERBERG PROVIDES.



RIVERVIEW MANOR

SOUTH AFRICA'S PREMIER SPECIALIST CLINIC

Since 1999 RiverView Manor has provided effective and professional inpatient treatment for people struggling with many debilitating problems including:

- Alcohol abuse & dependence • Substance abuse & dependence • Depression • Anxiety • Gambling addiction
- Eating Disorders (Anorexia, Bulimia, Binge eating, Obesity) • Trauma • Stress • Bipolar Mood Disorder and many other debilitating problems

RIVERVIEW MANOR HAS A POSITION AVAILABLE FOR A YOUNG, QUALIFIED PSYCHIATRIST WHO WOULD LIKE TO SET THEMSELVES UP IN PRIVATE PRACTICE WITH A GUARANTEED INCOME WHILE DOING SO. FOR FURTHER INFORMATION AND TO APPLY FOR THIS POSITION, PLEASE CONTACT GENERAL MANAGER ON 033 701 1911 OR GENERALMANAGER@RIVERVIEWMANOR.CO.ZA

Tel: +27(0)33 701 1911 • A/H Cel: 082 922 5911 • Fax: +27(0)33 701 1339
Web: www.riverviewmanor.co.za • Email: admin@riverviewmanor.co.za

Choose Life!

RECRUITMENT IN PSYCHIATRY

This statement was developed by Drs Greg Shields (UK), Roger Ng (Hong Kong), Antonio Ventriglio (Italy), Joao Castaldelli-Maia (Brazil), Julio Torales (Paraguay) and Professor Dinesh Bhugra (UK). Approved by the Executive Committee of the WPA (Feb 2016) Due for renewal/revision in 2019

The problem of recruitment in psychiatry is universal and there are very few countries where it is not a problem. These variations have to be seen in the context of health care systems and training options and educational systems.

The problem of recruitment in psychiatry is universal and there are very few countries where it is not a problem. These variations have to be seen in the context of health care systems and training options and educational systems.

The WHO has set a target of 1 psychiatrist per 10,000 population globally. While this target is met in most European countries, North America, and Japan, just under half of the world population live in countries with less than 1 psychiatrist/100,000 population. The rates are extremely low throughout Africa and South America (as low as 0/100,000), Southeast-Asia (0.2/100,000), and Subcontinental Asia (0.4/100,000), with high urban-rural disparity.

Despite the relatively high numbers of psychiatrists, many high-income countries are suffering from a perceived 'recruitment crisis'. In many countries vacancy rates in training posts remain over 10%. To complicate matters further, often International Medical Graduates who may see psychiatry as popular take up much of the slack, further contributing to 'brain drain' from their countries of origin.

WHO CHOOSES PSYCHIATRY, AND WHAT INFLUENCES THEIR CHOICE?

Many students choose medicine for the specific purpose of doing psychiatry but some change their mind during their training. Others see the process through. Some students fall into psychiatry either passively or choose it actively. The reasons are often complex.

Most of the studies have focused on understanding issues in Europe and the USA. As duration of undergraduate training in psychiatry varies from 2-8

weeks, it is important to explore and understand these variations. WPA studies have shown that female doctors are slightly more likely to choose psychiatry. A personal or family history of mental illness increases the likelihood of choosing psychiatry.

Medical students with undergraduate exposure to psychology or social sciences are more likely to choose psychiatry. Having a positive experience of psychiatry teaching and placement with clinical activities and exposure to psychotherapy during medical school, and/or additional exposure through clinical electives also influence the choice of psychiatry.

WHAT FACTORS NEGATIVELY INFLUENCE RECRUITMENT?

A fall in levels of interest in psychiatry during undergraduate training can be attributed to poor exposure to teaching, a lack of psychiatric facilities and limited clinical exposure.

Furthermore, the quality of mental healthcare in many parts of the world is extremely poor, and largely inpatient, with little opportunity for exposure to community-based psychiatry or other specialities. As such, students may be turned off psychiatry by what they witness during placements.

The relative lack of financial reward can also affect career choice. Other factors are stigma against the psychiatric profession and against mental illness in general resulting in perception of psychiatry as unscientific, ineffective, or apart from mainstream medicine. There is a perceived lack of respect from colleagues in other specialities and a poor public image.

Furthermore, misconceptions and prejudices against the mentally ill themselves make psychiatry an undesirable proposition. The stereotypes of psychiatric patients being dangerous or unpredictable and chronicity of psychiatric disorders can also put medical students off psychiatry.

HOW CAN RECRUITMENT BE IMPROVED?

Increasing the availability and quality of psychiatric care in LMICs, with a focus on community-based structures. Increasing the quantity and quality of psychiatric teaching and clinical attachments within medical schools, especially in LMICs, and making psychiatry an examinable part of the curriculum at par with other specialities. Psychiatry being the inherent part of medical school curriculum from day one. Integrating physical and mental health teaching with better focus on public mental health is important.

Reducing stigma against mental illness through public education campaigns and educational projects

aimed at school-age students, and by challenging media representation of mental illness

Increase representation of mental health professionals on medical school interview panels where possible and selection candidates with attributes likely to guide them towards psychiatry

Increased and better involvement of psychiatrists in medical school curriculum development, healthcare policy development, healthcare lobby groups, and medical accreditation bodies

Encourage and support the development of extra-curricular 'enrichment' opportunities that give medical students additional teaching and clinical exposure during their training. These may include a psychiatry society or special interest group, elective and residency programmes, early experience programmes, special study modules, using medical humanities in the curriculum and developing local solutions.

WHY CHOOSE PSYCHIATRY

DO YOU WANT AN EXCITING AND CHALLENGING CAREER IN A GROWING SPECIALITY?

DO YOU ENJOY HAVING THE TIME TO WORK HOLISTICALLY WITH YOUR PATIENTS?

WOULD YOU LIKE TO WORK IN A SUPPORTIVE AND STIMULATING ENVIRONMENT THAT MAKES A REAL DIFFERENCE TO PEOPLE'S LIVES?

Psychiatry is more than just the treatment of mental illness. Being a psychiatrist means thinking about your patient as a complete person, investigating and managing psychiatric illness, psychological dysfunction, and social problems.

Psychiatrists have a diverse range of flexible career options open to them, with a range of subspecialties throughout adult, child & adolescent, and old age specializations.

These include forensic psychiatry, eating disorders, neuropsychiatry, medical psychotherapy, and much more. There are opportunities to fit a wide range of interests and working styles.

TOP FIVE REASONS TO CHOOSE PSYCHIATRY:

1. Psychiatry is an intellectually stimulating medical speciality, integrating medicine with philosophy, medical humanities, social sciences, and psychology.
2. Psychiatry gives you the opportunity to really get to know patients and their families and carers and work creatively with them to improve their mental health and lifestyles.
3. The science of psychiatry is evolving rapidly, with fascinating clinical and research opportunities in neuroimaging, epidemiology, genomics, and drug development, psychological and social therapies
4. Psychiatrists are increasingly expected to use their medical skills to monitor and manage physical illness, as well as mental illness.
5. Psychiatry is full of passionate, creative, thoughtful, and supportive doctors, providing an ideal environment to train and abundant opportunities to develop your own special interests in a number of sub-specialities. ■

AN ARTIST

STATISTICS & MENTAL ILLNESS

Christoffel Grobler

Earlier this year (June 2016) I was privileged to attend the opening of Liberty Battson's solo art exhibition, "I bet you wish you did this", at the Absa Gallery, Main Street, Johannesburg. The only reason I was invited to this prestigious event was because my daughter, a design artist herself, assisted the artist with this exhibition.

I was truly awestruck! What impressed me the most about the exhibition at first glance was the elegant beauty and intelligence of it. As I stood mesmerized in front of the paintings, I felt a little bit intimidated by the sheer volume of information. Frantically paging through the accompanying essay, trying to comprehend and process what I was seeing, I eventually had to ask my daughter to interpret for me.

I could not deny that I was moved by what I saw, and suddenly felt a deep sense of compassion and sadness for my fellow human beings, and South Africans in particular, as I realised that statistically, out of the most searched statistics in Google, for topics starting with the first four letters of the alphabet and taking the first four most commonly searched for terms with each letter, twelve of the possible sixteen possibilities were subjects related to mental illness in South Africa in November 2015; alcohol, alcohol abuse, abuse in South Africa, bullying, breast cancer, body image, bipolar disorder, climate change, cyber-crime, cyberbullying, crime in South Africa, drugs, depression in South Africa and drugs in South Africa.

And in February 2016 the most searched for statistics globally were for bullying, social media, depression and smoking. In South Africa for the month of February specifically it was depression in SA, social media, Christmas and bullying.

The following excerpts are verbatim quotes from the Liberty Battson Catalogue, available at the exhibition.



Liberty Battson

Dr Paul Bayliss, Absa Art and Museum Curator:

The artist, Liberty Battson, is the 2014 Barclays L'Atelier winner. The exhibition taps into the very heart of our current technology-based culture to reveal those statistics that were most searched for by online users. The results are represented statistically and visually, allowing viewers to actively participate in the exhibition by inviting them to be part of and decode the searched results. The exhibition offers a glimpse on so many different levels into the current psyche of the global population.

“How beautifully
leaves grow old.
How full of light
and colour are
their last days.”

S4 **Cognimet 10**

MEMANTINE HYDROCHLORIDE
A.34 Other
Reg. No. 44/34/0438

S4 **COGNIMET
(MEMANTINE
HYDROCHLORIDE)**

INDICATIONS¹

For moderately severe to
severe Alzheimer's disease.

Efficacy has not been
established beyond
6 months.

Harmony in Mental Health

Dr. Reddy's



HELPLINE

0800 21 22 23 www.sadag.co.za

Dr. Reddy's



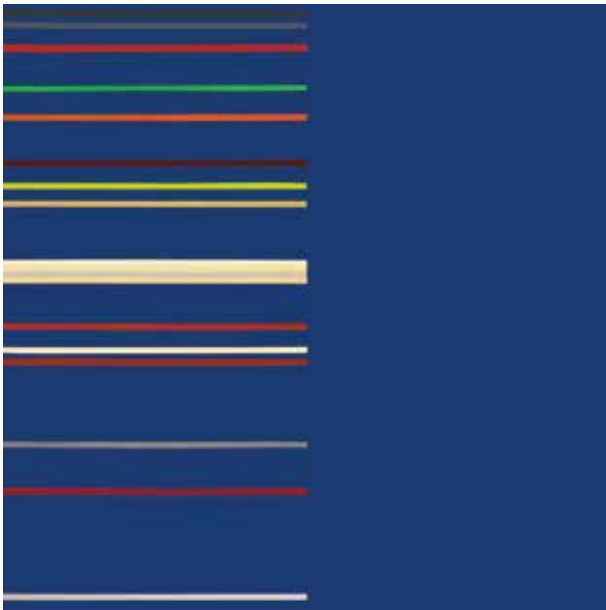
NEUROPSYCHIATRY

GOOD HEALTH CAN'T WAIT

¹ Cognimet Package Insert.

S4 Cognimet 10. Each tablet contains memantine hydrochloride 10 mg. Contains lactose monohydrate. Reg. No. 44/34/0438. Dr. Reddy's Laboratories (Pty) Ltd. Reg. no. 2002/014163/07. North Wing, The Place, 1 Sandton Drive, Sandton 2196, South Africa. Tel: +27 11 324 2100, Fax: +27 11 388 1262, www.drreddys.co.za. ZA/05/2016/Cog/213.

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



Johan Myburg:

Intrigued by stripes and the modernist notion of "pure and absolute divinity through abstraction" Battson researched the origin of the stripe and its role as a discourse in painting, but decided to appropriate its role. She wanted to create stripes with a purpose.

For *I bet you wish you did this*, her first solo exhibition, she decided to use Google, the most used search engine, and with a feature built into it called "Search suggest" or "Google Instant". This feature numerically ranks the most searched results and in doing this, the actual numbers and article related results become irrelevant, and the most searched research becomes the fascinating aspect.

Charles Shields of the Everard Read Gallery in Cape Town had the following to say about the artist:

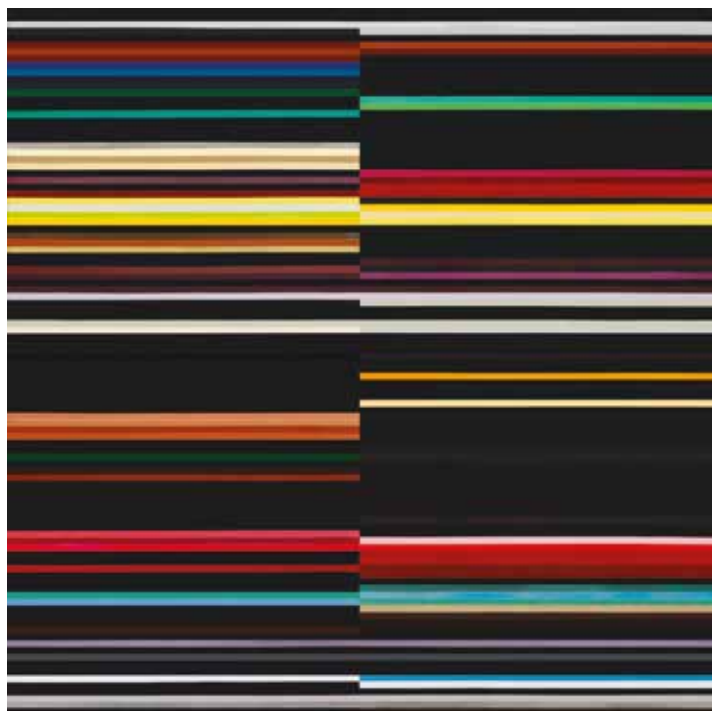
Liberty Battson has the ability to perceive and extract information from an often opaque and unintelligible world, to distil and translate that information into coherent interpretations, and then to present these in intelligent matrices that are also ravishingly beautiful. Her signature, tongue in cheek approach belies the gritty underlying investigations into the human mind and soul as presented by the organic data systems we have evolved and are there for all to see, namely here, Google. Liberty's strength is in being able to present these snapshots that represent a contemporary statistical status quo and yet hint at a deeper, intrinsic human truth.



GOOGLE

"I USED GOOGLE INSTANT WITH THE PHRASE 'STATISTICS ABOUT' COUPLED WITH EACH LETTER OF THE ALPHABET" BATTSON EXPLAINS ABOUT HER METHOD. "THIS FORMULA ENABLED ME TO OBTAIN STATISTICALLY THE MOST SEARCHED STATISTICS. I TRACKED THE SEARCH EVERY MONTH AND WAS ABLE TO DOCUMENT WHAT WAS BUMPED OFF THE CHARTS, WHAT DROPPED, WHAT BECAME 'MORE IMPORTANT' OR SEARCHED FOR. THE DATA OBTAINED THIS WAY REPRESENTED IN MY OPINION A TRUTH TRUER THAN THE ACTUAL NUMBERS".

The exhibition covers Battson's searched statistics for the last six months with each searched result coded in a particular colour. A series of paintings follow the central work representing the changes that occur each month thereafter. The viewer is able to track the changes visually and decode it by means of the legend in the catalogue. Her Google (re)search offered random yet interesting results – for example, statistically Belgium seems to be interested in statistics about Virgins, France about immigration, Greenland about refugees and Kenya about James Bond.

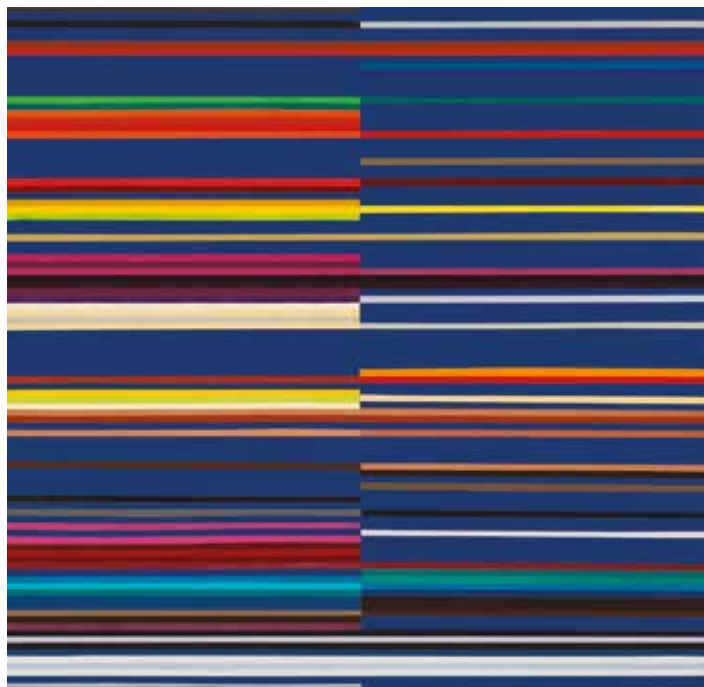


Her paintings allow us as viewers to re-imagine lives, to forge connections between personal biography and social structure, between personal and the political.

A couple of other interesting statistics that Liberty captured in stripes are:

- 46% of South Africans have access to the internet.
- 50% of the world population uses the internet.
- 64% of the world uses Google as their preferred search engine.
- 94% of South Africans use Google as their preferred search engine.
- 19% of Africa as a whole have access to the internet.

BY DECODING THE PAINTING, THE VIEWER WILL BE ABLE TO ACCESS NARRATIVES, TRUTHS AND STATISTICS, WHATEVER YOU WANT TO CALL IT, OF SELECTED SOCIETIES AND THEIR FEARS, HOPES, ASPIRATIONS AND QUIRKS. SINCE (GOOGLED) NARRATIVES DO NOT MIRROR BUT MERELY REFLECT THE PAST, BATTSON'S DOCUMENTED ACCOUNTS ARE IMPORTANT NOT AS RELIABLE REPRESENTATIONS OF A WORLD AT A SPECIFIC HOUR ON A SPECIFIC DAY OF THE MONTH, BUT IN THE SHIFTING CONNECTIONS THEY FORGE AMONG PAST, PRESENT AND FUTURE.



LIBERTY'S WORK WAS ON EXHIBITION FOR THE MONTH OF JUNE AT THE ABSA GALLERY IN JOHANNESBURG AND IN AUGUST HER EXHIBITION MOVED TO THE EVERARD READ GALLERY IN CAPE TOWN.

Christoffel Grobler is a psychiatrist and an Associate Professor, Walter Sisulu University, a Research Associate at Nelson Mandela Metropolitan University and Clinical Head, Elizabeth Donkin Hospital, Port Elizabeth, South Africa.

Correspondence: dr.stof@mweb.co.za

PSYCHOTHERAPY TRAINING FOR PSYCHIATRISTS IN SOUTH AFRICA

Manfred Böhmer

Psychotherapy is an endangered species. Psychiatry's world has become increasingly reductionistic.¹ It would be a great loss to psychiatry if this continues. Knowledge about different schools of psychotherapy, about different views of persons and their psychopathology, linked to a better understanding of the mind-brain interface, is a prerequisite for a sophisticated approach to the treatment of persons suffering from mental illness.

In addition, a sensitivity to existential problems of life, to those things of ultimate concern,² is another quality one would wish to find in a psychiatrist.

In South Africa limited resources and poor funding restricts not only service delivery,³ but also psychotherapy training. Where does psychotherapy fit in if 75 to 80 per cent of individuals with common mental disorders do not receive any treatment?⁴ Furthermore, what is the place of western schools of psychotherapy in Africa?⁵ Are they appropriate and relevant?^{5,6}

The last question was addressed by a meta-analysis of 17 studies that showed efficacy for psychological treatment of depression and anxiety disorders in low- and middle-income countries.⁶ Universal psychotherapeutic approaches should, however, be integrated with contextual phenomena.⁵

An integrative approach is needed in which general aspects of psychotherapy are married with cultural factors.⁵ We furthermore need to find innovative ways to introduce psychotherapeutic approaches in African countries despite socio-economic and resource problems.⁵

Psychotherapy training is of great importance for many reasons. Such training is not only about the ability to conduct psychotherapy, but also essential to help registrars build, maintain and repair therapeutic alliances. Therapeutic alliances not only



Manfred Böhmer

improve engagement and satisfaction with health care services, but also medication adherence and the outcome of treatment.⁷⁻¹²

In thinking about training in South Africa it is useful to look at a model developed in the USA.

PSYCHOTHERAPY TRAINING IN THE USA: THE Y MODEL

THE PSYCHIATRY RESIDENCY REVIEW COMMITTEE OF THE USA REVISED THEIR PROGRAMME IN 2007, REQUIRING COMPETENCY IN ONLY THREE FORMS OF PSYCHOTHERAPY: SUPPORTIVE PSYCHOTHERAPY, COGNITIVE-BEHAVIOURAL THERAPY AND PSYCHODYNAMIC PSYCHOTHERAPY.¹³

The American Psychiatric Association's Commission on Psychotherapy by Psychiatrists developed the so-called 'Y Model', a conceptual approach for teaching these three schools of psychotherapy in a way that frees residents and psychiatrists from unhelpful competition between psychotherapy schools.^{13,14}



THE Y MODEL

The Y Model structure first describes the core features common to both CBT and psychodynamic psychotherapy and as a second step describes features that are particular to each school.¹³

THE STEM OF THE Y: CORE FEATURES ACROSS SCHOOLS

The following modules are taught under the stem of the Y:

- Both CBT and psychodynamic therapy share certain fundamental characteristics. These **common characteristics** are taught to help decrease confusion about multiple approaches. The focus is on the skills needed to build and maintain a **therapeutic alliance**. The other common core features are, amongst others, empathic listening, identification of repeating dysfunctional patterns, attending to boundaries, timing and nature of interventions, matching treatment goals to the presenting problems and patient capacities, motivation, diagnosis and developing a formulation. Early on registrars need to learn to manage the transition from an interviewing stance to a psychotherapeutic approach.

Differences between the two models in their basic assumptions about therapeutic factors and different theoretical concepts are introduced at this stage.

- **Combining medication and psychotherapy.** How to combine CBT or psychodynamic psychotherapy with medication, and how to manage integrated or split treatment, is taught. (The latter refers to the prescribing of medication and the conducting of psychotherapy by one person, or the different tasks being split between two professionals.)
- Core competencies about **brief psychotherapy** and how it is practiced in both schools.
- Teaching in **supportive psychotherapy**.

THE TWO BRANCHES OF THE Y: CBT AND PSYCHODYNAMIC THERAPY

Teaching the features mentioned under the stem are followed by teaching of the two schools of psychotherapy, CBT and psychodynamic psychotherapy.

COMMENTS ON THE Y MODEL

Psychotherapy schools are often defended with the same zeal as religious faiths.¹⁵ The Y Model represents

a valuable effort to emphasise commonalities and limit conflict, which can have a detrimental effect on learning.¹⁴ Furthermore, it is rarely feasible for a single theory to account for the rich variety of clinical phenomena related to mental disorders as well as lesser disturbances in mental health.¹⁵

However, teaching the differences between the two schools as part of the stem of the Y is confusing, since the different schools of psychotherapy are discussed at a later stage as the two branches of the Y. Furthermore, supportive psychotherapy, taught as part of the stem of the Y, might not get the appropriate recognition as a therapeutic approach in its own right.

PSYCHOTHERAPY TRAINING IN SOUTH AFRICA

It is unfortunate that the attitude of so many psychiatrists in South Africa seems to be negative towards psychodynamic psychotherapy. The psychiatrist and Nobel Prize winner Eric Kandel described the psychoanalytic model of mind as the most coherent and intellectually satisfying view of mind we currently have.¹⁶ It would be sad if the richness of this model and the insights it offers into the inner life of patients and ourselves is lost. It also seems that many psychiatrists are not up to date with the latest research about the efficacy of psychodynamic psychotherapy.¹⁷⁻¹⁹

Yet, psychodynamic expressive psychotherapy should not be taught, since the limited time does not allow registrars to reach competency in this form of psychotherapy. Those who wish to pursue and attain competency in this valuable form of psychotherapy will have to do so after having qualified as a psychiatrist.

THE KEY CONCEPTS OF PSYCHODYNAMIC PSYCHOTHERAPY SHOULD HOWEVER BE TAUGHT, BECAUSE THESE ARE NEEDED TO PRACTICE SUPPORTIVE PSYCHOTHERAPY.

In addition, the outcome of pharmacotherapy can be enhanced through the use of psychodynamic concepts, such as the interpretation of medication transference and understanding of resistance.¹² Unprocessed countertransference can also be a problem for prescribers, for example rejection of treatment non-responders or irrational polypharmacy.¹²

Supportive psychotherapy is a psychotherapy with the goal of relieving symptoms and improving self-esteem, ego function and adaptation to reality.²⁰⁻²³ Although it is probably the most widely used of psychotherapeutic interventions, supportive psychotherapy is often misunderstood.²³ It is not an eclectic approach of 'being supportive', or nice; nor is it an umbrella term for 'anything goes'. Supportive psychotherapy was previously seen as a 'second-rate therapy for second-rate patients'.²³ In many studies supportive therapy has, however, done well. One study, comparing Transference-focussed Psychotherapy (TFP), Dialectical Behaviour Therapy (DBT) and supportive therapy for borderline patients found no clear differential outcome among treatments.²⁴ In another study, supportive therapy matched CBT for depressed HIV-positive patients, despite fewer sessions.²⁵ In a study on PTSD, fewer patients dropped out of supportive therapy than exposure therapy.²⁶

Supportive psychotherapy is based in a psychodynamic understanding of the patient and all interventions of the therapist should be consistent with that understanding.²⁰ A psychodynamic formulation is thus required. Such a formulation is an attempt to reach a better understanding of the unique inner life of the patient and to guide the treatment interventions.²⁷

THINKING IN A PSYCHODYNAMIC WAY AND CREATING SUCH A FORMULATION DOES NOT MEAN THAT THE PSYCHIATRIST WILL NECESSARILY WORK IN A PSYCHODYNAMIC THERAPEUTIC WAY WITH THE PATIENT.

For example, such a formulation could lead to the recommendation to use CBT as treatment approach and is also of importance in patients where a biological approach will be followed.²⁷ Although supportive psychotherapy is here described as a form of psychodynamic psychotherapy, it is informed by other approaches, such as the cognitive-behavioural approach.²¹ A combination of psychodynamic and cognitive-behavioural techniques can be used in supportive psychotherapy.¹³

South African registrars carry a heavy load trying to balance training and service delivery. A realistic approach to psychotherapy training would therefore be to focus the teaching on CBT and supportive psychotherapy.

A SOUTH AFRICAN MODEL COULD LOOK AS FOLLOWS:

1. Teaching of core features across schools of psychotherapy
2. Psychodynamic concepts
3. Creating a psychodynamic formulation

4. CBT
5. Supportive psychotherapy
6. Teaching combining medication and psychotherapy.

SOME FINAL COMMENTS ON TEACHING PSYCHOTHERAPY IN SOUTH AFRICA

In South Africa, as evidenced inter alia by the psychotherapy blueprinting of the College of Psychiatrists of South Africa, there is an unrealistic expectation that more schools of psychotherapy should be taught to registrars.

This expectation indicates an underestimation of the difficulty in reaching competency in a single form of psychotherapy. It is preferable to train in a few key and broadly applicable psychotherapies that will allow for more depth in knowledge and greater competency in that psychotherapy, than to train in many more, but with the unfortunate result of more superficial knowledge and less competence. Consequently, the College of Psychiatrists of South Africa is hereby encouraged to pursue teaching and training in a few key psychotherapies, leaving the pursuit of other schools of psychotherapy to already qualified psychiatrists.

Finally, Gabbard has some important tips how not to teach psychotherapy.¹⁵

A SELECTION OF THOSE ARE:

- Don't teach psychotherapy as though it is entirely isolated from the rest of psychiatry.
- Don't use 'straw man' arguments to denigrate approaches that are different from yours. Meta analyses generally show few differences in the outcome of most psychotherapies, with the exception of some specific disorders, e.g. OCD.
- Psychotherapy research has demonstrated that the therapeutic relationship accounts for most of the variance in outcome, especially when the therapist is experienced and flexible in his or her way of conducting therapy. Technique only accounts for 12 - 15 per cent of the variance across different kinds of psychotherapies.
- Don't assign non-psychiatrist faculty to teach psychotherapy to residents. This is not because they might be inept, but rather because registrars internalise role models. They observe what and how their consultant psychiatrists practice.¹⁵

IN THE END WHAT MATTERS MOST IS HOW THE REGISTRAR INTERACTS WITH THE PATIENT & WHETHER THE PATIENT IS TREATED AS A PERSON.

Acknowledgement: The author would like to thank the clinical psychologist Jeanette Blom and the psychiatrist Professor Pierre Joubert for helpful comments on a draft of this article.

Manfred Bohmer is a psychiatrist in the Department of Psychiatry, Weskoppies Hospital, University of Pretoria. References are available from the author. **Correspondence: Manfred.Bohmer@up.ac.za**

Yelate
DULOXETINE

YELATE
(DULOXETINE)

INDICATIONS¹

Yelate is indicated for the treatment of:

- Depression as defined by DSM-IV Criteria
- Diabetic peripheral neuropathic pain (DPNP)



Harmony in Mental Health

Dr. Reddy's



HELPLINE

0800 21 22 23 www.sadag.co.za

¹ Yelate Package Insert.

^{SS} Yelate 30/60. Each capsule contains duloxetine hydrochloride equivalent to duloxetine 30/60 mg. Reg. No's 44/12/0114/0115. Dr. Reddy's Laboratories (Pty) Ltd. Reg no. 2002/014163/07, North Wing, The Place, 1 Sandton Drive, Sandton 2196, South Africa. Tel: +27 11 324 2100, Fax: +27 11 388 1262, www.drreddys.co.za. ZA/12/2015/YEL/17B.

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

Dr. Reddy's



NEUROPSYCHIATRY

GOOD HEALTH CAN'T WAIT

THE DELUSION OF INDEPENDENCE A REFLECTIVE ESSAY

Thirusha Naidu

AMBOUS MUNDOS

*A hotel on El Cocodrilo,
Seasoned by Yemaya's salty breath drifting over
The Malecon at the crossing of two worlds
Two men of letters converse across time
Three hundred years apart, joined in one mind
Hemingway, a wayward independent
A son of the brave and the free
Re-sounding the words of Donne Metafisico
"Do not send to know for whom the bell tolls...It tolls for thee"
Do not ask whose time has come...It is yours
The Bald Eagle swoops down on shadow wings
His fateful talons to crack the Alligator's
sun-drenched back
Hemingway and Donne in one voice call
"No man is an island unto himself,
Not one is a person without people
Yemaya's single cloak of liquid azure shared at the shores
Of two worlds, crashing connecting colliding
Me and my people without whom I cannot be
My people I leave, but I cannot away.
I am them and they are me
Any one's death diminishes me
I will never send to know for whom the bell tolls
It tolls for me...*



Thirusha Naidu

In December 2015 I visited Cuba. A last desperate trip before capitalism swooped to sink its eagle claws into the verdant alligator-shaped atoll. At first glance the city of Havana appears to be a derelict abandoned city scattered with crumbling buildings and garish patched together 60 year old cars. Haute couture does not swish through Havana's cobbled streets.

Cubans have a quaint but distinctive fashion sense that hovers between Caribbean beach wear and China mall knock offs and which stands out in stark contrast to its free healthcare, free education and a 98.2% literacy rate- none of which are branded. Cuba's public health system is exemplary in the Caribbean where its neighbors such as Jamaica and Haiti struggle with basic health care needs and maintaining decent mortality statistics.

INDEPENDENCE

CHILDREN ARE INFLUENCED THROUGH PARENTING, IN SCHOOLS AND IN THE MEDIA TO BE INDEPENDENT.

No single Cuban is 'well-off' and until recently Cubans could not own property, so there may be a price to pay for this "for the good of all" approach. Almost 80 years ago and a mere 13 years before Fidel Castro and Ché Guevara would lead the Cuban revolution which forged Ché's image as an icon of rebellion and independence, another wayward spirit, Ernest Hemingway, struggled with ideas of personal and political independence portrayed in his most famous novel "For whom the bell tolls". This iconic work was written whilst Hemingway lodged at Havana's aptly named *Ambous Mundos* ("Two worlds" in Spanish) Hotel. The title of Hemingway's novel echoes a line from 17th century metaphysical writer and poet John Donne's extensively quoted line from the homily "No man is an island".

THE TERMS *AMBOUS MUNDOS* (TWO WORLDS) AS IT IS USED IN SPANISH MAY REFER TO THE DEVELOPING AND DEVELOPED WORLDS; LIVING BETWEEN TWO CULTURES OR TWO SPACES- THE INNER (PERSONAL WORLD) AND OUTER (SOCIAL WORLD) OR THE INDIVIDUAL WORLD AND THE COLLECTIVE WORLD. MODERN WESTERN CULTURE VENERATES PERSONAL ACHIEVEMENT, SELF-SUFFICIENCY AND INDEPENDENCE. CHOICE, AUTONOMY, LIBERTY AND AGENCY HAVE UNDENIABLY POSITIVE, EVEN ASPIRATIONAL, OVERTONES. SELF-DETERMINATION, SELF-SUFFICIENCY, EXCLUSIVITY AND SECLUSION AS A CHOICE ARE PRESENTED AS CRAFTILY CULTIVATED REWARDS FOR SHAKING OFF THE SHACKLES OF ACCOUNTABILITY.

This separation and the person and the group is so entrenched that American social scientist Robert Putnam had to reintroduce the concept of social co-operation and the value of communal

interdependence to America as social capitalism in his seminal book "Bowling Alone" (Putnam, 2001). Putnam explains how interdependence, trust and reciprocity amongst other social values are crucial for strengthening the fabric of society and ultimately benefits both individuals and their groups. Despite being commonplace concepts in collectivist Southern Italy where Putnam conducted his fieldwork that led to his observation, they were novel and even revolutionary in the individualist social environment of the United States. It is interesting that Putnam had to temper what could easily be misinterpreted as socialism by described these social phenomena as jointly increasing "social capital"! A vestige of the industrial revolution in Europe fueled this striving for independence, promoting the notion of each person for him/her self and encouraging a drive for personal material success. In the capitalist discourses that have arisen from the hearth of the industrial revolution, personal wealth is idealized as the ultimate indication of success. This drive has permeated every level of Western society and has come to be taken for granted as the norm. Children are influenced through parenting, in schools and in the media to be independent.

We subtly influence our young to value their own opinion over others, to prize speaking over listening, voice over humility, agency over fellowship and assertiveness over conformity. We revere leaders and forget followers and in so doing we deprive our descendants of the skill required to participate cooperatively with tact, patience, humility and diplomacy in social groups. All of are far more valuable for a social species, such as ourselves, than individual advancement. As any evolutionary biologist will attest, we are in effect committing evolutionary suicide through this veneration of individuality. In our social reality, in all our actions, we affect and are affected by others.

INDEPENDENCE

From a mental and social health perspective the modern human striving for independence and self-sufficiency might akin to a destructive imperative. Harari (2011) notes that we pay a high physical cost for our advanced brain, having to eat more and sacrificing physical prowess, yet unlike other social species (other primates, elephants, dolphins etc.) we have neglected skills that allow us to reciprocate in our social grouping in favour of individual success, a counter-evolutionary choice. It has been suggested that the most impairing of mental illnesses, schizophrenia is the price we pay as a species for the rapid development (in evolutionary terms) of the neocortex (Burns, 2007). Burns (2007) makes an elegant argument for why personal freedom is in fact based on a strong identification with one's social origins. Social stratification and fragmentation characteristic of the last millennium has disenfranchised people from social and communal connections.

While there is the popular emphasis on independence, thought leaders are swinging the pendulum towards a more social approach to thinking. In his book, *Social Intelligence*, Daniel Goleman presents the idea of social intelligence to a lay audience proposing it essentially as a means to succeed socially and improve personally. Goleman (2006) in a development of the idea, presented in his book "Emotional Intelligence" (Goleman, (2000), proposes the idea that "good relationships nourish and support health and toxic relationships poison us". Whilst this may seem to be a basic skill, effective social interaction and the interpretation and prediction of others' behaviour requires an advanced set of proficiencies developed over an extended period of time.

SOCIAL ANIMALS LEARN, IN CONTEXT, ABOUT THEIR INDIVIDUAL SOCIAL POSITIONS; HOW TO INTERPRET AND INFLUENCE THE BEHAVIOUR OF OTHERS IN THE GROUP THROUGH TRIAL AND ERROR, MODELLING AND MEDIATION BY OTHERS (USUALLY PARENTS). IN WESTERN CONTEXTS SOCIAL INTELLIGENCE OR THE ABILITY TO READ, AND INTERPRET SOCIAL CUES IN GROUP OR INDIVIDUAL INTERPERSONAL CONTEXTS HAS SUFFERED NEGLECT...

Attachment theorists contend that personality disorders, especially the disorganized structure and manifestations of borderline personality, result from flawed attachment to a primary object (caregiver) with consequent poorly mediated and replicated relationships and a poor sense of self. Peter Fonagy and Anthony Bateman have utilized mentalisation based therapy to help patients relearn the social skill of reading the behaviour of others and reflecting on the responses of others to their own behaviour (Bateman and Fonagy, 2004; 2006).

THEY POSSESS THE COGNITIVE ABILITIES THAT CAN CREATE THE MOST ADVANCED TOOLS & PROCESSES THAT MAKE HUMAN BEINGS AS DISTINCTIVE IN THE ANIMAL WORLD AS OUR COMPLEX SOCIAL BRAINS & ATTRIBUTES.

Mentalisation is the process by which we implicitly and explicitly interpret the actions of self and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs, and reasons (Bateman and Fonagy, 2004; 2006). Psychologist and neuroscientist Louis Cozolino (2010) offers a comprehensive and well researched case for why psychotherapists should take a neuroscience perspective of social brain approach in psychotherapy. He illustrates how the brain's architecture is related to the problems, passions, and aspirations of human beings and that an understanding of the brain rests on the notion that the healthy, living brain is inextricably embedded in a community of other brains. Cozolino is emphatic about relationships being our natural habitat.

OUR SOCIAL BRAINS HAVE EVOLVED TO ENHANCE OUR VERY SURVIVAL VIA OUR ABILITY TO DETECT AND INTERPRET THE BEHAVIOURS AND INTENTIONS OF THOSE AROUND US (COZOLINO, 2010; COZOLINO, 2014)

Autism is possibly the clearest manifest problem with the social brain. Investigative journalist, Steven Silberman (2015) presents the idea that autism and people who present with behaviour on the autism spectrum have always been prominent in society, contrary to traditional views that it is a new condition resulting from reactions to vaccinations or

an increasingly individualistic society encouraged by flourishing cyber-socialising. Silberman presents an argument for the idea that the range found in an autistic presentation represents evidence for social neurodiversity amongst humans. He suggests that people on the autistic spectrum might now be more visible because of a generally reduced social tolerance for difference. In more co-operative societies, as existed in the past, autistic people and those with more subtle manifestations of the spectrum, such as schizoid personalities, had their place in society and were supported by other individuals within families or their immediate social group.

SILBERMAN NOTES THAT IN AREAS OF HUMAN ENDEAVOUR THAT REQUIRE DISTINCTLY NON-SOCIAL ATTRIBUTES SUCH AS ADVANCED MATHEMATICS, THEORETICAL PHYSICS, ENGINEERING AND COMPUTER CODING, CERTAIN TYPES OF AUTISTIC AND SCHIZOID THINKERS THRIVE.

They possess the cognitive abilities that can create the most advanced tools and processes that make human beings as distinctive in the animal world as our complex social brains and attributes. It is tempting to see this as further evidence that both people with distinctly social and technical brains would benefit most from social groupings where each benefits from the others talents.

It tolls for me...

While all of this makes for a convincing argument that humans are indeed social animals in form and function, it leaves clinicians in the dark as to how to apply this in clinical contexts.

AFTER DECADES OF TRAINING AND PRACTICE IN MENTAL HEALTH AND PSYCHIATRY, CLINICIANS AND THEIR PATIENTS MAY CONTINUE TO BE CONVINCED, AND TO TEACH, THAT BY CHANGING ONE'S MIND OR MEDICATION ONE COULD CHANGE ONE'S LIFE. IT WILL TAKE GARGANTUAN EFFORTS TO PERSUADE CLINICIANS THAT IN FACT SOME OF THEIR PATIENTS MIGHT BEST BE SERVED BY ADJUSTMENTS TO THEIR SOCIAL CIRCUMSTANCES AND CONTEXTS.

Perhaps the recent explosion of interest on mirror neurons and empathy, exploring the workings of highly specialised neurons which fire in response to merely observing others expressing emotions, present convincing evidence for the fact that the workings of the social brain are identifiable and therefore may be influenced at a cellular level (Iacoboni, 2008; Singer & Lamm, 2009).

Harking back to the work of Thomas Szaz, who proposed the idea of mental illness as a metaphor where illness is something that people have and behaviour is something that people do. Szaz opposed the idea that schizophrenia was a true illness, citing the idea that illness represents "malfunctions of the human body, of the heart, the liver, the kidney, the brain" while "no behaviour or misbehaviour is a disease or can be a disease".

He essentially warned against the secularization of religion's hold on the human species through what he termed scientism "Since theocracy is the rule of god or its priests, and democracy the rule of the people or of the majority, pharmacracy is therefore the rule of medicine or of doctors".

Developments in neuroscience through the work of various neuroscientists show there are neurological bases for conditions such as schizophrenia, autism, bipolar disorder etc. Neuroplasticity ensures that the brain can undergo physical change in response to environmental (social) conditions resulting in conditions such as borderline (and other) personality disorders. There is mounting evidence for epigenetic foundations for mental conditions such as schizophrenia (Akbarian, 2014; Shorter and Miller, 2015) and definitive investigation towards epigenetics in Autism Spectrum Disorders. It remains to be seen when and how intensively researchers will research the effects of social environments on genes. Admittedly given the global diversity and complexity of modern human social groups and contexts this will need to be preceded by research into environmental factors that are common in most human communities and contexts.

What would Szaz's response be if he were presented with the current neuroscience revolution? It is not inconceivable that he would point out, as Baron-Cohen & Belmonte (2005) and other neuroscientists have done, that this is in fact a social neuroscience revolution and that this new epoch is likely to be characterized not by theocracy, democracy, pharmacracy or even communalism, but by co-operation, flux and a consideration of context.

IN THE FUTURE THE TREATMENT OF MENTAL CONDITIONS WILL CONSIDER THE KIND OF GENES, THE KIND OF BRAIN, THE KIND OF CONTEXT, AND THE KIND OF SOCIAL GROUP THE PERSON PRESENTS WITH - ALL IN EQUAL MEASURE. THEN, AS IF THAT WERE NOT ENOUGH ON ITS OWN, HOW ALL OF THIS WORKS (OR DOESN'T) TOGETHER. THIS WILL CALL FOR AS YET UNPRECEDENTED COLLABORATION BETWEEN THE SOCIAL AND MEDICAL SCIENCES - A TASK OUR SOCIAL BRAIN WAS DESIGNED FOR.

Thirusha Naidu is a clinical psychologist in the Department of Behavioural Medicine, School of Nursing and Public Health, Nelson R Mandela School of Medicine, University of KwaZulu-Natal and Head of Unit: Psychology, King Dinuzulu Hospital Complex. References are obtainable for the author. **Correspondence: Naidut10@ukzn.ac.za**

S5 **rispacor**
risperidone

Do your patients suffer from:

- Schizophrenic Psychoses¹,
- Affective symptoms associated with schizophrenia¹,
- Dementia related behavioural disturbances¹,
- Disruptive behaviour (Paediatrics aged 5-12 years)¹.

Revive Normality



Reference: Refer to package insert for more info.

S5/Rispacore 0.5; 1; 2; 3 and 4

Each tablet contains 0.5; 1; 2; 3 and 4 mg of Risperidone respectively.

Reg. No's.: 42/2.6.5/0155; 42/2.6.5/0156; 42/2.6.5/0157; 42/2.6.5/0158 and 42/2.6.5/0159

Applicant: Accord Healthcare (Pty) Ltd. Reg. No.: 2004/011257/07.

For full prescribing information refer to the package insert approved by the Medicines Regulatory Authority.

accord
healthcare

Accord Healthcare (Pty) Ltd
Building 2, Tuscany Office Park, 6 Coombe Place,
Rivonia, Gauteng, SOUTH AFRICA. Tel: +27 11 234 5701 Fax: +27 11 234 5700
Postnet Suite 182, Private Bag X51, Rivonia 2128, medinfo@accordhealth.co.za



www.accord-healthcare.co.za

ANGUISHED CHILDREN

Guddi Singh

Through the brown haze of pollution the sun signals the arrival of afternoon on row upon row of tiny, tin-shack mirrors. “New homes,” my guide, Annie says, “to replace the old ones by the river”.

Look to where Annie points: dirty and dilapidated lean-tos, surrounded by mud. The new homes are certainly better: bright silver, high and dry; but they are still no more than 2 by 2 metres of corrugated zinc. This is not sci-fi dystopia but life on earth. We drive through Alexandra township in Johannesburg, South Africa, en route to a clinic to learn more about kindness.

UBUBELE - ZULU FOR KINDNESS - OFFERS MENTAL HEALTH SERVICES TO THE PEOPLE OF ALEXANDRA. ESTABLISHED IN 2001 BY SOUTH AFRICAN CLINICAL PSYCHOLOGISTS, TONY AND HILLARY HAMBURGER, UBUBELE REPRESENTS MORE THAN ITS LITERAL MEANING, HOWEVER.

Alexandra was originally founded in 1917 as Johannesburg’s demand for cheap black labour surged. When Nelson Mandela arrived in the city in 1940, he rented a room there, describing it as “desperately overcrowded: every square foot occupied either by a ramshackle house or tin-roofed shack... Gangsters – known as tsotsies – carrying flick-knives were plentiful and prominent at night. Police raids were a regular feature of life”. 75 years later, Alexandra remains an impoverished black ghetto. Poor housing and overcrowding; extreme poverty and unemployment, serious crime and HIV: the heady cocktail of life in the townships.

Light filtered in, illuminating dust suspended in the air like sediment in a pond; my head felt like a sack of pulp. Ububele puts into practice what I



Guddi Singh

dimly remember from a dusty Cambridge lecture once upon a time. John Bowlby was one of the first psychoanalysts to recognize the importance of attachment for infant growth and wellbeing. “Intimate attachments to other human beings are the hub around which a person’s life revolves, not only when he is an infant, toddler or schoolchild, but through his adolescence and years of maturity on into old age.”

SINCE ITS INTRODUCTION ATTACHMENT THEORY HAS BECOME AN IMPORTANT TOOL FOR UNDERSTANDING THE CENTRALITY OF A HEALTHY RELATIONSHIP BETWEEN CAREGIVER AND NEWBORN CHILD.

Inadequate attachment is thought to drive many of the psychopathologies that plague our families and communities: borderline personality, post-traumatic stress, conduct and anxiety disorders all have their roots in it.

But in a place with 20% of the population in extreme poverty, more HIV-infected people than any country in the world, and a health system in crisis, attachment may seem an odd thing to prioritize.

MANDELA SAID: "THE REWARD OF THE ENDING OF APARTHEID WILL, AND MUST BE, MEASURED BY THE HAPPINESS AND WELFARE OF OUR CHILDREN."

Yet many township children are burdened by emotional suffering arising from poverty, unemployed or absent parents, physical and sexual abuse, and an HIV/AIDS pandemic that robs them of their childhoods. To ignore the mental scars of a country that only emerged from the horror of apartheid two decades ago - and which now suffers unprecedented levels of inequality - is to misunderstand South Africa's real predicament.

Take Alexandra: close to 180,000 people live in substandard homes, many lacking basic amenities like running water and reliable electricity. Up to 15% of households with children experienced hunger in 2012. Yet Sandton, Africa's richest neighborhood, is just a stone's throw away. Opulent malls, luxury housing; the gleaming towers of glass and steel cast long shadows over the wretched lives of Alexandra.

SOUTH AFRICA'S TRAUMA IS ONGOING: HIGH SPIKED GATES, SECURITY GUARDS AND CLOSED-CIRCUIT TELEVISION REFLECT THE DEEP ANXIETIES OF PEOPLE LIVING IN FEAR. HAVING NEVER TRULY RESOLVED THE CRIMES OF THE PAST, SOUTH AFRICA IS SUSPENDED IN A FRAGILE PEACE: CITIZENS AT WAR EVERY DAY, IN MINISCULE WAYS. IN JO'BURG, THE HOMICIDE RATE IS 31 FOR EVERY 100,000 OF THE POPULATION (IT'S JUST 1 PER 100,000 IN THE UK), WHILE THE COUNTRY AS A WHOLE HAS THE HIGHEST RAPE RATE IN THE WORLD. APARTHEID AS A POLICY MAY BE OVER, BUT PEOPLE'S MINDS - AND LIVES - REMAIN FRACTURED.

Annie is an Ububele graduate. She first came to the centre when she was four years old, having been repeatedly raped by a seventeen year-old cousin, who in turn had been tortured in prison. His crime: stealing to feed the family. Today her calm, measured disposition belies this history, but when she first came to Ububele, she acted out the sexual assault by violently rocking on a wooden horse, before alternating between hurting and comforting dolls.

This is where Ubebele comes in. Money alone cannot right the wrongs of racial discrimination and grotesque wealth inequality. People need tools to help them come to terms with the world, and they need them early. Researchers have identified the first 1,000 days of a child's life—from pregnancy to the 2nd birthday—as critical to intellectual development and lifelong health.

In terms of nutritional, emotional and mental health, this is a period of enormous potential and vulnerability; children who enjoy nurturing relationships during this period are 50% less likely to engage in criminal activity and drug use or need antidepressants in later years. Through psychotherapy, Ububele provides the children of Alexandra with tools for reconciling the

past and the present. But in communities where sexual and domestic abuse abound, and where people still grapple with the repercussions of AIDS, caregivers are often emotionally crippled themselves.

Ububele has pioneered a program called "Umdlezane". In Zulu culture, Umdlezane is the period after parturition when mothers are released from their duties to focus on their newborns. The program is designed to assist HIV-infected mothers in bonding with their child: prophylaxis against future mental health problems. In the local clinic, I got to see one popular example in action: "The Baby Mat". A rush mat is placed on the waiting room floor; mothers and babies take their seats to interact with a psychologist and with each other. Closed wounds open; statue-faces melt. Women immobilized by patriarchy, poverty and poor health come alive on the mat, an island of confession in a sea of uncertainty. After this initial divulgence of secret worries and woes, a follow-up can be made to more closely investigate the surrounding health and social situation, facilitating early identification and referral. Close links are thus forged between biomedical and psychological services, integrating care in an anything but integrated health system.

WHAT ABOUT LOVE, TIME AND TOUCH?

The late summer heat comes in earnest; the trees I walk beneath are wilting umbrellas. Climbing the hill to the hospital, I sprout a thin moustache of sweat. But I'm not in South Africa anymore; I'm in Barnet, London. Leafy, quaint and prosperous, the dust of Alexandra seems a million miles away.

Here I encounter another Annie: same name, same kind of problem, just different circumstances. With ten times the population of Jo'burg in about an equivalent area, London pulses with the heartbeat of the 21st century.

A hive of hope, ambition, festering grievance and ambient envy, is there a soul in this enriching, unequal city who doesn't blame their dissatisfaction on someone else? Wealthy citizens accuse council estate dwellers and street beggars of making the city filthy and unlivable, even as an oversupply of human labour keeps the wages of their cleaners, drivers and security guards low. Poorer residents complain about the obstacles - both physical and social - that the rich and powerful erect to prevent them from sharing in the wealth.

At 15, Annie is told she is one of the lucky ones. She lives in a nice suburban home with a spacious bedroom; she has her own smartphone and receives a tidy allowance to spend with friends at private school. But she's on the ward when I meet her, because when she walks down the street she has an almost irrepressible urge to throw herself under a bus.

She finds relief in scoring her skin with kitchen knives, chalking up her pain for all to see. Her parents, financial traders, leave the house before she wakes

and return just in time to chastise her for binging on YouTube. She is lonely. She can't remember the last time she was hugged.

HAVING PLENTY IS CLEARLY NOT ENOUGH.

Healing the mind is an art, as well as a science, and one that we in the West are only just beginning to fathom. At Barnet, I am struck by the disproportionately high number of children presenting with suicidal ideation, deliberate self-harm and depression.

Modern paediatrics is burdened with increasing numbers of children with medically unexplained symptoms. Perhaps what these children really lack is closer attachment? A recent Children's Society report, which looked at 15 diverse countries, ranked England 14th for life satisfaction in its young people - ahead only of South Korea. Children in England are among the unhappiest in the world.

WHAT ARE WE DOING WRONG? ADMITTEDLY, CHILDREN HERE HAVE THINGS – MATERIAL COMMODITIES – BUT WHAT ABOUT LOVE, TIME AND TOUCH? AND TO WHAT EXTENT DOES THE MEDICAL MODEL RECAPITULATE THE PARADOXICAL POVERTY OF THIS APPROACH? IN PEDDLING PILLS AND POTIONS, WESTERN MEDICINE IS LIKE THE PARENT EXPERIENCING THE GENERATION GAP: THE NOSTRUMS ARE NOT JUST ILL-SUITED TO THE PROBLEM, THEY DON'T EVEN BEGIN TO GET IT.

By contrast, Ububele's novel combination of Western and traditional African methods – bringing the insights of psychotherapy and collectivism together – critically, moves us away from treatment to prevention. Programmes designed to support early childhood development and wellbeing cost significantly less than therapeutic intervention in adolescence and adulthood.

Across the globe, mental health is now the number one cause of adult morbidity – but 50% of these disorders appear before the age of 15. In the UK, suicide is the second leading cause of death in young people. Yet, even here, for every child psychiatrist, there are 1400 children with diagnosable mental health problems; a long period of austerity only further enfeebles the already fragile provisions for child mental health.

When 40% of paediatric outpatients have a significant mental health aspect to their presentation, why don't doctors screen for it with every consultation? Medicine's fear of the intangible world of the psyche hamstrings both its own potency and the future of our children.

I consider the UK today – widening inequality, growing intolerance, and the withdrawal of the social safety net – and I shudder to think about the mental futures of children in places like Tower Hamlets, Glasgow and Liverpool. Or even Barnet. Places not so far away from Alexandra, after all.

South Africa teaches that we are breeding a future of discontent in the UK. But to have any hope of dealing with this, it's going to take more than just programmes like Ububele.

GIVING CHILDREN A HAPPY CHILDHOOD SHOULD BE OUR TOP PRIORITY. RESILIENCE IS ONE THING, BUT WHAT WE REALLY NEED IS A KINDER SOCIETY: ONE THAT FACILITATES EQUALITY INSTEAD OF STRATIFICATION, CONNECTEDNESS INSTEAD OF ALIENATION, AND CONTENTEDNESS INSTEAD OF CONSUMERISM. OUR POLICIES, HOWEVER, RUN IN EXACTLY THE OPPOSITE DIRECTION. RECOGNIZING THIS IS THE FIRST STEP – OR WE WILL NEVER BE ABLE TO CREATE A WORLD WHERE CHILDREN LIKE ANNIE CAN REALLY FEEL LOVED.

Guddi Singh is a paediatric registrar in London (Barnet Hospital, National Health Service, UK) with wide experience in global health. Most recently, she was Economic Justice Programme Co-ordinator for Medact, a UK based organisation of health professionals concerned with global health, working on issues related to conflict, poverty and the environment. She studied medicine at the University of Cambridge before obtaining a Masters in Public Health from Harvard University in 2010. She also has a Diploma of Tropical Medicine and Health (DTM&H) from the London School of Hygiene and Tropical Medicine (LSHTM) and has experience of work in India, Tanzania, Uganda and South Africa. Passionate about social justice and challenging barriers to access to health, Guddi has previously worked for the World Health Organization (WHO) and has actively campaigned against the privatization of the National Health Service (NHS). **Correspondence:** guddisingh@doctors.org.uk

DEPARTMENTS OF PSYCHIATRY UNIVERSITY OF THE WITWATERSRAND



NEUROPSYCHIATRY SEMINAR

21st - 23rd SEPTEMBER 2016



From L to R: Mlinganisi Sibandze, Craig Bracken, Sandra Fernandes, Islam Hassan, Annie Kuan (UBC), Trevor Hurwitz, Ralf Brummerhof, Janice Buckley, Gregory Jonsson, Pevashnee Naicker, Yvette Nel and Carla Kotze (University of Pretoria).

The Department hosted a 3 day seminar (21st - 23rd September) in collaboration with the University of British Columbia (UBC) and funded by the Wits Donald Gordon Medical Centre (WDGMC). A range of lectures were presented, by both local and international speakers, covering a range of topics related to neuropsychiatry.

These included traumatic brain injury/post-concussion syndrome, dementia (neuropsychiatric aspects/neuropathology/neurogenetics), HIV related neurocognitive disorder and epilepsy. Local psychiatrists presented relevant case material. The event was held at the WDGMC but also included presentations at Tara Hospital and Milpark Hospital.

Dr Gregory Jonsson developed the program and coordinated the seminar on behalf of the Department's Neuropsychiatry working group and the WDGMC.

Comments from the UBC attendees included those received from Annie Kuan

"Thank you so much for organizing the seminar and for the great hospitality. It was nice to meet everyone, and Jo'burg has been an amazing experience"

and from Islam Hassan

".. let me also express my appreciation for the warm hospitality and stimulating academic interaction. It has been a rich experience on numerous levels and I look forward to future collaboration."

The intention is host an annual seminar in collaboration with UBC and the WDGMC.



From L to R: Trevor Hurwitz (UBC), Islam Hassan (UBC), Gregory Jonsson (Wits), Christopher P.Szabo (Wits)

UNIVERSITY OF THE WITWATERSRAND



FACULTY OF HEALTH SCIENCES: RESEARCH DAY



Lesley Robertson and Ugash Subramaney

The organising committee of the University of the Witwatersrand's Faculty of Health Sciences Research Day invited the Department of Psychiatry's Ugash Subramaney and Lesley Robertson to participate in a round table discussion on the topic of: "Are we winning the fight in managing mental health issues in the country?".

Other panelists included Professor Daleen Casteleijn (OT, Therapeutic Sciences) Dr Nkoko Nkoko (Registrar, School of Public Health) and Dr Gail Langley (Psychiatric nurse from the Wits School of Nursing, retired).

Issues raised by the panelists included:

1. Changes (for better or worse) in managing mental health issues in the country in the last five years?
2. Priorities to be considered in the management of mental health issues in the country in the next five years.
3. Will the additions in the new sustainable development goals be sufficient to put the spotlight on mental health issues in South Africa?

Lively discussion was held with regard to these issues and the entity of public mental health and community psychiatry was again at the forefront.

PSYCHOTHERAPY WORKSHOP

JULIAN STERN



Craig Bracken, Ugash Subramaney, Julian Stern, Cora Smith

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

CERTIFICATE OF ACHIEVEMENT


TAU FELLOW

Adj Prof. Subramaney successfully completed all the requirements of the TAU Fellowships Programme (2015-2016).



UNIVERSITY OF KWA-ZULU NATAL





health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:
TOWN HILL HOSPITAL
HUMAN RESOURCE

Hyslop Road, Pietermaritzburg, 3200
Private Bag X400, Pietermaritzburg, 3200
Tel: (033) 341 5648 Fax: (033) 345 5720 Email: sindisiwe.khumalo@kznhealth.gov.za
www.kznhealth.gov.za

Post	: Medical Specialist Psychiatrist Grade 1, 2 or 3 (4 posts)
Centre	: Townhill Hospital
Reference	: THH 12 /2016
Remuneration	: All-inclusive salary package (This inclusive Package Consists of 70% basic salary and 30% flexible portion that may be structured in terms of the applicable rules)
Grade 1 Salary	: R 924 378.00 P.A.
Experience	: Not applicable
Grade 2 Salary	: R 1 056 915.00 P.A.
Experience	: 5 years appropriate experience as a Medical Specialist after registration with HPCSA as a Medical Specialist
Grade 3 Salary	: R 1 226 595.00 P.A.
Experience	: 10 years appropriate experience as a Medical Specialist after registration with HPCSA as a Specialist.
Other benefits	: A fixed commuted overtime PLUS 13 th cheque Medical Aid (optional) Housing allowance (employee must meet prescribed Requirements)

MINIMUM REQUIREMENTS:
Registered as a Specialist Psychiatrist with the HPCSA.
Qualifications: FCPsych (SA), MMed(Psych) or equivalent.
Code 08 driver's license

OTHER REQUIRMENTS

- Computer Literacy: Word, Spreadsheet, Presentation and search engine software/ applications.

KNOWLEDGE, SKILLS TRAINING AND COMPETENCIES REQUIRED
Clinical, administrative and management abilities.
Experience and knowledge of mental health legislation and other documents.
Policies and practices relevant to the organization of mental health services.
Knowledge of teaching and training health care professionals in mental health.
Leadership, communication and organizational skills.
Programme planning, implementation and evaluation.
Knowledge and ability to develop programmes focused on psychosocial rehabilitation and the management of substance abuse comorbidity with mental illness.
Management of human resources, experience in providing expert opinion in psychiatry, clinical research skills and computer literacy.

KEY PERFORMANCE AREAS

- Provide specialist psychiatric care, assessments and evaluations of mental health care users (MHCU's) both in institutions and community where indicated.
- Provide academic teaching and clinical training to students and trainees in Medical, Nursing and Allied Health Professions.
- Provide specialist advice, guidance and training to clinical paramedical and management staff both within the tertiary services and as part of Outreach to Area 2.
- Participate in the development of clinical management guidelines, protocols and referral pathways for the management of MHCU's.
- Attend to administrative matters as pertains to the inpatient and outpatient services.
- Ensure the effective, efficient and economical use of allocated resources inclusive of human resources.
- Stimulate, participate in and supervise research.

ENQUIRIES : Dr SRH Maharaj on 033-341 5654



APPOINTMENT

ACTING HEAD OF DEPARTMENT

Prof. Jonathan K Burns left UKZN at the end of July 2016 and has joined the University of Exeter, UK, from 1 September 2016.

Dr Suvira Ramlall was appointed as Acting Head of Department with effect from 1 August 2016.



UNIVERSITY OF CAPE TOWN

DR SIMONE HONIKMAN - BOARD ELECTION



Dr Simone Honikman, director of the Perinatal Mental Health Project, in the Alan J Flisher Centre for Public Mental Health, UCT, has been elected on to the Board of the International Marcé Society for Perinatal Mental Health, which is a key global body in

the field. Simone is the first African board member. She and her colleagues continue to provide a wide range of innovative clinical services, while also conducting training, research and advocacy work. Details about the project may be accessed at www.pmhp.za.org

DR PIETER NAUDE - POST DOC

Dr Pieter Naude, a post-doc in the Division of Psychopharmacology & Biological Psychiatry, has won a Brain-Behaviour Foundation Junior Investigator Award for his work in the area of neuro-inflammation.

ANTOINETTE BURGER BEST ORAL PRESENTATION

Antoinette Burger, a PhD student of Fleur Howells, our Sarah Turoff Lecturer in Neuroscience, won the best oral presentation at the Young Scientists Competition at the recent African College of Neurosychopharmacology (AfCNP) meeting.

DR DEIRDRE PIETERSE SENIOR REGISTRAR



Dr Deirdre Pieterse, senior registrar in Consultation Liaison Psychiatry, received a full travel award to attend the annual European Association for Psychosomatic Medicine conference in Sweden.

INTERNATIONAL MEETING FOR AUTISM RESEARCH (IMFAR) PANEL ON TUBEROUS SCLEROSIS



Left to right: Loren Leclizio, Prof Petrus de Vries, Dr Robert Waltereit, Dr Mustafa Sahin and Dr Tosca Heunis

The International Meeting for Autism Research (IMFAR) is the premier annual international conference on autism spectrum disorder. A team from the University of Cape Town, led by Prof Petrus de Vries, were selected to present a panel on Tuberous Sclerosis Complex (TSC). The panel included a presentation on an animal model of TSC (Dr Robert Waltereit, Germany), clinical trials of TSC (Dr Mustafa Sahin, USA), executive skills in TSC (Loren Leclizio, UCT) and biomarker development in autism and TSC (Dr Tosca Heunis, Stellenbosch).

EXSIRA SIGNIFICANTLY IMPROVES HOME, SOCIAL AND WORK LIFE¹

Exsira significantly improves work impairment in major depressive disorder, by reducing absenteeism and increasing productivity*^{1,2}

The logo for Exsira desvenlafaxine features a stylized human figure in blue and green, followed by the brand name 'Exsira' in a bold, sans-serif font, and 'desvenlafaxine' in a smaller, lowercase font below it.

EFFICACY MADE SIMPLE^{1,3}

* As measured by the WPAI (Work Productivity and Activity Impairment) scale.

References: 1. Boyer P, Montgomery S, Lepola U, Germain J-M, Brisard C, Ganguly R, et al. Efficacy, safety, and tolerability of fixed-dose desvenlafaxine 50 and 100 mg/day for major depressive disorder in a placebo-controlled trial. *Int Clin Psychopharmacol.* 2008;23(5):243-253. 2. Dunlop BW, Reddy S, Yang L, Lubaczewski S, Focht K, Guico-Pabia CJ. Symptomatic and Functional Improvement in Employed Depressed Patients: A Double-Blind Clinical Trial of Desvenlafaxine Versus Placebo. *Journal of Clinical Psychopharmacology.* 2011 Oct;31(5):569-576. 3. Pae C-U. Desvenlafaxine in the treatment of major depressive disorder. *Expert Opin Pharmacother.* 2011;12(18):2923-2928.

EXSIRA 50 mg and 100 mg extended-release tablets (Reg. nos.: 42/1.2/0935, 41/1.2/0427). Each tablet contains desvenlafaxine succinate equivalent to 50 mg and 100 mg desvenlafaxine respectively. **LICENCE HOLDER:** Pfizer Laboratories (Pty) Ltd. Reg. No. 1954/000781/07, 85 Bute Lane, Sandton, 2196, South Africa. Tel. No.: 0860 PFIZER (734937). Please refer to detailed package insert for full prescribing information.



Working together for a healthier world™

Pfizer Call Centre: 0860 Pfizer (734 937)
Website: www.Pfizer.co.za

PP-EXS-ZAF-0008

DR INGRID ELOFF MIMED PSYCHIATRY DISSERTATION



Dr Ingrid Eloff recently completed her MMed Psychiatry dissertation:

“Switching from First to Second Generation Antipsychotics: Findings in an Eastern Cape Psychiatric Hospital”

Dr Eloff will remain in the Eastern Cape Department of Health as a state employed psychiatrist.

FORENSIC PSYCHIATRY - SUB SPECIALIST REGISTRATION

Dr Hester Jordaan, Profs Mo Nagdee and Helmut Erlacher have Forensic Psychiatry subspecialist registration.

HPCSA ACCREDITATION VISIT - SUB SPECIALTY TRAINING IN FORENSIC PSYCHIATRY

Fort England Hospital (Grahamstown) is awaiting finalisation of the accreditation process.

POPSTARS MULTIDISCIPLINARY INITIATIVE

Introducing PoPSTARS, A WSU-Dora Nginza Hospital Multidisciplinary Initiative: This initiative was started by the WSU Department of Psychiatry in Port Elizabeth in early September 2016 targeting teenage pregnancy in high school learners.

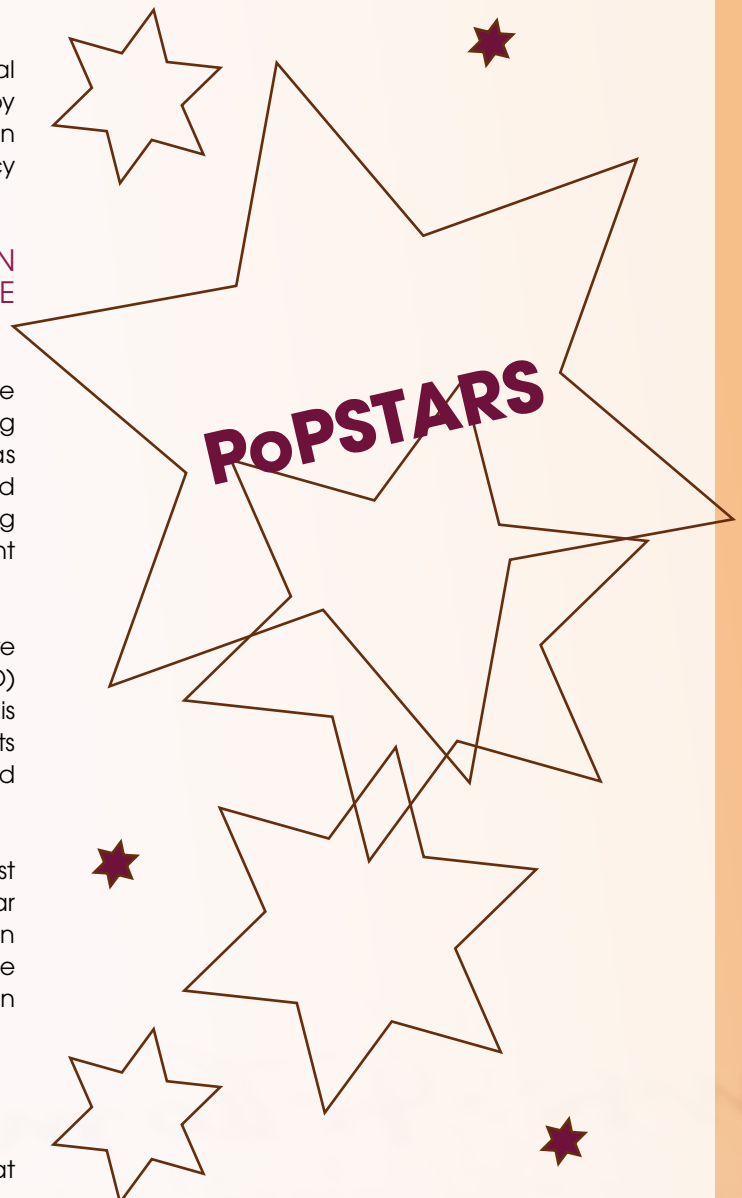
IT HAS BEEN TERMED THE PREVENTION OF PREGNANCY – STARS PROGRAMME (POPSTARS PROGRAMME).

The learners chose this name for the programme to indicate their active involvement in preventing teenage pregnancy. They see themselves as promoters of responsible sexual behaviour and planned parenthood but wanted a different spelling to set them apart from popstars in the entertainment industry.

It is run in the form of weekly MDT facilitated interactive group workshops with pupils and Life Orientation (LO) teachers of 3 schools over a period of 6 weeks. It is done in collaboration with the WSU-DNH Departments of Psychiatry and Obstetrics and Gynaecology and focuses on Grade 8 and 9 learners.

A total of 40 children have been enrolled for the first intake and 3 sessions have been conducted so far with the last session scheduled for end October. An annual follow-up of the 40 initial PoPSTARS will be done until they reach Grade 12, recording their progress in terms of:

- a. school performance,
- b. rates of pregnancy or fathering children while at school



UKHANYO CENTRE

A PARTNERSHIP ADDRESSING THE MENTAL HEALTH NEEDS OF A COMMUNITY-IN-NEED.

Zukiswa Zingela

The UKhanyo Centre is a community mental health partnership initiated by the Walter Sisulu University (WSU) Department of Psychiatry in Dora Nginza Hospital (DNH) and the Nelson Mandela University (NMMU) in Port Elizabeth.

This initiative is run in conjunction with the NMMU Department of Psychology at the Missionvale Campus and the WSU-Eastern Cape Department of Health medical training site represented by the DNH Department of Psychiatry. It was established in early 2015 to address the challenges with accessing mental health services for the community of Missionvale, a low socioeconomic shack and RDP house settlement in the Northern areas of Port Elizabeth. It consists of a Child and Adolescent outpatient service as well as an Older Adult outpatient service delivered by a multidisciplinary team from DNH, WSU and NMMU.

BACKGROUND

Prior to 2011, children below 16 years with mental health problems struggled to access services in Port Elizabeth. Although those under 12 years were still getting a service from the Department of Paediatrics at the local general hospital (DNH), if they had significant mental health problems there was no service available for them or those between 12 and 16 years of age. In 2011, an outpatient child and adolescent service was initiated in the DNH Department of Psychiatry, run from the acute mental health unit. This started with 200 patients in 2011 and grew to 560 in 2013, 718 in 2014 and over a thousand by end of 2015.

The range of disorders seen has been: Attention Deficit Hyperactivity Disorder, Autistic Spectrum Disorder, Depression, Post Traumatic Stress Disorder, Conduct



Zukiswa Zingela

Disorder, Oppositional Defiant Disorder, Intellectual Impairment, Bipolar Disorder, non-specific behavioural problems in the context of significant psychosocial stressors. The demand increased to such an extent that the frequency of the clinics had to be increased from 2 to 3 times a week.

CHALLENGES IN THE DELIVERY OF MENTAL HEALTH SERVICE FOR CHILDREN

Challenges and limitations arose due to suboptimal staff numbers and lack of comprehensive multidisciplinary team care. Other limitations related to the lack of Psychometric and Developmental Assessment tests which were unavailable at the Dora Nginza Hospital site at the time of starting the service.

THIS RESULTED IN SOME CHILDREN IN NEED ACROSS PORT ELIZABETH AND THE WIDER NELSON MANDELA METRO HAVING TO GO ON LONG WAITING LISTS TO ACCESS THE ASSESSMENTS AT THE TESTING FACILITIES HOUSED WITHIN THE NMMU DEPARTMENT OF PSYCHOLOGY CLINIC AT THE MISSIONVALE CAMPUS.

In early 2015, a plan was agreed upon between WSU Department of Psychiatry and NMMU Department of



Psychology to devise a realistic strategy to address these challenges and assist with decreasing the waiting list. This resulted in the WSU-ECDoh driven services and the NMMU Psychometric Assessment services combining under one roof at the UKhanyo Centre operating from the NMMU Missionvale campus.

IT WAS ANTICIPATED THAT THE STRENGTH OF THIS PARTNERSHIP WOULD BE THE POOLING OF RESOURCES OF BOTH THE WSU TEAM AND THE NMMU TEAM TO ADDRESS THE DIRE NEED IDENTIFIED IN THE NELSON MANDELA BAY METRO.

UKHANYO CENTRE AND MISSIONVALE

DEMOGRAPHICS

The 2011 census indicated the total population of The Metro to be 1,152,115. Of this, 25% were under the age of 14, and 6% were over 65 years at the time of the census. The Missionvale area forms part of Bethelsdorp which together with IBhayi have a total population of 400 000 (35% of The Metro population). The majority of people living in Missionvale are Black and isiXhosa speaking, followed by Coloured, Afrikaans speaking people.

MISSIONVALE HEALTH SERVICES

The Missionvale Municipal Clinic data for 2014/15 indicate that a total number of 19,456 people of all ages received services from the clinic. Most of these services however did not include any assessment or treatment for mental health problems or disorders. There is a non-governmental organization (NGO) run Missionvale Health centre which operates at a site adjacent to the municipal clinic. The need for the centre arose as a direct result of malfunctioning municipal health services. It meets a lot of the Missionvale community's health challenges except the psychological or psychiatric health service needs. The setting up of UKhanyo Centre was thus directed at

this unmet need not only for Missionvale residents but for all children in The Metro between the ages of 12 -18 years and younger ones referred from Paediatrics.

WHAT DOES UKHANYO MEAN?

THE NAME UKHANYO MEANS "LIGHT". IT ALSO MEANS "ENLIGHTENMENT". IT WAS CHOSEN TO REPRESENT A BEACON OF HOPE IN AN IMPOVERISHED SECTOR OF THE COMMUNITY WHERE ACCESS TO MENTAL HEALTH SERVICES IS IMPEDED BY A NUMBER OF FACTORS INCLUDING POVERTY, LOW EDUCATION LEVELS AND SUB-OPTIMALLY FUNCTIONING MUNICIPAL HEALTH SERVICES.

It opened its doors in April 2015 with a formal launch. There was also an announcement of its services to the Metro via a local newspaper (see image at end of article).



The UKhanyo Clinic Team: front, from left, Miss Cora Bekker, Miss Jenny Jansen, Prof Zukiswa Zingela, Prof Louise Stroud and back, Mr. Darren Coxhill, Dr Alti Bronkhorst. The picture and interview with the team appeared in *The Herald*, July 9, 2015, when the centre had been in operation for 3 months

UKHANYO



OPERATIONAL ISSUES:

A multidisciplinary team completes the assessment and management of children and older adults with psychological and psychiatric problems. Members of the team are drawn from the already existing MDT within the DNH Department of Psychiatry while the rest of the team is made up of NMMU Department of Psychology staff or students. Prescribed medication when required is collected from the DNH pharmacy. This is because the centre has been operating without a formal budget. The main advantage of presenting at the Ukhanyo Centre has been the elimination of a long waiting list prior to accessing psychological, psychometric or psychiatric assessments or interventions.

The WSU-DNH MDT visits the UKhanyo Centre site one day a week (1 Registrar, 1 Social Worker, 1 Clinical Psychologist and 2 Occupational Therapists). They join a team of registered counsellors, an Educational Psychologist and a centre Manager from NMMU who man the centre the rest of the week. They have access to a full library of assessment tools provided by the NMMU Department of Psychology which includes psychometric tests, developmental assessment tests,

rating scales for different childhood, adult and older adult assessments.

PERFORMANCE:

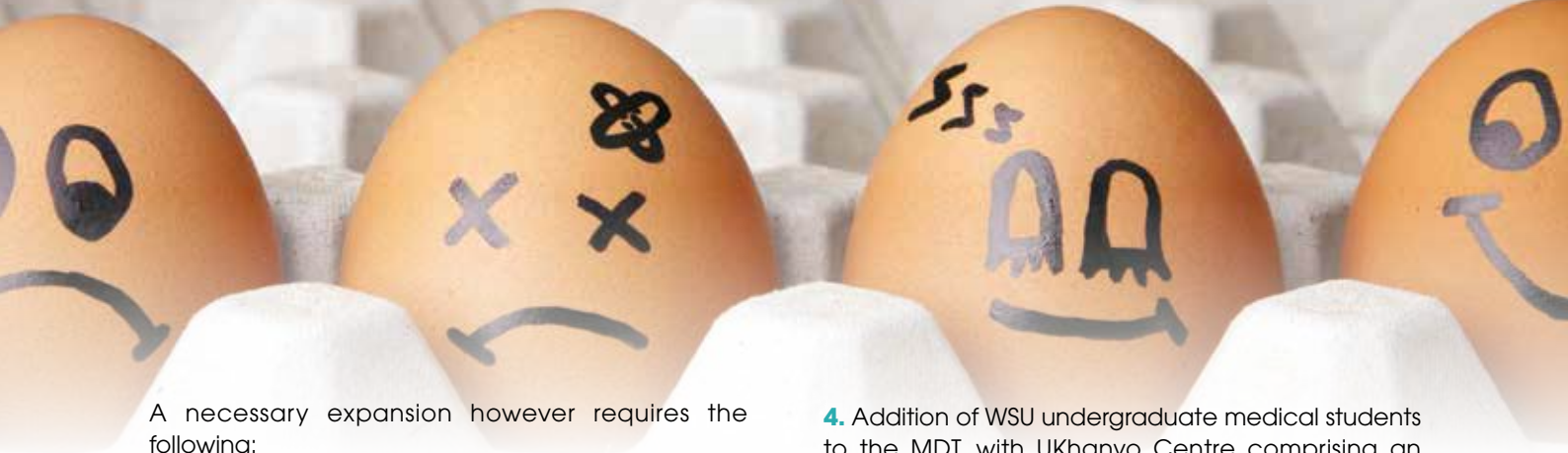
The 2015 annual report showed that Missionvale Clinic rendered services to 264 people in 2015 (Table 1). This reflected an increase of 54% in individual patients seen at the Missionvale site compared to 2014. Of these, 102 were assessed by the DNH MDT. The age analysis of the Missionvale site patients reflects an overall increase in those aged 01-12 years of age and in those aged 13-18 years. This is most likely due to the expanded capability to assess children after the initiation of the UKhanyo initiative.

SUSTAINABILITY:

The initiative has been largely sustained by dedicated staff from both universities. itself with minimal extra funding due to the fact that it relies on services and staff who are already working and paid a salary by the 3 partnering organizations and institutions. Since NMMU will be carrying the costs for the site and psychometric tests, no other extra costs are expected.

AGE GROUP	2015 CLIENTS SEEN (n)	2014 CLIENTS SEEN (n)	2015 % CLIENTS SEEN	2014 % CLIENTS SEEN
01-12 years	111	66	42	46.5
13-18 years	129	45	48.9	31.7
18 years and older	24	31	9.1	21.8
Total	264	142	100%	100%

Table 1



A necessary expansion however requires the following:

- 1.** Procurement of medication and dispensing on site. This is because the majority of families who access this service are poverty stricken and can scarcely afford the taxi-fare required to make the trip to DNH pharmacy to collect their medication when required would be enabling dispensing of medications from the Missionvale site in future. If this were to be undertaken then it would have implications for medication costs. This would only be required however if practical or logistical problems were to be encountered with the system of prescribing treatment at the site and having the meds dispensed from DNH.
- 2.** MDT transport to enable home visits in cases where people cannot come to the centre due to financial constraints or severity of sickness.
- 3.** Addition of DNH Department of Paediatrics service to the MDT. This has already been negotiated and agreed upon, with a Paediatrics registrar to join the team from October 2015.

- 4.** Addition of WSU undergraduate medical students to the MDT, with UKhanyo Centre comprising an additional rotation site for Department of Psychiatry students from January 2017.

TWO OF THE FACTORS MENTIONED IN THE ABOVE LIST VIZ. ACCESS TO MEDICATION ON-SITE AND DIFFICULTY PRESENTING TO THE CLINIC DUE TO SEVERITY OF ILLNESS OR DEGREE OF POVERTY, HAVE CONSTRAINED PRACTICE AT THE CENTRE, WITH LOSS OF CONTACT WITH SOME STILL SICK PATIENTS AS A RESULT. THE PLAN IS TO APPLY FOR FUNDING FROM DIFFERENT SOURCES TO ENABLE THE TEAM (TABLE 2) TO UNDERTAKE THE PROPOSED EXPANSION PLAN.

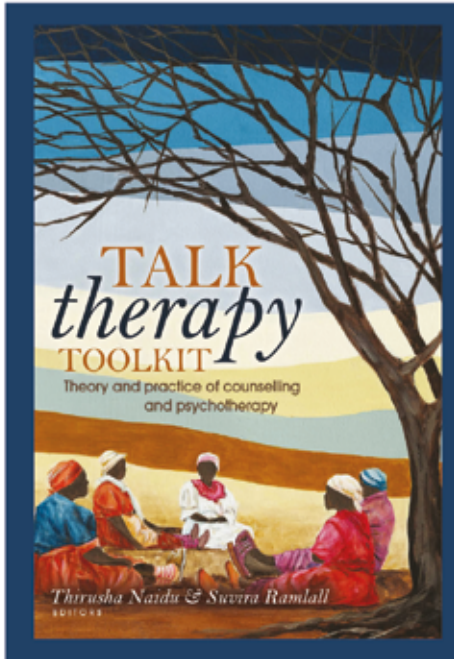
Institution	Name of team member	Position
WSU and ECDoh	Z Zingela	Head of Psychiatry
	S van Wyk	Consultant Psychiatrist
	A Bronkhorst and Dr C Groves	Psychiatry Registrars
	Leanne Kay	Clinical Psychologist
	Cora Bekker	Social Worker
	E Loades and K Engelbrecht	Occupational Therapists
NMMU	L Stroud	Director of School of Behavioural Sciences
	J Jansen	Clinical Psychologist
	R Exner	Educational Psychologist
	BA Psychology and Social Work students from NMMU	
To be added from WSU and ECDoh	L Pepeta	Head of Paediatrics
	1 Paediatrics Registrar	
	WSU final year medical student rotation for Psychiatry	Students from Department of Psychiatry

Table 2

Zukiswa Zingela is the current Head, Department of Psychiatry, Walter Sisulu University, Umtata.

Correspondence: zingelaz@mweb.co.za

PRESS RELEASE



Title: Talk therapy toolkit
Subtitle: Theory and practice of counselling and psychotherapy
Editors: Thirusha Naidu & Suvira Ramlall
ISBN: 978-0-627-03410-7; R599.00
eISBN: 978-0-627-03411-4; R539.10
Publication date: October 2016
Number of pages: 448

***Talk therapy toolkit* addresses the unique and diverse social and cultural characteristics of the South African milieu. This collaboration between psychology and psychiatry delivers a resource that reflects the reality faced by health care professionals in their working environment.**

Through the development of increasingly complex human social groups, social and economic changes and challenges, industrialisation, technological advancement, global mobility and electronic communication, a significant gap of care has emerged. The erosion of the intimate social support systems that originally nurtured, protected and developed the human psyche,

has necessitated the emergence of various talk therapies as alternative forms of psychosocial and emotional support. *Talk therapy toolkit* is a practical and accessible text aimed at introducing emergent practitioners to the theory, techniques and practice of counselling and psychotherapy.

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

Contents include the following:

- Basic counselling skills
- Supportive psychotherapy
- Grief, trauma and crisis counselling
- Psychodynamic therapy
- Cognitive behavioural therapy
- Narrative therapy
- Motivational interviewing
- Group therapy

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

To purchase this title: Go to your nearest academic bookstore | Buy online at www.takealot.com
Contact customer services at orders@vanschaiknet.com

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

Lindiwe Ntuli
Van Schaik Publishers
Tel (012) 342 2765
Lindiwe.Ntuli@vanschaiknet.com

Help Shape A Future for Your Patients with Schizophrenia



Xeplion[®] is an option for any patient for whom long-term treatment is needed; it is effective, well-tolerated and promotes adherence^{1,2,3}

janssen
PHARMACEUTICAL COMPANIES
of Johnson & Johnson

ONCE-MONTHLY prolonged release suspension for injection
XEPLION[®]
paliperidone palmitate

Preventing relapse, enabling futures

References:

1. Javitt DC. Balancing therapeutic safety and efficacy to improve clinical and economic outcomes in schizophrenia: Exploring the treatment landscape. *Am J Manag Care* 2014;20(5):516-5173. 2. Altard A, Oletijnana D, Cornelius V, et al. Paliperidone palmitate long-acting injection - prospective year-long follow-up of use in clinical practice. *Acta Psychiatrica Scandinavica* 2013;116:3. Newton R, Ilustig H, Lakshmana R, et al. Practical guidelines on the use of paliperidone palmitate in schizophrenia. *Cur Med Res & Opin* 2012;28(4):559-567.

[S]XEPLION[®] 50 mg, Reg. No.: 44/2.6.5/0866, XEPLION[®] 75 mg, Reg. No.: 44/2.6.5/0867, XEPLION[®] 100 mg, Reg. No.: 44/2.6.5/0868, XEPLION[®] 150 mg, Reg. No.: 44/2.6.5/0870. Prolonged release suspension for intramuscular injection. Containing 50mg, 75mg, 100mg, 150mg paliperidone palmitate respectively. Further information available on request from Market Authorisation Holder: JANSSEN PHARMACEUTICA (PTY) LTD (EDMS) BPK, (Reg. No./Regis. 1988/011122/07); Building 6, Country Club Estate, 21 Woodlands Drive, Woodmead, 2191. www.janssen.co.za. Medical Info Line: 0800 11 11 17. For full prescribing information refer to package insert (June 2013). Cert. No.: PHZA/XEP/0616/0001.

CIVIL FORENSIC PSYCHIATRY

Navanthree Govender

The Forensic Unit of Sterkfontein Hospital hosted its second Forensic Psychiatry seminar, this time centred on Civil Forensic Psychiatry, on the 23rd of April 2016, at Sterkfontein Hospital, a tertiary level forensic psychiatry hospital serving Southern Gauteng.

The seminar was well attended by over 50 mental health care practitioners, including private and state psychiatrists and psychologists, nurses and other allied workers.

Dr Anersha Pillay, a registered neuropsychiatrist, employed at Charlotte Maxeke Johannesburg Academic Hospital, and responsible for the commencement of the hospital's specialist Neuropsychiatry Clinic, began the day with an in-depth lecture on Traumatic Brain Injury (TBI).



Dr Anersha Pillay

Her introductory comments orientated the audience to the definition of a TBI. Neuropsychiatric literature defines a TBI as referring to a closed head injury where, in particular, the presence of neurological signs and symptoms, neuropsychiatric symptoms and/or intracranial pathology has been established.

The incidence in a first world setting, the USA, was then compared to that of South Africa, highlighting that even in the absence of a TBI data bank, the incidence of TBI in South Africa is approximately double that of the USA. Common causes and the epidemiology of TBI were then discussed and contrasted between the two countries.



Navanthree Govender

The classification of TBI was discussed with definitions given for each category. The audience was then informed of the pathophysiology behind the presentation of TBI with diagrammatic representations to assist the varied audience to develop a basic understanding of this pathophysiological process of traumatic injury to the brain.

THE CLINICAL ASPECTS OF THE PRESENTATION OF TBI WERE PRESENTED IN DETAIL DIFFERENTIATING BETWEEN THE SIGNS AND SYMPTOMS CHARACTERISING THE ACUTE PHASE FROM THAT OF THE CHRONIC PHASE OF TBI, WHEREIN NEUROPSYCHIATRIC AND NEUROCOGNITIVE SYMPTOMS TEND TO PREDOMINATE. THESE VARIOUS SYMPTOMS WERE DISCUSSED IN DETAIL WITH EXAMPLES OF THE CLINICAL FEATURES.

The latter half of the presentation involved a detailed discussion of the aetiological factors that need to be considered in the context of neuropsychiatric manifestations of TBI. Assessment of the patient presenting with the above was then presented. This included proposed bedside tests that can be used to assess each neurocognitive domain as well as an illustration of the associated cerebral lobe. Basic management principles of patients presenting with neuropsychiatric symptoms following a TBI were then discussed and the presentation concluded with a question and answer session.

CIVIL FORENSIC PSYCHIATRY



Dr Mike Ewart Smith

This session was followed by a talk from Dr Mike Ewart Smith, psychiatrist in private practice. From 1995 to present, Dr Smith's area of interest has been the assessment of disability on psychiatric grounds for which he has conducted more than 5000 assessments. From 1997-

2014 he was the Convenor of the task team of the South African Society of Psychiatrists (SASOP) investigating problems related to management of psychiatric disability. He is co-author of 'Guidelines to the Management of Disability Claims on Psychiatric Grounds, 2nd Edition' issued by SASOP. He is also the author of the chapter "The determination of psychiatric impairment for disability claims" in the Oxford University Press textbook *Psycholegal Assessment in South Africa*.

DR SMITH FOCUSED ON CIVIL ASSESSMENTS IN TRAUMATIC BRAIN INJURY. THE MAIN CATEGORIES OF PSYCHIATRIC DISTURBANCE FOLLOWING TBI ARE COGNITIVE IMPAIRMENT, IN SOME CASES WITH PSYCHOSIS, CHANGE OF PERSONALITY, MOOD DISORDERS, AND POST-TRAUMATIC ANXIETY AND STRESS. IN PRACTICE, COMPLEX ADMIXTURES OF SYMPTOMS ARE FREQUENTLY SEEN. ALSO, THE SO-CALLED POST-CONCUSSION SYNDROME CAN OCCUR AFTER MILD HEAD INJURY.

Over and above any obvious brain damage, there are a multitude of factors, constitutional

and environmental, that can decisively shape the psychiatric picture in the individual case. At the time of psychiatric assessment, the psychiatrist must attempt to identify the problems, consider the various contributory factors, and advise on the extent to which they are related to the actual brain injury.

Psychiatric evaluations of TBI in civil cases usually involve claimants who have been injured in road traffic accidents, or after work accidents, or in specific types of assault cases. Frequently the TBI was not a main focus of treatment in the initial post-accident stages. Particularly after road accidents, patients commonly have sustained multiple injuries, apart from any obvious head injury. It is known that factors involved in civil claims and compensation issues may, for complex reasons, aggravate and prolong disability.

THE PSYCHIATRIST MAY DEFER TO THE FINDINGS OF THE NEUROSURGEON, AND OTHER MEDICAL SPECIALISTS, REGARDING THE NATURE OF THESE INJURIES, THEIR MANAGEMENT AND SEQUELAE. THUS THE MAIN ROLE OF THE PSYCHIATRIST IS THE ASSESSMENT OF PSYCHIATRIC, PSYCHOLOGICAL AND BEHAVIOURAL SEQUELAE AND THEIR EFFECT ON FUNCTIONING AND RELATIONSHIPS.

The psychiatric report should assist the court in deciding (i) the nature and degree of the disablement; (ii) the likely future course of the disablement and its effect on the patient's quality of life; and (iii) the causative role of the brain injury. The fulfilling of these requirements within the psychiatric report was discussed.

The seminar concluded with a lecture from Advocate

CIVIL

FO

REN

NZ

S

I

CS



Devina Perumal,

Devina Perumal, a Senior Lecturer at the University of KwaZulu Natal's School of Law. Adv Perumal is an Advocate of the High Court, South Africa; and is actively involved in legal research and has published widely in a variety of areas, as well as co-authored textbooks.

Advocate Perumal's talk focused on the role of the expert witness (psychiatrist) from a legal perspective.

The points that were discussed included

- (i) the importance of obtaining detailed instructions from the instructing attorney – this provides a guide to the expert with regard to the nature of the enquiry;
- (ii) the nature of the evidence provided and its role in assisting the court come to a decision;
- (iii) the role of the expert in the court process and the importance of maintaining a non-adversarial approach;
- (iv) the importance of proper, detailed note-taking to aid in supporting one's opinion; and
- (v) the need to provide an adequate basis for one's opinion to add weight to the opinion provided. These points were illustrated with examples to provide a practical overview of the expert psychiatrist's role in the legal process. The talk was invaluable in aiding towards a better understanding of the role of an expert's testimony and how better to provide a well-reasoned opinion.

THE FORENSIC UNIT AT STERKFRONTEIN HOSPITAL AIMS TO HOST ONE SEMINAR PER YEAR. IT IS PROPOSED THAT IN 2017 CRIMINAL FORENSIC PSYCHIATRY WILL BE THE FOCUS OF ATTENTION.

Navanthree Govender is a psychiatrist working in the Forensic Unit at Sterkfontein Hospital and a lecturer in the Department of Psychiatry, University of the Witwatersrand, Johannesburg, South Africa. **Correspondence:** Navanthree.Govender@wits.ac.za

Some drugs are more equal than others¹



Truvalin[®]

- The clone of Seroquel[®] IR*
- A clone is:¹
 - An identical alternative to the originator in both quality and efficacy, with same origin
- Truvalin[®] is affordably priced at \approx 60% less than the originator²
- Allows switching without compromising efficacy and safety

Truvalin[®]
quetiapine

our effect is constant³

ZENTIVA
A SANOFI COMPANY

* Clone of Seroquel[®] IR

References: 1. Probyn AJ. Some drugs more equal than others: pseudo-generics and commercial practice. *Aust Health Rev* 2004;28(2):207-217 [cited 15 June 2016]. Available from: http://www.publish.csiro.au/?act=view_file&file_id=AH040207.pdf. 2. DOH Medicine Price Registry. Database of medicine prices 8 August 2016 [cited 15 June 2016]. Available from: <http://www.mpr.gov.za>.

[S5] Truvalin[®] 25 (tablet). Each tablet contains quetiapine fumarate equivalent to 25 mg of quetiapine free base. Reg. No.: 43/2.6.5/0159. [S6] Truvalin[®] 100 (tablet). Each tablet contains quetiapine fumarate equivalent to 100 mg of quetiapine free base. Reg. No.: 43/2.6.5/0160.

[S7] Truvalin[®] 200 (tablet). Each tablet contains quetiapine fumarate equivalent to 200 mg of quetiapine free base. Reg. No.: 43/2.6.5/0161. [S8] Truvalin[®] 300 (tablet). Each tablet contains quetiapine fumarate equivalent to 300 mg of quetiapine free base. Reg. No.: 43/2.6.5/0162.

PHARMACOLOGICAL CLASSIFICATION: A 2.6.5 Central nervous system depressants: Miscellaneous structures. **INDICATIONS:** Truvalin[®] is indicated for the treatment of schizophrenia and manic episodes associated with bipolar disorder.

For full prescribing information, refer to the package insert approved by the Medicines Regulatory Authority. Truvalin[®] is a registered trademark of the AstraZeneca group of companies.

NAME AND BUSINESS ADDRESS OF THE HOLDER OF THE CERTIFICATE OF REGISTRATION: AstraZeneca Pharmaceuticals (Pty) Ltd, Reg. No. 1992/005854/07, Building 2, Northdowns Office Park, 17 Georgian Crescent West, Bryanston, 2191, Tel: (011) 797 6000, Fax: (011) 797 6001, www.astrazeneca.co.za. Marketed by: Zentiva, a Sanofi Company, 2 Bond Street, Grand Central Ext.1, Midrand, 1685. Tel: (011) 256 3700, Fax (011) 256 3707, www.zentiva.com, TRU0916002 Expiry date: September 2017.

WHAT'S NEW IN SUBSTANCE ABUSE DISORDERS

Pevashnee Naicker

The SASOP – Southern Gauteng Subgroup (SGS) hosted its first CME event for 2016 on 7th May at Life Riverfield Lodge, Johannesburg.

With the ever increasing prevalence of addictions in South Africa, The CME topic 'What's new in Substances?' was chosen for its current day relevance and was well attended by over 50 delegates, including northern subgroup delegates and a few general practitioners. The event was also supported by pharma, Dr Reddy's and Equity Pharma.

The first speaker, Dr Hashen Ramjee, gave a comprehensive and practical update on Opioid Addiction. He emphasised looking at the addiction as: "a chronic relapsing disorder by impulsive drug-seeking and by long lasting chemical changes in the brain". The increasing abuse of over the counter and prescription opioid use disorders has superseded illicit opioid abuse in the US and seems to have the same trend, although under diagnosed in the SA setting.

THE PHASES OF TREATMENT FROM INDUCTION THROUGH TO STABILISATION AND MAINTENANCE THERAPY WERE DISCUSSED. THE UTILITY OF THE CLINICAL OPIATE WITHDRAWAL SCALE (COWS) AND OBJECTIVE OPIOID WITHDRAWAL SCALE (OOWS) WAS EMPHASISED TO BE ABLE TO MONITOR THE PATIENT IN A CONSISTENT MANNER.

An approach to Substitution therapy with medication such as Methadone and Buprenorphine, was recognized as indispensable and hence on the WHO essential drug list. There are 'medical, economic and social benefits; the treatment works and is evidence-based'. 'Maintenance therapy is often recommended over medically supervised withdrawal, as it has a higher likelihood of success and is well supported by various clinical trials.' Dr Ramjee however also emphasised looking at addiction treatment holistically by using other broader psychosocial interventions to improve outcomes.

The second speaker was Dr Nai'm Moola, a psychiatrist at Riverfield Lodge and team member of their dual diagnoses unit. His topic: A dual diagnosis approach to substance use disorder in Private practice';



Pevashnee Naicker

looked at a useful approach to this complex presentation. The bidirectional relationship between substance use and mental illness was discussed but "in general, individuals with mental illness use substances for the same reasons as individuals without mental illness"

Although the term dual diagnoses might seem non-specific and under-target the resultant effects of low level substance use, a dual diagnoses conceptualisation is helpful in managing the patient in a less fragmented way. The common mental health problems in dual diagnoses included mood disorders, anxiety disorders and other psychotic disorders. Apart from the multitude of substance addictions, including prescribed substances addiction, these patients can also have gambling, sex and food addictions. The critical components of the dual diagnoses programme were looked at with motivational interventions showing evidence based success.

Professor Solly Ratemane thereafter had a lively debate regarding the heated topic of ethics of decriminalisation of marijuana. After exploring the definitions of legalisation, where the consumer faces no penalties, even the cultivation and trading, versus decriminalisation, where possession of small amounts for personal use does not lead to a criminal record, and larger amounts may lead to penalties or fines; the jury was still out as to what would be the best approach.

TRENDS FROM CANNABIS DECRIMINALISATION IN COUNTRIES SUCH AS PORTUGAL ARE SHOWING MIXED OUTCOMES, "WITH INCREASED USE OF CANNABIS AND ASSOCIATED PROBLEMS; DECREASED USE OF HEROIN BUT INCREASED USE OF OTHER DRUGS SUCH AS ECSTASY." ALTHOUGH THERE WAS A 'REDUCTION IN DRUG RELATED DEATHS, DECRIMINALISATION NEEDED A WELL MANAGED IMPLEMENTATION STRATEGY.'

SUBSTANCE ABUSE



The mechanism of the active ingredient, tetrahydrocannabinol (THC) on the cannabinoid receptors in the brain and body explained both the clinical and adverse effects of cannabis. The ever growing list of medical uses of marijuana from headaches, cancer pain, HIV associated anorexia to nerve pain speaks to the “medical innovations bill” that was introduced in parliament in 2014. “The Bill creates a legal dispensation which applies only in research pilot hospitals authorised by the Minister of Health where medical practitioners are granted greater professional discretion to administer innovative and alternative medical treatments on the basis of the patient’s informed consent.”

IN TRYING TO ALLOW SOCIETY AUTONOMY TO CHOOSE AND ACCEPTING THAT THERE ARE CERTAINLY BENEFITS TO CANNABIS USE (BENEFICENCE) AND JOB CREATION IN A CANNBIS INDUSTRY, WE ALSO HAVE TO KEEP IN MIND THE ‘GATEWAY THEORY, INCREASE IN VIOLENCE AND ADDICTIVE NATURE OF THE DRUG’ (MALEFICENCE). WITH THE OVERCROWDED JAILS IN SOUTH AFRICA, DECRIMANALISATION MAY REDUCE LAW ENFORCEMENT LOAD TO ALLOW FOCUS ON OTHER CRIME. AND WE WERE STILL LEFT WITH THE QUESTION ON DISTRIBUTIVE JUSTICE WHETHER LEGALISING CANNABIS WILL BENEFIT SOCIETY AS A WHOLE!

The SASOP –SGS will be hosting another CME on Adolescent Psychiatry on the 17th September 2016, which also promises to be another educational and insightful session.
(A report will be published in the February 2017 Issue - Editor)

Pevashnee Naicker is a psychiatrist at Tara Hospital, Johannesburg and a lecturer in the Department of Psychiatry, University of the Witwatersrand, Johannesburg, South Africa. She is the Treasurer of SASOP’s Southern Gauteng Subgroup.

Correspondence: pevashnee@gmail.com

CONSULTATIVE WORKSHOP ON THE PUBLIC HEALTH DIMENSIONS OF NARCOTIC AND PSYCHOTROPIC SUBSTANCES ABUSE PROBLEM

Tiaan Schutte

This consultative workshop (14 -15 July 2016, Holiday Inn, Johannesburg International Airport, Boksburg), organised by the National Department of Health, took place in the context of the April 2016 United Nations General Assembly Special Session on the World Drug Problem (UNGASS).

This thirtieth Special Session reviewed the progress that has been made in the implementation of the Political Declaration and Plan of Action on International Cooperation towards an integrated and balanced strategy to counter the world drug problem.

The workshop was attended by various key stakeholders including civil society, government departments, non-governmental organisations, academia and research institutions that are involved in narcotic and psychotropic substances control and prevention initiatives.

IN HER KEY NOTE ADDRESS, DIRECTOR-GENERAL FOR HEALTH, MS MP MATSOSO HIGHLIGHTED THE CURRENT DIRE DRUG SITUATION IN SOUTH AFRICA WHICH SHE DESCRIBED AS A 'TICKING TIME-BOMB' AND THAT WE MAY FACE AN ENTIRE 'LOST GENERATION' IF THE CURRENT LEVEL OF SUBSTANCE USE AMONG YOUNG PEOPLE IS NOT ADDRESSED.

From an international perspective, **Madam Ruth Dreifuss**, current Chair of the Global Commission on Drug Policy (and former Swiss Health Minister) and Ms Z Akisheva, Regional Representative of the UNODC (United Nations Office on Drugs and Crime) outlined changing trends and the shift in focus of current international drug control policy: 'After more than half a century of punitive global drug prohibition, there is now overwhelming evidence that it has not only failed to achieve its own objectives, but has also generated serious social and health problems.'

The current recommendation is that governments should aim to reach a 'compromise' between the old repressive, individualistic and judgemental approach vs. the more liberal, permissive, protective and inclusive public health approach if they are serious in safeguarding the safety, health and human rights of their citizens, whilst still fighting against drugs and crime.

From a local perspective, **Dr. Nadine H Burnhams**, Senior Scientist at the Alcohol, Tobacco and Other Drug Research Unit of the SA Medical Research Council, highlighted a very significant increase in alcohol consumption between 2008 - 2011, in the under 13yr age group. This especially in Gauteng province, when compared to Eastern Cape, Western Cape and national figures.

Also disturbing, according to **Prof. Bronwyn Myers** of UCT and Chief Specialist Scientist at the Alcohol, Tobacco and Other Drug Research Unit, is the fact that only a mere 5% of those individuals requiring drug and alcohol rehabilitation treatment will actually receive such treatment as a result of a variety of barriers to adequate care. Furthermore, there is a > 75% drop-out rate in out-patient treatment which occurs typically during the first two weeks of treatment.



Prof B Myers

Currently in development is a system of culturally appropriate Screening and Brief Intervention and Referral to Treatment (SBIRT), being rolled out at various primary healthcare clinics. SBIRT would typically involve 2 - 4 highly structured sessions, provided by trained lay councillors and would focus on motivational interviewing and problem solving skills and the appropriate referral to definitive treatment.

It is hoped to further extend SBIRT services to mental health, ante-natal clinics and emergency room departments across the country.

Dr. S. Ramlall, Specialist Psychiatrist at the University of Kwazulu-Natal, presented national guidelines on the detoxification of alcohol and other drugs. She emphasised the important principle that detoxification itself, only forms but one part along a continuum of care and that it should never be regarded as a treatment on its own. One of the many challenges faced by the public healthcare system is that detoxification services are offered by the Dept of Health and yet most rehabilitative services are managed by Dept of Social Development with no clear and smooth alignment between services.



Dr S Ramlall

A strong recommendation was made to ensure stronger future collaboration between the DoH and the DSD. Dr Ramlall further illustrated 4 levels of detoxification services, based on the morbidity and complexity of each case:

1. Community based out-patient detox (with adequate emergency backup),
2. Intensive out-patient detox – with daily contact for example opioid detox,
3. Clinic managed in-patient or residential detox and
4. Intensive management of medical and psychiatric co-morbidities in specialised units.



Dr H Temmingh

Dr. H Temmingh, psychiatrist at Valkenberg Hospital and UCT, emphasised the high co-morbidity of substance use disorders and mental illness: Up to 75% of those suffering from mental illness will have a co-morbid substance use disorder. Although

systematic reviews of available literature has shown very weak overall evidence for any specific or unique medications or treatment interventions for these patients, the need for specialised Dual Diagnosis treatment units and harm reduction strategies remain important in this challenging group of patients.

Finally, the recommendations from the workshop to the Department of Health can be summarised as:

1. Building capacity within the public healthcare system to effectively implement substance abuse programmes for prevention, early intervention, treatment, recovery, rehabilitation and social reintegration as well as measures aimed at minimising the adverse public health consequences of drug abuse.
2. Government to become involved in long term Opioid Substitution Treatment (OST) and Maintenance programmes, in-line with overwhelming scientific evidence and WHO guidelines, as well as further investigation into other possible harm reduction strategies such as needle exchange programmes and consumption houses which have proven highly successful in other countries. This will also aid in the prevention of transmission of HIV/AIDS, viral hepatitis and other blood-borne infections among users injecting drugs.



Dr T Schutte, Ms JR Hunter, Dr N Morgan



Dr Lochan Naidoo

Tiaan Schutte is a psychiatrist at Sterkfontein Hospital and a lecturer in the Department of Psychiatry, University of the Witwatersrand, Johannesburg, South Africa. **Correspondence:** tiaansch@gmail.com

2ND AFRICAN COLLEGE OF NEUROPSYCHOPHARMACOLOGY CONGRESS - JULY 2016

Dan Stein, Kerry-Ann Louw and Fleur Howells

The International College of Neuropsychopharmacology (CINP) is the oldest international organization working in this area, and has played a key role in encouraging conversations between basic and clinical researchers.

In recent years, sister Colleges have developed in America (ACNP), Asia (AsCNP), Europe (ECNP), and Scandinavia (SCNP). In 2015, CINP encouraged an initial meeting of African psychopharmacologists in Kenya. This year, the second African College of Neuropsychopharmacology Congress was hosted at Spier in Stellenbosch, Western Cape, South Africa over the weekend of 30-31 July 2016.

This event was convened by Professor Dan Stein (Department of Psychiatry and Mental Health, University of Cape Town (UCT)), Dr Gerhard Grobler (Dept of Psychiatry, University of Pretoria) and Professor Lukoye Atwoli (Moi University, Kenya). The event hosted 268 delegates with representation from Kenya, South Africa, Tanzania, Uganda, Ethiopia and Namibia. The congress focussed primarily on updating clinicians about current thinking on pharmacological approaches to the major psychiatric disorders. There were also presentations on basic neuroscience topics and a parallel "Young Scientists" Programme.

The meeting was generously supported by CINP (represented by keynote speaker Prof Brian Dean) and ECNP (represented by keynote speaker Prof Joseph Zohar), as well as by a range of local pharmaceutical companies. Other international faculty included Professor Lukoye Atwoli (Moi University School of Medicine, Kenya), Professor David Baldwin (University of South Hampton, United Kingdom), Professor David Castle (University of Melbourne, Australia), Professor Damiaan Denys (University of Amsterdam, Netherlands), Professor Brian Leonard (University of Galway, Ireland) and Professor Gregers Wegener (Aarhus University, Denmark). Local faculty included Dr Samantha Brooks (UCT), Professor Bonga Chiliza (Stellenbosch University), Dr Eric DeCloedt (Stellenbosch University), Dr Janita De Vries (UCT), Dr Gerhard Grobler (Steve Biko Academic Hospital), Professor John Joska (UCT), Dr Fleur Howells (UCT), Dr Kerry-Ann Louw (UCT), Professor Solomon Rataemane (Sefako Makgatho Health Sciences University), Professor Dan Stein (UCT), Dr Mike West (UCT), Dr Bavi Vythilingum (UCT) and Dr Zukiswa Zingela (Walter Sisulu University).



Dan Stein

There were excellent talks by both international and local faculty. Some of the highlights included Prof Zohar's talk on Neuroscience Based Nomenclature (NbN) which identified criticisms of current psychopharmacology nomenclature; particularly the failure of current nomenclature to identify drug mechanisms of action and their lack of clinical utility in guiding clinicians to select the best agents for their patients. ECNP, ACNP, AsCNP and CINP together with IUPHAR have proposed a new pharmacologically-driven nomenclature focussing on Pharmacological Domain and Mode of Action. The Neuroscience Based Nomenclature includes four additional dimensions of information: Approved Indications, Efficacy and Side Effects, Practical Notes and Neurobiology. The first edition of NbN includes 108 compounds. Professor Zohar talked the audience through the use of an NbNomenclature App that can be downloaded for free from the iOS App Store and the Google Play Store.

SEVERAL TALKS ADDRESSED KEY CLINICAL ISSUES SUCH AS THE PHARMACOTHERAPY OF MAJOR PSYCHIATRIC DISORDERS (MAJOR DEPRESSIVE DISORDER, INSOMNIA DISORDER, GENERALIZED ANXIETY DISORDER, POST-TRAUMATIC STRESS DISORDER, OBSESSIVE COMPULSIVE DISORDER, ALZHEIMER'S DISEASE, ADHD, SCHIZOPHRENIA AND SUBSTANCE USE DISORDERS), THE USE OF TREATMENT GUIDELINES, PRESCRIBING IN PREGNANCY & DRUG-DRUG INTERACTIONS.

Dr Zingela's lecture on the cross-cultural aspects of psychopharmacology explored factors that contribute to differences between individuals' response to psychopharmacological interventions including cultural beliefs, treating psychiatrist

Help your depressed patient take

a LEAP back to LIFE^{1,2}



Wellbutrin® XL contains bupropion, the dual acting antidepressant which targets noradrenaline and dopamine^{1,3}

- WELLBUTRIN® XL targets residual symptoms of depression^{4,5,6,7}
- WELLBUTRIN® XL contains bupropion which has a lack of serotonergic activity with a low risk of sexual dysfunction and a low risk of somnolence vs SSRIs¹

WELLBUTRIN® XL Safety Information:

SIDE EFFECTS AND SPECIAL PRECAUTIONS: Very common: weight loss, insomnia, headache, dry mouth, gastrointestinal disturbance including nausea and vomiting. Common: hypersensitivity reactions such as urticaria, anorexia, agitation, anxiety, tremor, dizziness, taste disorders, visual disturbance, tinnitus, increased blood pressure (sometimes severe), flushing, abdominal pain, constipation, rash, pruritus, sweating, fever, asthenia, chest pain.

Special Precautions: Discontinue treatment promptly if patients experience hypersensitivity reactions during treatment. Symptoms may persist after discontinuation & clinical management should be provided accordingly. Treatment in renal impairment should be initiated at reduced dosage. Should be used with caution in patients with mild hepatic impairment and reduced frequency of dosing should be considered. Closely monitor patient for possible adverse effects that could indicate elevated blood & tissue levels of drug & metabolites. A reduced frequency of dosing may be required in the elderly. Caution should be exercised in patients with cardiovascular disease. Exercise caution before driving or use of machinery until certain effects.

References: 1. Fava M, Rush AJ, Thase ME, et al. 15 Years of Clinical Experience with Bupropion HCl: From Bupropion to Bupropion SR to Bupropion XL. *Prim Care Companion J Clin Psych* 2005;7:106-113. 2. Stahl SM, Pradko JF, Haight BR, et al. A Review of the Neuropharmacology of Bupropion, a Dual Norepinephrine and Dopamine Reuptake Inhibitor. *Prim Care Companion J Clin Psychiatry* 2004;6(4):159-166. 3. Guard BP, Mansari ME, Blier P. Prospect of a Dopamine Contribution in the Next Generation of Antidepressant Drugs: The Triple Reuptake Inhibitors. *Curr Drugs Targets* 2009;10(11):1069-1084. 4. Hewett K, Chrzanowski W, Schmitz M, et al. Eight-week, placebo-controlled, double-blind comparison of the antidepressant efficacy and tolerability of bupropion XR and venlafaxine XR. *J Psychopharmacol* 2008;23(5):531-538. 5. Hewett K, Chrzanowski W, Jokinen R, et al. Double-blind, placebo-controlled evaluation of extended-release bupropion in elderly patients with major depressive disorder. *J Psychopharmacol* 2009;24(4):521-529. 6. Soczynska JK, Ravindran LN, Styra R, et al. The effect of bupropion XL and escitalopram on memory and functional outcomes in adults with major depressive disorder: Results from a randomized controlled trial. *Psychiatry Research* 2014;220:245-250. 7. Nutt D, Demyttenaere K, Janka Z, et al. The other face of depression, reduced positive affect: the role of catecholamines in causation and cure. *J Psychopharmacol* 2007;21(5):461-71.

ESI WELLBUTRIN® XL 150/300 extended-release tablets (Reg. No. 411/2/0371 & 0372 respectively). Each tablet contains 150 mg/300 mg of bupropion hydrochloride respectively. **PHARMACOLOGICAL CLASSIFICATION:** A 1.2 Psycho-analgetics (antidepressants). **INDICATIONS:** Treatment of depression as defined by DSM IV Criteria. **CONTRA-INDICATIONS:** Patients under 18 years; hypersensitivity to any component of the preparation; in patients with a seizure disorder, should not be administered with any other preparation containing bupropion; abrupt discontinuation of alcohol or sedatives; current or previous diagnosis of bulimia or anorexia nervosa; concomitant administration with MAOIs; liver disease (Child-Pugh grades B and C, range 7-13). **WARNINGS:** Recommended dose should not be exceeded. Should not administer to patients with one or more conditions predisposing to a lowered seizure threshold, including history of head trauma, CNS tumour, history of seizures, concomitant administration of medications known to lower the seizure threshold, excessive use of alcohol or sedatives, diabetes treated with hypoglycaemics or insulin & use of stimulants or anorectic products. Caution should be used in circumstances associated with an increased risk of seizures. Should be discontinued & not recommenced in patients who experience a seizure while on treatment. Observe patients closely for clinical worsening & suicidality, especially at the beginning of therapy, or at the time of dose changes, either increases or decreases. Symptoms reported in patients treated with antidepressants: anxiety, agitation, panic attacks, insomnia, irritability, hostility (aggressiveness), impulsivity, akathisia, hypomania & mania. Consideration should be given to changing the therapeutic regimen, including possible discontinuation, in patients for whom such symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms. Neuropsychiatric symptoms, in particular, psychotic and manic symptomatology has been observed, mainly in patients with a history of psychiatric illness. Aggression, rage and violent behaviour may occur. Prior to initiating treatment, patients should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression. Safety & efficacy in patients under 18 years not established. **INTERACTIONS:** Concomitant therapy with certain beta-blockers, anti-arrhythmics, SSRIs, TCAs, antipsychotics & medication metabolised by CYP2D6 should be initiated at the lower end of the dose range or the concomitant medication, Citalopram. Co-administration of drugs known to induce metabolism (e.g. carbamazepine, phenobarbitone, phenytoin) or inhibit metabolism may affect its clinical activity. Ritonavir reduces bupropion exposure. Consumption of alcohol should be minimised/avoided. Concurrent treatment with either levodopa or amantadine should be with caution. Concomitant use with Nicotine Transdermal System (NTS) may result in elevations of blood pressure. **PREGNANCY & LACTATION:** Safety not established. Epidemiological studies following maternal exposure in the first trimester have reported an association with increased risk of some congenital cardiovascular malformations, including ventricular septal defects and left ventricular outflow tract defects. Mothers should be advised not to breastfeed. **DOSAGE AND DIRECTIONS FOR USE:** The initial dose is 150 mg taken as a single daily dose in the morning. Patients not responding to this dose may be increased to 300 mg/day, given once daily. Tablets should be swallowed whole and not cut, crushed or chewed. When switching patients from SR tablets to XL tablets, give the same total daily dose when possible. A reduced frequency of dosing should be considered in patients with mild hepatic impairment. **Children and Adolescents:** Contra-indicated in children or adolescents aged less than 18 years. **Elderly:** A reduced frequency and/or dose may be required. **Renal Impairment:** Treatment should be initiated at a reduced frequency and/or dose. **Liver Impairment:** Use with caution in patients with mild liver impairment - a reduced frequency of dosing should be considered. Contra-indicated in patients with moderate to severe hepatic cirrhosis. **SIDE EFFECTS AND SPECIAL PRECAUTIONS:** Very common: weight loss, insomnia, headache, dry mouth, gastrointestinal disturbance including nausea and vomiting. Common: hypersensitivity reactions such as urticaria, anorexia, agitation, anxiety, tremor, dizziness, taste disorders, visual disturbance, tinnitus, increased blood pressure (sometimes severe), flushing, abdominal pain, constipation, rash, pruritus, sweating, fever, asthenia, chest pain. **Uncommon:** confusion, depression, concentration disturbance, tachycardia. **Other:** more severe hypersensitivity reactions including angioedema, dyspnoea/bronchospasm and anaphylactic shock. Arthralgia, myalgia and fever have also been reported in association with rash and other symptoms suggestive of delayed hypersensitivity; blood glucose disturbances; aggression, hostility, irritability, restlessness, hallucinations, abnormal dreams, depersonalisation, delusions, paranoid ideation; seizures, dystonia, ataxia, parkinsonism, incoordination, memory impairment, paraesthesia, syncope; palpitations; vasodilation, postural hypotension; elevated liver enzymes, jaundice, hepatitis; erythema multiforme and Stevens Johnson syndrome; switching; urinary frequency and/or retention. **Special Precautions:** Discontinue treatment promptly if patients experience hypersensitivity reactions during treatment. Symptoms may persist after discontinuation & clinical management should be provided accordingly. Treatment in renal impairment should be initiated at reduced dosage. Should be used with caution in patients with mild hepatic impairment and reduced frequency of dosing should be considered. Closely monitor patient for possible adverse effects that could indicate elevated blood & tissue levels of drug & metabolites. A reduced frequency of dosing may be required in the elderly. Caution should be exercised in patients with cardiovascular disease. Exercise caution before driving or use of machinery until certain effects. **MANAGEMENT OF OVERDOSAGE:** Hospitalisation is advised. ECG and vital signs should be monitored. Ensure an adequate airway, oxygenation & ventilation. Gastric lavage may be indicated if performed soon after ingestion. The use of activated charcoal is also recommended. No specific antidote is known. For full prescribing information refer to the package insert approved by the medicines regulatory authority. All adverse events should be reported by calling the Aspen Medical Hotline number or directly to GlaxoSmithKline on +27117456000. HCR: GlaxoSmithKline South Africa (Pty) Ltd. (Co. Reg. No. 1948/000195/07). 39 Hawkins Ave, Epping Industria 1, Cape Town. ZAF/BHQ/0004/16. A21247 09/16.

bias, genetic polymorphisms, and dietary and environmental factors. Basic neuroscience lectures included Dr Brookes' presentation on the neural basis of psychotherapy for anxiety and related disorders, Professor Leonard's lecture debating whether neuroinflammation is a cause or co-incidence in mood disorders and Professor Dean's lecture on advances in the field of biomarkers. In the final presentation of the programme Dr Jantina de Vries, a bioethicist, discussed the ethical issues of genomic research in the African context.

A "Young Scientists" Parallel Session was held, supported by the Scandinavian College of Neuropsychopharmacology (SCNP) and the journal *Acta Neuropsychiatrica*. This Session included a Young Researcher Career Workshop which attracted postgraduate and postdoctoral fellows. This workshop was led by Prof Wegener and Dr Howells. During this interactive workshop there was discussion of developing research collaborations and networks, publication processes, and sharing of research experiences and research goals.

THE WORKSHOP WAS FOLLOWED BY POSTER AND ORAL PRESENTATIONS SUBMITTED BY YOUNG SCIENTISTS, WITH A BROAD ARRAY OF WONDERFUL PRESENTATIONS FROM BASIC TO BEDSIDE RESEARCH STUDIES.

Poster presentations were given by Lian Taljaard (Stellenbosch University), Ingrid Eloff (Department of Health, Eastern Cape), Kavendren Odayar (Department of Health, Eastern Cape), Mari Retief (Stellenbosch University), Eileen Thomas (Stellenbosch University), and Duyilemi Ajonijeju (University of Kwa-Zulu Natal). Oral presentations were given by Lian Taljaard (Stellenbosch University), De Wet Wolmarans (North-West University), Khayelihle Makhathini (University of Kwa-Zulu Natal), Antoinette Burger (University of Cape Town), Sarel Brand (North-West University), Madeleine Uys (North-West University), and Phuti Choshi (University of Cape Town). Miss Antoinette Burger from the University of Cape Town was awarded the best Young Scientist presentation. In addition to the academic programme the congress hosted a meeting to draw up the constitution of the AfCNP, aligning the organisation as a sister college alongside the American (ACNP), Asian (AsCNP), European (ECNP) and Scandinavian (ScCNP) neuropsychopharmacology colleges. The third African College of Neuropsychopharmacology Conference is being planned for East Africa in 2017.

Dan Stein is Professor and Head, Department of Psychiatry and Mental Health, University of Cape Town, Cape Town, South Africa. **Kerry-Ann Louw** is a psychiatrist and senior lecturer in the University of Cape Town's Department of Psychiatry and Mental Health. **Fleur Howells** is a neuroscientist and senior lecturer in the University of Cape Town's Department of Psychiatry and Mental Health. **Correspondence:** kerrylouw@gmail.com

2ND AFRICAN COLLEGE OF NEUROPSYCHOPHARMACOLOGY CONGRESS - JULY 2016



MY ADHD

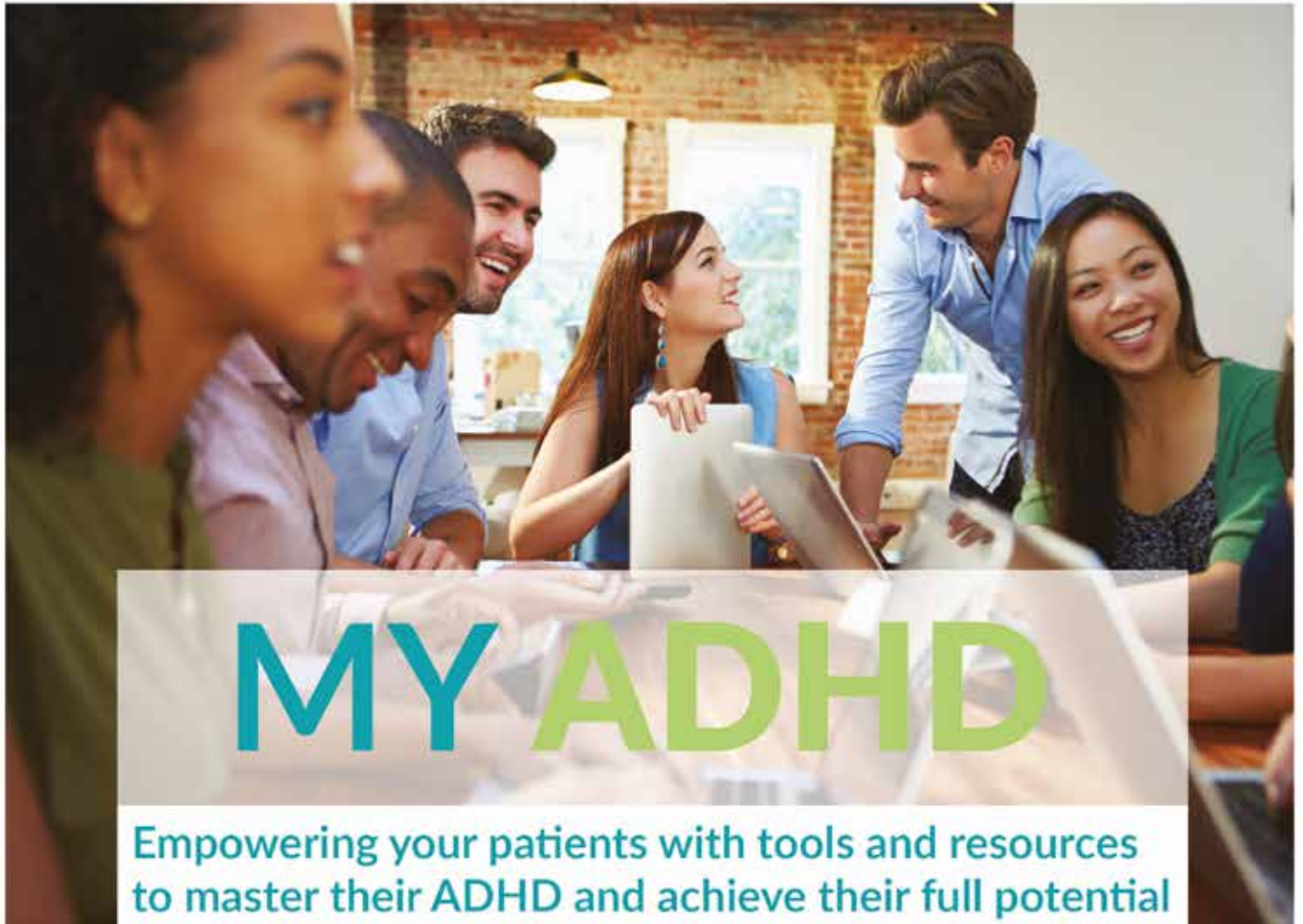
www.myadhd.co.za

If you are living with ADHD, are a parent, teacher or family member associated with ADHD, **MY ADHD** brings you a rich resource of information on how to cope, manage and excel in living with ADHD.

 www.myadhd.co.za

 <https://www.facebook.com/myadhdSA>

 Go to www.myadhd.co.za for Blog site information



- Comprehensive dedicated ADHD information website: www.myadhd.co.za
- An interactive, daily refreshed Facebook page
- Innovative unique new ADHD blog page - quality content by ADHD specialists and patients
- Appropriate and informative content about dealing with ADHD in all age groups and daily situations

Janssen
THE PHARMACEUTICAL COMPANY

Johnson & Johnson

 **CONCERTA**[®]
methylphenidate HCl

ADULT ADHD WORKSHOP

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

Renata Schoeman



On a Saturday, 6 August 2016, the SASOP adult ADHD SIG, hosted an adult ADHD workshop in Bloemfontein – made possible through educational grants from Eli-Lilly and Janssen. The friendliness and enthusiasm of the multidisciplinary attendees and the capable staff of Dersley Manor, warmed up the chilly morning for the “foreigners”.

Dr Ian Westmore acted as chairperson of the meeting. In his opening, Dr Pieter Pienaar gave an overview of the history of the SASOP adult ADHD SIG (which was launched during September 2015, with Drs Rykie Liebenberg and Renata Schoeman as convenor and co-convenor respectively). The overall objective of the ADHD SIG is to improve the basket of care available to patients with ADHD. This is only possible through a combined and concerted effort of individuals with a special interest in and passion for ADHD to improve knowledge about and funding for the care of individuals with the disorder.

One of the specific aims of the ADHD SIG is to facilitate workshops and conferences (both at regional and national level) to promote appropriate and relevant continuing education and professional development with regard to ADHD and psychiatry. He quoted from new African guidelines for the diagnosis and treatment of adult ADHD (under review):

“THE NOTION THAT ADHD IS A DISORDER OF CHILDHOOD, PREVAILED UNTIL THE 1990’S. RIGOROUS RESEARCH, INCLUDING LONGITUDINAL STUDIES, AND PUBLIC AWARENESS HIGHLIGHTED THE PRESENCE OF ONGOING SYMPTOMS IN 65 PERCENT OF ADULT PATIENTS. ADULT ADHD IS NOW A RECOGNISED PROBLEM. ASSOCIATED SYMPTOMS OF ADHD INCLUDE BEHAVIOURAL, COGNITIVE, EMOTIONAL AND SOCIAL PROBLEMS. PROBLEMS WITH PLANNING, TASK-INITIATION, TASK-COMPLETION, IMPATIENCE AND IMPULSIVITY CAN CAUSE NUMEROUS WORK-RELATED AND INTERPERSONAL PROBLEMS.”

This set the scene for the day.



Renata Schoeman

The first speaker was Dr Jack Krysztofiak (psychiatrist) who presented *“Emotional dysregulation – a common link between ADHD, BPD, BMD and GAD?”*. Emotional dysregulation (ED) is the inability to flexibly respond to and manage emotions. It refers to the dynamic interplay between emotion

sensitivity, an elevated and labile negative affect, an invalidating environment, a deficit of appropriate regulation strategies, and a surplus of maladaptive regulation strategies. ED is present in 30-70% of adults with ADHD, with up to 34% of adults with ADHD having comorbid BPD. The pathophysiology underlying ED include “bottom-up” deficits (such as amygdala hyperactivity), “top-down” deficits (such as impaired regulation of parasympathetic responses to negative stimuli) and executive dysfunction (with impaired cognitive control of emotions). Dr Krysztofiak continued to discuss the fronto- limbic dysfunction underlying all disorders marked by impulsivity and ED – which also adds to the complexity with regard to the diagnostic distinction between ADHD and BMD (type 2). He also emphasised the importance of the impact of the environment on early attachment and the negative cascade leading to ED, depression, and GAD – should attachment be insecure. This highlights the importance of addressing ED in patients with ADHD – not only for themselves, but also for their children.

Mrs Marlene Wells (clinical psychologist) presented *“Adult ADHD cognitive behaviour therapy and mindfulness: a paradigm shift”*. Mrs Wells gave a thorough overview of the brain structures and circuits implicated in ADHD, as well as the evidence for the use of psychotherapy and the effect thereof on the neuroplasticity of the brain. Although psychostimulants remain the first line of treatment for adults with ADHD, many adults opt not to use medication, or cannot tolerate medication. Psychotherapy is therefore an important adjunctive strategy in treating adults with ADHD. With cognitive behaviour therapy (CBT) the

basic concept proposes that thoughts affect emotions which in turn determine behaviour. The basis of CBT is to enable the patient to identify their negative and problematic thoughts or thought distortions and to reevaluate these to effect better emotional response and behavioural outcomes. More recently the addition of Mindfulness to CBT (MCBT) has expanded the therapeutic tool to bring a different and more targeted approach. This paradigm shift embraces the best of both approaches allowing the patient to engage in metacognition (thinking about their thinking) and empowering them to address the core triad of ADHD (inattention, hyperactivity and impulsivity) directly through conscious breathing, and simply being aware of their chaotic mind, to accept it, but not to engage with it. Gaining this mastery results in more focus, less distraction and realistic goal direction.

Dr Renata Schoeman (psychiatrist) presented "*The social impact of adult ADHD*" in which she took a different perspective on our traditional view of ADHD. She highlighted the role of impaired social cognition in the workplace and family environment, as well as how the core triad of symptoms contribute to the life of perpetual failure patients with adult ADHD often experiences.

INDIVIDUALS WITH ADHD OFTEN, DESPITE BEING HIGHLY INTELLIGENT AND CREATIVE, LEAD A LIFE OF UNDERACHIEVEMENT AND PERPETUAL FAILURE WHICH INCLUDE POOR ACADEMIC AND WORK RECORDS, INTERPERSONAL CONFLICT AND MARITAL DISORDER AND FINANCIAL DIFFICULTIES.

She examined the direct, indirect and intangible costs of ADHD (also providing South African data) and demonstrated how the presence of adult ADHD doubles to triples all healthcare costs, and decreases economic activity and financial health. Not only does ADHD impedes workplace productivity, but it also increases the risk of absenteeism and workplace accidents and injuries. Although ADHD is NOT a disability, the Employment Equity Act (1998) aims to prevent unfair discrimination and to promote equity in the workplace. Furthermore, affirmative action legislation emphasises that reasonable accommodation for people with disabilities should be provided to make the workplace more accessible according to the person's needs, access to information and technology, re-organising workstations to ensure that people with disabilities can work effectively and efficiently, and changing training and assessment materials and processes. Different intervention strategies (workplace accommodations, social skills training, and family intervention) were discussed.

Renata Schoeman is a Psychiatrist in private practice and the Co-convenor of the South African Society of Psychiatrist's adult ADHD Special Interest Group. **Correspondence:** bibitica@mweb.co.za

The workshop closed with a lively debate between Drs Rykie Liebenberg (psychiatrist) and Pieter Pienaar (who kindly stood in for Dr Nowbath who experienced problems with his flight) on the use of cognitive enhancers in adults without ADHD. Their positioning during the debate did not necessarily reflect their personal positions – which added to the challenge. Enhancement is deliberate intervention to improve existing capacities, or to create new capacities. Dr Liebenberg highlighted the ethical principles of autonomy, beneficence, non-maleficence, and justice in her argument for the use of cognitive enhancement in healthy adults. Although cognitive enhancers such as stimulants can be considered safe and effective, there is always a "but"... Dr Pienaar highlighted the paucity of evidence for the efficacy and long-term safety of these drugs in the use of adults without ADHD. The justice principle – where there is already a lack of access to diagnosis and treatment for those with ADHD, is another counterargument for only benefitting a select few who can afford the treatment. Although the use of stimulants as enhancers is prevalent (up to 18% of students at the University of Stellenbosch admits to the use thereof in the absence of ADHD), the ideal would have been to call for a moratorium on the use until more data is available. It is also important to distinguish between illegal versus unethical use. It is important that psychiatrists diagnose and treat individuals responsibly and with integrity. This will include distinguishing between prescribing medication for cognitive enhancement or for the treatment of ADHD – and refraining from assigning diagnostic codes to healthy individuals merely to obtain funding for medication. Mental healthcare professionals should also familiarise themselves with the content of the SASOP position statement on the treatment of ADHD (<http://www.sasop.co.za/Statements/AdhdTreatment>).

The workshop was a stimulating day, with thought provoking information and questions - challenging our current way of thinking about adult ADHD.



From left to right: Sean Searle (Janssen), Dr Ian Westmore (Bloemfontein), Dr Pieter Pienaar (Bloemfontein), Dr Renata Schoeman (Cape Town), Dr Jack Kryztofiak (Durban), Umbalica Balrishie (Eli-Lilly), Velmie van der Linde (Eli-Lilly), Dr Rykie Liebenberg (Sandton), Marlene Wells (Durban), Portia Mmenu (Janssen)

MENTAL HEALTH AT THE RURAL HEALTH CONFERENCE

7-9 AUGUST 2016, GRAHAMSTOWN

Kate Sherry

The annual Rural Health Conference (RHC) brings together rural healthcare workers of all disciplines, academics, students, health activists and others with an interest in promoting healthcare for rural populations in southern Africa. Founded by the Rural Doctors Association of South Africa (RuDASA), the conference is now jointly hosted with Rural Rehab South Africa (RuReSA), the Rural Health Advocacy Project (RHAP), the Professional Association of Clinical Associates (PACASA) and the Rural Nurses Association (RuNurSA).

The diversity of delegates fosters a vibrant, practically oriented program, with many informal opportunities for sharing experiences, making connections and being inspired by the passion and creativity of the rural health movement.

In 2014, a growing concern among the rural health partners about the state of mental health services for rural populations led to the launch of the Rural Mental Health Campaign (RMHC). A process of stakeholder mapping drew together interested partners from the public sector, NGO's and Mental Health Care Users (MHCU's), including Cape Mental Health, the South African Federation for Mental Health (SAFMH), Section 27, the Stop Stock Outs campaign and the Treatment Action Campaign. A workshop at the 2014 RHC in Worcester produced a steering committee, and a campaign plan. During 2015, the RMHC produced a report entitled "Rural mental health: A call to action", which outlined the challenges faced by rural mental healthcare users and providers, alongside expert pieces on budgeting, rehabilitation, stigma and discrimination and other key topics.

While public sector mental health services present cause for concern across South Africa, the situation in rural areas is particularly dire. The poverty typical of rural populations, especially in the former homelands,

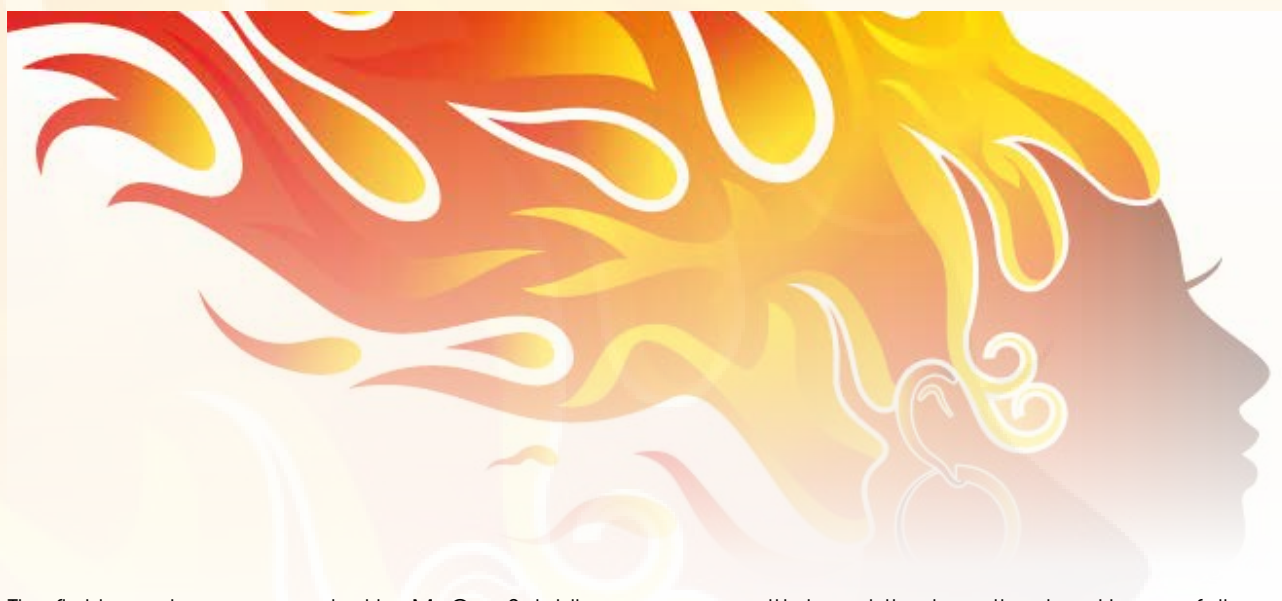
creates high risk for mental illness of all kinds, and the breakdown of family and social structures due to labour migration and other factors renders people with mental illness in these areas particularly vulnerable. The poor quality (or absence) of basic services, education and general healthcare also



Kate Sherry

contribute. Persons living in rural areas may have little or no access to specialist services, including psychiatrists, psychologists, occupational therapists and social workers, which tend to be concentrated in urban areas.

Since 2014, the annual RHC has featured a mental health track, bringing together academic research, clinical experience and an advocacy focus. This year, the track featured a morning plenary with two keynote speakers on the mental health and wellness theme, followed by a parallel/breakaway session featuring two oral presentations and campaign report-back and planning. The mental health track as a whole was coordinated and chaired by two members of the RMHC committee, Shannon Morgan and Kate Sherry.



The first keynote was presented by Ms One Selohilwe of the Alan J. Flisher Centre for Public Mental Health, and the Programme for Improving Mental Healthcare (PRIME). Her address outlined the development and piloting of a district mental health plan in North-West province, in the context of Primary Healthcare Re-engineering and NHI pilot work in this area, showcasing the excellent technical work being done by the Centre towards implementation of the National Mental Health Strategic Framework.

Prof Steve Reid, of the UCT Primary Healthcare Directorate, was the second keynote speaker, with a thought-provoking address entitled "Singing from the Edge", a reflection on the nature of health based on the concept of Leading Causes of Life (and two actual songs, performed by the entire audience). The talk raised questions about how we conceive of the health of health systems themselves (particularly at the rural periphery), and encouraged us to think about how practice might be moved from "rescue medicine" towards the promotion of life and health for communities.

TOGETHER THESE TWO EXCELLENT AND CONTRASTING KEYNOTES STIMULATED CONSIDERABLE DISCUSSION OVER THE FOLLOWING DAYS OF THE CONFERENCE, AND PRODUCED EXCELLENT ATTENDANCE AT THE SUBSEQUENT MENTAL HEALTH PARALLEL SESSION.

The mental health track continued after a tea-break, with a presentation by Prof Melvyn Freeman of the Non-Communicable Diseases Directorate at the National Department of Health. Drawing on his substantial engagement with the international community on the implementation of the United Nations Convention on the Rights of Person with Disabilities, Prof Freeman spoke on key concerns around the removal of legal provisions for involuntary

committal, and the insanity plea. He was followed by Ms Adele Middlecote, an occupational therapist at Zithulele Hospital in the Eastern Cape, who presented lessons learnt in implementing depression support groups in this remote rural context. The two presentations balanced a broad international perspective with a local and hands-on one, setting the scene perfectly for the ensuing discussion on the future of the Rural Mental Health Campaign.

AT PRESENT, KEY CONCERNS IN RURAL MENTAL HEALTH INCLUDE THE IMPLEMENTATION OF THE MHSE, IN THE PRESENCE OF HUMAN RESOURCES FOR HEALTH (HRH) PRESSURES, FOLLOWING NATIONAL BUDGET CUTS IN 2016. PARTICIPANTS IN THE DISCUSSION RAISED THE NEED FOR INCREASING THE CAPACITY OF NURSES, PARTICULARLY AT PHC LEVEL, TO ADDRESS MENTAL HEALTH. TRADITIONAL HEALERS WERE ALSO IDENTIFIED AS A SIGNIFICANT RESOURCE. IT WAS ALSO POINTED OUT THAT REHAB WORKERS, SPECIFICALLY OCCUPATIONAL THERAPISTS AND OT TECHNICIANS (MID-LEVEL WORKERS), ARE WELL PLACED TO IMPLEMENT MENTAL HEALTH SERVICES, ESPECIALLY COMMUNITY-LEVEL PSYCHOSOCIAL REHABILITATION (PSR). UNFORTUNATELY TO DATE, THE POTENTIAL FOR A SHARED SERVICE PLATFORM FOR PSR AND REHABILITATION FOR OTHER KINDS OF DISABILITIES HAS NOT BEEN RECOGNISED BY THE DEPARTMENT OF HEALTH.

One participant raised the example of HAART in South Africa, pointing out that when first available, this treatment was considered completely unaffordable by the public sector. Today, HAART is freely available to all, thanks to vigorous advocacy by civil society and by healthcare workers. She argued that the same could be achieved for mental health, and encouraged the Campaign to continue its work. The need for frontline healthcare workers to identify

RURAL MENTAL HEALTH

and report on mental health needs was raised, with experience shared by PRIME on training PHC nurses in screening and assessment. Increased identification of such needs in the population can be used to make the case for more resources for mental health. However, healthcare workers' own mental health needs have been found to impact their capacity to deal with mental illness in their patients, and also need to be addressed.

THE MINISTERIAL TECHNICAL ADVISORY COMMITTEE CONTINUES TO WORK ON IMPLEMENTATION GUIDELINES, AND INCLUDES REPRESENTATIVES FROM PRIME AND THE SOUTH AFRICAN FEDERATION FOR MENTAL HEALTH, BOTH OF WHICH ORGANISATIONS HAVE BEEN ACTIVE IN THE RMHC. WE CONSIDERED THE OPPORTUNITY FOR EXISTING GOOD PRACTICE IN RURAL MENTAL HEALTH TO BE SHARED AND BUILT UPON, BOTH WITH THIS BODY AND MORE BROADLY. ONE PARTICIPANT IDENTIFIED HERSELF AS A DISTRICT MANAGER, AND ASKED THE GROUP FOR ASSISTANCE WITH DEVELOPING A MENTAL HEALTH PLAN FOR HER DISTRICT.

The breakaway session was attended by a diverse group, many of whom had no previous involvement in mental health or the campaign. This was an encouraging sign of the campaign's impact within the rural mental health movement. Mental health was also included in other tracks and presentations across the conference program, for example a workshop on "The first 1000 days", and several rehab presentations.

The conference was an opportunity for reflection and fresh inspiration for the RMHC, with new stakeholders engaged and strategic opportunities emerging.

We would like to thank all participants, particularly Prof Freeman, the keynote speakers and other presenters, as well as the conference organisers. The RMHC steering committee is currently at work on our strategy for 2017.

If you are interested in learning more about the campaign or becoming involved, please contact us at ruralrehabsa@gmail.com. You can also download the 2015 report at <http://www.ruresa.com/rural-mental-health-campaign.html>.

Kate Sherry is an occupational therapist and Exco member for Rural Rehab South Africa (RuReSA). On behalf of this organisation, she helped to launch the Rural Mental Health Campaign in 2014, and continues to serve on the campaign's steering committee. She recently completed a PhD in Public Health (UCT), researching the interactions between rural people with disabilities and the primary healthcare system.

Correspondence: kate.sherry@gmail.com

S5 Dopaquel
QUETIAPINE

S5 DOPAQUEL
(QUETIAPINE)

INDICATIONS¹

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



Harmony in Mental Health

Dr. Reddy's



HELPLINE

0800 21 22 23 www.sadag.co.za

Dr. Reddy's



NEUROPSYCHIATRY

GOOD HEALTH CAN'T WAIT

1. Dopaquel Package Insert.

S5 Dopaquel 25/100/200/300. Each tablet contains quetiapine fumarate equivalent to quetiapine 25 mg/100 mg/200 mg/300 mg. Reg No's 43/2.6.5/0429;0430;0431;0432. Dr. Reddy's Laboratories (Pty) Ltd. Reg no. 2002/014163/07. North Wing, The Place, 1 Sandton Drive, Sandton 2196, South Africa. Tel: +27 11 324 2100, Fax: +27 11 388 1262, www.drreddys.co.za. ZA/12/2015/Dop/175.

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

ME BEFORE YOU

A film review by Franco P. Visser

A Metro-Goldwyn-Mayer (MGM) / New Line Cinema / Sunswept Entertainment Production

Screenplay by Jojo Moyes

Directed by Thea Sharrock

In the busy and fast-paced lives that we live these days hardly a thought is ever given to the possibility that life as one knows it might suddenly come to an end. Death and dying, disease and illness, accidents and catastrophes are topics usually associated with the more 'serious' part of life. The average human being seldom jokes about these important issues and when these topics dare stray into social conversations at parties, it is greeted with such awkward silence that you would think that guests have gone mute! Well, at least that is the 'average' human being. For those of us in the 'people's business', these topics are almost part of our lives as it is often what we have to work with on a daily basis.

When I flipped through the film list one evening I came upon *Me Before You*, and I remember reading the short information caption of the film as saying something about the necessity of keeping tissues handy. I chose the film and began viewing it with the necessary film-related indulgences to the left and right of my most comfortable chair at home. To jump the gun just a bit I need to say that I was awfully happy that I did view the film at home and not in a public cinema, the reason for this will become evident later one.

The film opens with a handsome and obviously wealthy and successful Will Traynor (played by Sam Claflin) getting up one morning in his chic London apartment that he shared with his chic London girlfriend. After dressing in the best of Savile Row, he leaves the apartment and tries to get the attention of a taxi driver when he is suddenly hit by an oncoming motorcycle that he did not see coming. Move a few years forward and the scene is set with the enigmatic and 'colourful' Lou Clark (played by Emilia Clarke) working at The Buttered Bun, a local tea shop, although she does not keep her waitressing position for long as The Buttered Bun runs out of business. Lou's family struggles financially, and when Lou loses her job at the tea shop, her parents become frantic as the family is without a stable income to survive on.



Lou visits the employment agency, and whilst she is there a position is advertised for a 'caregiver' to be employed by a local, wealthy family. Lou goes for the interview, held at the family's estate, and the interview is conducted by Camilla Traynor (played by Janet McTeer), Will's mother. Will became paralyzed from the neck down following the accident with the motorcyclist in London, and his family built him a special annex onto their palatial mansion in the grounds near a dilapidated old castle on a hill. Here Will receives daily care from his nurse, Nathan (played by Stephen Peacocke), and when Camilla employs Lou, who has no experience in caring for disabled individuals, their journey of discovery with each other starts. Lou's dress sense, or rather total lack thereof, Will's stubborn ignorance and Lou's constant positive presence as his 'companion' trigger very interesting and exciting moments for, and between the two of them.



Franco P. Visser

But Will has a secret, one that his parents know about and that he is withholding from Lou. Will's secret is also breaking his mother's heart, as she never stops hoping that her son will find a way to find a positive and meaningful life for himself given his extreme physical limitations. It is here, after all the fun and laughter, the magic and the romance that the dark questions about life and death come out, confronting you in a manner that I have never experienced like I did with this film.

I do not want to divulge any further information about what happens in the movie, as *Me Before You* is surely one of the best films that I have watched in a while. Four words summarise the film for me: fascinating, magical, heart-breaking, thought-provoking. What I can say is that at the end keeping some tissues was not enough. I felt like I was going to use the whole box! *Me Before You* is a film with many layers of complexities, and it is definitely worth your time and effort in obtaining a copy to view. Until next time.

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**

OCTOBER 2016

headline



OFFICIAL NEWSLETTER OF THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS (SASOP)

SASOP: THE ALTERNATIVE SOLUTION

FROM THE EDITOR

At the WPA International Congress in Cape Town in November, South African Psychiatrists will play host to the world as we welcome delegates from across the globe to our corner of world. It will see the culmination of months and years of hard work and preparation from many colleagues across South Africa, together with other parties such as the pharmaceutical industry, the PCO Scatterlings, government and non-government organizations and consumer groups – perhaps the first taste of what has become our “social contract” and congress theme.



Ian Westmore

Prof Bernard Janse van Rensburg, our incoming SASOP President and Congress Convenor, has been working exceptionally hard, to ensure that the Congress will be the success that we envisaged when we embarked on the project more than five years ago. He has shown exceptional leadership and dedication in the process and we look forward to his on-going lead in the next two years.

At the same time, we reflect on the dedication and commitment of our outgoing President, Dr Mvuyiso Talatala, who has steered the SASOP ship ably over the last two years. His term has seen SASOP grow and face many challenges, and his enthusiasm, good humour and vision have been inspirational. We, as the collective SASOP membership salute him, and look forward to his continued involvement in our organization as Past President.

Dr. Ian Westmore (Editor)

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

FROM THE PRESIDENT

We have just about a month left before my term of Presidency and the term of our current Board of Directors of SASOP comes to an end. It has been an extremely busy term with many successes and challenges. The relations that SASOP has with important stakeholders such as the government, Medical Aid Schemes, patient advocacy groups, NGOs in mental health, patients and SASOP members have evolved quite dramatically. At the core of our interactions with all of these stakeholders is the SASOP’s commitment to the social contract.

SASOP has had to step out of its comfort zone and speak up about deinstitutionalisation in Gauteng Province that is being implemented without the development of community based mental health care. The Gauteng Department of Health claimed that its termination of the contract for the care of chronic and severely mentally ill patients in the facilities of Life Healthcare Esidimeni was part of the policy of deinstitutionalisation. SASOP warned the government about unintended consequences if the process of closure of these facilities was not done with care. We have witnessed multiple deaths of mentally ill patients who were recently discharged from Life Healthcare Esidimeni. The National Minister of Health has requested the Health Ombudsman, Prof M. Makgoba, to investigate the deaths of these patients and all other related matters.

SASOP has continued to support the communities in their battle on the Life Healthcare Esidimeni issue. This has meant that SASOP has had to respond to media questions and speak against government. Speaking up against government in an attempt to look after patients poses ethical dilemmas. As medical practitioners we are expected and have

headline

a responsibility to defend patients right to dignified mental health care, even against government. That has its own risks for the individual practitioner who may be a State Employee as well as risks for SASOP.

SASOP is continuing to strengthen its communication strategy and is even considering rebranding. Media presence in the past 6 months has been notable. This has been further strengthened by the efforts of the Psychiatry Management Group (PsychMg) with Dr Renata Schoeman and Dr Sebolelo Seape being at the forefront. I have also led all efforts to strengthen SASOP's media presence. In addition to these recent efforts, I would like to thank Dr Ian Westmore, the editor of *Headline*, who has revived *Headline* and had it published regularly. SASOP has managed to steer its official journal, *South African Journal of Psychiatry (SAJP)*, forward. The biggest challenge with SAJP is its financing. Sponsorship and advertisements have been declining over the years. SAJP is an important asset for SASOP and we will have to find funds to keep the journal supported.



Dr Mvuyiso Talatala chairs his final Board of Directors meeting in Johannesburg in September 2016.

SASOP is continuously improving its relations with other international bodies and societies in Africa and across the world. We are currently encouraging SASOP members to join APA through a SASOP/APA membership discount project. APA membership obtained through this project has several benefits including the huge discount in membership offered by SASOP, PsychMg and APA. The usual APA membership benefits will apply and these include the access to *American Journal of Psychiatry*, the discount in the registration fee for the APA annual meeting, online courses and others.

I am in contact with psychiatrists in Southern Africa in an effort to strengthen psychiatry in Southern Africa. On the 6th of October 2016, I visited Lusaka, Zambia, where I met psychiatrists from Lusaka and discussed several areas of cooperation in the region. In June 2017 SASOP will host the first workshop of the leadership of psychiatry in Southern Africa.

I hope most psychiatrists in South Africa will attend the 2016 WPA International Conference in Cape Town where I will hand over the SASOP Presidency to Prof Bernard Janse van Rensburg. The annual General Meeting (AGM) will be held on Sunday 20th November 2016 at 16H30. I am making a plea to all SASOP members to attend the AGM. This will be followed by the President's dinner at 19H00. I wish all our members well as we wind down the year towards the end of the year holidays.

Dr Mvuyiso Talatala
President

3. MEMORANDUM OF UNDERSTANDING ON COLLABORATION BETWEEN THE ROYAL COLLEGE OF PSYCHIATRISTS, SASOP AND THE COLLEGE OF PSYCHIATRISTS OF SOUTH AFRICA.

We have previously reported on the negotiations between the three parties over the last few years. The WPA Congress in Cape Town in November will provide an opportunity for further discussions, and it is hoped that this agreement will be signed and entered into at that time.

4. REPORTS FROM THE SASOP NATIONAL COUNCIL MEETING

The SASOP National Council Meeting was held in Johannesburg on Saturday 10 September 2016. This was an opportunity for members of different subgroups, divisions and Special Interest Groups (SIG) to report to the Board of Directors (BOD) on their activities since the last meeting held a year ago. In the past year, these "report backs" have been ongoing, as selected members of these SASOP groups have been present at the BOD meetings, in an effort to keep the BOD informed throughout, and also to



Drs Brink, Seape and Kewana during the National Council Meeting.

headline

provide an opportunity for SASOP office bearers to gain insight into the “day to day” work of the Board.

4.1 PSYCHMG (DR S SEAPE)

PsychMg Scientific & Business Weekend: The 7th annual Scientific & Business Weekend took place on 12 – 14 August 2016 at Zimbali in KZN and was attended by 130 members of PsychMg. We thank Aspen Pharmacare for their generous sponsorship without which this event would not be possible. The board had a strategic planning meeting on the 12 August 2016. Some of the discussions included:

- Plans to invest more in members, e.g. training workshops, business sessions, practice management sessions, mentorship programmes and others;
- A five year budget and financial strategy;
- Strategies to make PsychMg financially independent.

PSYCHMG ANNUAL GENERAL MEETING (AGM):

The AGM took place on 13 August 2016 where the Annual Financial Statements 2015 were presented, auditors were appointed and the leadership for the next term was elected. Dr Paul Strong, Dr Paslius Mazibuko and Dr Judy Bentley were not available for re-election and we thank them for their support over the last term. We wish to welcome Dr Renata Schoeman who was newly elected to the board.

The leadership for the 2016/2017 term is as follows: myself, Sebolelo Seape (Chairperson), Kali Tricoridis (Vice Chairperson), Lerato Dikobe, Thabo Rangaka, Shaquir Salduker, Renata Schoeman, Mvuyiso Talatala and Ian Westmore. Eugene Allers remains involved as an external consultant. I wish to thank these individuals who devote a tremendous amount of their time to this organisation.

The board recognizes the trust the membership has placed on us and we shall continue to honour that.

MEMBERSHIP:

PsychMg has continued to grow both by numbers and liquidity. At present there are 230 paid up members. The finances are in good standing and all statutory requirements have been met. It is important to note that PsychMg membership automatically transfers to the member, the following additional membership:

- SASOP
- Biological Psychiatry Special Interest Group
- World Federation of Societies of Biological

Psychiatry (WFSBP)

- World Psychiatric Association (WPA) and the
- South African Private Practitioners Forum (SAPPF).
- Negotiations are underway between SASOP and the American Psychiatric Association (APA). PsychMg is willing to put up an extra R50 000 to subsidise members.

INTERACTION WITH MEDICAL SCHEMES AND ADMINISTRATORS:

The PsychMg board of directors continuously engage with funders on private practice matters, e.g. Discovery Health regarding the Psychiatry Governance Project; GEMS is under new (younger) management and we believe the relationship will be more effective in future; and POLMED met with us regarding the interpretation of coding and general audits.

FORENSIC INVESTIGATIONS:

During 2015 there was a decrease in forensic investigations; however, we have seen a dramatic increase over the last few months. Various administrators and schemes are now 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.

MENTORSHIP:

PsychMg has great interest in assisting with mentorship, but the actualization has not been great to date. The board has since made a concrete decision to have a mentorship workshop in the first quarter of next year. We would like to invite psychiatrists, who feel the need for assistance in this regard, to contact the board of directors so that they can register for this programme and a mentor can be assigned or chosen.

WPA 2016 CONGRESS:

PsychMg will put up a further R1 000 per member (over and above the R2 000 from SASOP) for registration, for members who did not receive sponsorship.

Sanofi Zentiva Psychiatry-in-Focus Weekend: This

readline

very successful event took place at Mount Grace on 12 - 13 March 2016. We thank Sanofi Zentiva who has already committed to present this weekend again next year. Save the date: 24 - 26 Feb 2017!

HOSPITAL VALIDATION PROJECT:

The board has drawn up a hospital validation document and this was presented by Dr Tricoridis at the PsychMg weekend.

DR REDDY'S SASOP PUBSEC WEEKEND:

The Dr Reddy's SASOP PubSec weekend will take place on 9 - 11 June 2017. It has been agreed that parallel sessions will be arranged for the private practice delegates.

GOVERNMENT ENGAGEMENTS:

These have been done in conjunction with SASOP. PsychMG board members attended the Ministerial Advisory Committee on the 10 August 2016. Topics presented were:

- Admission of children
- Shortage of beds
- PMBs
- The need to review the IUSS document
- District services
- Training of interns in psychiatry
- Life Esidimeni issue.

FROM THE SPECIAL INTEREST GROUPS

4.2 BIOLOGICAL SPECIAL INTEREST GROUP (PROF S SEEDAT)

COMMITTEE:

Three new members have joined the committee during 2016. They are: Prof. Jackie Hoare and Drs. Leigh van den Heuvel and Mari Retief. Prof. Dana Niehaus has resigned with effect from August 2016. Prof. Jonathan Burns will be relocating to the United Kingdom later in 2016, but for now he remains involved in the committee.

BIOLOGICAL PSYCHIATRY AWARDS 2016:

Fifteen applications were received (4 from established career researchers and 11 from early career researchers) and three outside adjudicators were appointed. Three awards were made: Biological Psychiatry Established Research Career Award: R200 000-00 to Prof. Christine Lochner, and the Biological Psychiatry Early Research Career Award: R100 000-00 each to Dr. Nathaniel Wade McGregor and Dr. Petrus Johan Naude. Criteria for the allocation of these awards will be re-evaluated during the course of this

year with transformational criteria in terms of gender, race and HEI being seen as of high importance for inclusion. These new criteria will be finalized prior to the awards being adjudicated next year.

CONGRESS 2017:

Three tenders were received to host the 2017 Congress. The applicants were interviewed and scored according to an agreed set of criteria. Londocor was chosen as the PCO. After a site visit, the Century City Congress Centre is the preferred venue. The dates for the congress will be 22 to 24 September 2017.

CONGRESS 2015 PROFITS:

We have agreed to pursue the possibility of utilizing financial support from the profits of the 2015 congress in terms of international speakers who could be invited to do WPA pre-congress presentations in Cape Town and other venues. The possibility of sponsoring medical students and junior doctors to attend the WPA 2016 congress will also be pursued.

CHANGES WITHIN THE BIOLOGICAL SPECIAL INTEREST GROUP (BPIG):

A proposal was tabled, and accepted at the July BOD Meeting, that in future, the Biological Psychiatry Congress Organizing Committee will be a stand-alone committee, with the Biological Special Interest Group being separate. The BPIG will be an SIG in the Biological Psychiatry Division (Cluster). Individuals could participate in one or both of these committees. The new Biological Psychiatry Division Committee will likely consist of two representatives from each Biological Special Interest Group from whom a chair, treasurer and a secretary will need to be appointed.

FINANCES:



Mardi Roos and Casper Venter from Healthman, with Prof Bernard Janse van Rensburg, Dr Sebo Seape and Prof Liezl Koen during the final BOD Meeting in September.

headline

The two accounts have been audited. These accounts will reside with the Biological Psychiatry Congress Organizing Committee. The provision of start-up funding to the BPIG was agreed to by the Biological Psychiatry Congress Organizing Committee.

MEMBERSHIP OF WORLD FEDERATION:

Payment of subscriptions has been made.

4.3 OLD AGE PSYCHIATRY SIG (DR C KOTZÉ)

There are 3 qualified Old Age Psychiatrists grandfathered by the HPCSA and Stikland Hospital remains the only accredited training facility with two Old-Age Psychiatry subspecialty-training posts. The posts are not funded and candidates are advised to seek funding from external sources. Dr Lina Groenewald started her training for an MPhil in Old-Age Psychiatry at the beginning of 2016. The process to establish Alzheimer's disease as a PMB and to make at least one cognitive enhancer available at state level is ongoing, with support from pharma and caregiver support organizations (such as Dementia SA and the Alzheimer's Association of SA).

There is growing support and enthusiasm for Old-Age Psychiatry, but the establishment of new training units remains a challenge.

4.4 CELLULAR AND MOLECULAR PSYCHIATRY SIG (DR JP ROUX)

We held a second seminar on "Genetics and the Future of Personalized Medicine" at the Cipla Neurosciences weekend in February 2016. This seminar was well attended by all delegates. Cipla printed a booklet on proceeds from this Seminar that was distributed to psychiatrists. The SIG is hosting a follow-up seminar at the WPA Congress in Cape Town with emphasis on "Clinical Pharmacogenetic Analysis and its availability in South Africa".

Members met up with Dr D Meyersfield, CEO of DNalysis, a technology Lab which is concluding Pharmacogenetic testing. We have collected a group of ± ten psychiatrists at Glynnview, Denmar and Sandton Mediclinic Hospitals to do a naturalistic retrospective study on patients being treated with poly pharmacy and monotherapy to see how much the genetic information would contribute to better decisions in pharmacological treatment regimes.

Dr's Roux, Allers, Janet and Peter also attended the DNalysis launch to doctors and pharmacists in South Africa.

4.5 SUBSTANCE USE DISORDER SPECIAL INTEREST GROUP (SUDASIG) (DR L WEICH)

During the Biological Psychiatry Congress in 2015, it was decided that the SUDASIG will fall under the Biological Cluster of SASOP special interest groups. The special interest group recognises addiction psychiatry as an emerging field of interest in South Africa. It sees one of its primary roles as advocating for best practice in addiction care treatment in South Africa. The subgroup therefore supports the development of a subspecialty in addiction psychiatry in order to develop local expertise and training possibilities in the field of addiction psychiatry. The Certificate in Addiction Psychiatry of the Colleges of Medicine of SA, has been accepted recently, though the registration of a subspecialty is still pending with the HPCSA. The group is busy developing a database of persons interested in Addiction Psychiatry in order to develop a network for communication.

The special interest group is represented on the South African Addiction Medical Society (SAAMS) EXCO and ensures that the interest of Addiction Psychiatry is represented at this forum. This organisation represents the interests of the multidisciplinary team working in Addiction Care and advocates for evidence based addiction care treatment. SAAMS has produced opioid and alcohol treatment guidelines and endorses Smoking cessation guidelines.

It presented two addiction related pre-symposium workshops on the 19th of August 2016 and a successful Addiction Care symposium on the 20th of August 2016, called "Pieces of the puzzle; addressing comorbidities in addiction". The subgroup submitted a pre-congress workshop for the upcoming WPA congress on Cannabis.

4.6 ATTENTION DEFICIT HYPERACTIVITY SPECIAL INTEREST GROUP (ADHD SIG) (DR R SCHOEMAN)

The overall objective of the ADHD SIG is to improve the basket of care available to our patients with ADHD. This is only possible through

headline

a combined and concerted effort of individuals with a special interest in, and passion for, ADHD to improve knowledge about, and funding for, the care of individuals with the disorder.

SIG ACTIVITIES AND MILESTONES

- Current membership: 31
- 25 September 2015: Launch of the SIG and first SIG meeting, Lord Charles Hotel, Somerset West
- 21 November 2015, Adult ADHD Workshop (in collaboration with the SASOP Southern Gauteng Subgroup), Oxford Health Care Centre, Saxonwold
- 27 February 2016: SIG meeting, 10 Bompas Road, Johannesburg
- 28 May 2016: Adult ADHD Workshop (in collaboration with the SASOP KZN Subgroup)
 - Unfortunately this had to be cancelled due to communication and logistical problems between KZN and the sponsor. We relocated the meeting to Bloemfontein
- Release of SASOP's position statement on ADHD treatment (in response to article in the Sunday Times, 29 May 2016)
- 6 August 2016: Adult ADHD Workshop (in collaboration with the SASOP Free State Subgroup)
- 13 August 2016: SIG meeting, Zimbali, Ballito
- The SASOP/PsychMG Treatment Guidelines for adult ADHD
 - One of the specific aims of the ADHD SIG was to develop South African guidelines for the diagnosis and treatment of adult ADHD specifically, and update guidelines for the treatment of child, adolescent, and adult ADHD.

Renata Schoeman was tasked by the SIG with the drafting of guidelines. Rykie Liebenberg provided valuable input. The guidelines were then circulated to the SIG members, as well as the Chair of the Public Sector SIG, for written feedback and evidence based suggestions that were then incorporated into the guidelines.

The final guidelines were circulated for written approval by the SIG members, followed by formal approval at a SIG meeting held on 13 August 2016, after which it was submitted to the SASOP and PsychMG boards for

recommendation and ratification.

ADDITIONAL ADHD RELATED INDIVIDUAL ENGAGEMENTS:

members of the SIG have been very active in writing articles, doing press releases and engaging with the media, increasing awareness of the condition.

FUTURE PROJECTS (2016/2017)

- 18-22 November 2016: Adult ADHD Workshop, WPA, CTICC
- 2017: Translate guidelines into policy documents SOPs. Workshops for SIG members in diagnosis and treatment – to be able to standardise and for quality assurance. Regional workshops with primarily using local speakers. Creation of centralised "curriculum"/ database/ materials.

FROM THE SUBGROUPS

4.7 NORTHERN SUBGROUP (DR C KOTZÉ) THE EXECUTIVE COMMITTEE:

Dr C Kotze (Chairperson); Dr P Malherbe (Secretary); Dr RA van Schoor (Treasurer); Dr M Rademeyer (Private Practice representative); Dr H Eksteen (UP registrar representative) and Dr Muluvu (SMU registrar representative).

The CME meeting of 25 February 2016 with the topic, "Cognition in Bipolar Disorder" was well attended and a report was published in South African Psychiatry, May 2016 edition. The subgroup also hosted their annual mini-symposium on 18 June 2016. The topic was "Trauma and Mental Health" and the event was considered to be a great success with positive feedback from attendees. A report about the event has been submitted to South African Psychiatry.

The subgroup would have been involved with arrangements for some of the pre-congress lectures in Gauteng prior to the WPA congress. Unfortunately, due to unforeseen changes in the academic programme at UP, where the presentations would have been hosted, this will not be possible anymore. The subgroup has been encouraging registrars and other members to support the congress. Two registrars have received partial sponsorship from the subgroup to attend the WPA Congress in November.

The financial management remains a challenge and Dr van Schoor has been struggling with access to the bank accounts, because of outstanding documentation. ABSA has requested business rules / a written constitution from SASOP, to allow her access to the accounts. Healthman has been contacted about this and we are awaiting a response to finalize this matter. The subgroup would still prefer relinquishing control of the finances to the central governance of SASOP.

4.8 LIMPOPO SUBGROUP (DR MM KEWANA)

INFRASTRUCTURE: In the province there is only one Private Facility, but it is not accredited to admit adolescents and involuntary patients. In the state sector there are three Psychiatric Hospitals for five districts, namely Hayani, Thabamooop and Evuxakeni hospitals. There are some psychiatric wards in district and secondary hospitals, eg Letaba; Mankweng and Mokopane.

ACTIVITIES: The subgroup was apathetic in the past few years, but was recently "resuscitated" by Dr Kewana. Meetings are held once a month (sponsored by Dr Reddys). The subgroup is preparing to host our first symposium on 17th September. In the public sector we are faced with a huge backlog of Forensic assessments since the retirement of Dr Weiss.

INFRASTRUCTURE AND HUMAN RESOURCES CHALLENGES: We are a small group and there are few consultants for the Province. There seems to be less or no time for research and academic development. In addition, there are no defined subspecialties e.g. Child and Family, Substances etc. In the Province, Review boards are almost non existant.

5. SASOP AWARDS 2016

The SASOP Awards Committee has been reviewing the criteria for the different award categories. These awards will be made at the SASOP Congress Dinner in November. Subgroups, Divisions and Special Interest Groups can make nominations. The criteria will be placed on the SASOP website.

6. TERMS OF OFFICE FOR SASOP OFFICE BEARERS

All members should note that it was recently decided that in future, the terms of office of all office bearers within SASOP structures should be aligned with that of the SASOP Board of Directors. This means that even though e.g. subgroups and Special Interest Groups may hold elections prior to the SASOP AGM during which elections are held (every two years), the term of office will be considered to begin with a new SASOP Administration (when the new President and Board of Directors assumes office). This will make the administration of SASOP easier.

IT IS THEREFORE RECOMMENDED THAT, IN FUTURE, ALL THE STRUCTURES WITHIN SASOP TRY AND ALIGN THEIR TERMS OF OFFICE WITH THAT OF THE BOARD OF DIRECTORS (THE NEW PRESIDENT AND BOARD WILL ASSUME OFFICE AFTER THE AGM IN NOVEMBER 2016 AT THE CONGRESS).

it is hoped that the training will be rolled out in other substructures as soon as possible.

7. PROF DENISE WHITE ENDS HER TERM AS PRESIDENT OF SAMA

Prof Denise White concluded her term of office (one year) as SAMA President at a dinner on 23 September 2016. It is not often that a psychiatrist is elected to this position, and her involvement in SAMA and determining policy over the past year has been significant.

We hope to report more extensively on her achievements in the next issue of South African Psychiatry, but in the meantime, SASOP would like to congratulate her on her achievements.

She remained involved in opening the SAMA congress in October, and has also agreed to coordinate a specific SAMA/WMA forum on physician assisted suicide at the WPA Congress in November. ■

SASOP: THE ALTERNATIVE SOLUTION

INSTRUCTIONS TO AUTHORS

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

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

LETTERS TO THE EDITOR

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

FEATURES

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

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

REPORTS

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

NEWS

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

ANNOUNCEMENTS

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

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

REVIEW ARTICLES

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

- * A 300 word abstract that succinctly summarizes the content will be required.
- * Referencing should conform to the Vancouver style i.e. superscript numeral in text (outside the full stop with the following illustration for the reference section : *Other AN, Person CD. Title of article. Name of Journal, Year of publication; Volume (Issue); page number/s. doi number (if available)*)
- * The submission should be accompanied by the University/Faculty letter noting successful completion of the research report.
 - * This will constitute peer review given that the examination process involves 2 independent examiners, with any revisions generally having been undertaken to the satisfaction of both your supervisor and Head of Department.

All submitted content will be subject to review by the editor-in-chief, and where necessary the advisory board. All content should be forwarded to the editor-in-chief, Christopher P. Szabo - Christopher.szabo@wiits.ac.za

The fine art of Mental Health Treatment



Valeptic CR
SODIUM VALPROATE

The **FINE ART** of **CONTROL**
EPILEPSY / BIPOLAR

Valeptic CR 300: Each controlled release tablet contains sodium valproate 300 mg. Reg. No. 44/2.5/0067.
Valeptic CR 500: Each controlled release tablet contains sodium valproate 500 mg. Reg. No. 44/2.5/0068.



For full prescribing information, refer to the package insert approved by the medicines regulatory authority, 1004178 08/2016

Adcock Ingram Limited, Reg. No. 1949/034385/06,
Private Bag X69, Bryanston, 2021.
Tel: +27-11 635 0000 www.adcock.com

adcock ingram 
generics

THE ART OF REMISSION

THE ART OF CNS

THE ART OF SEDATION

Sandoz
Zopiclone

Zolpihexal[®]

Sandoz
Venlafaxine XL

Sandoz
Mirtazapine