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ABOUT the discipline FOR the discipline

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COVID-19 IN SOUTH AFRICA: BEYOND ANXIETY

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Features

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NOVEMBER 2020

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

Dear Reader,

welcome to the final issue for 2020...the 25th....something of a milestone I suppose...a quarter century of issues…noting that it is our first hard copy issue since the pandemic lockdown. As a consequence of the lockdown our annual advertiser breakfast with industry was a virtual affair...another first, and hopefully last... though certainly it was a novel experience (see content which follows).We also had occasion to make contributions to charitable organizations during this time... Operation Hunger and Meals on Wheels (see letters following this content). And so it has certainly been a year of new experiences, with not all being negative…not least of all the recent election of Prof Solly Rataemane as the new Chair of the Medical & Dental Professions Board of the HPCSA for the next 5 years – our heartiest congratulations.

Prof Solly Rataemane

Alas, however this has also been a year of loss...freedoms, trust...and life. Since the August 2020 issue there has been the passing of Jan Chabalala and Franco Visser.

Jan Chabalala

Franco Visser

Jan, a Wits trained psychiatrist who had taken a position within the South African National Defence Force, and Franco, a psychologist who previously worked at Sterkfontein Hospital within the Department of Psychiatry at Wits and was most recently working as a forensic psychologist.

Franco had written many columns for *South African Psychiatry*...as our resident Movie Review contributor...and Jan had in recent times contributed a fine article entitled "An African approach to mental health and illness" to the February 2020 issue of *South African Psychiatry*. It was a privilege to have published content from both Jan and Franco and they will both be missed. Our sincere condolences to the families. Herewith tributes for Jan:

Dr Jan Chabalala was a 'gentle giant' – always warm, smiling, and kind. He was committed during his term as SASOP President to improving the lot of psychiatrists and the care and welfare of the mentally ill. He had a wonderful laugh that would light up a room. I am saddened that his life and stellar career have been cut short. So many of us will sorely miss our interactions with him and the energy that he brought to the table.

Soraya Seedat

I have learnt of the sad news of the passing away of Dr. Jan Chabalala on 27th September 2020. I had the privilege of meeting him in several forums in and out of South Africa. He achieved a lot as a psychiatrist. He was a past President of SASOP. As a Board Member of the South African Depression and Anxiety Group, he played a key role in public awareness on mental illness, with special reference to suicide prevention through use of helplines. His practice helped many individuals and through them their families. We will miss him.

At this time of great loss, please accept my condolence on behalf of Psychiatrists from East and Southern Africa whom I represent at the World Psychiatric Association (WPA) Board. Our thoughts are with you and his family.

Prof. David M. Ndetei
WPA Zone 14 Representative

Dear David and colleagues,

Please accept the condolences of your colleagues in WPA, for you and SASOP and the family of the late Dr. Jan Chabalala on his untimely and tragic loss.

We recognise Dr Chabalala's life and work and his major achievements in national and international psychiatry and mourn with you his passing. As mentioned by Afzal we hope to receive your obituary notes for publication by WPA.

With kind regards
Helen

Professor Helen Herrman AO
President, World Psychiatric Association

WORLD PSYCHIATRIC ASSOCIATION

As 2021 approaches, the only thing I know for sure is that it will commence on the 1st of January... this year 2020 has taught me that whilst planning for the future is what we do...living each day fully is what we must do. I hope that the new year will find us all safely there...I look forward to seeing you then. Take care ■

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Thank you to those of you who attended our 1st Virtual Advertiser Breakfast event on Friday 2nd October! It was wonderful to spend the morning with you!

For those of you who were unable or would like to view the content again, please click on the link below to view the recording.

https://www.youtube.com/watch?v=E_Z03v3RPuk&feature=youtu.be

Prof. Renata Schoeman spoke on *'Rethink your resilience to successfully transition into the new normal'* which we found invaluable food for thought and transformation.

On a separate note, if you would like to host your own virtual networking event, much the same that we hosted, please feel free to enquire with Vanessa at The Source PR & Event Management (vanessa@thesourcepr.co.za) for all your in-person, virtual and hybrid event solutions ■

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Dear Natalie,

We write to express our sincere appreciation for the donation received on the 10th September 2020 from yourselves, the South African Psychiatry and it's advertisers towards our organization's FeedAfamily campaign.

On behalf of the communities and the individuals we serve, we wish to express our sincerest appreciation for your support, enabling Operation Hunger to accomplish its aims and objectives.

Your assistance makes it possible to change the lives of many struggling and afflicted individuals. More and more efforts are needed to improve the economic and social lives of poor families.

The original of this letter, with a Certificate in terms of Section 18 (A), will be forwarded to you in the post.

Yours sincerely,

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Many thanks to you for your generous contribution towards Meals on Wheels.

We would like you to know that we consider it a very special privilege to be associated with you in this way. It is in no small measure that your caring and free-giving spirit reinforces both our faith in humanity and our confidence for the future.

There are two things that never fail to amaze me - the first is the extent of the need that exists in our country - the second is the amazing support that we consistently receive to help us to meet that tremendous need.

Thank you for taking the time to imagine what the less fortunate of our country are going through; thank you for allowing your heart to embrace the plight of others and thank you once again for giving us the opportunity to learn about the formidable power of giving.

We wish you all the best.

Kindest regards

Meals on Wheels Team

PHARMA DYNAMICS LAUNCHES NEW AFFORDABLE ANTIPSYCHOTIC ORALLY DISINTEGRATING TABLET (ODT), *ZOXADON ODT*

Pharma Dynamics' first live, CPD-accredited webinar was well attended by many interested colleagues on Saturday, 15 August, in support of the launch of a new and more affordable antipsychotic orally disintegrating tablet (ODT).

Zoxadon ODT is prescribed for the treatment of schizophrenia, bipolar and other mood disorders, as well as for disruptive disorders in children and adults.

The webinar highlighted that *Zoxadon ODT*, while priced the same as the conventional tablet, combines the advantages of both conventional tablet and liquid formulations, thus affording greater administration convenience to doctors prescribing risperidone.

The webinar on the theme of *"The importance of formulations in psychopharmacology"* was presented by the esteemed **Dr J.P. Roux**, a psychiatrist in private practice at Life Glynnview Hospital and convenor of the SIG for Cellular and Molecular Psychiatry at *SASOP*.

"FOR CLINICAL PURPOSES, THE POTENCY OF A DRUG MAKES LITTLE DIFFERENCE AS LONG AS THE EFFECTIVE DOSE OF THE DRUG CAN BE ADMINISTRATED CONVENIENTLY."

Dr Roux spoke about the proven efficacy of ODT formulations in clinical psychopharmacology, highlighting that, for clinical purposes, the potency of a drug makes little difference as long as the effective dose of the drug can be administrated conveniently.

He gave an overview of mechanisms affecting the pharmacokinetics in terms of bioavailability and the ability of ODT formulations to bring about targeted receptor occupancy faster than conventionally ingested formulations. Additionally, he presented thought-provoking questions that still remain as to the impact of the pharmacodynamics (particularly the *pharmacogenetics*) on different formulation effects and drug-drug interactions.

The gene modulation that results in "cognitive enhancement," or the mood elevating properties, mimicking the effects of cocaine, from SSRI-use combined with methylphenidate (like Ritalin) usage was used as an example.

ZOXADON ODT COMBINES THE SAME CLINICAL EFFECT OF CONVENTIONAL SOLID AND LIQUID DOSAGE FORMS WITH SPECIAL ADVANTAGES, SUCH AS MORE CONVENIENT, RELIABLE AND SAFE ADMINISTRATION, AT NO ADDITIONAL PRICE.

THE FOCUS OF THE WEBINAR WAS TO SHOW THAT ODT FORMULATIONS PROVIDE THE SAME CLINICAL EFFECT OF SOLID AND LIQUID DOSAGE FORMS WITH SPECIAL ADVANTAGES, INCLUDING:

- The bioavailability of the drug absorbed in the mouth, pharynx and oesophagus is increased.
- This rapid pre-gastric dissolution avoids individual variation in gastric absorption and reduces first-pass hepatic metabolism; thereby, increasing bioavailability further and ensuring potentially faster and more reliable loading-absorption.
- The solid form of ODT formulations also enables accurate dosing, in addition to good stability and easy and low-cost manufacturing through direct compression, which, moreover, ensures a greater percentage of active ingredient to potential "fillers".
- This form is most convenient, with smaller packaging size and easier handling by patients.
- No water is needed for ODT usage, presenting no gastrointestinal obstruction (chance of choking), thus increasing safety for patients such as those who are travelling.
- As it dissolves and cannot be spat out, ODT formulations enable improved administration to those with dysphagia, the elderly, children with behaviour disorders or sub-average intellect, and those who cannot or refuse to take medication.

As such, the webinar firmly places Zoxadon ODT as the antipsychotic mediation that doctors and psychiatrists have been waiting for: an advantageous psychopharmacological formulation offered at no additional price.

**Zoxadon ODT is now available at leading pharmacies in packs of 30 tablets, in doses of 0,5 mg, 1 mg and 2 mg.*

If you would like to access the webinar, you can request a recording from Pharma Dynamics at a.kenny@pharmadynamics.co.za.

Please apply to the same address if you would like to access referenced material.

As a leading provider of central nervous system medication and advocate of mental health in South Africa, Pharma Dynamics is committed to providing more affordable psychiatric medication, including through the provision of effective generic medicines.

Pharma Dynamics would like to thank Dr Roux for his presentation and expert insight, and South African Psychiatry for providing details of the event for its publication

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SOUTH AFRICANS' STRESS LEVELS HAVE SHOT UP BY 56% SINCE START OF PANDEMIC ACCORDING TO SURVEY

A national survey conducted by a leading pharmaceutical firm and advocate for mental wellness has revealed a significant increase in psychological and emotional stress among South Africans as a result of the COVID-19 pandemic.

The results were made public in October, which is recognised as Mental Health Awareness Month to address the mental health dimension of the pandemic.

More than 1 200 South African adults were polled across the country by Pharma Dynamics to gain an insight into how South Africans have been impacted by the pandemic.

ABDURAHMAN KENNY, MENTAL HEALTH PORTFOLIO MANAGER AT PHARMA DYNAMICS SAYS MANY PEOPLE WHO PREVIOUSLY COPED WELL ARE NOW LESS ABLE TO MANAGE DUE TO MULTIPLE STRESSORS GENERATED BY THE PANDEMIC, WHILE THOSE WITH PRE-EXISTING MENTAL HEALTH CONDITIONS MAY HAVE EXPERIENCED A WORSENING OF SYMPTOMS.

He says the survey assessed a broad range of psychosocial effects related to the pandemic, which affected a large majority of the population in the following ways:

- more than half (53%) of respondents either lost their jobs, had to take a pay-cut or were forced to close a business,
- 56% have higher levels of psychological and emotional distress than before the pandemic,
- 81% turned to unhealthy food, 20% to alcohol, 18% to cigarettes, 6% to smoking cannabis and 22% to antidepressant or anti-anxiety medication to help them cope with the stressors of the last few months,
- 65% admitted to neglecting their health,
- 52% has trouble sleeping,
- 20% of couples are quarreling more than before, physical spousal abuse has also increased by 5%,
- 68% are worried about the impact of the pandemic on society and the economy,
- 44% struggle to relax and,
- 49% feel anxious, 48% frustrated, 31% depressed and a significant 6%, have contemplated suicide.

TO DEAL WITH THE STRESS OF THE PANDEMIC, MANY HAVE RESORTED TO JUNK FOOD, ALCOHOL, SMOKING AND OTHER ADDICTIVE SUBSTANCES, WHICH DOESN'T BODE WELL FOR PHYSICAL OR EMOTIONAL WELL-BEING.

Kenny says as the effects of the pandemic take hold on daily life in the coming months, mental health professionals need to be prepared for an increase in substance abuse.

He says the majority of respondents have also had personal experiences with COVID-19 that have

exacerbated anxiety levels. The survey found that 6% caught the virus, among 27% a family member was diagnosed with COVID-19 and 50% knew someone who passed away from the Coronavirus."

Symptoms typically associated with depression and anxiety were also found to be more common among respondents:

- 38% feel tired and complained of low energy levels
- 35% are easily annoyed and irritated
- 33% have trouble concentrating
- 28% feel restless and on edge
- 22% feel a sense of loss
- 19% are lonely
- 14% feel hopeless

Kenny says given the far-reaching emotional and financial consequences of the COVID-19 pandemic, it is important that adequate attention is given to the mental health needs of the population as it could have long-term implications.

"The disruptions in routine and economic activity that the pandemic has caused, has had a devastating impact on mental health. Record high unemployment levels, economic uncertainty – both locally and abroad, having to social distance and isolate ourselves, taking on additional childcare responsibilities (home schooling) while juggling work and the constant fear of contracting the virus are all factors that increase anxiety and stress.

We are likely to see much higher rates of mental illness among South Africans post the pandemic and need to increase psychosocial support efforts to avoid a COVID-19 related mental health crisis".

"THE FACT THAT NEARLY HALF (49%) OF RESPONDENTS WANTED TO REACH OUT TO A THERAPIST FOR HELP DURING THE PANDEMIC, BUT COULDN'T DUE TO LIMITED FINANCIAL RESOURCES OR ACCESS, HIGHLIGHTS DECADES OF NEGLECT AND UNDERINVESTMENT IN MENTAL HEALTH SERVICES IN OUR COUNTRY".

"Due to the sheer size of the problem, most mental health needs remain unaddressed and have been hindered by a lack of funds in mental health promotion, prevention and care. Much more needs to be done to protect those facing mounting mental pressure. The psychological well-being of our communities and society at large requires immediate attention," comments Kenny.

THOSE WHO ARE MOST AT RISK INCLUDE THE ELDERLY, FRONTLINE HEALTH WORKERS, TEENS, WOMEN AND THOSE WITH PRE-EXISTING MENTAL HEALTH ILLNESSES.

"It's important that the country builds the human resource capacity to deliver quality mental health and social care in communities," emphasises Kenny.

"Through policy reform, a proper system can be put in place to ensure the widespread availability of health and psychosocial support services. Secondly, shifting care away from institutions to community services will improve access to care even in remote areas and thirdly, prioritising funds and research towards mental health will be central to successfully navigate the mental health consequences of the pandemic".

"HOWEVER, IT IS ENCOURAGING TO SEE THAT 33% HAVE SOUGHT COMFORT FROM FAMILY AND FRIENDS AND MADE EXERCISE A DAILY PRIORITY IN ORDER TO FEND OFF NEGATIVE THOUGHTS. WHILE 40% HAVE STAYED HOME EXCLUSIVELY UP UNTIL NOW, 26% ARE STARTING TO VENTURE OUT AND RESUME NORMAL SOCIETAL ACTIVITIES, WHICH IS IMPORTANT," HE SAYS.

If you feel weighed-down by the pandemic and don't know who to turn to, contact Pharma Dynamics' toll-free helpline on 0800 205 026, which is manned by trained counsellors who are on call from 8am to 8pm, seven days a week. For additional support, visit www.letstalkmh.co.za

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CORONAVIRUS DISEASE 2019 (COVID-19) AND PSYCHIATRIC SEQUELAE IN SOUTH AFRICA: BEYOND ANXIETY

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[3]Department of Anthropology, Northwestern University, Evanston, IL, USA

ABSTRACT

The 2019 coronavirus (COVID-19) pandemic has brought unprecedented challenges to the health sector internationally. Across all disciplines, unique and novel modes of presentation with substantial morbidity and mortality are being encountered, and growing evidence suggests that psychiatric comorbidity is likely among COVID-19 patients. Current discussions in the psychiatric literature on COVID-19 report anxiety as a predominant clinical presentation during the pandemic. Given the impact of direct COVID-19 infection, associated psychopathological sequelae, and drastic lifestyle changes due to the COVID-19 pandemic in South Africa, a broader range of psychopathologies and other neuropsychiatric presentations are likely to emerge and are increasingly being reported worldwide. This article aims to broaden the current discussion on the psychiatric sequelae of COVID-19 and describes some additional psychopathological presentations reported among COVID-19 patients worldwide. Greater awareness of the various psychiatric conditions attributed to COVID-19 infection may allow for earlier screening, more effective treatment, greater positive health outcomes and better prepared health systems to address the growing pandemic in South Africa.

INTRODUCTION

Numerous countries worldwide have reported widespread increases in psychiatric morbidity, increased risk for mental distress and illness, and novel psychopathological presentations among afflicted patients and communities exposed to the 2019 coronavirus (COVID-19) pandemic.[1,2] Similar to the conditions faced in South Africa, the novel and dramatic societal shifts brought by national and international social policies aimed at mitigating the spread of COVID-19, including forced isolation and confinement, limited physical mobility, fears of infection, emotional distress, and for some, extreme threats to survival, are understood to underlie these

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psychiatric presentations and exacerbate existing clinical conditions.[2,3] The rapid, ongoing review of initial mental health research on COVID-19 has shared vital insights into the possible psychiatric consequences of the pandemic and highlights the prevalent presentation of anxiety disorders among affected patients and communities. Yet evidence from past viral epidemics and broader knowledge on the clinical, social, and environmental determinants of mental illness emphasize that the psychiatric sequelae of COVID-19 are likely much broader than what the current, initial literature presents.[3] In this review, we aim to describe the wider psychological sequelae and psychopathological risks due to the COVID-19 pandemic in South Africa. The following areas of psychopathologies are reviewed in this paper: neuropsychiatric sequelae, anxiety and anxiety disorders, obsessive compulsive disorder, mood disorders, psychotic disorders, child and adolescent mental health, and specific threats to healthcare workers.

NEUROPSYCHIATRIC SEQUELAE

The neuropsychiatric sequelae of COVID-19 include a range of mental conditions that may occur due to brain damage or other physiological damage resulting from infection by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), either due to direct effects of infection of the central nervous system (CNS) or through indirect mechanisms such as the body's immune response to the infection.[2] Due to the lack of data on the manifestations of the COVID-19, researchers have drawn upon the epidemiology and findings from studies on two similar strains of coronaviruses, which also caused widespread respiratory disease across the world, for additional insights: 1) severe acute respiratory syndrome coronavirus (SARS-CoV), initially encountered in 2002 and responsible for severe acute respiratory syndrome (SARS), and 2) Middle East respiratory syndrome coronavirus (MERS-CoV), first identified in 2012 and responsible for Middle East respiratory syndrome (MERS).[2,3] These comparisons have been on the basis that the three coronaviruses are structurally and genetically highly homologous and hence are largely comparable.[3]

A SERIES OF NEUROPSYCHIATRIC PRESENTATIONS HAVE BEEN PREVIOUSLY REPORTED IN CASES OF MERS, SARS, AND COVID-19. RESEARCH SUGGESTS THAT DELIRIUM IS A COMMON PRESENTATION IN THE ACUTE STAGE OF COVID-19 – ESPECIALLY IN THE SEVERELY ILL.[2]

Early studies show that 20-30% of patients with COVID-19 will either present with or develop delirium; this is much higher in cases of severe illness, where 60-70% of patients have presented with delirium.[4] In older patients with COVID-19, the presentation of the disease may be quite atypical as delirium presents in the absence of other related signs and symptoms, such as fever or dyspnoea.[4] Preliminary evidence on elderly MERS patients also reports that delirium is associated with raised mortality.[2] A recent study also reported acute new-onset psychosis among COVID-19 patients with no prior history of psychosis. Patients in this study exhibited presentations of agitation, disorganization, paranoid ideation, and auditory hallucinations.[5] Additionally, among severe COVID-19 patients requiring intensive care unit (ICU) admission, neurocognitive impairment (e.g. dysexecutive syndrome) may be a feature in the longer term (e.g. months to years) after recovery from COVID-19.[2] For SARS and MERS, there is evidence for depression, anxiety, fatigue, impaired memory, insomnia, and post-traumatic stress disorder occurring in the post-illness period (i.e. in the following months to years), but it is yet unknown whether this is also the case with COVID-19.[2-3]

GROWING EVIDENCE ILLUSTRATES THE ROLE OF PSYCHONEUROINFLAMMATORY PATHWAYS IN PRECIPITATING A WIDE RANGE OF PSYCHIATRIC CONDITIONS (E.G. DEPRESSION, ANXIETY, SCHIZOPHRENIA) AS WELL AS THE NEUROPSYCHIATRIC CONDITIONS ASSOCIATED WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION. SIMILAR MECHANISMS MAY UNDERLIE THE NEUROPSYCHIATRIC PRESENTATIONS OF COVID-19.

In addition to acute stress from COVID-19, infection with SARS-CoV-2 may lead to a hyperinflammatory state and a heightened, sustained inflammatory response to the infection, which has been described as a "cytokine storm" (also a feature of SARS and MERS).[2,5,7] In a case report of three COVID-19 patients with psychosis, patients exhibited elevated levels of systemic inflammation a few days prior to a positive COVID-19 diagnosis.[5] These patients were otherwise asymptomatic (e.g. normal vitals, no delirium, no other physical illness).[5,6] Even with no infiltration of the virus into the CNS, peripheral cytokines involved in the anti-viral response may give rise to neuropsychiatric manifestations by precipitating neuroinflammatory responses and/or compromising blood-brain-interface (BBI) integrity, leading to peripheral immune cell transmigration into the CNS and disruption of neurotransmission.[7] Overall, the aetiology of neuropsychiatric manifestations of COVID-19 is likely multifactorial and may be affected by a variety of influences, including the current state of immune function, direct effects of the viral infection (e.g. infection of the central nervous system), the degree of physiological compromise (e.g. hypoxia), pre-existing cerebrovascular disease, in addition to the availability and quality of medical interventions and the larger psychosocial experience of COVID-19.[1]

ANXIETY AND ANXIETY DISORDERS

Anxiety symptoms may range from a wide variety of concerns around contracting or spreading the

virus, inability to regulate uncertainty, limited social interactions, unsafe living conditions, and economic fallout, among others.[8,9] While these symptoms might not constitute an anxiety disorder per se, they are currently among the most common symptoms emerging during the COVID-19 pandemic.[2,3] A possible worsening of symptomatology in pre-existing cases is described in the literature.[9] Here we describe some of the most frequent presentations of anxiety during the pandemic, however we do not comprehensively discuss anxiety disorders as this has been a major focus of the existing psychiatric literature on COVID-19. Further information about anxiety disorders during COVID-19 has been reviewed elsewhere.[9]

GENERALISED ANXIETY DISORDER IS AMONG THE MOST FREQUENTLY DESCRIBED PRESENTATIONS AMONG COVID-19 PATIENTS. A META-ANALYSIS OF SARS, MERS, AND COVID-19 STUDIES REPORTED THAT ANXIETY WAS COMMON IN THE POST-ILLNESS PHASE UP TO THREE YEARS AFTER INFECTION.[2]

A cross-sectional survey performed in China reported a relatively high prevalence of generalised anxiety disorder of 35.1%, particularly among patients below the age of 35 years and those who reported excessive rumination (≥3 hours a day) about the pandemic.[11] In one recent study on the mental health impact of COVID-19 in Soweto, while a majority of adults perceived that COVID-19 did not affect their mental health, a variety of stressors that caused deep worry, anxiety, and rumination ("thinking too much") were reported in approximately 20% of adults.[8] These concerns during the lockdown were driven and exacerbated by the inability to care for themselves and their families, crippling economic struggles, personal vulnerability due to illness, the invisible nature of COVID-19 transmission, and a lack of awareness on the disease.

As described above, health anxiety is another common presentation seen during the pandemic[9] and may result in individuals seeking medical assistance repeatedly, or conversely, avoiding help seeking behaviour even when unwell. Health anxiety may also result in a mistrust of or reluctance toward engaging health authorities.[10] These anxiety related behaviours may be erroneously attributed to an anxiety disorder and impart an added pressure on the already overburdened mental health system in South Africa.

PANIC ATTACKS MAY ALSO OCCUR AS A DISTINCT DISORDER OR IN COMBINATION WITH OTHER PSYCHIATRIC DISORDERS.

There is a paucity of literature regarding this in relation to COVID-19. However, panic attack symptoms such as shortness of breath, chills or heat sensations, and chest pain or discomfort may overlap with symptoms of COVID-19 infection. Individuals with pre-existing panic disorder or who experience panic attacks from any other medical or psychiatric disorder might experience panic attacks more frequently. New onset of panic attacks in individuals with other psychiatric diagnoses is also possible.

OBSESSIVE COMPULSIVE DISORDER (OCD)

Another prominent presentation in the COVID-19 environment, by virtue of the clinical symptoms of distinct thoughts and often linked behaviours, is obsessive compulsive disorder. This disorder was previously categorised under anxiety disorders and now exists as a separate category (OCD and related disorders) in the DSM-5 and can lead to significant functional impairment.[1] Numerous countries (e.g. China, United States, United Kingdom, Italy, India) have shown a recent increase in outpatients presenting with OCD symptoms, with exacerbation of symptoms such as hoarding and washing compulsions in already diagnosed OCD patients in response to stressors in the environment.[11,12] Lockdown measures may lead to panic buying and hoarding items such as hygiene products, flu medication, and groceries.[11] Patients may struggle to determine what constitutes excessive behaviour under these extraordinary circumstances and normalise their compulsions as a precautionary response to the global pandemic. Proper hand washing techniques recommended may also reinforce ritualistic behaviours, another clinical feature of OCD.

THE INFLUX OF INFORMATION FROM TV, NEWSPAPERS AND SOCIAL MEDIA SITES REGARDING THE VIRUS CAN ADD TO OBSESSIONS ABOUT CONTAMINATION,[12] DURING PREVIOUS EPIDEMICS SUCH AS SARS, MERS AND INFLUENZA, RESEARCHERS REPORTED A WORSENING OF OCD IN PATIENTS UP TO ONE YEAR LATER.[12]

MOOD DISORDERS

Direct infection of COVID-19 and the collateral impacts of the pandemic place many at risk for a variety of mood disorders. Seropositivity for viral illnesses linked to Influenza A & B and coronaviruses were shown to be associated with having a history of mood disorders, including depressive disorders, and increased suicide attempts.[13] One cross-sectional survey conducted in China during the COVID-19 outbreak found a prevalence of depressive symptoms of 20.1% and sleep disturbances of 18.2%.[10] Another Chinese study conducted during the early stages of the outbreak, found that 16.5% of the sample reported moderate to severe depressive symptoms.[14] As noted with the HIV/AIDS epidemic in South Africa, depression can increase the risk of acquiring the virus, and the presence of mental illnesses can also

be a stand-alone risk factor for acquiring the virus.[14] Human herpesvirus 6 has been also implicated in the development of bipolar disorder and depressive disorders, due to direct invasion of the CNS by the virus.[15] It has been hypothesised that coronaviruses typically invade the nervous system via the olfactory nerve. Thus, mood disorders can result directly from the virus, or secondarily through the resulting immunological response.[16,17] In persons with pre-existing mood disorders, infection with COVID-19 may result in a relapse of symptoms.

PATIENTS WITH MOOD DISORDERS OFTEN DISPLAY COGNITIVE CHANGES THAT MIGHT AFFECT THEIR ABILITY TO RATIONALISE THE RECOMMENDED MEASURES OF MAINTAINING SOCIAL DISTANCING, REGULAR WASHING OF HANDS AND SURFACES, AND THE USE OF A FACEMASK. SYMPTOMS OF ACUTE MANIA INCLUDE ELEVATED MOOD, IMPULSIVITY, INCREASED GOAL DIRECTED ACTIVITY AND OFTEN, PSYCHOSIS.[1] ACUTELY MANIC PATIENTS MIGHT BE UNABLE TO APPRECIATE THE IMPORTANCE OF THESE PREVENTATIVE MEASURES, AND HENCE BE AT HIGHER RISK OF CONTRACTING AND SPREADING THE VIRUS.

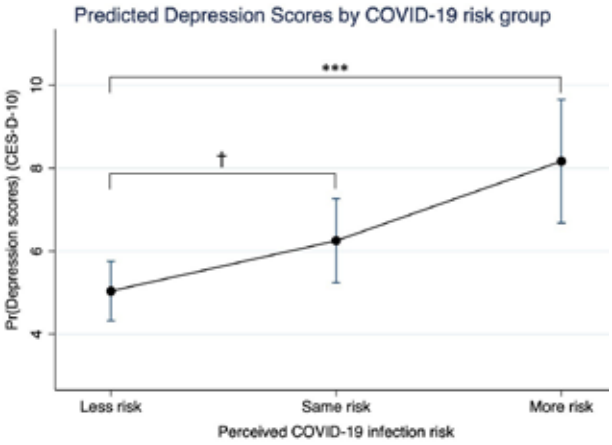
The numerous and ongoing psychosocial consequences of the pandemic can also result in relapse of depressive disorders, bipolar disorder and suicidal thoughts,[17] particularly due to the widespread economic shocks due to COVID-19. The United Nations Development Programme has estimated an income loss of more than $220 billion in developing countries such as South Africa due to the pandemic.[18] Recessions inevitably leading to job losses and unemployment is an independent risk factor for the development of depressive disorders.

A SYSTEMATIC REVIEW FOUND A POSITIVE ASSOCIATION BETWEEN RECESSION AND HIGHER SUICIDE RATES[19] WITH INCREASES IN GLOBAL SUICIDE RATES OF 20-30% DURING THE 2008 RECESSION.[20]

Social isolation is also a risk factor for depressive disorders. One study, concerning patients and staff who were placed in an isolation dialysis unit during the MERS outbreak in 2015 in South Korea found that isolation increased stress markers in both staff and patients.[21] Quarantine and social distancing measures, which limit social interactions and communal gatherings (e.g. schools, work, churches and mosques, parks, and other community facilities) during lockdown have removed vital social support systems for many patients. The lockdown also poses major barriers to accessing care. Some clinics, including in South Africa, are only allowing the patient to enter healthcare facilities, which is challenging in a discipline where collateral information is often imperative to assessing a patient's progress. Restrictions on the availability of transport may also lead to decreased follow-up at clinics, non-adherence and subsequent relapses.

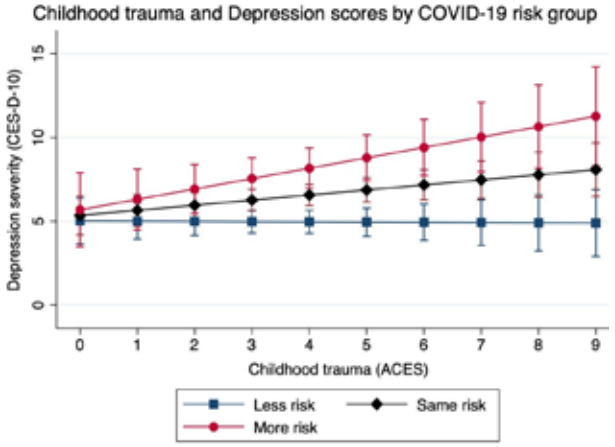
While studies on the psychological impact of COVID-19 in South Africa are limited, one recent study evaluated the mental health impacts of COVID-19 during the first six weeks of lockdown in Soweto.[8] In this community-based sample, 14.5% of adults displayed significant depressive symptoms, and greater knowledge of COVID-19 corresponded with lower perceived risk of COVID-19 infection but greater depressive symptoms.[8] Researchers also found that higher perceived risk of COVID-19 infection was associated with greater depressive symptoms, particularly among individuals with histories of childhood trauma (Figures 1 and 2).[8] An online survey conducted by the South African Depression and Anxiety Group found 65% of people felt stressed or very stressed about the imposed lockdown.[22] A majority of the respondents were from Gauteng (60%), and 59% had prior mental health disorders, and depression was the most common condition (46%). A portion of respondents reported a prior diagnosis with anxiety (30%) and bipolar disorder (12%). The main challenges faced during the lockdown included: anxiety and panic (55%), financial stress and pressure (46%), depression (40%), poor family relations (30%), feelings of suicide (12%), and substance abuse (6%).

***Figure 1*.Predicted depression scores by perceived COVID-19 risk group**



Note: Greater perceived risk of COVID-19 infection corresponds with greater depression symptomatology in adults living in Soweto. The effect of being in the "More risk" group is highly significant ($p = <0.001$) relative to being at "Less risk", while the effect of perceiving that one is at the "Same risk" of COVID-19 infection relative to other individuals living in Soweto on depression symptoms is marginally significant ($p = 0.095$). The respective predicted depression scores (assessed using the 10-item Centre for Epidemiologic Studies Depression Scale, CES-D-10) for each group are as provided: Less risk = 5.04, Same risk = 6.25, More risk = 8.17.[8]

***Figure 2.*Childhood trauma (ACES) and Depression scores (CESD) by COVID-19 risk group**



Note: Greater childhood trauma (ACES) potentiates the positive relationship between greater perceived COVID-19 risk and the severity of depressive symptomatology. The effect of the interaction between childhood trauma and perceived COVID-19 risk on depression is marginally significant (F[1, 206] = 3.53, p = 0.0617).[8]

PSYCHOTIC DISORDERS

It has been postulated that exposure to a virus *in utero* increases risk of developing schizophrenia later in life, with data from research conducted in the aftermath of the great Spanish influenza of 1918 demonstrating an association between exposure to general respiratory viruses such as influenza and subsequent psychotic episodes.[23,24] The response of immunoglobulin G was investigated against four human coronavirus strains that were prevalent at the time. Evidence showed that in approximately 90% of adults diagnosed with psychosis, elevated levels of antibodies to one or more viruses were found. Pandemics like the Spanish flu demonstrated that these viruses can have a more immediate effect, resulting in cases of acute psychosis soon after or at the time of infection. Further research is, however, required, as it remains unclear whether this is due to the direct effects of the virus on the brain, systemic inflammation due to infection, or perhaps a post-viral immune activation.[24]

Stress related to a pandemic may precipitate, exacerbate, or impact the content of the psychotic symptoms[25,26] Patients presenting with psychosomatic delusions may experience intense paranoia.[25] A 43-year-old male patient in Germany with psychiatric illness presented with auditory hallucinations commenting that he has not cared for his parents who could have died of COVID-19, paranoid delusions that his parents and neighbours had contracted COVID-19, as well as delusions that he had immunity from the virus after contracting the virus from a Chinese message on a WhatsApp message.[26] In another case, a 38-year-old married woman with secondary level education, good premorbid functioning, and no prior psychiatric history believed she was potentially infected with the virus after a visit to her dentist (who had recently vacationed in France and was not donning a mask). Within four days, she became anxious with malaise and fever, developed command auditory hallucinations to go to multiple health centres for testing and began to feel "an evil demonic force which would take her soul in order to possess her." She also had visual hallucinations of shadows, delusions of reference and a formal thought disorder. The voice ultimately ordered her to kill her family. She was diagnosed with an acute psychotic disorder and was treated effectively with antipsychotic therapy.[27]

ANXIETY IS A COMMON SYMPTOM IN PSYCHOTIC DISORDERS AS WELL AND CAN INTERFERE WITH RATIONAL DECISION MAKING, WHICH COULD ENGENDER MALADAPTIVE BEHAVIOURS SUCH AS EXCESSIVE HEALTH SEEKING, DISPROPORTIONATE HANDWASHING, OR PURCHASING PROTECTIVE GEAR.[27]

Media coverage during pandemics or crises will unduly influence psychotic manifestations.[26] These case studies emphasize the profound impact that a global pandemic can have on patients with established psychopathology, as well as those without prior history. Difficulties in distinguishing

***Table 1.* Multilevel determinants of children's reactions to novel situations**

INDIVIDUAL	FAMILY	ENVIRONMENTAL
• Developmental stage temperament • Coping strategies • Pre-existing illness • Anxiety and fear are expected and may be normal. • At times of adversity, children may present with regressed behaviours such as excessive clinginess, bed-wetting, tantrums or separation anxiety-like features • Some children are inherently more resilient and may adapt well to disruptions	• Communication styles • Parental psychopathology • Home stability • Interpersonal relationships • Children often model their behaviour on that of their care-givers • When caregivers deal with situations calmly and sensitively, they provide the best support to their children	• Peer relationships • Social support systems • Early adversity • Substance use • Social media

"normal paranoia" around the illness and psychosis is best managed by a mental health care practitioner.

CHILDHOOD ONSET MENTAL DISORDERS

Children's mental health has been overshadowed by the drastic and necessary measures taken to curb the spread of infection. The first onset of mental disorders typically occur in childhood or adolescence.[28] In a survey conducted on primary school children in Hubei Province, China that evaluated the impact of home confinement on the mental health of children, found increased rates of depressive and anxiety symptoms, and the authors concluded that "serious infectious diseases may influence the mental health of children as other traumatic experiences do."[29] The direct impact on a child may be related to: anxiety and uncertainty about an unfamiliar infectious condition, contraction of the virus (with the potential for self-isolation, quarantine in hospital, and separation from family), having vulnerabilities to contracting the illness (e.g. being immunocompromised or respiratory disease), or having a loved one experience or die from COVID-19.[30] A child's reaction to novel situations depends on 3 important factors (Table 1).

Social interactions are an important component of a child's emotional development and their capacity for social competence.[31] In addition to academic and social losses, school closure in South Africa has also led to further challenges due to limited access to online education, malnutrition (with the suspension of school feeding programmes), and the lack of provision of school-based therapeutic interventions for children with disabilities (e.g. occupational therapy).

ADDITIONALLY, PLAY RESTRICTIONS DUE TO LOCKDOWN LIMIT THE POTENTIAL PSYCHOLOGICAL BENEFITS OR EFFECTS OF EXERCISE AND PHYSICAL ACTIVITY FOR CHILDREN.

Furthermore, many South African children live in overcrowded, confined spaces and do not have access to private outdoor areas. Financial strain is a potent parental stressor and may have an impact on family stability. Co-parenting, custody arrangements, and movement of children between households during lockdown might also lead to added stress in children. National epidemiological data are guiding the proposed re-opening of schools but there are legitimate concerns about the sector's ability to implement measures to limit transmission (e.g. maintenance of social distancing in the classroom and the playground, provision of adequate protective apparel and sanitisation, conduction of screening protocols, psychological first aid training, etc.). Table 2 highlights special groups of children with elevated risk of psychiatric morbidity

Table 2. **Special groups of children at elevated risk of psychiatric morbidity during COVID-19**

SPECIAL GROUPS	
Pre-existing mental illness	• Specific concerns include exacerbation of symptoms, non-compliance to treatment, and difficulties in adjusting to new routines. • Children with Autistic Spectrum Disorders do not adapt well to change and the wearing of masks is sometimes problematic in those with tactile sensitivities. • Caregivers of children with OCD, who may have contamination obsessions or compulsive hand washing, find it challenging to navigate the need for sanitising. • Confinement and the lack of sufficient physical activity can worsen the low frustration tolerance of children with Attention Deficit Hyperactivity Disorder.
Institution-based children	• Most of the emphasis on children housed in children's homes, juvenile detention centres, child and youth care centres and "places of safety", has been on curbing transmission of COVID-19. • The poor conditions of most facilities, potential exposure to violence, lack of contact with family, and the suspension of academic and therapeutic programmes magnifies the unmet medical, mental health and social needs of this vulnerable population.
Child-headed households	• There is a dearth of information on the psychosocial impact of the pandemic on child-only households in South Africa.
Survivors of maltreatment	• COVID-19 has had a deleterious effect on victims of abuse in terms of diminished access to support structures (shelters, police, extended family, support groups) and together with poverty, overcrowding and unemployment potentially increases risk for domestic and gender-based violence.

Children with limited access to medical care	• International data[30,31] suggest a decrease in clinic visits, vaccinations and treatment follow-ups, and delays in screenings, referrals and assessments for various medical conditions.

HEALTHCARE WORKERS

Healthcare workers are employed in environments that regularly present them with often unique and hazardous challenges, many of which are seen as an inherent part of work responsibilities. The COVID-19 pandemic introduced additional work hazards in the healthcare environment.[31] Globally, various difficulties have been exacerbated due to the pandemic and newer challenges have emerged. These include the requirement for much stricter biosecurity measures, the constant risk of contracting the disease, increased workloads, concerns about putting family members at risk and the stigma faced by healthcare workers.[1] The World Health Organisation (WHO) has acknowledged an increased risk of anxiety amongst healthcare workers and a possible increase in burnout and PTSD.[32,33,34] Healthcare workers have also been faced with significant shortages of personal protective equipment, the lack of specific treatments, constant media coverage and a sense of not being supported adequately.[2] Additionally, reasons for psychological distress include fears of contracting the virus, passing on the virus to families, increased patient load, and staff shortages.[35,36]

One cross-sectional study of healthcare workers in multiple hospitals in China between 29 January-03 February 2020 assessed the mental health outcomes and associated factors among healthcare workers who were involved in managing COVID-19 patients.[35]

IN THIS STUDY 50.4% OF PARTICIPANTS REPORTED SYMPTOMS OF DEPRESSION, 44.6% ANXIETY, 34.0% INSOMNIA AND 71.5% DISTRESS. SYMPTOMS WERE MORE SEVERE ACROSS ALL MEASUREMENTS AMONG NURSES, WOMEN, FRONTLINE WORKERS AND THOSE WORKING IN WUHAN, THE EPICENTRE OF THE EPIDEMIC. THERE HAVE ALSO BEEN REPORTS OF MEDICAL PERSONNEL SUCCUMBING TO SUICIDE DURING THE COVID-PANDEMIC. EVEN DURING NON-PANDEMIC CIRCUMSTANCES, PHYSICIANS AND HEALTHCARE WORKERS FACE ELEVATED RISKS FOR SUICIDE.[37]

A significant number of healthcare workers have been infected and succumbed to the disease internationally. This places an added burden on an already constrained workforce, thereby increasing the workload and risks faced in the workplace, particularly as the number of admitted cases exponentially increase during peaks of the pandemic.[38]

THIS MAY CREATE A SENSE OF POWERLESSNESS AMONG HEALTHCARE WORKERS AND THUS INCREASE THEIR VULNERABILITY TO ADVERSE MENTAL HEALTH OUTCOMES. ONE OF THE MOST IMPORTANT FACTORS THAT MAY HAVE A DETRIMENTAL EFFECT ON MENTAL HEALTH OUTCOMES IS THE ASSEMBLY LINE CONDITIONS THAT MAY EXIST IN THE HEALTHCARE SYSTEM,[3] WHICH HAVE BECOME INCREASINGLY PREVALENT IN THE CURRENT PANDEMIC.

The COVID-19 pandemic and the severe constraints on resources have thrown to the fore certain serious ethical dilemmas faced by frontline workers.[39,40] One of the most important of these has been patients' access to life-saving interventions such as critical care beds and ventilation. Health care workers often have to make decisions on who these are allocated to. This responsibility can have negative effects on health care workers' mental health outcomes. Specific interventions designed to meet the concerns and challenges faced by health care workers during the pandemic must include the availability and accessibility of mental health services to health care workers within the workplace to enable early detection and management of mental health issues.

CONCLUSION

This review highlights some of the possible psychiatric sequelae resulting from infection and experiences due to the recent COVID-19 pandemic. In addition to the focus on anxiety among afflicted patients, we expand the scope of COVID-19 related psychopathological presentations and disease trajectories that have been documented worldwide and that may arise in South Africa. Other important disorders such as trauma and stressor related disorders and bereavement issues have not been included here. The global disruption in economies, health systems, and daily life has inevitably made a comprehensive impact on South Africa society. Future risks include limited allocation of funding to state and non-governmental mental health and social services, greater challenges to pre-existing service delivery limitations, and threats to quality of care.

WE CAUTION THE EXTRAPOLATION OF CURRENT RESEARCH FINDINGS ON COVID-19 AND ENCOURAGE A CRITICAL APPRAISAL OF EARLY STUDIES ON THE DISEASE.

We offer this broader review of the psychopathological impacts due to and exacerbated by the COVID-19 pandemic and offer further insight into the possible psychiatric presentations that clinicians may face in the near future and to prepare health systems as the pandemic escalates in South Africa.

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Further information is available on request to the holder of registration. Litha Pharma (Pty) Ltd. Co. Reg. No. 1994/008717/07. 106 16th Rd, Midrand, 1686. www.acino.co.za. LP3142 07/2020

CMSA

ELECTION RESULTS TO MEMBERS
TRIENNIUM 2020 - 2023
COLLEGE OF PSYCHIATRISTS

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SECRETAR KOTZE Carla

REPRESENTATIVES ON SENATE:

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SEEDAT Soraya

OTHER MEMBERS OF COUNCIL

BRACKEN Craig Anthony
BRUMMERHOF Ralf Arnold
CHILIZA Bonginkosi
KHAMKER Nadira
MASHAPHU Sibongile
TALATALA Mvuyiso

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

Prof. Suvira Ramlall

EXSIRA tablets are indicated for the treatment of major depressive disorder (MDD)[1].

Discontinuation symptoms:

Adverse reactions reported in association with abrupt discontinuation, dose reduction or tapering oftreatment in MDD clinical trials at a rate of ≥ 2 % include: dizziness, withdrawal syndrome, nauseaand headache. In general, discontinuation symptoms occurred more frequently with longer duration of therapy[1].

S5 **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.

Reference:

1.Exsira 50 mg and 100 mg Package Insert. Approved: 06 March 2014

PP-EXS-ZAF-0124

Breakthroughs that change patients' lives

S5 **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. **PHARMACOLOGICAL CLASSIFICATION:** A 1.2 Psychoanaleptics (antidepressants). **INDICATIONS: Major depressive disorder:** EXSIRA tablets are indicated for the treatment of major depressive disorder (MDD). **CONTRAINDICATIONS:** Hypersensitivity to EXSIRA, venlafaxine hydrochloride or to any excipients in the EXSIRA formulation. EXSIRA is an inhibitor of both norepinephrine and serotonin reuptake. EXSIRA must not be used in combination with a monoamine oxidase inhibitor (MAOI), or within at least 14 days of discontinuing treatment with an MAOI. Based on the half-life of EXSIRA, at least 7 days should be allowed after stopping EXSIRA before starting an MAOI. Severe adverse reactions have been reported when therapy is initiated with SSRI/SNRI medicines such as EXSIRA soon after discontinuation of an MAOI and when an MAOI is initiated soon after discontinuation of SSRI/SNRI medicines. These reactions have included tremor, myoclonus, diaphoresis, nausea, vomiting, flushing, dizziness, hyperthermia with features resembling neuroleptic malignant syndrome, seizures and death (see INTERACTIONS). Children less than 18 years of age, as safety and efficacy have not been established (see WARNINGS AND SPECIAL PRECAUTIONS and SIDE EFFECTS). Pregnancy and lactation (see PREGNANCY AND LACTATION). **WARNINGS AND SPECIAL PRECAUTIONS: Clinical worsening of depressive symptoms, unusual changes in behaviour, and suicidality:** Patients with major depressive disorder may experience worsening of their depression and/ or the emergence of suicidal ideation and behaviour, whether or not they are taking antidepressant medicines. This risk may persist until significant remission occurs. Patients being treated with EXSIRA should, nevertheless, be observed closely for clinical worsening and suicidality, especially at the beginning of a course of therapy or at any time of dose changes, either increases or decreases. Because of the possibility of co-morbidity between major depressive disorder and other psychiatric and non-psychiatric disorders, the same precautions observed when treating patients with major depressive disorders should be observed when treating patients with other psychiatric and non-psychiatric disorders. The following symptoms have been reported in patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and non-psychiatric: anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia, hypomania, and mania. Although a causal link between the emergence of suicidal impulses has not been established, consideration should be given to changing the therapeutic regimen, including possibly discontinuing EXSIRA in patients for whom such symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms. If the decision is made to discontinue treatment, EXSIRA should be tapered (see DOSAGE AND DIRECTIONS FOR USE). Short-term trials did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond the age of 24 years; there was a reduction in the risk of suicidality with antidepressants compared to placebo in adults age 65 years and older. There have been reports of hostility, suicidal ideation and self-harm with use of SSRIs in children under the age of 18 years. **Paediatric use:** Safety and efficacy in children under 18 years of age has not been established (see CONTRAINDICATIONS and SIDE EFFECTS). **Mania/hypomania:** In clinical trials, mania was reported for 0,03 % of patients treated with EXSIRA. EXSIRA should be used cautiously in patients with a history or family history of mania or hypomania (see SIDE EFFECTS). **Serotonin syndrome:** The development of a potentially life-threatening serotonin syndrome may occur with EXSIRA treatment, particularly with concomitant use of other serotonergic medicines (including SSRIs, SNRIs and triptans) and with medicines that impair metabolism of serotonin (including MAOIs). Serotonin syndrome symptoms may include mental status changes (e.g. agitation, hallucinations, and coma), autonomic instability (e.g. tachycardia, labile blood pressure, and hyperthermia), neuromuscular aberrations (e.g. hyperreflexia, incoordination) and/or gastrointestinal symptoms (e.g. nausea, vomiting, and diarrhoea) (see INTERACTIONS). The concomitant use of EXSIRA with serotonin precursors (such as tryptophan supplements) is not recommended. **Narrow-angle glaucoma:** Mydriasis has been reported in association with EXSIRA; therefore, patients with raised intraocular pressure or those at risk of acute narrow-angle glaucoma (angle-closure glaucoma) should be monitored (see SIDE EFFECTS). **Ischaemic cardiac adverse events:** In clinical trials, there were uncommon reports of ischaemic cardiac adverse events, including myocardial ischaemia, myocardial infarction, and coronary occlusion requiring revascularisation; these patients had multiple underlying cardiac risk factors. More patients experienced these events during EXSIRA treatment as compared to placebo. **Discontinuation symptoms:** Adverse reactions reported in association with abrupt discontinuation, dose reduction or tapering of treatment in MDD clinical trials at a rate of ≥ 2 % include: dizziness, withdrawal syndrome, nausea and headache. In general, discontinuation symptoms occurred more frequently with longer duration of therapy (see DOSAGE AND DIRECTIONS FOR USE). **Adverse reactions leading to discontinuation of therapy:** The most common adverse reaction leading to discontinuation in at least 2 % of the EXSIRA-treated patients in the short-term trials, up to 12 weeks, was nausea (2 %); in the long-term studies, up to 11 months, no events lead to discontinuation in at least 2 % of the patients and at a rate greater than placebo in the double-blind phase. **Adverse reactions reported with other SNRIs:** Although gastrointestinal bleeding is not considered an adverse reaction for EXSIRA, it is an adverse reaction for other SNRIs and may also occur with EXSIRA. **Effects on activities requiring concentration and performance: Interference with cognitive and motor performance:** The results of a clinical trial that assessed the effects of EXSIRA on behavioural performance of healthy individuals revealed no clinically significant impairment of psychomotor, cognitive, or complex behaviour performance. However, since any CNS-active medicine may impair judgement, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that EXSIRA therapy does not adversely affect their ability to engage in such activities. **Abuse and dependence: Physical and psychological dependence:** Although EXSIRA has not been systematically studied in preclinical or clinical trials for its potential for abuse, no indication of drug-seeking behaviour was seen in the clinical trials. **Co-administration of medicines containing venlafaxine and/or EXSIRA:** EXSIRA is the major active metabolite of venlafaxine, a medication used to treat major depressive, generalised anxiety, social anxiety and panic disorders. EXSIRA should not be used concomitantly with products containing venlafaxine hydrochloride or other products containing EXSIRA. **Effects on blood pressure: Increased blood pressure:** Increases in blood pressure were observed in some patients in clinical trials, particularly with higher doses. Pre-existing hypertension should be controlled before treatment with EXSIRA. Patients receiving EXSIRA should have regular monitoring of blood pressure. Cases of elevated blood pressure requiring immediate treatment have been reported with EXSIRA. Sustained blood pressure increases could have adverse consequences. For patients who experience a sustained increase in blood pressure while receiving EXSIRA, either dose reduction or discontinuation should be considered. Caution should be exercised in treating patients with underlying conditions that might be compromised by increases in blood pressure (see SIDE EFFECTS). Postural hypotension (see Geriatric use). **Cardiovascular/cerebrovascular:** Caution is advised in administering EXSIRA to patients with cardiovascular, cerebrovascular, or lipid metabolism disorders. Increases in blood pressure and heart rate were observed in clinical trials with EXSIRA. EXSIRA has not been evaluated systematically in patients with a recent history of myocardial infarction, unstable heart disease, uncontrolled hypertension, or cerebrovascular disease. Patients with these diagnoses, except for cerebrovascular disease, were excluded from clinical trials (see SIDE EFFECTS). **Serum lipids:** Dose-related elevations in fasting serum total cholesterol, LDL (low density lipoprotein) cholesterol, and triglycerides were observed in clinical trials. Measurement of serum lipids should be considered during treatment with EXSIRA (see SIDE EFFECTS). **Seizures:** Cases of seizure were reported in pre-marketing clinical trials with EXSIRA. EXSIRA has not been systematically evaluated in patients with a seizure disorder. Patients with a history of seizures were excluded from pre-marketing clinical trials. EXSIRA should be prescribed with caution in patients with a seizure disorder (see SIDE EFFECTS). **Discontinuation effects:** During marketing of SNRIs (Serotonin and Norepinephrine Reuptake Inhibitors), and SSRIs (Selective Serotonin Reuptake Inhibitors) such as EXSIRA, there have been spontaneous reports of adverse events occurring upon discontinuation of these medicines, particularly when abrupt, including the following: dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g. paraesthesias such as electric shock sensations), anxiety, confusion, headache, lethargy, emotional lability, insomnia, hypomania, tinnitus, and seizures. While these events are generally self-limiting, there have been reports of serious discontinuation symptoms. Patients should be monitored when discontinuing treatment with EXSIRA. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered (see DOSAGE AND DIRECTIONS FOR USE and SIDE EFFECTS). **Abnormal bleeding:** Medicines that inhibit serotonin uptake in platelets may lead to abnormalities of platelet aggregation. As with other agents that inhibit serotonin reuptake, EXSIRA should be used cautiously in patients predisposed to bleeding. **Hyponatraemia:** Cases of hyponatraemia and/or the Syndrome of Inappropriate Antidiuretic Hormone (SIADH) secretion have been described with SNRIs and SSRIs, including EXSIRA, usually in volume-depleted or dehydrated patients, including elderly patients and patients taking diuretics (see SIDE EFFECTS). **Geriatric use:** No dosage adjustment is required solely on the basis of age; however, possible reduced renal clearance of EXSIRA should be considered when determining dose (see DOSAGE AND DIRECTIONS FOR USE). In the short-term placebo-controlled trials, there was a higher incidence of systolic orthostatic hypotension in patients treated with EXSIRA who were ≥ 65 years of age (6 %) compared to patients < 65 years of age (0,9 %). **Effects on ability to drive and use machines:** EXSIRA may impair judgement, thinking and motor skills. Therefore, patients should be cautioned about their ability to drive or operate hazardous machinery. **INTERACTIONS: Monoamine oxidase inhibitors (MAOI):** Adverse reactions, some of which were serious, have been reported in patients who have recently been discontinued from a monoamine oxidase inhibitor (MAOI) and started on antidepressants with pharmacological properties similar to EXSIRA (SNRIs or SSRIs), or who have recently had SNRI or SSRI therapy discontinued prior to initiation of an MAOI. These reactions have included tremor, myoclonus, diaphoresis, nausea, vomiting, flushing, dizziness, hyperthermia with features resembling neuroleptic malignant syndrome, seizures and death. Concomitant use of EXSIRA in patients taking monoamine oxidase inhibitors (MAOIs) is contraindicated (see WARNINGS AND SPECIAL PRECAUTIONS and CONTRAINDICATIONS). **Central nervous system (CNS)-active agents:** The risk of using EXSIRA in combination with other CNS-active medicines has not been systematically evaluated. Consequently, caution is advised when EXSIRA is taken in combination with other CNS-active medicines. **Serotonin syndrome:** Serotonin syndrome, a potentially life-threatening condition, may occur with EXSIRA treatment, particularly with concomitant use of other agents that may affect the serotonergic neurotransmitter system (including triptans, SSRIs, other SNRIs, lithium, sibutramine, tramadol, St. John's Wort [*Hypericum perforatum*], pethidine), with medicines that impair metabolism of serotonin (such as MAOIs, including linezolid [an antibiotic which is a reversible non-selective MAOI], see CONTRAINDICATIONS), or with serotonin precursors (such as tryptophan supplements). Serotonin syndrome symptoms may include mental status changes, autonomic instability, neuromuscular aberrations and/or gastrointestinal symptoms (see WARNINGS AND SPECIAL PRECAUTIONS). **Ethanol:** Patients should be advised to avoid alcohol consumption while taking EXSIRA. **Potential for other medicines to affect EXSIRA: Inhibitors of CYP3A4:** CYP3A4 is involved in EXSIRA elimination. In a clinical trial, ketoconazole (200 mg twice daily) increased the area under the concentration vs. time curve (AUC) of EXSIRA (400 mg single dose) by approximately 43 %, a weak interaction and C_{max} by about 8 %. Concomitant use of EXSIRA with potent inhibitors of CYP3A4 may result in higher exposure to EXSIRA. **Inhibitors of other CYP enzymes:** Based on in vitro data, medicines that inhibit CYP isozymes 1A1, 1A2, 2A6, 2C8, 2C9, 2C18, 2C19, and 2E1 are not expected to have significant impact on the pharmacokinetic profile of EXSIRA. **Potential for EXSIRA to affect other medicines: Medicines metabolised by CYP2D6:** Clinical trials have shown that EXSIRA is a weak inhibitor of CYP2D6 at a dose of 100 mg daily. Concomitant use of EXSIRA with a medicine metabolised by CYP2D6 may result in increased concentrations of that medicine and decreased concentrations of its CYP2D6 metabolites. **Medicines metabolised by CYP3A4:** In vitro, EXSIRA does not inhibit or induce the CYP3A4 isozymes. Concomitant use of EXSIRA with a medicine metabolised by CYP3A4 may result in lower exposures to that medicine. **Medicines metabolised by a combination of both CYP2D6 and CYP3A4 (tamoxifen and aripiprazole):** Clinical studies have shown that EXSIRA (100 mg daily) does not have a clinically relevant effect on medicines metabolised by a combination of both CYP2D6 and CYP3A4 enzymes. **Medicines metabolised by CYP1A2, 2A6, 2C8, 2C9 and 2C19:** In vitro, EXSIRA does not inhibit CYP1A2, 2A6, 2C8, 2C9, and 2C19 isozymes and would not be expected to affect the pharmacokinetics of medicines that are metabolised by these CYP isozymes. **P-glycoprotein transporter:** In vitro, EXSIRA is not a substrate or an inhibitor for the P-glycoprotein transporter. **Electroconvulsive therapy:** There are no clinical data establishing the risks and/or benefits of electroconvulsive therapy combined with EXSIRA treatment for MDD. **PREGNANCY AND LACTATION:** EXSIRA must not be administered to pregnant or lactating women. Safety during human pregnancy and lactation has not been established (see CONTRAINDICATIONS).**DOSAGE AND DIRECTIONS FOR USE: Major depressive disorder:** The recommended dose for EXSIRA is 50 mg once daily, with or without food, with a maximum dose of 100 mg per day. The dose increase should occur gradually and at an interval of not less than 7 days. **Use in patients with renal impairment:** The recommended starting dose in patients with severe renal impairment (24-hr CrCl < 30ml/min) or end-stage renal disease (ESRD) is 50 mg every other day. Because of individual variability in clearance in these patients, individualisation of dosage may be desirable. Supplemental doses should not be given to patients after dialysis. **Use in patients with hepatic impairment:** No dosage adjustment is necessary for patients with hepatic impairment. **Paediatric use:** Safety and efficacy in patients less than 18 years of age has not been established. **Use in elderly patients:** No dosage adjustment is required solely on the basis of age; however, possible reduced renal clearance of EXSIRA should be considered when determining dose. **Discontinuing EXSIRA:** Symptoms associated with discontinuation of EXSIRA, other SNRIs and SSRIs have been reported. Patients should be monitored for these symptoms when discontinuing treatment. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the medical practitioner may continue decreasing the dose but at a more gradual rate (see WARNINGS AND SPECIAL PRECAUTIONS and SIDE EFFECTS). **Switching patients from other antidepressants to EXSIRA:** Discontinuation symptoms have been reported when switching patients from other antidepressants, including venlafaxine, to EXSIRA. Tapering of the initial antidepressant may be necessary to minimise discontinuation symptoms. **SIDE EFFECTS:** Very common: ≥ 10 %; Common: ≥ 1 % and < 10 %, Uncommon: ≥ 0,1 % and < 1 %; Rare: ≥ 0,01 % and < 0,1 %; Very rare: < 0,01 %. Cardiac disorders: Common: Palpitations, tachycardia. Ear and labyrinth disorders : Common: Tinnitus. Eye disorders : Common: Blurred vision, mydriasis. Gastrointestinal disorders : Very common: Nausea, dry mouth, constipation. Common: Diarrhoea, vomiting. General disorders and administration site conditions : Common: Fatigue, chills, asthenia, feeling jittery, irritability. Immune system disorders : Uncommon: Hypersensitivity. Investigations : Common: Increased weight, increased blood pressure, decreased weight. Uncommon: Increased blood cholesterol, increased blood triglycerides, abnormal liver function test, increased blood prolactin. Metabolism and nutritional disorders : Common: Decreased appetite. Rare: Hyponatraemia. Musculoskeletal, connective tissue and bone disorders: Common: Musculoskeletal stiffness. Nervous system disorders: Very common: Dizziness, headache. Common: Somnolence, tremor, paraesthesia, dysgeusia, disturbance in attention, vertigo. Uncommon: Syncope. Rare: Convulsion, dystonia. Psychiatric disorders : Very common: Insomnia. Common: Anxiety, abnormal dreams, nervousness, decreased libido, anorgasmia. Uncommon: Withdrawal syndrome, abnormal orgasm, depersonalisation. Rare: Hypomania, hallucinations. Renal and urinary disorders : Uncommon: Urinary hesitation, pollakiuria, urinary retention. Reproductive system and breast disorders : Common: Erectile dysfunction*, delayed ejaculation*, ejaculation failure*. Uncommon: Ejaculation disorder*, sexual dysfunction. Respiratory, thoracic and mediastinal disorders: Common: Yawning. Uncommon: Epistaxis. Skin and subcutaneous tissue disorders: Very common: Hyperhidrosis. Common: Rash. Uncommon: Alopecia. Rare: Photosensitivity reaction, angioedema. Not known: Stevens-Johnson syndrome*. Vascular disorders: Common: Hot flush. Uncommon: Orthostatic hypotension (see WARNINGS AND SPECIAL PRECAUTIONS), peripheral coldness. *Frequency is calculated based on men only. *Adverse reaction identified during post-approval use. **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. PI Ref.: 06/03/2014.

WORLD PSYCHIATRIC ASSOCIATION

WPA ANNOUNCES NEW EXECUTIVE COMMITTEE AND BOARD MEMBERS FOR 2020-2023 TRIENNIUM

The World Psychiatric Association (WPA) has announced details of those candidates elected to open Executive Committee and Board positions for the 2020-2023 triennium. The online election closed during the association's triennial General Assembly meeting on 16 October which, for the first time in the organisation's history took place virtually.

The new Executive Committee and Board are shown below.

WPA EXECUTIVE COMMITTEE 2020-2023 (NEWLY-ELECTED IN RED)

(Top Row, L-R)
President: Afzal Javed
President-Elect: Danuta Wasserman
Secretary General: Petr Morozov
Secretary for Education: Roger Ng

(Bottom Row, L-R)
Secretary for Finances: Paul Summergrad
Secretary for Meetings: Edmond Pi
Secretary for Publications: Michel Botbol
Secretary for Scientific Sections: Thomas G. Schulze

WPA BOARD 2020-2023 (ZONAL REPRESENTATIVES)

Zone 1. Canada Mysore S. RENUKA PRASAD
Zone 2. United States Bernardo NG
Zone 3. Mexico, Central America and the Caribbean Thelma SÁNCHEZ-VILLANUEVA
Zone 4. Northern South America Rodrigo Nel CÓRDOBA ROJAS
Zone 5. Southern South America Santiago Andrés LEVÍN
Zone 6. Western Europe Gisèle APTER
Zone 7. Northern Europe Ramune MAZALIAUSKIENE
Zone 8. Southern Europe Konstantinos N. FOUNTOULAKIS
Zone 9. Central Europe Igor FILIPČIČ
Zone 10. Eastern Europe Oleg Alekseevich SKUGAREVSKY
Zone 11. Northern Africa Amine LARNAOUT
Zone 12. Middle East Mahdi ABU MADINI
Zone 13. Central and Western Africa Aïda SYLLA
Zone 14. Eastern and Southern Africa Juliet NAKKU

Zone 15. Central and Western Asia Seyed Ahmad JALILI
Zone 16. Southern Asia Pichet UDOMRATN
Zone 17. Eastern Asia Yong Chon PARK
Zone 18. Australasia and the South Pacific Allister BUSH

WPA Secretariat

https://www.wpanet.org/post/wpa-announces-new-board-and-executive-committee-for-2020-2023-triennium?lang=es

WORLD PSYCHIATRIC ASSOCIATION

WPA MESSAGE FROM THE PRESIDENT

OCTOBER 2020

Dear friends

Let me first thank you all for your support to the WPA. It is indeed a pleasure to start my term as President and to lead this prestigious organisation over the coming triennium. It is my honour to represent our membership as we work together to strengthen our profession – especially during this difficult period.

Psychiatry is currently facing several challenges, and although our profession may be seen as being under threat, there are many opportunities that can help us consolidate psychiatry as an inspiring branch of medicine. The WPA is the umbrella organisation for psychiatrists worldwide and therefore has a major responsibility for leading the profession. This leadership can only be achieved through the full participation of our members and the engagement of our professional colleagues.

I am pleased that, despite the challenges presented to us, we were able to organise our General Assembly in a remarkably successful way.

THIS IS THE FIRST TIME IN THE HISTORY OF THE WPA THAT WE HAVE HELD THE ASSEMBLY ONLINE. WITH THE HELP OF OUR PROFESSIONAL CONGRESS ORGANISING PARTNER, KENES, WE WERE ABLE TO COMPLETE EVERYTHING ON OUR AGENDA AS PLANNED.

I am grateful for their assistance and for the work of our Secretariat in ensuring this excellent result. Similarly, the experience of having online elections was an impressive achievement.

Dr Afzal Javed

I am sorry that we experienced a technical error in the tabulation of results, but its swift correction ensured a successful outcome nonetheless. Thanks to Civica for helping us with this task.

I would also like to take this opportunity to congratulate all the candidates on running fair and honest campaigns under challenging conditions. A special congratulations to those that were successfully elected and a warm welcome to our incoming Executive Committee members: President-Elect, Danuta Wasserman; Secretary General, Petr Morozov; Secretary for Finances, Paul Summergrad; Secretary for Meetings: Edmond Pi; and of course, our very important Zonal Representatives.

IT IS ALSO GRATIFYING TO NOTE THAT THE WPA GENERAL ASSEMBLY APPROVED THE PROPOSED ACTION PLAN. AS YOU KNOW, THE WPA ACTION PLAN FOR 2020-2023 DEFINES EMERGING NEEDS AND PRIORITIES FROM A WORLDWIDE PERSPECTIVE.

LOOKING AT THE GLOBAL SITUATION, ONLY A MINORITY OF PEOPLE WITH MENTAL DISORDER RECEIVE ANY TREATMENT. THERE IS AN OUTSTANDING NEED TO IMPROVE ACCESS TO HIGH QUALITY MENTAL HEALTH CARE IN ALL COUNTRIES AND TO SUPPORT PSYCHIATRISTS AND OTHER MENTAL HEALTH PROFESSIONALS IN THEIR IMPORTANT ROLES AS POLICY MAKERS, DIRECT SERVICE PROVIDERS, TRAINERS AND SUPPORTERS OF HEALTH CARE WORKERS IN PRIMARY AND COMMUNITY HEALTH CARE SYSTEMS.

The key goals of the Action Plan are as follows:

- *To promote psychiatry as a medical specialty in clinical, academic and research areas and to promote public mental health as a guiding principle.*
- *To highlight the specific role of psychiatrists in working with other professionals in health, public health, legal and social aspects of care*
- *To ensure WPA's positive engagement with member societies and WPA components, mental health professionals and general health care workers*

The 2020-2023 Action Plan also looks at targeted areas that need attention with input from various WPA components during the next triennium.

IT WILL WORK WITHIN AN INTERNATIONAL PERSPECTIVE FOCUSING SPECIFICALLY ON IMPROVING COVERAGE OF INTERVENTIONS TO TREAT MENTAL DISORDERS, PREVENT MENTAL DISORDERS AND TO PROMOTE MENTAL WELLBEING INCLUDING THROUGH RELEVANT TRAINING OF MENTAL HEALTH AND OTHER PROFESSIONALS.

This Action Plan will also build on the 2017-2020 Action Plan to ensure continuity in the WPA's work.

The six areas of the WPA Action Plan 2020-23 include:

- Public Mental Health: Population approach to mental health to sustainably reduce mental disorders and promote mental wellbeing by improving coverage of effective interventions to treat mental disorders, prevent associated impacts,
- Child, Adolescent & Youth Mental Health: Improving coverage of public mental health interventions including for higher risk groups such as those with learning disability, Autism, Early onset of psychosis and refugees
- Addressing co-morbidity in mental health: Training, capacity building and engagement with other mental health professionals
- Developing partnerships for joint collaborative work and strengthening partnerships with mental health and other organisations
- Continuation and completion of previous Action Plans

All the areas covered in the Action Plan are of high priority. However, due to time limitations and scarcity of resources, there will be greater focus on specific areas. The WPA has established working groups that have started formulating plans and pilot projects in different areas of the plan and once the findings of these pilot projects are available, we will share these reports and seek funding to implement these ideas in different settings and countries.

I AM MINDFUL THAT THE RAPID SPREAD OF COVID-19 AROUND THE WORLD IS FURTHER INCREASING RISK OF DEVELOPING MENTAL DISORDERS, RELAPSE OF EXISTING MENTAL DISORDERS AND POOR MENTAL WELLBEING WHICH REQUIRES ACTION AT A POPULATION LEVEL.

It is hoped that the 2020-23 will set new directions for all WPA components to develop guidelines and directions for future work. I rely on your dedication and support and look forward working with the Council, Board, WPA components and Member Societies during the next three years.

Long live the WPA and I look forward to receiving support, active input, and advice from our membership in setting these priorities and making a real difference in mental health.

Dr Afzal Javed
President
World Psychiatric Association

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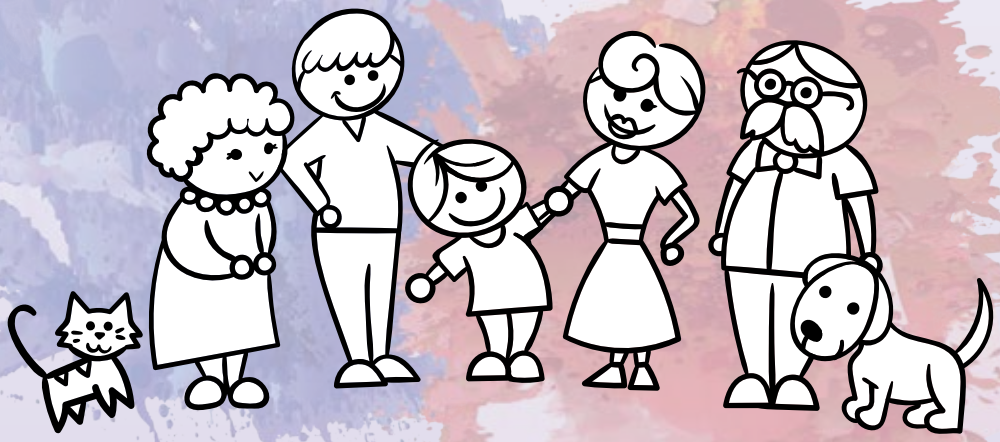

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*Not actual size

References: 1. Coghill D, Seth S. Osmotic, controlled-release methylphenidate for the treatment of ADHD. *Expert Opinion Pharmacotherapy* 2006;7(15):2119-2138. 2. Data on File.

S6 NEUCON® OROS® 18 mg, 27 mg, 36 mg or 54 mg extended-release tablets containing 18 mg, 27 mg, 36 mg, 54 mg of methylphenidate hydrochloride, respectively. Reg. No's.: 46/1.2/0380; 46/1.2/0381;46/1.2/0382; 46/1.2/0383.

For full prescribing information, refer to the package insert April 2018.

LICENCE HOLDER: Janssen Pharmaceutica, Reg. No.: 1980/011122/07, No. 2, Medical Street, Halfway House, Midrand, 1685. Tel: (011) 518 7000. www.janssen.co.za
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1ST SOUTHERN AFRICAN MULTIDISCIPLINARY ADHD CONGRESS

1 - 6 SEPTEMBER 2020

Renata Schoeman

Attention Deficit/Hyperactivity Disorder (ADHD) is the most common psychiatric disorder in children – affecting 5% of the school-aged population. Sixty-five percent of patients' symptoms persist into adulthood, with estimates of the prevalence of adult ADHD being 2.5-4.3%. ADHD is now recognised as a common neurodevelopmental disorder, present throughout life, with a chronic, costly and debilitating course – if untreated.

A COMPREHENSIVE DIAGNOSTIC APPROACH AS WELL AS ACCESS TO MULTI-DISCIPLINARY AND MULTI-MODAL INTERVENTION IN PREVENTING THE LONG-TERM COSTS OF ADHD ARE NEEDED. IN SOUTHERN AFRICA, ACCESS TO CARE REMAINS A CHALLENGE, AND CARE DELIVERY – IN BOTH THE PUBLIC AND PRIVATE SECTOR – REMAINS FRAGMENTED.

We are very grateful for the success of the recent 1st Southern African Multidisciplinary ADHD Congress, hosted by the University of Stellenbosch Business School, in partnership with the Goldilocks and the Bear Foundation and LifePath Group. Due to the Covid-19 pandemic, what was initially envisioned as a three-day congress was re-designed as a virtual congress presented over 6 days. With thirty speakers, of which 3 were international, a wide variety of topics (see www.adhdcongress.co.za) were covered and truly enhanced all healthcare providers' knowledge of ADHD.

Renata Schoeman

This congress aimed to bring together psychiatrists, paediatricians, general practitioners, psychologists and occupational therapists – the whole team involved with the optimal management of ADHD across the lifespan. Three hundred delegates attended: 73 allied health care practitioners, 114 specialists, 45 registrars, 15 general practitioners and 53 trade representatives. We also had delegates representing 7 countries: South Africa, Namibia, the United Kingdom, Canada, Australia, the United Arab Emirates, and France.

A big word of appreciation for our sponsors: Dr Reddy's, Cipla, Mylan, Novartis and Sanofi, as well as Londocor for the event logistics and support.

We are looking forward to welcoming you to the 2nd Southern Africa Multidisciplinary ADHD Congress during the first week of September 2021!

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ADHD CONGRESS

1 - 6 SEPTEMBER 2020

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1ST SOUTHERN AFRICAN **MULTIDISCIPLINARY ADHD CONGRESS**

CONFERENCE NOTES

Linda Kelly

SUMMARY

Session 1 and 2 comprised of a SASOP ADHD SIG Workshop chaired and presented by Professor Renata Schoeman and Dr Rykie Liebenberg.

The workshop gave an overview of the aetiology, diagnosis and management of ADHD. The final session was presented by Dr Chris Verster and was an ethics discussion.

SESSION ONE OVERVIEW

Session 1 comprised of the following four presentations:

Neurobiology of ADHD, presented by Prof R Schoeman

ADHD is known to have complex multiple genetic and environmental risk factors.

IT IS CONSIDERED TO BE A NEUROBIOLOGICAL DISORDER WITH GENETIC FACTORS PLAYING A BIGGER ROLE THAN OTHER BIOLOGICAL FACTORS AND PSYCHOSOCIAL ADVERSITY. IT IS THE MOST COMMON PSYCHIATRIC DISORDER IN CHILDREN AND THE MOST HERITABLE CONDITION IN PSYCHIATRY.

The prevalence is 3 to 5 % in children with 60 to 70% persistence into adulthood.

Family, twin and adoption studies confirm the genetic basis for ADHD explaining 60% of the variance. No one gene has been identified and it is more likely that there are several interacting genes of modest effect. Linkage studies have identified chromosomes 4 and 16 as potential areas of interest.

Association studies have found the DRD4 and DAT genes, and 5HTP,5HT 1Band, and SNAP25 to be significant in ADHD research.

Neuroimaging

Structural neuroimaging is currently only used for research, and not for diagnosis.

Significant decreases in total cerebral and cerebellar volume have been found. Abnormalities are found in frontostriatal areas, temperoparietal lobes, basal ganglia, corpus callosum, cerebellum, amygdala, hippocampus and thalamus.

There is global reduction in grey matter as well as altered structural connectivity in white matter.

There seems to be a maturational delay averaging 2 to 3 years which seems to catch up by age 25 and this is apparent particularly in the frontal and temporal cortex.

FUNCTIONAL MRI STUDIES SHOW SIGNIFICANT HYPOACTIVITY IN THE FRONTOPARIETAL REGIONS WITH COMPENSATORY HYPERACTIVATION OF FRONTAL AND PARIETAL AREAS THAT ARE DIFFERENT FROM THE HYPOACTIVE AREAS.

Impairments in prefrontal striatal networks contribute to the inattention whereas impairments in the frontolimbic network may be linked to symptoms of hyperactivity.

Neurophysiology

EEG Is not used to diagnose ADHD. Findings have shown an increased slow wave activity with an elevated Theta Beta power ratio especially over frontal and central cortical regions. This may be indicative of a developmentally immature cortex.

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Neurochemistry

Dopaminergic and adrenergic systems are mainly involved, with reduced dopamine receptors (DA) available and increased dopamine transporter binding (DAT).

All current medications have their main action to block reuptake of dopamine and noradrenaline, or increase their release.

Serotonergic and cholinergic systems may also play a role.

(A useful paper on the neurobiology of ADHD by Faraone 2015, Nature Reviews)

Neuropsychology of ADHD, presented by Dr Rykie Liebenberg

ADHD is considered to be a disorder of executive functioning and attention.

Executive functioning includes abilities such as planning, prioritizing, flexibility, emotional control, self-monitoring, working memory, impulse control and task initiation, all of which may be problematic in ADHD.

Executive functioning deficits include:

- Response inhibition (impulsivity, distractibility)
- Nonverbal working memory (time management difficulty, reduced self-awareness)
- Verbal working memory (difficulty following instructions, reduced reading comprehension)
- Self-regulation of emotion and motivation (emotional displays, frustration tolerance)
- Planning and problem solving.

Postulated mechanisms of ADHD:

- Inhibition deficit (Barkley)
- Cognitive energetic model (Sergeant)
- Executive control deficit (Brown)
- Working memory deficit (Kofler)
- Dopamine transfer deficit (Tripp, Wickens)
- Prefrontal cortex dysfunction (Arnsten, Rubia)
- Reward deficiency syndrome (Blum)

PREVALENCE OF EXECUTIVE FUNCTION DEFICITS IS 30 TO 50% IN ADHD SO IS VERY COMMON AND IS ASSOCIATED WITH SIGNIFICANTLY LOWER LEVELS OF EDUCATION, OCCUPATION AND MORE IMPAIRED INTERPERSONAL FUNCTIONING.

Neuropsychological testing:

These assessments are not to make the diagnosis, but more to identify neuropsychiatric dysfunction, to comprehensively assess cognitive strengths and weaknesses and establish a baseline functional level in order to plan and monitor response to treatments. They may also be used to look for comorbid disorders such as learning disabilities.

The Diagnosis of Adult ADHD, presented by Prof R Schoeman

ADHD is a condition most often diagnosed in childhood. It is now recognized that adults may be diagnosed with ADHD, but this is not a separate disorder, more a late recognition and diagnosis.

THE CONSEQUENCES OF UNDER OR MISDIAGNOSIS AND THEREFORE TREATMENT MAY HAVE SIGNIFICANT FUNCTIONAL AND QUALITY OF LIFE CONSEQUENCES. THE CORE TRIAD OF INATTENTIVE, HYPERACTIVE AND IMPULSIVE SYMPTOMS AND ASSOCIATED BEHAVIOURAL, COGNITIVE, EMOTIONAL AND SOCIAL PROBLEMS MAKES THE DIAGNOSIS ACROSS THE LIFESPAN.

Symptoms appear to decrease over time, which may indicate that the individual has become more adept at managing the symptoms or finds ways to compensate through lifestyle or occupational choices.

There are a few changes to the diagnosis according to DSM 5 for adult ADHD, including a threshold of 5 symptoms instead of 6, and present since age 17 years. The symptoms occur across more than one setting, and significantly impact on functioning across social, academic and occupational functioning.

There are 2 South African clinical diagnosis guidelines:

a) NICE-guidelines for children (Hawkridge and Flisher) in 2013
b) Adult guidelines (Schoeman and Liebenberg) in 2017

There is consensus from these guidelines that the diagnosis should be made by a specialist in the field, such as by a child psychiatrist, neurologist or paediatrician in childhood, and in adulthood by a psychiatrist or neurologist with appropriate

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training and experience and that it should be a comprehensive assessment with sufficient consultation time.

Screening tools (Adult ADHD self-report scale Kessler et al) can be used by patients and clinicians to identify possible symptoms, but should always be followed by a full clinical diagnostic assessment. Other screening tools include those by Barkley, Conners, Copeland, Wender and Weiss.

Clinical evaluation should include:

- Assessing the presence of core symptoms
- Developmental history (including pregnancy, perinatal period, milestones, early temperament)
- Family history
- Social history, substance use
- Educational history in detail
- Objective evidence of significant functional impairment which may include collateral information
- Psychiatric history in patient and the family
- Physical examination, appropriate to the individual

CLINICAL EVALUATION OF SYMPTOMS IN ADULTS REQUIRES FAMILIARIZATION BY THE CLINICIAN OF HOW CORE SYMPTOMS PRESENT COMPARED TO CHILDHOOD SYMPTOMS.

There are a number of diagnostic interviews which may assist clinicians. The ACE for children and ACE plus for adolescents and adults created by Professor Susan Young is a semi structured interview, also translated into Afrikaans, and is available free of charge.

Impairment due to ADHD is an essential component in making the diagnosis, and presents differently in children and adults:

Children	Adult
School failure or underachievement	Job failure or underachievement
Injuries	Car accidents, risky behaviour
Drug experimentation	Drug dependence
ODD and conduct disorder	Antisocial PD, criminal activity
Impulsivity and carelessness	Unwanted pregnancies, STDs
Repeated failure	Hopelessness, frustration

Differential diagnosis should include: lack of effort, poor vocational match, psychiatric or medical diagnosis.

COMORBIDITY IS THE RULE AND IT COMPLICATES THE COURSE AND MANAGEMENT.

Special investigations

If an underlying medical condition, substance abuse or deficiency is suspected or as a baseline safety assessment then appropriate investigations should be done.

There is no neurological or psychological diagnostic investigation for ADHD, these are done more to exclude other conditions.

There are also no psychometric diagnostic instruments, but these may be used to confirm ADHD and monitor treatment progress.

The Pharmacology of ADHD, by Prof R Schoeman

Treatment should be initiated after a comprehensive assessment by a specialist. Patient education and individualized care is critical as pharmacotherapy remains the cornerstone of treatment. Pharmacotherapy is also cost-effective compared with no treatment or psychosocial treatment.

Consistent with the catecholamine hypothesis of ADHD the drugs that effectively treat the disorder modulate catecholamine pathways. Enhancement of dopaminergic and nor adrenergic neurotransmission in the pre-frontal cortex is critical to the therapeutic efficacy of ADHD pharmacotherapy. Stimulants such as methylphenidate are by far the best studied and most effective treatment for ADHD across the lifespan and an average response rate of 70% is expected.

Methylphenidate improves ADHD symptoms in a dose dependent manner, it is generally well tolerated with mild side-effects which are usually transitory. When methylphenidate is used by

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patients who have a diagnosis of ADHD, their pre-frontal cortex has a relative deficiency of dopamine and noradrenaline and therefore side-effects are milder than in patients who do not have ADHD and use methylphenidate.

Atomoxetine is a non-stimulant pharmacological treatment available in South Africa, this targets noradrenaline reuptake inhibition, not dopamine. It is considered a first line treatment for ADHD with comorbid anxiety. It provides 24-hour cover of ADHD and may be a useful medication for adults who require cover into the evenings. Atomoxetine requires somewhere in the region of 3 to 6 months of treatment before full efficacy is realized so patients need to be prepared for this.

Noradrenergic agonists, Tricyclic antidepressants, mood stabilisers and SSRIs are not registered for treating the core symptoms of ADHD in adults.

BUPROPION IS THE ONLY ANTIDEPRESSANT THAT HAS EVIDENCE OF EFFICACY IN ADULTS WITH ADHD.

SESSION TWO OVERVIEW

Session 2 comprised of the following four presentations:

Non-Pharmacological Interventions for ADHD, presented by Prof Renata Schoeman

Two meta analyses, one by Sonuga Barke and the other by Faraone revealed that only pharmacological intervention reached an effect size of greater than 0.6, while most of the non-pharmacological interventions did not.

Cognitive training and neuro feedback have been studied as potential interventions for ADHD, conclusions from studies is that more evidence is needed and at this point there is weak evidence that this is an effective intervention. In addition many of the studies did not have the required scientific rigor in terms of their methodology.

Dietary intervention trials have looked at food colourants and preservatives, sugar reduction, mega dose vitamins, vitamin deficiencies, omega fatty acids over the years. Again, studies were not of a high calibre and some were author sponsored. Currently most research is focused on omega 3 fatty acids.

Complementary and alternative medicine or CAM includes health and wellness products and techniques not presently considered to be part of conventional western medicine. Complimentary products are used alongside conventional medicine and alternative products are used in place of conventional medicine. Integrative medicine combines and integrates the best of conventional medical care with the best of evidence-based CAM.

CAMS INCLUDE OTHER MIND BODY INTERVENTIONS, SUCH AS YOGA AND MEDITATION.

A detailed discussion of what is available on the shelves, the evidence of efficacy and potential side effects of various products used for ADHD was useful. The following were mentioned:

- Omega fatty acids,
- Citicoline
- Acetyl L carnitine amino acid.
- Dimethylethanolamine (DMAE)
- L - theanine
- Traditional Chinese medicine
- Bacopa monnieri (Keen Mind, Mentat)
- Indian ginseng
- Celastrus paniculatus (potentially dangerous)
- Ginkgo biloba (potentially a problem if combined with psychiatric medications)
- American and Asian ginseng (potentially dangerous)
- Neurovance
- Curcumin
- Guarana (potentially dangerous and should not be used with lithium or antidepressants)

STUDIES ARE FEW AND FAR BETWEEN AND THOSE THAT ARE, ARE OF QUESTIONABLE QUALITY AND WITH INADEQUATE SAFETY DATA.

In conclusion meta-analyses do not indicate that interventions and supplementation have much benefit for the treatment of ADHD but there are a multitude of products on the market. When recommending treatments there should be converging lines of scientific evidence that supports the safety and efficacy of products. More research is needed with better evidence for efficacy before CAM can be supported for the treatment of ADHD.

Comorbidity With ADHD, by Dr R Liebenberg

Most adults with ADHD have comorbidities and this is often what they present with to the clinician. If they are missed, they have a negative and confounding

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effect on the course of treatment. This applies to the diagnosis of ADHD being missed too.

- 87% have more than one psychiatric disorder.
- 57% have more than two psychiatric disorders.
- Mood disorders 19 to 37%.
- Anxiety disorders 25 to 50%.
- Personality disorders 10 to 20% (most common cluster B).
- Substance abuse 32 to 53% (1 in 5 have a substance abuse disorder).

Or, other way around, ADHD is comorbid in 20% of psychiatric patients.

ADHD HAS AN EARLIER ONSET THAN MOOD DISORDERS, ANXIETY AND SUD, IT IS A RISK FACTOR FOR A RANGE OF COMORBID DISORDERS. DEPRESSION IS COMORBID IN 30% OF ADHD. EARLIER TREATMENT OF ADHD LEADS TO LOWER OCCURRENCE OF ANXIETY AND MOOD DISORDERS. (KESSLER)

Anxiety and ADHD:

Highly comorbid, and the risk of true anxiety increases with age. ADHD emotional dysregulation may mimic anxiety. It is more common with the Inattentive subtype. There is less impulsivity but more sleep problems and greater social difficulties. Time of onset, clinical course and whether the symptoms are episodic can be useful ways to distinguish between anxiety and ADHD.

TREAT ANXIETY FIRST. TREATMENT USING SSRIS AND SNRIS DOES NOT BENEFIT THE ADHD SYMPTOMS WHICH REQUIRE EITHER ATOMOXETINE OR STIMULANTS. BOTH CAN BE USED WITH SSRIS AND MOST ANTIDEPRESSANTS.

Bipolar Disorder:

- In children 37 to 95% have ADHD
- In adults 15 to 18% have ADHD

and

In ADHD:

- In children 10 to 22% had Bipolar disorder
- In adults 10% had Bipolar disorder

In 88% of cases with ADHD and Bipolar disorder it was found to be Bipolar type 2. There is more combined type ADHD, more impairment, more suicide attempts and aggression and a chronic course of the mood disorder. There is also a family history of Bipolar disorder.

Taking a careful history with collateral and looking for chronicity and age of onset are important pointers. The principle remains that ADHD is a constant state while the mood disorder symptoms will be episodic, start later in life and will be absent when the patient is euthymic and well.

Treatment requires a staged approach. Firstly remove offending agents like stimulants and antidepressants, secondly maximize mood stabilizers before re- introducing ADHD medication and or antidepressants. Try mood stabilizers that treat both mania and depression or consider bupropion.

Depression and ADHD:

The two conditions together lead to a higher risk of poorer long-term outcomes with more risk of suicide and hospital admissions. Depression is more common among females with ADHD and there is also a higher prevalence of Generalized anxiety disorder and Social phobia.

There is overlap of symptoms between the two conditions necessitating once again a detailed history attending to the time course of the symptoms and the related psychopathology.

Treat the more severe and disabling condition first, usually the depression. Antidepressants with noradrenergic or dopaminergic effects may be beneficial for cognition. Once the depression has improved ADHD treatment can then be started.

ADHD and Borderline personality disorder:

This can be a difficult distinction to make as there are many overlapping symptoms between the two conditions. Once again a good longitudinal history will elucidate the differences. ADHD has attentional problems as the core feature whereas Borderline personality disorder has instability of mood as the core feature.

Substance abuse and ADHD:

Treatment naive ADHD adults have a lifetime risk of 52% of developing a substance use disorder versus 27% of non-ADHD adults. Similar findings indicate that ADHD is more prevalent among substance users by 15 to 25%, who had never been treated for ADHD. The presence of comorbid psychiatric disorders with ADHD increases the risk of substance abuse. Importantly various studies have shown that

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untreated ADHD leads to higher rates of substance abuse than in individuals who have been treated. Substance use is often earlier and more severe in individuals with ADHD and there is a greater likelihood of a variety of substances being used.

Treatment should be closely supervised particularly with stimulants where abuse or diversion is a concern. Atomoxetine might then be selected or long acting stimulants with lower abuse potential. Importantly, evidence does not support the idea that treating ADHD with stimulants leads to drug abuse either by sensitization or as a gateway drug.

Sleep problems

VERY COMMON, 66% OF PATIENTS HAVE SOME FORM OF SLEEP PROBLEM.

Lifestyle interventions For ADHD, by Dr R Liebenberg

Most international guidelines recommend a multimodal management approach for the treatment of ADHD which includes pharmacological management as well as psychosocial interventions. Exercise, sleep management and dietary interventions all have a role to play.

Psychotherapy of various types and coaching can be useful targeting individual patient issues. Workplace interventions can also be very helpful in assisting adults with ADHD to more efficiently navigate their working lives.

ADHD: Ethical Issues, by Dr C Verster

There are numerous studies looking at the use of methylphenidate as a cognitive enhancer amongst students. The samples are generally small and the overall effectiveness is not convincingly shown. Despite this, students continue to use methylphenidate. There is no clear guidance by regulatory bodies, but the medical community has a duty to evaluate the risk benefit ratio and inform patients and families of this. This bioethical conundrum will increasingly be encountered.

When parents refuse to let their children with ADHD use methylphenidate:

This was discussed using the pillars or principles of Bioethics, including Autonomy, Beneficence, Non-Maleficence and Justice.

Exposure to negative information is a common cause of parental concern and suspicion. The single most effective factor regarding the attitude towards methylphenidate treatment is the quality of the doctor's explanation.

The anti-psychiatry movement and Scientology have a role to play in promoting negative information. Pharmacists and General practitioners may also have unhelpful and misinformed attitudes regarding the validity of ADHD as a construct and the use of medication.

Mainstream psychiatry recognizes ADHD as a disorder, the treatment as being well described and proven and that NOT treating ADHD is far more damaging. Methylphenidate is highly regulated, but it has a very good safety record, nevertheless concerns are generally acknowledged.

NOT TREATING ADHD IN LIGHT OF ALL THAT IS KNOWN DOES NOT FIT WITH THE PRINCIPLE OF NON-MALEFICENCE.

The Children's Act of 2005 states that all actions or decisions concerning a child must be in the best interests of the child.

THE ACT ALSO STATES THAT NO GUARDIAN MAY REFUSE TO ASSIST THE CHILD OR WITHHOLD CONSENT FOR WHATEVER REASON UNLESS THEY CAN SHOW THAT THERE IS A MEDICALLY ACCEPTED ALTERNATIVE CHOICE.

The question "Should parents be forced to let their children be treated?" was looked at from the perspective of the Harm principle and compared to life threatening conditions where it is clearer, such as refusal of blood transfusion.

The question of whether doctors may refuse to prescribe methylphenidate, was discussed with referral to other conditions where conscientious objection may occur.

In conclusion, our ethical responsibilities regarding ADHD include following evidence-based medicine, ensuring that patients and families are psycho-educated, promote community education, confront misinformation, and if necessary, approach the press ombudsman.

This workshop over two evenings was extremely comprehensive, with up to date scientific information presented in a very accessible way. Thank you to the presenters for all the hard work and time that went into preparing their presentations.

Linda Kelly is a child and adolescent psychiatrist in private practice in Johannesburg. Her interests include ADHD, ASD and anxiety disorders, amongst others

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HOT TOPICS IN ADHD: NEURODEVELOPMENT

Anusha Lachman

The session hosted three leading experts in the field of Neurodevelopment in South Africa. The content is a summary of the essential "take home" messages from each talk.

DR ANDROULA LADIKOS: OVERLAP BETWEEN ADHD AND AUTISM

This talk highlighted the comorbidity and increased impairment in children who have both features of ADHD and Autism Spectrum Disorders. These frequently co-occur and inadequate treatment as a result of inaccuracy in identification and diagnosis often can result in a suboptimal response. There are no specific diagnostic tests to differentiate the conditions, as the overlap may be in part explained by the interplay between genetic factors, the environment and individual vulnerabilities.

A SUGGESTED APPROACH WOULD BE TO IDENTIFY WHICH ARE THE MOST OBVIOUS SYMPTOMS AND WHICH CAUSE THE MOST FUNCTIONAL IMPAIRMENT AND THEN DIRECT THE INTERVENTIONS ACCORDINGLY. THERE ARE RED FLAGS OR EARLY WARNING SIGNS HOWEVER NONE ARE SPECIFIC OR DEFINITIVE.

In general look for deficits in Social engagement, atypical sensory reactivity, stereotypies and poor communication skills when considering a child with ASD that has ADHD co-occurring. Motor restlessness and dysregulation could also be a helpful symptom cluster to differentiate.

A reference that was suggested from this talk: *Young, S., Hollingdale, J., Absoud, M., Bolton, P., Branney, P., Colley, W., & Gudjonsson, G. (2020). Guidance for identification and treatment of individuals with attention deficit/ hyperactivity disorder and autism spectrum disorder based upon expert consensus. BMC Medicine, 18, 1-29.*

Anusha Lachman

PROF KIRSTY DONALD: GENETIC TESTING FOR NEURODEVELOPMENTAL DISORDERS

This session explored the complexities of genetic testing in early neurodevelopmental disorders and highlighted the challenges in the field, especially since non – European ancestry is under represented in current GNAS data. Prof Donald explained the central dogma of genetics including the difference in genetic inheritances of polygenic versus mendelian inheritances when it comes to developmental delays in children.

THE CAUSE OF A CONDITION MAY BE AN INTERPLAY BETWEEN GENETICS AND ENVIRONMENTAL FACTORS. EARLY ADVERSITY ESPECIALLY DURING SENSITIVE PERIODS OF DEVELOPMENT WILL IMPACT ON BIOLOGICAL RESPONSES AND SYSTEMS.

These biological changes include epigenetic and homeostatic alterations, neuronal disruption and

excess inflammation. Both early adversity and biological changes can impact on adult outcomes. Developmental disorders are collectively common (1-5%) of the population and approaches include differentiating between congenital versus acquired conditions, environmental versus genetic and combinations of these.

IT IS DIFFICULT TO INTERPRET MULTIPLE GENETIC TESTING RESULTS SO CAUTION IS ADVISED AND A DIRECTED MORE FILTERED APPROACH IS RECOMMENDED.

A reference outlining this approach is suggested: *Fieggen, K. J., Lambie, L. A., & Donald, L. A. (2019). Investigating developmental delay in South Africa: A pragmatic approach. SAMJ: South African Medical Journal, 109(4), 210-213.*

PROF PETRUS DE VRIES: INTERVENTIONS FOR AUTISM

This talk involved a recap of the new categorization of Autism Spectrum Disorders in the DSM 5 with a reminder that there are two major domains namely social affect domain and the restricted repetitive behaviours.

THERE IS A HETEROGENEITY OF PRESENTATIONS IN AUTISM INCLUDING THE CLASSIFICATIONS, PHYSICAL AND EMOTIONAL MANIFESTATIONS, CULTURAL AND CONTEXTUAL DIFFERENCES.

Prof de Vries discussed a helpful approach to consider when deciding on management options for ASD. This included the following "Ten Principles for ASD interventions":

1. Comprehensive Assessment to guide interventions: including a full history, observation, mental and family health information, cognitive and allied health assessments
2. No single intervention is successful for all: individualized programs are key. Combine approaches: behavioural, developmental and educational strategies.
3. Accommodate: work around deficits. Teach general strategies but it cannot be all that is done for ASD
4. Build skills: through the core difficulties of ASD. Teach communication, imitation, play joint attention etc. An example would be the Early Start Denver Model.
5. Look for and treat conditions that co-occur with ASD eg Mental and physical health
6. Focus on Family: management of a child with ASD must include parents, carers and the community
7. Early intervention in early years before the age of 3. Prevents secondary problems for the child, optimizes outcomes and improves independence
8. Understand the meaning of the behaviours. Instead of thinking only about what medication is best to prescribe, rather ask what is the meaning or function of the challenging behaviours
9. Use Evidence Based Interventions – rather than popular science
10. Parent Education and Training (PET) – fundamental step in the management of ASD is to give accurate, important and meaningful information to empower parents.

Anusha Lachman is a child & adolescent psychiatrist at Stellenbosch University. She serves as the Secretary of the Board of SASOP. **Correspondence: anusha.sasop@gmail.com**

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SUPPORTING THE "OTHER"

GROUP THERAPY FOR SIBLINGS OF CHILDREN WITH SPECIAL NEEDS

Derine Louw

WHY SUPPORT THE SIBLINGS?

In my personal and professional life, there has always been a theme of what siblings of children with special needs deal with daily. As a young student I worked with children with autism as a tutor at the homes and could see that even in the most organised and loving households, these siblings take strain. I decided to focus my research on the experience of these siblings and highlighted various themes, which I knew I would want to include in therapy for these kids one day. In my personal capacity, as a young adult – I received the exciting news that a baby brother was on his way.

FAST FORWARD A FEW YEARS, AND HE WAS DIAGNOSED ON THE AUTISM SPECTRUM. NEWS THAT GAVE MY EARLIER CAREER RESEARCH WAY MORE MEANING.

WHY SUPPORT IN GROUPS?

Derine Louw

Group therapy gives group members a sense of not being alone in their experience. That aha moment of 'Me too!!' is invaluable. Considering the cost of mental health services in South Africa, it provides a more cost-effective mode of treatment than individual sessions. Peer support is also of cardinal importance – it is just so much easier to learn from others your age you can identify with that have been able to overcome similar hardships.

GROUP THERAPY CAN ALSO SERVE AS A GATEWAY FOR INDIVIDUAL THERAPY SHOULD THAT BE INDICATED – MAKING THE WORLD OF THERAPY A LITTLE LESS SCARY OR DAUNTING.

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SUPPORTING THE OTHER - GROUP THERAPY PROGRAMME

The programme is divided into 8 sessions and comprises of 6 group members. Theoretically it is based in Gestalt Theory and provides the opportunity for sharing, telling narratives, reflection, growth, peer support, learning new skills and having fun. Activities include psychoeducation, individual activities, team activities and child-parent activities.

The different sessions are set out as seen in Figure 1. One of the most important features of the programme is to get parents involved during the first and the last session.

THE RATIONALE IS TO BUILD A BRIDGE OF COMMUNICATION WHERE THE CHILD CAN VOICE THEIR EXPERIENCE AND CHALLENGES OF LIVING WITH A SIBLING WITH SPECIAL NEEDS.

THE WAY FORWARD

The programme will be rolled-out in the near future for tweens and teens. On completion of the programme, monthly group support will be available for those who feel that a monthly check-in will be of benefit. The programme will also be adapted for adult siblings of people with special needs.

Derine Louw started her private practice in 2020, after working as a senior psychologist at Stikland Psychiatric Hospital in Bellville, Cape Town since 2010. Her focus is on therapeutic interventions in child, adolescent and adult mental health with a special interest in mood and anxiety disorders, body-focused repetitive behaviours (hair-pulling, skin picking), as well as working with siblings and care givers of children with special needs. Intervention modalities include Gestalt Therapy, Dialectical Behaviour Therapy, Psychodynamic Therapy and Cognitive Behavioural Therapy. **Correspondence: www.derinelouw.co.za**

Figure 1

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PSYCHOTHERAPY FOR ADHD

Frans A Korb

During the first week of September 2020 the 1st Southern African Multidisciplinary Virtual ADHD Congress was held. The purpose of the congress was to address various academic and practical clinical issues in the management of ADHD across the lifespan. Psychotherapy for ADHD was spread over two sessions.

Dr Frans Korb (Psychiatrist in private practice in Johannesburg) as Chairperson of the second psychotherapy session gave the initial introduction on 'ADHD and Its Psychotherapeutic Treatments'. A comprehensive treatment approach remains the backbone for the successful management of ADHD in both children and adults. Virtually all treatment guidelines e.g. NICE and BAP, recommend a multi-modal treatment approach with psychosocial interventions as adjunctive treatment to medication.

PSYCHOSOCIAL INTERVENTIONS ARE NON-MEDICATION TREATMENTS AND RELATED SUPPORT SERVICES DESIGNED TO REDUCE IMPAIRMENT AND IMPROVE COPING SKILLS WITH ADHD.

Psychotherapy as an adjunct to ADHD medication is important when there is incomplete symptom remission, where there are co-morbid psychiatric diagnoses e.g. mood disorders, anxiety, and substance use/abuse as well as ongoing impairments despite effective ADHD medication.

Frans A Korb

The targets of psychotherapeutic treatment for adult ADHD should include treating the core symptoms (inattention, impulsivity, and hyperactivity) and associated problems. Such problems may include aspects of mood, anxiety, anger, low self-esteem, distorted thinking, poor social skills, sleep problems, relationship and employment issues and substance abuse.

THERE IS A MYRIAD OF PSYCHOSOCIAL INTERVENTIONS WHICH CAN BE TAILORED TO THE INDIVIDUAL PATIENT. IN GENERAL PSYCHOEDUCATION ABOUT THE DISORDER REMAINS KEY.

In general patients can attend Cognitive Behavioural Therapy (CBT) which may include Dialectical Behavioural Therapy; Meta-Cognitive Therapy; Cognitive Remediation Programmes; Mindfulness Based Therapy; and Cognitive Rehabilitation Rrogrammes. The services of ADHD

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coaching and a life coach can be helpful where available. Relationship difficulties, e.g. couples or family therapy should also be addressed. Where necessary Educational and Employment accommodations, Financial management, and the 12-Step programme for substance abuse can be organized.

After the introduction Hannelie Spies (Educational Psychologist based in Stellenbosch) gave an overview of 'BWRT for ADHD'. BWRT is the abbreviation for 'Brain Working Recursive Therapy' that was created by Terence Watts in 2011. BWRT is different from any other treatment modalities and in essence has been designed to 'remove emotive responses from memories that are deeply troubling and create new, adaptive neutral pathways that do not have the old undesirable responses attached to it.' The procedure is firmly based in neuroscience.

BWRT USES THE IDEA OF LEARNING A NEW WAY OF REACTING AND BEHAVING VIA REPETITION, REHEARSAL, AND REFLECTION ON SUCCESSES. IN DOING SO THE BRAIN PROVIDES A NEW NEURAL PATHWAY NETWORK.

The difference with BWRT is that rather than acquiring a new behaviour, it is about changing an undesired behaviour in favour of a better behaviour. In behavioural terms there is a cognitive gap (a space) between stimulus and response where "stuff goes on" before the conscious mind knows about it. BWRT gets into that cognitive gap and stops the emotive responses before it gets anywhere near the conscious mind. In order to do this the therapy is conducted according to a strict protocol which then ensures maximum effectiveness.

BWRT has reported success with most psychopathology especially all the anxiety disorders, mood disorders and addictions. Specifically, in ADHD a person has been living with a lifetime of mistakes, mishaps, misunderstanding, and missed deadlines resulting in low self-esteem and negative automatic thoughts and responses.

IT IS WELL KNOWN THAT THE PSYCHO-SOCIAL IMPAIRMENTS IN ADHD GO FAR BEYOND THE THREE DIAGNOSTIC CORE SYMPTOMS. SOCIAL IMPAIRMENT IN ADHD RANGES FROM WITHIN THE FAMILY TO POOR PEER RELATIONSHIPS AND LACK OF FRIENDSHIPS.

Emotional impairment includes poor self-regulation of emotions, excessive emotional expression, poor self-esteem, and anxiety. Avoidance behaviour, irritable mood and constant low mood may develop to mention but a few psychological consequences. Russell Barkley puts deficient emotional self-regulation / emotional dysregulation at the core of ADHD. The aim of BWRT is thus to reduce the effect of all these psychological issues.

Anton Kruger (Clinical Psychologist from Somerset West) followed the short break in the session to speak about 'A Daily Struggle: The Curse of ADHD'. He started his lecture stating that ADHD is 'A Life of Continual Chaos ……' with the 4 'UNs' i.e. UNdetected, UNdiagnosed, UNtreated and UNder Performance. He confirmed the value of CBT in the management of ADHD on the basis that CBT dissects the interaction between thoughts, behaviour, and emotions in a structured, goal-directed, and skills-based paradigm.

CBT IS AIMED AT THE MODIFICATION OF INGRAINED DESTRUCTIVE THOUGHTS AND CORE BELIEFS AND THE DEVELOPMENT OF APPROPRIATE BEHAVIOURAL PATTERNS AND SKILLS.

CBT has developed from the traditional principles first described by Aaron Beck and Albert Ellis. It has now expanded with the 'third wave' that includes amongst others Mindfulness Based Cognitive Therapy (MBCT), Acceptance & Commitment Therapy (ACT) and Compassion Focussed Therapy (CFT). MBCT focusses on selective attention training with increased defusion and self-compassion that enhances self-awareness first described by Kabat-Zinn.

Traditional CBT is aimed at enhancing levels of awareness and insight regarding the diagnosis of ADHD and the treatment process by modifying the destructive, cognitive, emotional, and behavioural patterns in a patient.

WITH THERAPY THE PATIENT SHOULD DEVELOP AND REFINE THEIR PSYCHOLOGICAL FLEXIBILITY AND COPING STRATEGIES. TO ACHIEVE THIS THE COLLABORATION BETWEEN THE PATIENT AND THE THERAPIST IS ESSENTIAL.

ACT is used to develop psychological flexibility through the process of acknowledgement and

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acceptance. ACT focusses on the present moment, cognitive defusion, committed action and self-compassion.

CFT ON THE OTHER HAND UTILIZES INTERNAL COMPASSIONATE INTERNAL DIALOGUE TRAINING BY MODIFYING HIGH LEVELS OF SHAME AND SELF-CRITICISM. THIS IS USEFUL BECAUSE ADHD PATIENTS USUALLY HAVE A HISTORY OF FAILURE, NEGLECT, AND CRITICISM.

Finally, Anton gave an overview of the treatment format for CBT with well defined, goal-orientated sessions as well as examples like time management and coping with procrastination. In this era of technology, the use of apps should also be utilized like One Note and Simple Mind.

The psychotherapy session was closed with a Marlene Wells (Clinical Psychologist with special interest in Neuropsychology) on the topic 'From Neuroscience to a Skills-Based Intervention of ADHD'. Her approach to the management of ADHD is based on neuropsychotherapeutic principles and defines ADHD as the relationship between biology, neuroanatomy, and cognition.

SCIENTIFIC RESEARCH INDICATED THAT BRAIN STRUCTURES, BRAIN FUNCTIONS AND BRAIN NETWORKS ARE IMPAIRED IN ADHD. AN EXAMPLE IS THE DEFAULT MODE NETWORK (DMN). TREATMENT PROGRAMMES SHOULD THUS INCLUDE REMEDIATION OF THESE BRAIN NETWORKS.

Mindfulness Based Cognitive Therapy (MBCT) is aimed at emotional, thought, and behavioural self-regulation. In relation to the Default Mode Network (DMN) MBCT can be utilized to prevent loop shifting to a distractor. This can be applied to several problems presenting in the ADHD patient e.g. cognitive flexibility, working memory, time management, problem solving, emotional dysregulation and mood instability.

As an example, in the approach to the remediation of working memory the patient will be taught to focus his/her attention on the relevant facts by rehearsing and using visual cues and holding information in working memory. Adequate time management will be utilizing the use of a daily planner and the listing of priorities keeping in mind the realistic probability of completing a task in the given time frame. Problem solving skills should include breaking a task down in realistically workable 'chunks'. The problem to be solved should be clearly defined, what needs to change and what are the alternatives.

IN THIS SESSION ON PSYCHOTHERAPY FOR ADHD VARIOUS PSYCHOTHERAPEUTIC APPROACHES WERE DISCUSSED ALL BASED IN WELL-PROVEN RESEARCH AND EXPERIENCE. THE MESSAGE REMAINS CLEAR THAT THE MANAGEMENT OF ADHD REMAINS COMPLEX AND THAT A MULTIMODAL APPROACH SHOULD BE UTILIZED TO MANAGE SUCH PATIENTS FOR THE BEST OUTCOMES AND TO ENHANCE THEIR QUALITY-OF-LIFE.

Frans August Korb received the following university qualifications: B.Sc. (Hons) (UFS), M.A. Clinical Psychology (Wits), M.B. Ch.B. (UCT), M.Med. Psychiatry (Wits). He is currently in full-time private practice as a Psychiatrist and Clinical Psychologist in Sandton and consults for SASOL. For Life Healthcare he consults at both Baneng Care Centre and Waverley Care Centre. Yearly he has been an invited lecturer at the Departments of Psychology at the University of Johannesburg and the University of Pretoria. He has been involved with the CMSA FCPsych Part 1 exams for the last 20 years. He is currently the Board Chairman of the South African Depression and Anxiety Group (SADAG).

He has participated in many clinical trials for various pharmaceutical companies. He regularly attends and presents at local and international conferences, workshops, presents posters, courses and CPD Programmes. Past executive appointments include the University Science Students' Association of Southern Africa (USSASA), Associated Scientific and Technical Societies of South Africa (AS&TS), Southern African Association for the Advancement of Science (S2A3), University of the Witwatersrand Psychiatry Registrars' Association, South African Association for Child and Adolescent Psychiatry and Allied Professions (ACAPAP), South African Society of Psychiatrists (SASOP), Southern African Society of Biological Psychiatry, the Rotary Club of Sandown, South African Sexual Health Association (SASHA), South African Medical Association (SAMA) and the South African Depression and Anxiety Group (SADAG). Currently he is editor of 'Mental Health Matters' (Journal for general practitioners on mental health) and on the Editorial Board of 'Neuron SA'. He has published in both peer-reviewed journals and in the daily press and enjoys doing regular radio and TV interviews. In 1989 and 1992 he received a Certificate of Merit from the Southern African Association for the Advancement of Science.

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HOT TOPICS IN ADHD AND THE TALE OF THE GOLDILOCKS AND THE BEAR FOUNDATION

Claire Tobin

The last day of the ADHD Congress was filled with invaluable information that highlighted the importance of research into the definition, treatment and aetiology of ADHD, early diagnosis, and comorbidities commonly seen in individuals with ADHD. It also drew attention to the particularly important work done by the Goldilocks and The Bear Foundation to assist in the early intervention of mental health conditions in children.

Dr Anton Rossouw, the CEO and founder of Lifepath Health Group opened proceedings on the last day.

HE DESCRIBED THEIR INVOLVEMENT IN THE CONGRESS AS A PASSION-DRIVEN INITIATIVE WHICH CAN MAKE A DIFFERENCE IN THE LIVES OF MANY INDIVIDUALS AND TO BE PART OF DEVELOPING A SOLUTION-DRIVEN PLATFORM FOR ADHD.

This included raising funds for the Goldilocks and the Bear Foundation, a registered non-profit organisation, who are the driving force for screening and intervention of ADHD in under-resourced communities. He also highlighted that:

- According to the 2017 Global Burden of Disease Study, the ADHD prevalence rate worldwide amounts to approximately 73 million people.
- In South Africa in particular, the ADHD Support Group of South Africa, estimates that between 8 – 10% of people present with ADHD (approximately 5 million people).

Claire Tobin

LANDMARK PUBLICATIONS IN ADHD: JUNE 2018 – JUNE 2020

This interesting topic was presented by a pioneer in child psychiatry, Dr Rene Nassen, who is both the head of the Child and Adolescent Mental Health Services at Lentegeur Hospital and a senior lecturer at the University of Stellenbosch. She laid the foundation for her presentation by summarizing a research review by Cortese, et al. (2020) which identified the scientific advances in research on ADHD during the past 20 years. This included the transition of the diagnostic definition of ADHD from the DSM 4 to the DSM 5, epidemiological changes, possible genetic and environmental causes of ADHD, neuroimaging and neurocognition studies

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and the advancement in treating ADHD. She also highlighted clinical concepts and the risk markers associated with individuals with ADHD. Connecting recent studies in the biological underpinnings of ADHD, Dr Nassen provided an insightful review of how neuroimaging has revealed specific brain areas involved in the brain dysfunction associated with ADHD, such as regions involved in lapses in attention.

SHE POINTED OUT THAT RESEARCH HAS REVEALED THAT ADHD HAS A HIGH HERITABILITY RATE OF APPROXIMATELY 70 – 80% (DEMONTIS, ET AL., 2019).

Dr Nassen went on to describe clinical concepts in ADHD, specifically diagnostic issues relating to late identification outlined by Anderson et al. (2018). In particular, she identified possible explanations of why individuals may have gone undiagnosed and whose ADHD was not identified in childhood. These include: falling below the diagnostic threshold; a supportive family environment or high IQ; misdiagnosis; gender differences.

A common misperception relating to ADHD is that the prevalence rate is much higher in males than in females. Some of the reasons for this was explained by Dr Nassen, including that females:

- Often compensate and mask their behaviour and are more able to follow socially acceptable norms.
- May internalise their symptoms, leading to the development of additional comorbid conditions. As a result, the symptoms of secondary conditions could become more prominent, making ADHD more difficult to identify.
- Do not display some of the behaviour difficulties associated with ADHD and emotional dysregulation, leading to misdiagnoses.

The emotional dysregulation in children with ADHD, which is one of the core criteria, especially in combined-type ADHD, was also reviewed (Faraone et al. 2018). Dr Nassen discussed a few other concepts such as the behavioural, biological and genetic markers in individuals with ADHD, as well as the role of maternal vitamin D levels in pregnant women.

INTERESTING TO NOTE IS THAT INDIVIDUALS WITH ADHD HAVE SHOWN A 50-60% HIGHER RISK OF BEING DIAGNOSED WITH A LEARNING DISORDER.

Dr Nassen's talk outlined the complexity of the diagnosis and treatment of ADHD, she went on to highlight areas that require more research, and reminded healthcare professionals to remain aware of the different ways in which ADHD can present itself across the lifespan.

ADHD AND SLEEP DISORDERS ACROSS THE LIFESPAN

This topic was presented by Dr Nai'm Moola, a psychiatrist in private practice. Dr Moola explained the relationship between sleep and ADHD is both complex and multifaceted. He intimated that sleep difficulties may be an intrinsic characteristic of ADHD and that ADHD may even exacerbate symptoms of sleep difficulties or vice versa.

SLEEP DIFFICULTIES MAY ALSO LEAD TO THE DEVELOPMENT OF ADHD-LIKE SYMPTOMS, AS WELL AS THE DEVELOPMENT OF COMORBID CONDITIONS.

The function of sleep for individuals, including its impact on memory, physical health, hormone regulation and daytime productivity was also discussed by Dr Moola.

THE RELATIONSHIP BETWEEN SBDS AND ADHD, WAS EXAMINED BY DR MOOLA. HE EXPLAINED THAT CIRCADIAN RHYTHM SLEEP DISORDER (CRSD), RESTLESS LEG SYNDROME (RLS), INSOMNIA AND NARCOLEPSY, CAN CONTRIBUTE TO COGNITIVE, EMOTIONAL AND PHYSICAL IMPAIRMENTS IN ALL AGE GROUPS.

Research has shown that comorbid ADHD and SBDs correlate with increased hyperactivity and inattention and have a negative impact on cognitive and emotional functioning (lower quality of life and more symptoms of depression and anxiety). It has also been linked to physical impairments (such as allergic rhinitis) in pre-school aged children with both ADHD and SBD.

Some interesting outcomes from a range of studies on ADHD and SBDs were explained by Dr Moola. Some of these findings include:

- Adults with both ADHD and narcolepsy show reduced verbal fluency and poorer performance on measures of executive functioning. Both school aged children and adults with both ADHD and narcolepsy showed

increased sleepiness, depression and weight related issues.

- The impact of ADHD on RLS, which includes increased leg movements, disruptive sleep, hyperkinesia, periodic limb movement, as well as daytime impairments.
- That adolescents with both ADHD and insomnia produce more errors in cognitive assessments.

Dr Moola emphasised that when diagnosing and treating of ADHD and SBDs, it important to do a complete and comprehensive assessment, in order to determine the impact on daytime, emotional and physical wellbeing and to subsequently follow a multidisciplinary approach to the management of both disorders. He outlined various treatment options for various age groups, which include medication, psychoeducation and sleep hygiene.

Important to note is that Dr Moola highlighted a dearth in the literature regarding sleep disorders and ADHD, as well as a lack of empirical evidence regarding daytime impairments.

HE WAS CONCERNED THAT THE DATA IN RECENT STUDIES CAN LEAVE AN INDIVIDUAL A BIT DISARRAYED AND POINTED OUT THAT THERE IS A NEED FOR MORE RIGID STUDIES, ASSESSMENT TOOLS AND STRUCTURES IN STUDY DESIGN THAT CAN GIVE MORE CONSISTENT DATA.

ADHD AND ANXIETY

Dr Larry Klasse, a psychiatrist based in Canada, comprehensively explored the relationship between ADHD and anxiety and noted that there are many comorbid conditions that often present in individuals who have ADHD. He outlined the prevalence of mood and anxiety disorders in adults with ADHD. Anxiety was noted to have the highest prevalence (47.1%) and dysthymia the lowest (12.8%).

ADDITIONALLY, HE INDICATED THAT THERE WAS A HIGH COMORBIDITY RATE OF ADHD IN OTHER MOOD AND ANXIETY DISORDERS.

It was emphasised that health professionals should be aware that there are many overlapping symptoms in ADHD and comorbid conditions. For example, substance use disorder can include restlessness/agitation, impulsivity, and concentration difficulties and hypomania in bipolar mood disorder can include excessive talking, restlessness/agitation, racing thoughts, impulsive behaviours, concentration and attention difficulties, as well as mood swings.

Dr Klasse described the effect of how comorbid anxiety disorders and ADHD can impact an individual. He highlighted the following regarding ADHD and comorbid anxiety:

- An individual will struggle with more severe anxiety, earlier onset of anxiety and additional psychiatric conditions.
- The presence of anxiety in adult ADHD, may give rise to additional clinical effects resulting in more impairment and poorer prognosis and greater resistance to treatment.
- Children with both ADHD and anxiety, were shown to be more likely to struggle with a more severe course of anxiety and other comorbidities (Mancini, et al. (1999), Schatz et al. (2006), Alexander et al. (2013) Biederman (2004), Alm et al. (2005)).

Furthermore, Dr Klasse highlighted research indicating that that there are some individuals that have been diagnosed with psychiatric disorders that have undiagnosed ADHD. This is often associated with poor treatment response, non-compliance of treatment and lack of improvement in symptoms. He emphasised that it is imperative to treat the ADHD to prevent the worsening of comorbidities. (Barkley PA, Brown TE, 2008).

A diagnostic priority in how to treat ADHD as well as comorbidities was emphasised by Dr Klasse.

THIS INVOLVES TREATING THE MOST SEVERE CONDITION FIRST AND ONLY ONCE THOSE SYMPTOMS ARE MANAGED, TO THEN ADD TREATMENT TO ADDRESS OTHER AREAS OF CONCERN (GOODMAN D, 2005).

Both pharmacological and psychological treatment and benefits were outlined in his presentation. Dr Klasse notes that the correct treatment of individuals can help in avoiding sequelae, such as developing secondary disorders, preventing car accidents, and developing substance use disorder (Biederman et, al., 2019).

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THE GOLDILOCKS AND THE BEAR FOUNDATION

The ADHD Congress would not have been possible without the passion from Professor Renata Schoeman, who co-founded the Goldilocks and The Bear Foundation with Mr Nic de Beer. The Foundation was introduced by Ms Tawni Voges, the operations manager at the Foundation. Ms Voges described the history of the Foundation, from its founding in 2017, to where it has grown and the many partnerships which have developed.

THE FOUNDATION STRIVES TO REMOVE MENTAL HEALTH BARRIERS TO EDUCATION BY PROVIDING SCREENING AND EARLY INTERVENTION TO UNDERPRIVILEGED CHILDREN TO ENSURE THAT ALL CHILDREN HAVE THE NECESSARY SUPPORT TO DEVELOP THEIR FULL POTENTIAL.

The Foundation's team, together with an incredible network of volunteers and partners, provide multidisciplinary services to support children. This process includes identification and screening of children who present with emotional, behavioural and learning difficulties.

This information is then clinically reviewed and if needed, the child will be referred for other services. Referral pathways include clinic appointments, visual and auditory assessments, occupational therapy, educational assessments, psychosocial support and counselling, and social work.

The team believes passionately in spreading awareness about mental health by providing education and support through parental guidance meetings and offering free training to teachers, government, and community organisations. In 2019, the Foundation took their vision of spreading awareness one step further and launched their best-selling book. "All of these things are important to me" which explores the adventurous life of Zee in a short and colourful narrative in English, Afrikaans, isiXhosa, isiZulu and Sesotho (all in one book). A book can be purchased online for R100 at www.gb4adhd.co.za.

Claire Tobin is a registered Psychometrist (Independent Practice) currently employed by the Goldilocks and The Bear Foundation, where she performs screening for ADHD and other mental health barriers. She also conducts educational assessments for children to assess for learning difficulties/barriers. Claire recognises the importance of early intervention and has a passion for psychoeducation to prevent stigma, as well as the secondary implications of untreated mental health and learning difficulties.

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EMOTIONAL REGULATION IN ADHD: CLASSROOM STRATEGIES

Marelé Venter

EMOTIONAL REGULATION AND ADHD

Emotional regulation (ER) refers to the process by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions. It can be automatic or controlled, conscious or unconscious, and may have effects at one or more points in the emotion producing process. ER encompasses both positive and negative emotions, along with how we can strengthen them, use them, and control them. It has to do with initiating and inhibiting actions triggered by emotions and modulating responses triggered by emotions.

Children develop self-regulation through warm, responsive relationships and by watching the adults around them self-regulate. ER development thus begins when children are babies, develops most during the toddler and preschool years, but also keeps developing into adulthood. However, before we however can expect children to self-regulate their emotions, they first need to have had healthy co-regulating experiences. Adults example of modelling healthy emotional self-regulation is crucial. (Children are brilliant imitators: we need to give them something healthy to imitate).

SO WHY IS ER ESPECIALLY RELEVANT TO CHILDREN WITH ADHD? UNLIKE POPULAR BELIEF, ADHD IS PRIMARILY ABOUT EMOTIONAL REGULATION AND SELF-CONTROL AND IS NOT JUST ABOUT INATTENTION, IMPULSIVITY, AND HYPERACTIVITY.

ER is foundational to social, emotional, and academic success, but is often underdeveloped in children with ADHD. The prefrontal cortex of the brain, for example, in children with ADHD develops more slowly (as much as 30% or more) than in children without ADHD. Thus a 10-year-old child with ADHD may have self-regulation skills similar to a typically developing (neurotypical) 7-year old. Medication helps decrease impulsive, hyperactive, and/or inattentive behaviour for children with ADHD, but cannot teach children the skills they need to regulate.

Marelé Venter

Most interventions for ER are ineffective for ADHD because they rely on using the cognitive brain (executive functions - which are usually affected by ADHD) to control the emotional brain. Instead, we should look at harnessing the power of the emotional brain, as it is powerful, infinite, a strong motivator, fast, and contagious. We need to focus on proactively regulating positive emotions.

CHILDREN WHO HAVE DIFFICULTY REGULATING THEIR EMOTIONS OFTEN HAVE TROUBLE LEARNING IN THE CLASSROOM AND ARE LESS PRODUCTIVE AND ACCURATE WHEN COMPLETING ASSIGNMENTS.

The emotional brain (the limbic system) has the power to open or close access to learning, memory, and the ability to make novel connections. The ability to regulate emotions is an essential prerequisite for adaptive development and behaviour.

STRATEGIES FOR ER IN THE CLASSROOM

1. **Keep the end goal in mind:** The end goal is not to simply decrease children's challenging behaviour, but to teach skills. When children

learn how to cope with stress, their behaviour will improve, and they will be able to handle changes in their environment better and respond to stress more calmly.

2. **Develop realistic expectations:** Assess children's skills to determine where they need support (e.g., instruction, self-awareness, practice, feedback). Remember that younger children have less developed brains and are less able to regulate themselves. Demand from children as much as they can handle, keeping in mind that success leads to more success. Be prepared for setbacks as part of learning and growth.

3. **Connect to correct:** Help children feel cared about, valued, and understood as they learn to regulate. Show genuine interest and engage with them as a coach and mentor.

4. **Structure and consistency:** Let children know what to expect and what is expected of them (e.g., routines, clear rules, proactive planning) as predictability helps to decrease stress.

5. **Fun, collaborative learning:** Be creative when helping children develop, practice, and adapt coping strategies toward regulation. Listen to their ideas and talk about 'learning to regulate' in ways they can understand.

6. **Understanding the brain:** Teach children about their brains and the role of the downstairs brain in their stress response (fight-flight-freeze, reactive, act before thinking, emotional reactions, bodily functions), as well as the upstairs brain in their regulation (receptive, think before acting, control emotions/body, decision making, focus/concentration, empathy, self-awareness). Another example is Dan Siegel's "Hand model of the brain" (flipping your lid). Books can also be utilized effectively during psychoeducation for the whole class (e.g. "All these things are important to me"), helping all children understand ADHD and decreasing the stigma around it.

7. **Ensure a full tank:** Be pro-active! Ensure that children's resource pools for regulation is regularly replenished. Rest, a balanced diet, and regular physical activity are essential. Plan for activities children enjoy and in which they do well.

8. **Emotional self-awareness:** Expand their vocabulary by talking to children about their feelings. Teach them about their resource pool and enhance their self-awareness to help them self-monitor. Help children rate their emotions and energy reserve ("zones of regulation") and assist them in identifying strategies to calm and ways to refill their resource pools.

9. **ER Classroom Toolkit:** Help children develop a toolbox of coping strategies to use when dysregulated. The idea is to help children stop in the moment, stay calm and think, and not act on their big emotions. These could include mental breaks (books, music, colouring, creativity, games), physical breaks (dance, sports, walk, stretch), sensory breaks (sound, taste, touch, movement), grounding breaks (deep breathing, slow counting, visual imagery) and positive affirmations (affirmation jar/sticky notes).

10. **Feedback and reinforcement:** Give immediate and specific feedback and try to focus on the effort rather than the result. Reframe failures as opportunities for learning and growth. Use rewards, positive reinforcement, and words of encouragement. Rewards could include common everyday classroom privileges. Help motivate children to learn and practice regulation and remember to celebrate even the small successes.

ER IN THE CLASSROOM STARTS WITH US. AS ADULTS, WE NEED TO MANAGE OUR STRESS AND GET OUR OWN NEEDS MET SO THAT WE CAN BEST SUPPORT THE CHILDREN WE ENCOUNTER. WE ARE THE EMOTIONAL CLIMATE CONTROL IN OUR CLASSROOMS AND NEED TO MODEL HEALTHY ER OURSELVES.

By changing our perspective of a dysregulated child as being naughty or attention-seeking to being connection-seeking instead, our approach will automatically change. We spend time meeting children's emotional needs either by filling their cup with love pro-actively or reactively by dealing with the behaviours caused by their need. Either way, we spend time.

Marelé Venter is an Occupational Therapist (special interest in child and adolescent mental health)

"Raise your words, not voice. It is rain that grows flowers, not thunder." -Rumi

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REFLECTIONS ON THE 1ST SOUTHERN AFRICAN MULTIDISCIPLINARY ADHD CONGRESS

Lene le Roux

It was a privilege to have the opportunity to attend the first two sessions of the first Southern African Multidisciplinary ADHD congress. As a registrar in my final year of training I found the first session particularly valuable in terms of revision of the neurobiology of ADHD. This is generally covered in the first year of registrar training and is not addressed during practical training during child and adolescent psychiatry, so it was very valuable to revise these concepts and improve on the basic understanding I had prior.

WE MOVED ONTO THE DIAGNOSIS OF ADHD AND WERE PROVIDED WITH VERY USEFUL RESOURCES AND SCREENING TOOLS THAT CAN FACILITATE DIAGNOSIS.

We are exposed to the diagnosis of childhood ADHD quite regularly during our child and adolescent rotation as registrars, and have a fair understanding of this clinical assessment, but rarely see adults with ADHD and this is always a stressful consultation for a registrar to have. There is so much controversial information available on the diagnosis of ADHD in adulthood, especially where a childhood presentation is not obvious and it was extremely valuable to learn of the validated screening tools, as well as have the confirmation that there is no such diagnosis as adult-onset ADHD and that a childhood history of symptoms is important to establish, even if this means calling in collateral from parents of the adult. We covered the types of executive deficits including responsive inhibition, non-verbal working memory, verbal working memory, self-regulation and problem solving. We also revised the core triad and associated symptoms of ADHD in adults including behavioural, cognitive, emotional and social aspects as well as work related and interpersonal problems. It was helpful to learn that symptoms often decrease over time, which may be as a result of the adult's improved ability to manage symptoms and compensate for impairment through lifestyle and career choices. Although adult ADHD is often diagnosed by general practitioners in practice, it was emphasised that this should not only be diagnosed by a general psychiatrist, but rather by a psychiatrist with experience in ADHD. As a registrar this is particularly helpful in realising the scope of practice and when to refer to specialist psychiatrists supervising us.

Lene le Roux

We moved on to the pharmacology of ADHD which was once again a very useful revision of the method of actions of the drugs we have available including atomoxetine which is a monoamine reuptake inhibitor and Ritalin, Concerta, Neucon and Contramyl which are monoamine releasing agents. It was also emphasised that the side effects of these treatments in adults are usually transient and mild if the patient does have ADHD. We learnt about alternative treatments including bupropion which has been found effective due to its effects as a NA and DA re-uptake inhibitor. Other agents sometimes used but not recommended include clonidine, tricyclic antidepressants, modafinil and venlafaxine. There is also no evidence to support the use of SSRIs, anticonvulsants, mood stabilisers or antipsychotics.

We discussed alternative and complimentary treatments for ADHD which was a fascinating presentation including many over the counter medications and supplements that claim to improve attention, concentration and cognition. Some of these supplements contain little to no active ingredients despite their marketing and are not useful to prescribe. However L-Theanine is a good aid for attention and concentration and is recommended. This is particularly helpful when seeing a client who does not meet the criteria for ADHD but would like medication to assist with

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inattention and difficult concentrating and I have actually been able to recommend this to a few patients following this workshop.

Another important topic covered in the sessions was the comorbidity of ADHD and this is something we are often confronted with in our outpatient settings as registrars and leads to some difficulty in diagnostic clarity as there is significant symptom overlap. Comorbid anxiety is very common and it was useful to learn that the focus should be on first treating the anxiety. CBT is recommended to treat the anxiety as well as the use of an antidepressant. SSRIs do not benefit attention and concentration, so it is better to use a SNRI. Bupropion has good evidence and venlafaxine is also a recommended choice. In treating the ADHD, atomoxetine is used as it does not worsen the anxiety symptoms. The overlap between Bipolar Mood Disorder and ADHD was also covered and again there can be significant symptom overlap. A helpful distinguishing factor is that ADHD is constant, whereas mood disorders such as bipolar mood disorder present with a more episodic nature. In terms of treating comorbid bipolar mood disorder the recommendation is to remove stimulants and antidepressants and first maximise mood stabilisers before reintroducing ADHD medication. Another helpful recommendation was that stimulants are safe to use with lithium, valproate and antipsychotics. Substance abuse was another common comorbidity and treatment of ADHD in adolescents reduces the likelihood of developing substance use disorder. Patients with comorbid substance use disorder and ADHD tend to have an earlier onset of abuse and more severe substance use disorder. Atomoxetine is considered first line, and long acting stimulants have a lower abuse potential. Despite recent media controversies, Ritalin should not be considered a "gateway drug" and it is important to effectively treat ADHD to reduce the incidence of substance use disorders in these patients.

Next we discussed psychosocial interventions for ADHD and it was helpful to understand the role of the multidisciplinary team in this regard. Some of the interventions recommended for sleep included sleep hygiene, melatonin, light therapy in the morning, as well as the importance of timing stimulants. It is useful to note that stimulants wearing off can in fact cause wakefulness in patients with ADHD and it is not necessarily the stimulant keeping them awake. Psychotherapy modalities recommended include CBT, DBT, mindfulness practice and coaching including financial coaching. We spent some time exploring workplace adaptions as patients with ADHD have difficulty with organisation and often feel overwhelmed. They also tend to have strong emotional reactions which can lead to interpersonal problems and they struggle with inconsistent performance. The choice of career is important as they do better in structured environments with constant stimulation and are often self employed. Some of the recommendations were to use reminders, rewards, set realistic goals, social skills training and to have adequate supervision and structure. One can also include movement breaks and divide tasks into smaller groups.

The session ended with an ethics discussion which focussed on various aspects of ADHD management.

OF INTEREST WAS THAT THERE IS A SIGNIFICANT INCREASE IN THE USE OF ADHD MEDICATION IN HEALTHY STUDENTS AND IT IS VERY PREVALENT IN SOUTH AFRICA, ESPECIALLY AMONGST MEDICAL STUDENTS.

Another interesting subject was the responsibility of the health care practitioner when parents refuse to let their children with ADHD use Ritalin. When thinking of beneficence in this case we want to do what is good for the child as the evidence base is to treat the ADHD. To be beneficent as practitioners we have to have the knowledge to do a risk benefit assessment and be clinically competent. Children have limited autonomy and parents are acting as the substitute autonomy. This is impaired by incapacity, ignorance and coercion. We discussed the reluctance of parents to give Ritalin to their children and some of the reasons identified was the suggested link between Ritalin and other drugs, as well as the influence of the anti-psychiatry movement. Citizen's Rights Organisation have also made claims that psychiatrists and paediatricians are pushing drugs and claim that when children grow up taking Ritalin they will turn to cocaine as adults to support stimulant addiction. Interestingly, it was also found that pharmacists did not have a favourable attitude towards Ritalin which may also influence parent buy-in. As psychiatrists we disagree and are able to recognise the diagnosis of ADHD and focus on the well described evidence base for treating, as well as be sound in the knowledge that not treating is damaging to the patient. Although the Child Act says that we should act in the best interests of the child and that no parent should withhold treatment unless they can prove there is an alternative medically accepted choice, the discussion led to a conclusion that parents would be unlikely to be forced to give their children Ritalin if this was to be heard in court.

Overall, the congress was a fantastic combination of revision and new information that was presented in a very applicable and interactive way. I feel more confident treating ADHD especially in adults and am more aware of the complexity of treatment and management of comorbid conditions.

Lene le Roux is a psychiatry registrar in her final year of training. She is currently working in the therapeutic unit at Valkenberg Hospital, with a special interest in maternal mental health. She hopes to make this the focus of her practice in future

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ADHD AND CANNABIS/CANNABIDIOL: THE INFLUENCE ON THE DEVELOPING BRAIN

Mahendra Kumar Ramdeyal

Cannabis has been associated with mankind for thousands of years, with many civilizations throughout the world using it for its "claimed" medicinal properties.[1,2] For the last few decades CBD compounds have once again risen in cannabis culture popularity. With changes in the legal status of cannabis globally and more recent scientific research being conducted, debates around cannabis continue with much "huff and puff" around the globe… from street corners all through to parliaments.

Cannabis has over 500 distinct compounds of which there have been about 115 cannabinoid compounds isolated from the plant. The best studied cannabinoids include tetrahydrocannabinol (THC) – isolated in 1964, is responsible for the intoxicating "high" of cannabis and can affect perception, mood, emotion, cognition and motor function, and Cannabidiol (CBD), a non-psychoactive compound ,isolated in the late 1930s, influences the way THC interacts with the cannabinoid receptors and can therefore influence exactly how a cannabis product will affect one .

IT HAS ALSO BEEN FOUND TO BE A POTENT ANTI-INFLAMMATORY AGENT, TO ATTENUATE THE MEMORY -IMPAIRING EFFECTS OF THC AND TO POSSESS SOME LIMITED OTHER MEDICALLY USEFUL PROPERTIES.[3]

Cannabis has long been known to produce cognitive and emotional effects by driving the brains endogenous system – Endocannabinoid System. It is one of the key regulatory mechanisms in the brain controlling multiple events such as mood, perception, learning, memory, pain, amongst others, by regulating the release of neurotransmitters, playing a modulatory role during synaptic plasticity, and homeostatic processes in the brain.[4]

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The FDA has only approved phyto-cannabinoid related drugs for the treatment of nausea, pain, seizures and wasting disease related to specific medical conditions, it is not for many reasons the wonder drug that its social media proponents claim it to be. It is being hailed in the treatment of a broad range of medical conditions.

ADHD HAS NOT BEEN SPARED IN ITS CLAIMS. THESE DAYS IT IS TOUGH TO FIND AN ONLINE COMMUNITY OR SOCIAL MEDIA GROUP NOT SINGING THE PRAISES OF CBD OR OFFERING TO SELL IT.

ADHD AND CANNABIS:

In one of the largest meta-analyses to date examining the prospective association of ADHD with cannabis use:[5]

- ADHD youth were nearly three times as likely to report cannabis use in later life compared to non-ADHD youth[6]
- ADHD children were more than 1.5 times as likely to be subsequently diagnosed with a Cannabis Use Disorder[7]
- ADHD symptoms are associated with increased cannabis use severity, craving, abuse, dependence, and earlier initiation of use[8]

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- Cannabis Use Disorder comorbidity with ADHD ranges from 33%-38%[9]

This relationship between ADHD and cannabis use is relevant given the known adverse effects of its use. The effect of early onset and long-term or heavy use include altered brain development, poorer educational outcomes - higher likelihood of dropping out of school , diminished life satisfaction, symptoms of and an increased risk for chronic psychotic disorders in people with a predisposition to such disorders.[10] Cardiovascular disease, poorer mental health, use of other illicit substances, and a range of poorer neurocognitive outcomes such as attention, executive functioning, and inhibition have also been identified.[11-15] Given that similar outcomes are associated with ADHD independent of cannabis use, including neurocognitive deficits, [16,17] the maladaptive effects of cannabis use may be particularly pronounced in ADHD patients.

INDIVIDUALS WITH ADHD ARE AT AN INCREASED RISK FOR BOTH CANNABIS USE AND CANNABIS USE DISORDER COMPARED TO THE GENERAL POPULATION.

I USE "WEED" TO TREAT MY ADHD:

Online health forums are filled with comments from people saying they use cannabis to treat symptoms of ADHD. Many adolescents and adults with ADHD are convinced that cannabis does help them and has fewer side effects than their ADHD medications. The internet is increasingly utilized as a source of health information by the lay public. Healthcare information obtained from online forums may influence perceptions and health seeking behaviour of the people conducting such searches. A qualitative analysis of online forum discussions on cannabis use and ADHD, analyzed some of these online threads or forums to systematically characterize the content that patients and caregivers may encounter about ADHD and cannabis.[18]

Of the 268 threads the researchers reviewed:

- 25% of posts were from individuals who reported that cannabis use was therapeutic.
- 8% of posts reported negative or harmful effects.
- 5% found both beneficial and harmful effects
- 2% said using marijuana had no effect on their symptoms.

THESE FORUMS AND COMMENTS ARE NOT CLINICALLY SIGNIFICANT AND ARE BASED ON THE OPINIONS OF THE USERS - NOT ON EVIDENCE-BASED RESEARCH.

EFFECTS OF CANNABIS ON THE DEVELOPING BRAIN:

Adolescence is often a period of especially heightened vulnerability due to the potential dissociations that may arise between the developing brain, behavioural and cognitive systems, that mature along different time scales and under the control of both common and independent biological processes. During adolescence, the brain undergoes major remodelling, especially in the PFC—one of the last brain regions to fully mature. This area is involved with high-level functions such as making decisions, controlling impulses, maintaining attention, planning, also playing a role in defining one's personality and helps one understand and respond appropriately to social situations.

ALL THIS ACTIVITY HAS LED TO THE THEORY THAT THE ADOLESCENT BRAIN COULD BE ESPECIALLY VULNERABLE TO INSULTS SUCH AS STRESS OR DRUGS.[19]

Many observational studies have suggested that adolescent cannabis use may be linked to long term harms, including cognitive impairment and increased risk of schizophrenia.[20] However there are several potential confounding variables, such as socioeconomic circumstances or family mental health history - *definitive evidence remains elusive*. In almost every area that researchers have examined, questions remain regarding the precise nature and strength of these associations:

1. What specific harms can individual users expect if they start using in adolescence?
2. Are only certain people susceptible to potential ill effects?
3. Is there a threshold age, or degree of cannabis use that is safe, or safer?
4. Is cannabis related damage reversible over time?

THERE SEEM TO BE LITTLE CONSENSUS AS TO WHETHER CANNABIS DIRECTLY CAUSES LONG-TERM HEALTH HARMS IN PEOPLE, WHETHER IT IS ONE OF SEVERAL RISK FACTORS, OR WHETHER IT SIMPLY CORRELATES WITH OTHER ROOT CAUSES.

Ultimately most researchers stress that cannabis use, especially during the perinatal and postnatal period for pregnant mothers, and during adolescence, is not benign. The public health message should be to encourage teens, pregnant and nursing mothers to abstain from cannabis use.

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WHAT DOES THE EVIDENCE SAY?

To better understand how cannabis affects the brain itself, some researchers have turned to controlled drug experiments that, for ethical and scientific reasons, can only be done in animals. The research is about understanding whether adolescent cannabis / THC use causes outsized neurological harms.

Research shows that THC exposure in adolescent female rats disrupted the maturation of multiple neurotransmitter systems in the PFC. In adulthood PFC neurons were less adept at rapidly adjusting their connection strengths – a key process in learning and memory.[21] Giving rats THC during early and mid-adolescence , but not late adolescence /adulthood, (approximately 16-17 adult years), interfered with the inhibitory neurotransmitter – GABA- in the PFC. As a result, the adult PFC failed to develop certain patterns of electrical activity typical of the mature brain, suggesting delayed brain development. This study showed that THC effects on brain development may be limited to specific windows of vulnerability.[22] Exposing adolescent rats to THC impairs GABA signalling in the PFC when the animals become adults.

THIS DISINHIBITION OF THE PFC ALSO LEADS TO OVERACTIVITY IN DOPAMINE NEURONS IN MIDBRAIN AREAS INVOLVED IN MOTIVATION AND REWARD PROCESSING.[23] SIMILAR FEATURES HAVE BEEN OBSERVED IN PEOPLE WITH SCHIZOPHRENIA.

MEMORY IMPAIRMENT AND THE HIPPOCAMPUS:

Rats exposed to THC in utero, soon after birth, or during adolescence, show notable problems with specific learning/memory tasks later in life. Moreover, cognitive impairment in adult rats was associated with structural and functional changes in the hippocampus from THC exposure during adolescence.[24]

MEMORY IMPAIRMENT FROM CANNABIS USE OCCURS BECAUSE THC ALTERS INFORMATION PROCESSING IN THE HIPPOCAMPUS.

Age related neuronal loss in the hippocampus decreases the ability to learn new information. Chronic THC exposure may hasten this age-related loss of hippocampal neurons.

COGNITION:

Several studies, including two large longitudinal studies, suggest that cannabis use can cause functional impairment in cognitive abilities but that the degree and/or duration of the impairment depends on the age when a person began using and how much and how long he or she used.[14,25]

THE ABILITY TO DRAW DEFINITIVE CONCLUSIONS ABOUT THE LONG-TERM IMPACT OF CANNABIS ON THE HUMAN BRAIN FROM PAST STUDIES IS OFTEN LIMITED BY THE FACT THAT STUDY PARTICIPANTS USE MULTIPLE SUBSTANCES, AND THERE IS OFTEN LIMITED DATA ABOUT THE PARTICIPANTS HEALTH OR MENTAL FUNCTIONING PRIOR TO THE STUDY.

Although animal studies like these have revealed several potential mechanisms by which cannabis might do harm, it is difficult to determine what this means for human teens. Over the next decade the National Institutes of Health is funding the Adolescent Brain Cognitive Development (ABCD) study—a major longitudinal study that will track a large sample of young Americans from late childhood, before first use of drugs, to early adulthood. The study will use neuroimaging and other advanced tools to clarify precisely how and to what extent cannabis and other substances, alone and in combination, affect adolescent brain development.[26]

CANNABIDIOL IN ADHD

Research on CBD oil specifically for ADHD is scarce, and relatively new. Much of what we know stems from cannabis research as a whole and not CBD as an isolated compound. In a randomized controlled trial, to assess cannabinoids in attention-deficit/hyperactivity disorder, a small sample study of thirty people with ADHD received a trial cannabinoid/CBD medication. The participants were evaluated for symptom levels and IQ performance on standardized tests. There was insignificant improvement on cognitive function and symptom reduction, and nominal improvement on impulsivity and hyperactivity, however the research authors stated that their results were inconclusive.[27]

In assessing the Impact of ADHD and Cannabis Use on Executive Functioning in Young Adults, research showed poor cognitive function outcomes for young adults who began using cannabis before the age of sixteen, including young people with an ADHD diagnosis. When evaluated for working memory, verbal memory, decision-making and recall, these young users had poor performance on all points. They made more mistakes when asked to complete questions or tasks.[28]

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CBD: NOT A NATURAL PRODUCT!

There is a critical difference between the CBD that is studied in labs for medical conditions, and CBD products that are sold to consumers for well- being. The trials are focused on the action and benefits of purified CBD compound, not an extract of CBD, which is typically found in commercial products .Contrary to some marketing claims, all CBD oil is not made from industrial hemp plants. Instead it is often extracted from Phyto-cannabinoid rich hemp. This plant is a recently developed variant of the cannabis family and only goes back to the 1990s. This plant retains many of the characteristics of the marijuana plant.[29]

The extraction method is a highly processed one, involving chemical solvents and other refining processes, and the final product has very little resemblance to the plant it started off as. The entire process relies on heavily refining the product to make it suitable for human consumption.

AND THE "PURER" THE PRODUCT, THE GREATER THE AMOUNT OF REFINING IT MUST GO THROUGH- THE LESS NATURAL IT IS.

CBD PRODUCTS ARE UNREGULATED: IT IS DIFFICULT TO KNOW WHAT YOU ARE GETTING!

CBD products are for the most part unregulated and one must rely on the quality assurances of the companies that manufacture and sell them. CBD oil is not supposed to contain any THC. Products on the market can have trace amounts of THC present, making them unsuitable for use by children and teens and by any adult concerned about possible addiction. Some CBD products contain dangerous chemicals or synthetic CBD oil.

MANY PRODUCERS DO NOT TEST THESE PRODUCTS IN LABORATORIES, NOR DO THEY SHARE HOW THEY ARE PRODUCED.

Forensic toxicologists at Virginia Commonwealth University examined nine e-liquids advertised as being 100 percent natural CBD extracts.They found one with dextromethorphan, or DXM, used in over-the counter cough medications and considered addictive when abused; and four with a synthetic cannabinoid, sometimes called Spice, that can cause anxiety, psychosis, tachycardia and death[30]

MISLABELING AND POISONING

A 2017 analysis of cannabidiol content oil, tincture, or liquid vape products purchased online in the US, showed that 69% were mislabeled, with 43% having higher and 26% lower content than stated on the product labels.[31] According to the American Association of Poison Control Centers for the period Sept 2018 – Sept 2019 , 1,090 people had contacted poison control centers about CBD induced illness, 33% are estimated to have received medical attention, and 46 were admitted into a critical care unit.[32]

NATURAL DOES NOT NECESSARILY MEAN IT IS LESS HARMFUL

CBD in any form is a drug! In October 2019, the FDA issued an advisory warning that the effects of CBD during pregnancy or breastfeeding are unknown, indicating that the safety, doses, interactions with other drugs or foods, and side effects of CBD are not clinically defined, and may pose a risk to the mother and infant.[33]

IN NOVEMBER 2019, THE FDA ISSUED CONCERNS ABOUT THE SAFETY OF CANNABIDIOL, STATING THAT CBD USE HAS POTENTIAL TO CAUSE INJURY TO THE LIVER, INTERFERE WITH THE PHARMACODYNAMICS OF DRUGS, PRODUCE DISORDERS, OR AFFECT ALERTNESS AND MOOD.[34]

There are many important aspects about CBD that we just do not know, such as:

- What happens if you take CBD daily for sustained periods of time?
- What level of intake triggers the known risks associated with CBD?
- How do different methods of consumption affect intake e.g., oral consumption, topical, smoking or vaping?
- What is the effect of CBD on the developing brain?
- What are the effects of CBD on the developing fetus or breastfed newborn?
- How does CBD interact with herbs and other plant materials?
- Does CBD cause male reproductive toxicity in humans, as has been reported in studies of animals?

SIDE EFFECT PROFILE OF CBD

Only a few small trials have examined the use of CBD in children and most of the data are derived from the FDA approved cannabidiol drug Epidiolex which has been approved for the treatment of two forms of refractory epilepsy in children (Dravet Syndrome and Lennox- Gastaut Syndrome).

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OTHERS ARE FROM INDIVIDUAL ANECDOTES FROM RESEARCHERS, DOCTORS AND FACEBOOK POLLS OF PARENTS GIVING CBD ENRICHED CANNABIS TO THEIR CHILDREN TO TREAT EPILEPSY. CBD HAS NOT BEEN STUDIED SPECIFICALLY TO TREAT ADHD

Side effects include:

- Changes in alertness, most commonly experienced as somnolence (drowsiness or sleepiness).
- Gastrointestinal distress, most commonly experienced as diarrhea and/or decreased appetite.
- Changes in mood, most commonly experienced as irritability and agitation.
- CBD can cause liver injury. It is metabolized in the liver and intestines by certain cytochrome P450 enzymes and isoenzymes (e.g. CYP3A4, CYP2C19, CYP2D6, CYP1A2).
- CBD can cause drug-drug interactions with many other therapeutic medicines, potentially causing serious side effects.

CBD has a "grapefruit" reaction, and like grapefruit it interferes with the cytochrome P450 enzymes that metabolize certain drugs

WHAT TYPES OF DRUGS SHOULD ONE NOT TAKE WITH CBD?

- Antiarrhythmics
- Antibiotics
- Anesthetics
- Angiotensin II blockers
- Antihistamines
- Antipsychotics
- Antidepressants
- Anti-epileptics
- Use of CBD with alcohol or other CNS depressants – benzodiazepines, increases the risk of sedation and drowsiness.

THE BOTTOM LINE:

The current research on CBD oil and other cannabis products as a possible intervention for ADHD does not show effectiveness for managing symptoms, and shows increased mental and physical health risks. There have not been any studies on the use of CBD oil in children; neither have there been studies on its long-term effects. Without sufficient high-quality evidence in human studies, we cannot pinpoint effective doses, and because CBD is currently mostly available as an unregulated supplement, it's difficult to know exactly what you are getting. So while some people are using it and have shared their results publically, researchers and medical professionals have not found evidence that it is an effective treatment for ADHD.

Prescribers need to consider a risk – benefit analysis before recommending unproven treatments or prescribing unregulated products. The efficacy, safety and quality of a product should take precedence over an individual's freedom to choose an unregulated, unproven product for the management of any medical condition.

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CAN WE UTILIZE **PHARMACOGENOMICS** TESTING TO INDIVIDUALIZE AND **OPTIMIZE PHARMACOTHERAPY** FOR **ADHD?**

Kobus Roux

Pharmacogenetics is the study of genetic variability in medication response. Some examples of pharmacogenetics variations are quite common and have been known to clinicians for many years. Examples include Scoline apnea syndrome, Intermittent porphyries, Neuroleptic malignant syndrome, Tardive dyskinesia, etc.

Allergic reactions to lamotrigine, carbamazepine, and valproate, as well as Stevens Johnson syndrome, may also underline genetic vulnerability.

Pharmacogenomics refers specifically more to the study of variations in genes and gene products, and their relation to medication response.[1] Utilizing pharmacogenomics in optimizing treatment strategies has the ideal to do genetic testing to predict response to medication.

Pharmacogenomics strives to understand and predict individual variability in the pharmacokinetics and pharmacodynamics of drug actions and interactions.

Obvious targets for pharmacogenomic investigations include polymorphisms in the genes coding for metabolizing enzymes (pharmacokinetics), drug transporters (pharmacokinetics), and cell receptors (pharmacodynamics).

The goal is to be able to identify so-called clinically actionable genetic variations, which would predict clinical response for specific individuals (personalized medicine).

AS RECENTLY AS MARCH 2020, THE CIPC AND ISPG HAVE ONLY CONFIRMED ALLELIC VARIATIONS IN FOUR DIFFERENT PHARMACOGENES TO BE CLINICALLY SIGNIFICANT:

Kobus Roux

a. Allelic variations in the **CYP2C19** gene, which leads to endophenotypes of poor metabolizers or ultra-rapid metabolizers.
b. Allelic variations in the **CYP2D6** gene causing endophenotypes of poor metabolizers or ultra-rapid metabolizers.
c. **HLA-B*15:02**
d. **HLA-A*31:01** both causing endophenotypes with higher risk of developing serious adverse events after introducing lamotrigine, carbamazepine, or oxcarbamazapine

In theory, the use of pharmacogenetics to optimize and individualize treatment, is very appealing, but clinical applications remain limited, although magnitudes of research papers are released. It is important to monitor developments in this field. Understanding the following genetic principles could be useful when evaluating the clinical utility of pharmacogenetics testing:

i. To understand the difference between genotype and endophenotype and its relation to clinical phenotypes.

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ii. Pharmacokinetics - the clinical relevance of polymorphic drug metabolizing enzymes.

iii. Pharmacodynamics – allelic variants in the genes coding for the proteins which are targets for drug treatment.

GENOTYPE → ENDOPHENOTYPE → CLINICAL PHENOTYPE:

Only in monogenetic or Mendelian disorders (with high penetrance) does allelic variations translate into clinical phenotypes. One example is Huntington's Chorea. These so-called "proper genetic disorders" are rare diseases, because the genes are under evolutionary pressure to be eliminated from the genetic pool.

For CYP2D6 for instance, there are more than 109 allelic variations / polymorphisms which have been identified to be clinically significant. Most scientists feel that only eleven mutations need to be identified to identify metabolizing endophenotypes.

GeneCHiP or SNP-typing tests mostly search for specific allelic variations.

To identify specific endophenotypes, namely: (i) poor metabolizers, (ii) normal to rapid metabolizers, (iii) ultra-rapid metabolizers, laboratories use complex formulations combining the incidence of specific allelic variations to identify the manifestation of these different endophenotypes.

PATIENTS WHO HAVE THE ENDOPHENOTYPE OF POOR METABOLIZERS, ARE AT GREATER RISK TO DEVELOP SERIOUS ADVERSE EVENTS (CLINICAL PHENOTYPES).

A well-known case study is that of a patient who was a poor metabolizer for codeine, and was given Codis TDS after a tonsillectomy. The patient eventually ended up in ICU with respiratory arrest. Ultra-rapid metabolizers of opioids are more likely to develop addictive behavior (clinical phenotypes).

THE CLINICAL RELEVANCE OF POLYMORPHIC DRUG-METABOLIZING ENZYMES

Drug metabolism in the liver generally occurs in two phases. Phase 1 involves cytochrome P450 enzymes and generally turns a fat-soluble molecule into its active metabolite, which act on cell receptors.

Phase 2 metabolism involves the conjugation pathways, which involves inter alia glucoronidation and acetylation to turn the molecule into inactive particles, which could be excreted, as waste. The allelic polymorphisms UGT2815 and SLC181 is relevant to the rate of elimination of drugs.

Let us explore CYP2C19 and individual variability in drug-drug interactions between methylphenidate and a SSRI, i.e. fluoxetine.

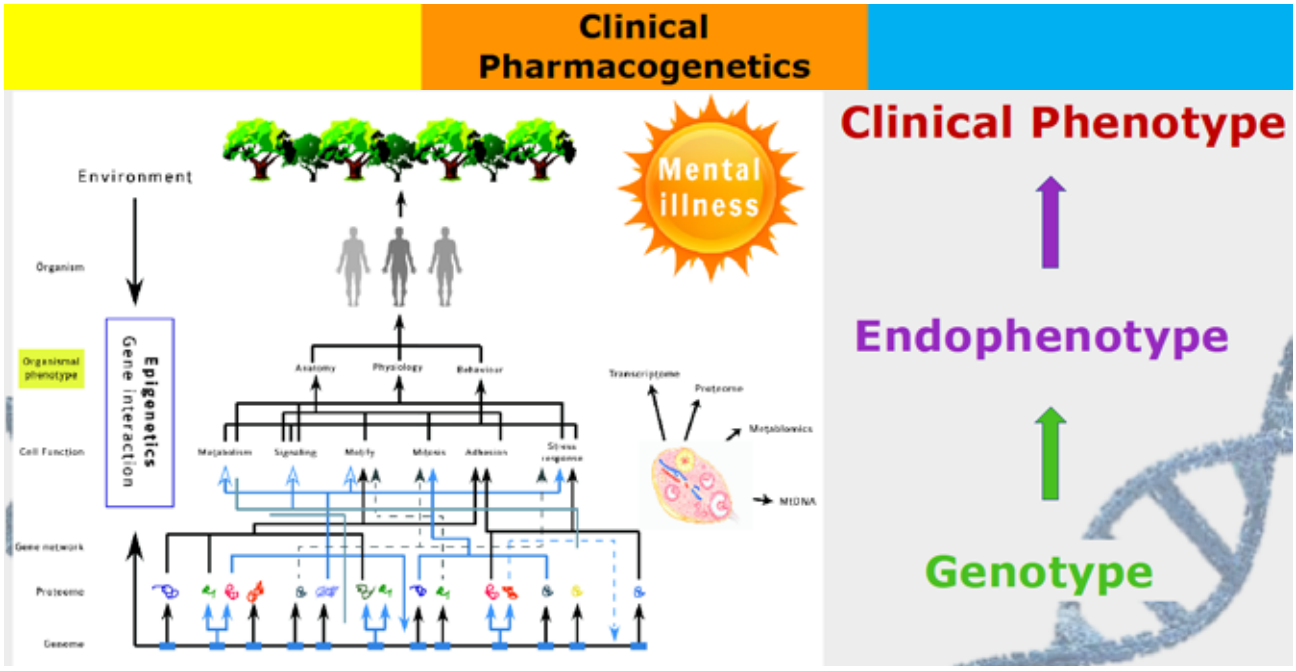

Figure 1: Illustrates the complex relationship between genotype and clinical phenotype

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SSRIs like Fluoxetine as well as methylphenidate are inhibitors of the CYP2C19 enzyme. Many SSRI's like fluoxetine, venlafaxine, and sertraline, are substrates for the enzyme. Although methylphenidate is not a substrate for CYP2C19, the amphetamine Adderall is.

There is a potential drug-drug interaction between Ritalin and fluoxetine at CYP2C19. If a patient is a poor metabolizer, this can lead to accumulation of certain metabolites in the body causing adverse effects, or a limited metabolism of the pro-drug to active compound, and thus poor efficacy.

In a study by Aldrich et al[3], it was shown that youth with anxiety and depression, who were also slower metabolizers at CYP2C19, had more side-effects with SSRI treatment, and were also more likely to discontinue treatment.

PHARMACODYNAMIC CANDIDATE GENES IN ADHD RESEARCH:

Potential candidate genes which are researched in patients with ADHD include: dopamine receptor genes (DRD4, DRD5); the dopamine transporter gene (DAT1); the serotonin transporter (SERT); synaptosomil – associated protein (SNAP-25); COMT; and the adrenergic receptor (ADRA2A).

Regarding the dopamine transporter gene (DAT1 / SL26A3), there are interesting findings regarding a specific allelic variant, namely a 10-repeat (480 base pairs) of variable number tandem repeats, which warrant further exploration.

Methylphenidate and, to some extent, amphetamines blocks the dopamine transporter. Patients with ADHD express increased DAT densities in the striatal regions. Patients with a 10/10 genotype, in one study, was more likely to improve on methylphenidate, than other genotypes.[4]

PHARMACOGENOMICS ANALYSIS OF METHYLPHENIDATE TREATMENT RESPONSE:

Another study, which evaluated transcriptomics and candidate gene protein expression, found that several biological processes were modulated by methylphenidate in Wistor Kyoto rats.[5]

Thus, the effects of methylphenidate are not limited to changes in the main targets, namely dopamine and noradrenergic transporters. The researchers in this study found interactions with other proteins, including AMPA receptors, as well as modulation of signaling of other neurotransmitters, including GABA and Glutamate. Many other pathways involved neuroplasticity, energy metabolism, cell differentiation and circadian rhythms were also affected by continued administration of methylphenidate.

THIS SHOWS THAT PHARMACOGENOMIC STUDIES COULD BE USED TO MONITOR THE SHORT TERM AND LONG-TERM EFFECTS OF SPECIFIC DRUGS.

CONCLUSION:

The clinical utility of pharmacogenomic testing in ADHD, and for that matter in most psychiatric disorders, is still very limited, but the possibilities are endless, and more and more uses are discovered almost on a daily basis.

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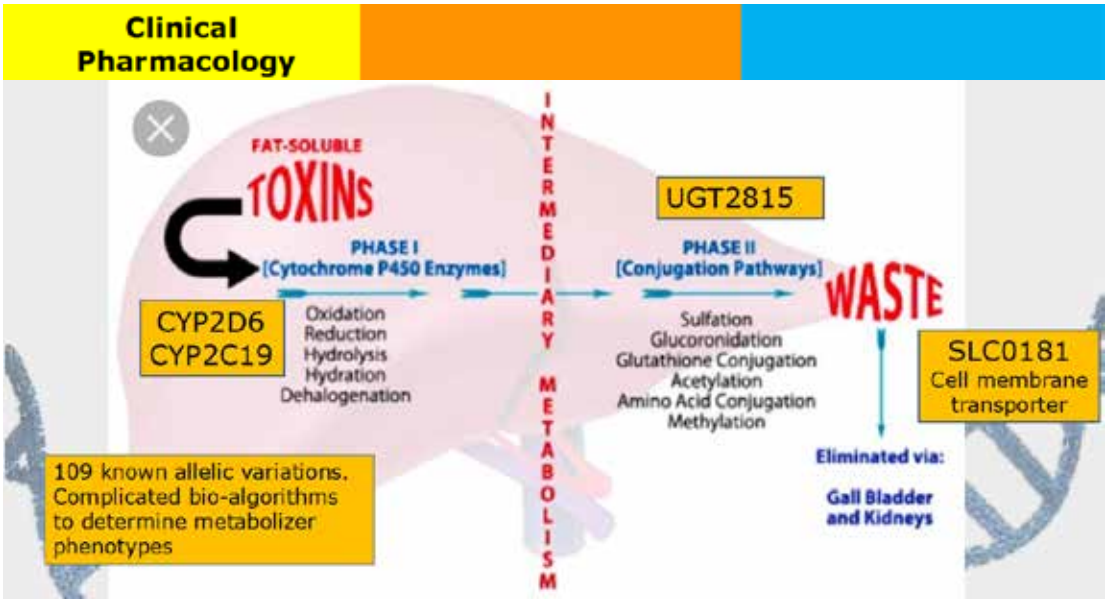
Figure 2: Illustrates the genetics of polymorphic drug metabolizing enzymes in the liver.



1ST SOUTHERN AFRICAN MULTIDISCIPLINARY **ADHD CONGRESS**

THE QUEST FOR CYBER WELLNESS

Rianette Leibowitz

Children need cyber savvy parents and adults to set an example while mentoring them to navigate the digital dilemmas they face and to become responsible digital citizens.

While some of us migrated to cyber space, the younger generations are being born into it. These digital natives need us to guide them through their journey of discovery and identity development.

If we don't build their confidence and teach them how to become thick skinned in both the online and offline worlds they could be more likely to fall victim to threats like grooming and sextortion.

Their reality and expectation of society doesn't put enough emphasis on the importance of age restrictions, understanding the community rules of the platforms they use and how to deal with issues such as cyberbullying, gaming addiction and social media's emotional roller-coaster.

WHILE HELPING CYBERCRIME VICTIMS AND CREATING AWARENESS FOR CYBER SAFETY, IT HAS BECOME EVIDENT THAT THERE IS NO AGE LIMIT, SPECIFIED INDUSTRY OR EVEN PREFERRED DEMOGRAPHIC WHEN CRIMINALS PREPARE FOR ATTACK. ALL THEY NEED TO DO IS TO SEND OUT FRIEND REQUESTS AND WAIT TO SEE WHO WILL TAKE THEIR BAIT.

They target the vulnerable and misinformed. Both adults and children are being caught and getting trapped in a web of manipulation by cybercrime syndicates and criminals.

FORMING A SAFETY NET OF SUPPORT

This is why it is so important and effective when we work together to not only empower families with the relevant information, but also to help them deal with the after-effects of social media and digital challenges.

Rianette Leibowitz

When it comes to cyberbullying, sextortion, grooming, online dating, sexting, hacked profiles, identity theft and sharenting, the consequences could include rejection, isolation and sadly, even self-harm and suicide. Families don't always know how to deal with the situation, and they underestimate the emotional impact these traumatic events have on both the victim and their families.

My hope is that we can take hands to ensure we are ready to support and guide patients and their families through the digital challenges they face.

CYBER WELLNESS

I have been focused on cyber safety for the past six years, however realised that we need to have a wider conversation. Our digital lives have become so intertwined with our physical lives and ordinary actions like banking, watching television and learning are now mostly happening through devices. Without realising it our spiritual, physical, emotional, intellectual, environmental and relational aspects of our lives have taken up space in cyber space.

It is important for us to become more aware and critically think about how we are spending our

1ST SOUTHERN AFRICAN MULTIDISCIPLINARY ADHD CONGRESS

time online, who we are following and how our moods are altered. To re-evaluate the networks we belong to and to let go of people and groups who do not inspire us to make positive change. People are being influenced by hashtag movements and manipulated by algorithms. If parents are challenged by this dilemma, then how do we expect young people to handle it effectively?

BESIDES THE CHALLENGES PRESENTED BY SOCIAL MEDIA AND INSTANT MESSAGING PLATFORMS, I HAVE NOTICED THE STRUGGLE ONLINE GAMERS (AND THEIR FAMILIES) HAVE WITH SCREEN TIME MANAGEMENT, ADDICTION AND HANDLING THEIR EMOTIONS.

With studies done by various parties and attention given to this by World Health Organisation, it is definitely an area of concern. On the other hand, eSports opens exciting new opportunities and career paths, but like with any career and sport it should be done responsibly.

My hope is that people will use their own power of choice and control to:

- Create personal digital boundaries;
- Be strict in terms of screen time management;
- Do regular digital decluttering and
- Make digital detoxing part of their wellness regime.

As online citizens are developing their digital footprints, they need to be reminded that every action they take, every comment they make and every post they share will create a lasting ripple effect. And it becomes part of their legacy, which could impact their careers, relationships and ultimately the exposure they get.

RAISING A SCREEN SAVVY CHILD

My book was published (in English and Afrikaans) with the aim to provide a toolkit that identifies the online risks and ways to manage it as a family. This book is not only for parents, but also for grandparents, au-pairs, uncles, aunts and teachers. It is also a resource for everyone who work with families – from psychologists, doctors and legal experts who need a one-stop-resource to prepare for discussions about digital parenting, cyber safety and cyber wellness. My aim is to spark conversation and to equip the reader. Besides getting a better understanding for the benefit of your patients and their families, it is a valuable resource to recommend for parents. It takes a team effort to ensure the wellbeing of children and to create better environments for them to thrive (and feel safe) in.

As digital citizens, we have a responsibility to look out for one another online, to consider the other people (and younger people) on the platforms we use and to become responsible with our own fingertips - being used to like, tweet and share.

To order books connect at www.rianette.com, Instagram @RianetteL and the other platforms.

Rianette Leibowitz is a Cyber Wellness Author & Thought Leader, Brand South Africa Play Your Part Ambassador and founder of SaveTNet Cyber Safety NPC **Correspondence: author@rianette.com**

1ST SOUTHERN AFRICAN MULTIDISCIPLINARY ADHD CONGRESS

THE MANAGEMENT OF ADHD DURING PREGNANCY

Renata Schoeman

In recent years, an increased awareness, diagnosis, and treatment of ADHD in adulthood caused a rapid rise in the number of women of childbearing age who are being treated for this condition. Young women with ADHD also have a higher incidence of risky sexual behaviour which can lead to unplanned pregnancies (Hosain et al., 2012). Both continuing and stopping drug treatment during pregnancy carries risk, and a judicious approach is called for. Furthermore, pharmacodynamic and pharmacokinetic changes during pregnancy could affect both the efficacy and the concentration of medication. At this stage, amphetamine, lisdexamfetamine, methylphenidate (MPH), atomoxetine (ATX), bupropion, and modafinil are all category C by FDA classification (Bazire, 2012), while "the effects of ADHD medications on the foetus and on the baby while breastfeeding are unknown and require careful weighing of any potential benefits and risks" (Canadian ADHD Practice Guidelines, 4th ed, 2018).

AGAINST THE BACKGROUND OF CONCERNS ABOUT THE USE OF MEDICATION OF ANY KIND DURING PREGNANCY AND BREASTFEEDING, IT IS REMARKABLE THAT THERE IS SO LITTLE INFORMATION AVAILABLE ON THE EFFECTS OF ADHD MEDICATION ON THE FOETUS AND NEWBORN.

Three questions that both clinicians and patients are likely to ask are the following:

- Should ADHD medication be stopped before, during or after pregnancy, or should it be continued throughout?
- Should ADHD medication doses be adjusted during pregnancy or after delivery?
- Should breastfeeding be encouraged or discouraged?

PHARMACOKINETIC AND PHARMACODYNAMIC CONSIDERATIONS

During pregnancy, prolonged gastric emptying may influence the timing and/or speed of action of methylphenidate and dexamphetamine. The increased volume of distribution may also impair the efficacy of medication and dose adjustments during pregnancy are needed. However, post-delivery a rapid rise in blood levels, with risk of toxicity to mother and increased exposure to baby, may occur, which necessitates vigilance and further dose adjustments.

LITERATURE REVIEW: TREATMENT DURING PREGNANCY

In a Danish register-based study (Haervig, Mortensen, Hansen & Strandberg-Larsen, 2014), 1 054 494 registered pregnancies (1999-2010) were included. Four-hundred-and-eighty (0.05%) pregnancies were exposed to ADHD medication (MPH, modafinil, or ATX). Exposed pregnancies were more likely to result in induced abortions on maternal request (odds ratio = 4.70, 95%CI = 3.77-5.85), induced abortions on special indication (odds ratio = 2.99, 95%CI = 1.34-6.67), and miscarriage (odds ratio = 2.07, 95%CI = 1.51-2.84) compared with unexposed pregnancies. However, compared with unexposed, women who used ADHD medication during pregnancy were more often younger, single, of lower educational attainment, received social security benefits, and used other psychopharmacology.

In a Danish population-based cohort study of all pregnancies in Denmark from 1997 to 2008 (Jiang, Zhang, Jiang & Fu, 2019), 186 (0.02%) of 989 932

registered pregnancies were exposed to MPH or ATX, while 275 (0.03%) were diagnosed with ADHD, but untreated. Exposure to MPH or ATX and exposure to untreated ADHD were associated with an almost identical increased risk of spontaneous abortion (aRR 1.55, 95% CI 1.03-2.36 and 1.56, 95% CI 1.11-2.20 respectively). The adjusted relative risk (aRR) of Apgar scores <10 was increased among exposed women (aRR 2.06, 95% CI 1.11-3.82) but not among unexposed women with ADHD (aRR 0.99, 95% CI 0.48-2.05). Untreated ADHD was associated with preterm birth (aRR 1.82; 95% CI, 1.01 - 3.29).

In a prospective, comparative, multicentre observational study performed in participating Teratology Information Services from Israel, Canada, the UK and Germany between 1996 and 2013 (Diav-Citrin, Shechtman, Arnon, et al., 2016), 382 MPH-exposed pregnancies were identified. MPH exposure relative to non-teratogenic exposure lead to more elective terminations of pregnancy (8.1% vs 2.6%), more miscarriages (14.1% vs 7.1%), and more perinatal complications (23.6 vs 13.5%). However, no increased risk for major congenital anomalies or cardiovascular anomalies was detected.

In a Swedish study (Norby, Winbladh & Kallen, 2017), examining perinatal outcomes after treatment with ADHD medication during pregnancy during 2006 to 2014, 1591 (0.2%) infants from 964 734 pregnancies were exposed to treatment. Of these, 1464 were exposed to stimulants (MPH (90%), amphetamine, dexamphetamine, lisdexamphetamine and modafanil), while 165 were exposed to ATX. Exposure during pregnancy increased the risk for admission to a NICU compared with both no use and use before or after pregnancy (aOR 1.5; 95% CI 1.3-1.7; aOR, 1.2; 95% CI 1.1-1.4), was associated with more central nervous system-related disorders (aOR, 1.9; 95% CI 1.1-3.1), and more often moderately preterm birth (aOR, 1.3; 95% CI 1.1-1.6) than nonexposed infants. However, no increased risk for congenital malformations or perinatal death were found. It is important to note that those who have used ADHD meds were younger, more often nulliparous, smokers, obese, more frequently lived without the father of the child, and they also used other medications to a larger degree. Furthermore, in Sweden, 26% of women between 26 and 34 years of age who use MPH were diagnosed with substance use disorders.

Weeks eight to eighteen of pregnancy are crucial for placentation, with concerns being raised about the potential vasoconstrictive properties of ADHD medication. A landmark study exploring potential placental complications associated with stimulant use during pregnancy (Cohen, Hernandez-Diaz, Bateman, et al, 2017) found a 1.6% increase in the risk to develop pre-eclampsia (3.7% vs 5.13%, with NNH = 63) and a 0.18% increase in the risk for preterm birth (1.1% versus 1.28%, with NNH = 556). However, women who used ADHD meds were younger, white, used alcohol, tobacco and other substances, were more likely to have other psychiatric comorbidity and were more likely to use medical and psychotropic drugs – i.e. significant confounding factors were present.

In another multisite, population-based, case-control study of risk factors for more than 30 major structural birth defects (Anderson, Dutton, Broussard, et al, 2018), 31965 cases (live births, stillbirths, and terminations) and 11 724 controls were included. The use of stimulants during early pregnancy (64 cases, 20 controls) increased the risk for gastroschisis even after adjusting for maternal age (cOR: 2.9, 95% CI 1.2;6.9).

HOWEVER, MOST WOMEN ARE UNAWARE OF THEIR PREGNANCY DURING THIS EARLY STAGE AND OTHER RISK FACTORS MAY ALSO HAVE BEEN PRESENT.

Another large cohort study of the Medicaid-insured population in the United States (N = 1 813 894) and, using the Nordic Health registries for 2003-2013 (N= 2 560 069), also examined the risk of congenital malformations associated with intrauterine exposure to stimulants (Huybrechts, Broms, Christensen, et al, 2018). Congenital malformations were detected in 35.0/1000 infants not exposed to stimulants, vs 45.9/1000 infants for MPH and 45.4/1000 for amphetamines. The risk for cardiac malformations were 12.7 (95% CI, 12.6-12.9), 18.8 (95% CI, 13.8-25.6), and 15.4 (95% CI, 12.5-19.0) per 1000 infants, respectively. These findings suggest a small increase in the risk of cardiac malformations associated with intrauterine exposure to methylphenidate but not to amphetamines during the first trimester.

Poulton, Armstrong and Nanan (2018) included 5056 women treated for ADHD with stimulant medication. Of these 3351 (66.3%) used stimulants before but not during the year preceding delivery, 175 (3.5%) before and during pregnancy, and 1530 (30.2%) had no stimulant treatment until after the index pregnancy. Treatment for ADHD at any time was associated with reduced likelihood of spontaneous labour (ORs 0.7), increased risk of caesarean delivery (ORs 1.2, 1.3, 1.3); active neonatal resuscitation (ORs 1.2, 1.7, 1.3.), and neonatal admission >4 h (ORs 1.2, 1.7, 1.2). Treatment before or before and during pregnancy was, in addition, associated with increased risk of pre-eclampsia, preterm birth <37 weeks, and 1-min Apgar <7. However, stimulant prescribing was low during pregnancy (3.5% of women received such

a prescription) and dropped during the 12 months before the due date from an average of 24.7 prescriptions per month in the first 6 months to 4.5 per month in the final 6 months. Therefore, none of these associations can be confidently attributed to stimulant treatment.

Jiang, Zhang, Jang and Fu (2019) performed a systematic review and meta-analysis of eight cohort studies that estimated adverse maternal or neonatal outcomes associated with exposure to ADHD medication during pregnancy. Exposure to ADHD medication was associated with an increased risk of neonatal intensive care unit (NICU) admission compared with no exposure at any time (RR 1.88; 95% CI 1.7-2.08) and compared with women with exposure either before or after pregnancy (RR 1.38; 95% CI 1.23-1.54). Exposure to MPH was marginally associated with an increased risk for cardiac malformation (RR 1.27; 95% CI 0.99-1.63) compared with no exposure.

HOWEVER, THEY CONCLUDED THAT EXPOSURE TO ADHD MEDICATION OUTSIDE OF, OR DURING, PREGNANCY, WAS NOT ASSOCIATED WITH AN INCREASED RISK FOR ADVERSE MATERNAL OR NEONATAL OUTCOMES.

Finally, in a qualitative systematic review of 8 studies (Li, Sujan, Chang, et al, 2020), the authors concluded that the use of ADHD medication during pregnancy do not result in significant adverse consequences for mother or offspring. No convincing evidence for teratogenic effects according to the relative risk of pregnancy-related and offspring outcomes are linked to ADHD medication. However, the data are too limited to make an unequivocal recommendation.

LITERATURE REVIEW: TREATMENT DURING LACTATION

The postnatal period is a stressful and challenging time for women with ADHD. Additional demands are present which requires a great deal of organisation and planning. If treatment was discontinued during pregnancy, women may request it to be reinitiated after delivery. Once again, the risks and benefits need to be carefully considered for each individual patient. Breast feeding is protective: children with ADHD were less likely to be breastfed at three and six months of age than children without ADHD (Mimouni-Bloch et al., 2013).

Little is known of the effects of ADHD medications reaching the child through breastfeeding; however, drugs that are licensed for use in children are in general less risky than those that have not been used in this population. The MPH relative infant dose is only 0.2% of the maternal dose (Collin-Levesque *et al.*, 2018) and therefore appears to be innocuous, particularly if given after the morning feed. However, the relative infant dose of dexamphetamine is 5.7% (Besag, 2014). Little is known about the relative infant dose of atomoxetine and at this stage caution is recommended. Bupropion should be avoided as it accumulates in breastmilk and increases the risk of seizures in the newborn.

Ideally, the prescribed medication should be given in a once-a-day formulation and 1–2 hours before the child's longest period of sleep, to avoid a feed occurring during the peak secretion period. The effects of the drug on the child's development should be monitored and the child's paediatrician should be informed of any changes in medication dosage or formulation.

CONCLUSIONS

It is important to be cognisant of the available information when weighing the risks and benefits of alternative treatment strategies for attention-deficit/hyperactivity disorder in women of reproductive age and during early pregnancy. Balanced, open, and honest discussions with the patient is crucial – and to acknowledge the relative lack of information available. In summary: consider the risk–benefit profile of not treating the mother, consider comorbid conditions, non-pharmacological strategies should be explored, liaison with the obstetrician is important, it is usually advisable to continue the drug prescribed during pregnancy, the teratogenic risk is low, and switching drugs post-partum for the purpose of breastfeeding is usually not sensible.

References available from the author

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IASP REVISES ITS DEFINITION OF PAIN FOR THE FIRST TIME SINCE 1979

The International Association for the Study of Pain (IASP) has revised the definition of pain for the first time since 1979, the result of a years-long process that the association hopes will lead to new ways of assessing pain.

"IASP and the Task Force that wrote the revised definition and notes did so to better convey the nuances and the complexity of pain and hoped that it would lead to improved assessment and management of those with pain," said Srinivasa N. Raja, MD, Chair of the IASP Task Force and Director of Pain Research, Professor of Anesthesiology & Critical Care Medicine, Professor of Neurology, Johns Hopkins University School of Medicine.

"Pain is not merely a sensation, or limited to signals that travel through the nervous system as a result of tissue damage," he said. "With a better understanding of an individual's pain experience, we may be able to, through an interdisciplinary approach, add a variety of therapies to personalise their treatment of pain," he added.

PainSA is the Southern Africa chapter of the IASP for the study of pain. Its mission is to improve all aspects of pain management in the region.

Professor Romy Parker, PainSA President, welcomed the updated definition of pain from IASP. "Pain, and chronic pain in particular, negatively affect significant numbers of South Africans with recent research showing that one in five South Africans of all ages have chronic pain (Kamerman et al, 2020)."

Prof Romy Parker

"South African health care professionals (nurses, doctors, physiotherapists, psychologists and other medical specialists) are faced with the challenge of treating people with pain on a daily basis. Understanding that pain is not just unpleasant, but affects people's ability to be active participants in their life is critical to the effective management of pain."

"This updated definition helps to focus our attention on the need to use a range of treatment techniques (from medicine to exercise to mindfulness and more) to not only reduce pain but to help patients re-engage in their lives," said Prof Parker.

THE REVISED DEFINITION IS 'AN UNPLEASANT SENSORY AND EMOTIONAL EXPERIENCE ASSOCIATED WITH, OR RESEMBLING THAT ASSOCIATED WITH, ACTUAL OR POTENTIAL TISSUE DAMAGE', AND IS EXPANDED UPON BY THE ADDITION OF SIX KEY NOTES AND THE ETYMOLOGY OF THE WORD PAIN FOR FURTHER VALUABLE CONTEXT:

- Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.
- Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons.
- Through their life experiences, individuals learn the concept of pain.
- A person's report of an experience as pain should be respected.
- Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.
- Verbal description is only one of several behaviours to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain.

A central change in the revised definition, compared to the 1979 version, is replacing terminology that relied upon a person's ability to describe the experience to qualify as pain. The old definition read: "An unpleasant sensory and

emotional experience associated with actual or potential tissue damage, or described in terms of such damage".

"This wording was interpreted as excluding infants, elderly people, and others – even animals -- who could not verbally articulate their pain," said Dr. Jeffrey Mogil, Director of the Alan Edwards Center for Research on Pain, McGill University and member of the Task Force.

The six points that comprise the Notes to the revised definition are a key modification. "They emphasise the three intertwined dimensions of the experience of pain- biological, psychological, and social, and the personal learned nature of that experience," said Dr. Milton Cohen, St. Vincent's Clinical School, UNSW Medicine, Sydney, and member of the Task Force.

The notes highlight that pain may have adverse effects on function and social and psychological well-being. One result of that distinction may be that the standard way a person describes pain – using a scale of 0-10 – may be updated to include whether a person's pain interferes with work, maintaining healthy relationships, daily living, and other psychological and social measures, said Dr. Bonnie Stevens, Lawrence S Bloomberg Faculty of Nursing, Faculties of Medicine and Dentistry, University of Toronto, and member of the Task Force.

The 1979 IASP definition of pain has become accepted globally by health care professionals and researchers in the pain field, and has been adopted by several professional, governmental, and nongovernmental organizations, including the World Health Organization, according to a recent article in *Pain*

ALTHOUGH SUBSEQUENT REVISIONS AND UPDATES HAVE BEEN MADE TO THE LIST OF ASSOCIATED PAIN TERMS OVER THE YEARS, THE IASP DEFINITION OF PAIN ITSELF HAS REMAINED UNCHANGED UNTIL NOW. IN RECENT YEARS, LEADERS IN THE FIELD HAVE VOICED THAT ADVANCES IN THE UNDERSTANDING OF PAIN IN ITS BROADEST SENSE WARRANT A FORMAL RE-EVALUATION OF THE DEFINITION.

"We included the etymology of the word pain because it frames our entire reference point; this English word stems from a Greek root meaning penalty or punishment," said Task Force Member Dr. Dan Carr, Program in Public Health and Community Medicine, Department of Anesthesiology and Perioperative Medicine, Tufts University School of Medicine, Boston, MA.

"Other words in daily use by the ancient Greeks emphasized pain's location or the distress it may cause. We would do well to return to thinking about pain as having multiple dimensions, so that we can assess and treat it more holistically."

BACKGROUND

"The revised definition was a true collaborative effort, written by a multi-national, multidisciplinary task force that received input from numerous stakeholders, including persons in pain and their caregivers," said Dr. Raja. Members of the task force were:

- **Chair: Srinivasa Raja**, MD, Department of Anesthesiology and Critical Care Medicine, Johns Hopkins University, School of Medicine, Baltimore, MD, United States
- **Dan Carr,** MD, Program in Public Health and Community Medicine, Department of Anesthesiology and Perioperative Medicine, Tufts University School of Medicine, Boston, MA, United States
- **Milton Cohen,** MD, St Vincent's Clinical School, UNSW Medicine, Sydney, New South Wales, Australia
- **Nanna Finnerup**, MD, Department of Clinical Medicine, Danish Pain Research Center, Aarhus University, Aarhus, Denmark, Department of Neurology, Aarhus University Hospital, Aarhus, Denmark
- **Herta Flor,** PhD, Institute of Cognitive and Clinical Psychology, Central Institute of Mental Health, Medical Faculty Mannheim, Heidelberg University, Mannheim, Germany
- **Stephen Gibson,** PhD, Caulfield Pain Management and Research Centre, University of Melbourne, Melbourne, Australia
- **Francis Keefe**, PhD, Duke Pain Prevention and Treatment Research Program, Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Durham, NC, United States
- **Jeffrey Mogil,** PhD, Departments of Psychology and Anesthesia, McGill University, Montreal, QC, Canada
- **Matthias Ringkamp,** MD, PhD, Department of Neurosurgery, Johns Hopkins University, School of Medicine, Baltimore, MD, United States
- **Kathleen Sluka,** PT, PhD, Department of Physical Therapy and Rehabilitation Science, University of Iowa, Iowa City, IA, United States
- **Xue Jun Song,** MD, PhD, SUSTech Center for Pain Medicine, Southern University of Science and Technology School of Medicine, Shenzhen, Guangdong, China
- **Bonnie Stevens,** RN, PhD, Lawrence S Bloomberg Faculty of Nursing, Faculties of Medicine and Dentistry, University of Toronto, Toronto, ON, Canada
- **Mark D. Sullivan,** MD, PhD, Psychiatry and Behavioral Sciences, University of Washington, Seattle, WA, United States
- **Takahiro Ushida,** MD, PhD, Multidisciplinary Pain Center, Aichi Medical University, Nagakute, Japan

ABOUT IASP

The International Association for the Study of Pain (IASP) works to support research, education, clinical treatment, and better patient outcomes for all pain conditions with the goal of improving pain relief worldwide.

With more than 7,000 members representing 125 countries, 96 national chapters, and 24 Special Interest Groups (SIGs), IASP fosters the exchange of ideas and education to advance the field of pain science. Membership is open to all professionals involved in research, diagnosis, or treatment of pain ■

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THE MALAWI QUICK GUIDE TO MENTAL HEALTH

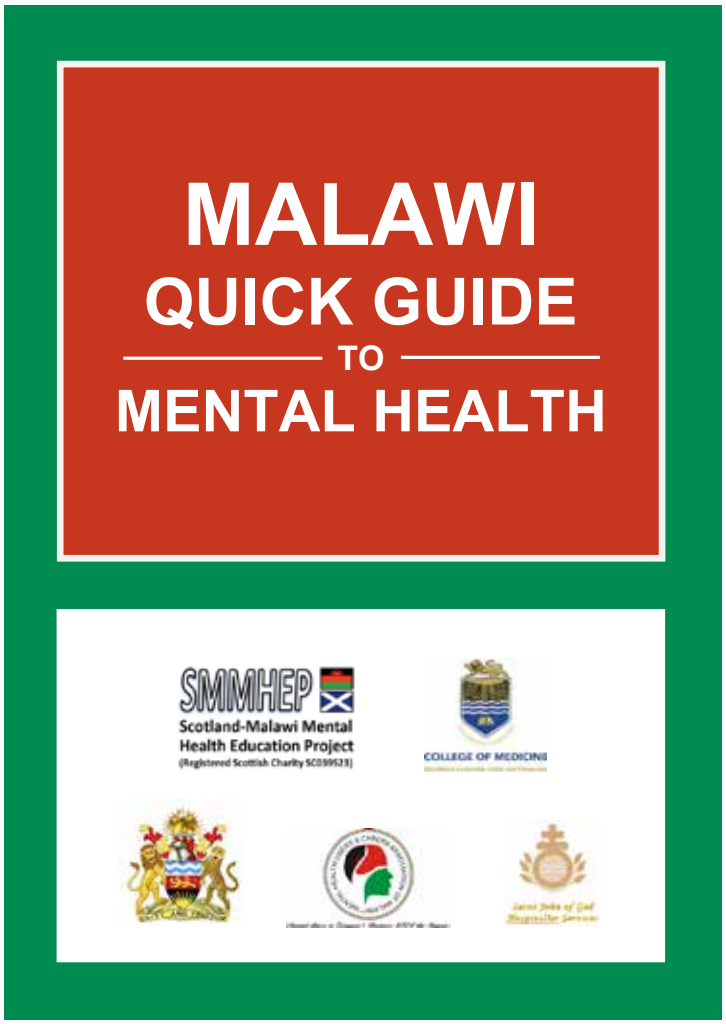
Along with partners in Malawi, SMMHEP is proud to launch 'The Malawi Quick Guide to Mental Health' aimed at healthcare professionals with little to no experience of managing mental illness or distress.

THE COVID-19 PANDEMIC HAS GALVANISED ITS COMPLETION DUE TO THE LIKELIHOOD OF INCREASED RATES OF MENTAL ILLNESS DURING AND AFTER THE PANDEMIC AND THE PREDICTED NEED FOR HEALTHCARE PROFESSIONALS TO CROSS COVER DIFFERENT SPECIALITIES.

SMMHEP is grateful for the very significant contribution of Dr Donncha Mullin who took the lead in writing and editing the Guide and in coordinating a very successful Malawian press launch. Many thanks also go to Owen Mwale, Atupele Milanzi and Rob Stewart for their roles in editing and translating the Guide into Chichewa, organising for it to be printed and then distributed to over 600 health centres and managing the press launch logistics.

Many thanks also to The College of Medicine at the University of Malawi, St John of God Hospitallier Services in Lilongwe and Mental Health Users and Carers Association (MeHUCA)

https://www.smmhep.org.uk/sites/default/files/eMalawi%20Quick%20Guide%20to%20Mental%20Health%20v1%20%281%29.pdf



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VACCINE CANDIDATE UPDATE

Johnson & Johnson Initiates Pivotal Global Phase 3 Clinical Trial of Janssen's COVID-19 Vaccine Candidate with South Africa Set to Participate

Johnson & Johnson has announced the launch of its large-scale, pivotal, multi-country Phase 3 trial (ENSEMBLE) for its COVID-19 vaccine candidate, JNJ-78436735, being developed by its Janssen Pharmaceutical Companies. The initiation of the ENSEMBLE trial follows positive interim results from the Company's Phase 1/2a clinical study, which demonstrated that the safety profile and immunogenicity after a single vaccination were supportive of further development. These results have been posted on the pre-print server medRxiv. The Phase 3 ENSEMBLE study is a randomized, double-blind, placebo-controlled clinical trial designed to evaluate the safety and efficacy of a single vaccine dose versus placebo in up to 60,000 adults 18 years old and older, including significant representation from those that are over age 60. The trial will include those both with and without comorbidities associated with an increased risk for progression to severe COVID-19, and will aim to enroll participants in Argentina, Brazil, Chile, Colombia, Mexico, Peru, South Africa and the United States. In order to evaluate the effectiveness of Janssen's COVID-19 vaccine, countries and clinical trial sites which have a high incidence of COVID-19 and the ability to achieve a rapid initiation will be activated.

FULL PRESS RELEASE:

https://www.jnj.com/johnson-johnson-initiates-pivotal-global-phase-3-clinical-trial-of-janssens-covid-19-vaccine-candidate

COVID-19 RESPONSE

Johnson & Johnson Increases COVID-19 Response in South Africa

The Johnson & Johnson Foundation and the Johnson & Johnson Family of Companies have committed more than R18 million to support frontline health workers and our communities across South Africa – including the provision of protective equipment, additional training, product support and mental health support. Johnson & Johnson's support focused on three key areas:

PRIORITIZE THE SAFETY OF HEALTH WORKERS DURING COVID-19 CARE DELIVERY, INCLUDING THE PROVISION OF PPE, TRAINING AND TECHNICAL SUPPORT:

- **The Public Health Enhancement Fund (PHEF):** Janssen Pharmaceuticals (a Johnson & Johnson Company) is a member of PHEF and through this group, contributed financially towards the purchase of mobile devices for frontline health workers doing vital door-to-door screening and testing work.
- **EMGuidance:** Johnson & Johnson's financial contribution is supporting more than 30000 healthcare professionals across Africa to access comprehensive, up-to-date information/guidelines on COVID-19 through a quick-access, 24/7/365 technology platform designed for low connectivity settings.
- **Mothers2Mothers (m2m):** Johnson & Johnson accelerated funding for long-time partners, Mothers2Mothers, to support the development of WhatsApp-based interactive platform - the Virtual Mentor Mother – where new and existing clients will receive vital COVID-19 and health information and support virtually.

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- **Praekelt.Org:** By supporting existing partners, Praekelt.org, Johnson & Johnson ensured they were able to scale HEALTHALERTS – a WhatsApp-powered interactive chatbot that shares updated information on COVID-19 related topics. In South Africa, this was launched with the National Department of Health in five languages and has over 3 million users. It also launched with the World Health Organisation (WHO) in the official UN languages and had over 10 million users in just three days.

PROVIDE MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT FOR HEALTH WORKERS AT THE FOREFRONT OF FIGHTING THE PANDEMIC:

- **Foundation for Professional Development (FPD):** Johnson & Johnson's support will provide access for more than 2500 healthcare professionals to mental health resilience training through digital platforms as well as training for PTSD.
- **DG Murray Trust:** As partners in the #MaskedHero campaign, Johnson & Johnson are supporting the provision of psychosocial support and supportive care to thousands of community care workers across South Africa.

SUPPORTING NATIONAL RESPONSE PLANS FOR PREPAREDNESS AND HEALTH SYSTEM STRENGTHENING:

- **SOLIDARITY Fund of South Africa:** Johnson & Johnson contributed more than R1 million to support the Solidarity Fund which seeks to strengthen the national health system response and protect frontline health workers.
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THE GREAT BARRINGTON DECLARATION

The Great Barrington Declaration – As infectious disease epidemiologists and public health scientists we have grave concerns about the damaging physical and mental health impacts of the prevailing COVID-19 policies, and recommend an approach we call Focused Protection.

Coming from both the left and right, and around the world, we have devoted our careers to protecting people. Current lockdown policies are producing devastating effects on short and long-term public health. The results (to name a few) include lower childhood vaccination rates, worsening cardiovascular disease outcomes, fewer cancer screenings and deteriorating mental health – leading to greater excess mortality in years to come, with the working class and younger members of society carrying the heaviest burden. Keeping students out of school is a grave injustice.

Keeping these measures in place until a vaccine is available will cause irreparable damage, with the underprivileged disproportionately harmed.

FORTUNATELY, OUR UNDERSTANDING OF THE VIRUS IS GROWING. WE KNOW THAT VULNERABILITY TO DEATH FROM COVID-19 IS MORE THAN A THOUSAND-FOLD HIGHER IN THE OLD AND INFIRM THAN THE YOUNG. INDEED, FOR CHILDREN, COVID-19 IS LESS DANGEROUS THAN MANY OTHER HARMS, INCLUDING INFLUENZA.

As immunity builds in the population, the risk of infection to all – including the vulnerable – falls. We know that all populations will eventually reach herd immunity – i.e. the point at which the rate of new infections is stable – and that this can be assisted by (but is not dependent upon) a vaccine. Our goal should therefore be to minimize mortality and social harm until we reach herd immunity.

The most compassionate approach that balances the risks and benefits of reaching herd immunity, is to allow those who are at minimal risk of death to live their lives normally to build up immunity to the virus through natural infection, while better protecting those who are at highest risk. We call this Focused Protection.

Adopting measures to protect the vulnerable should be the central aim of public health responses to COVID-19. By way of example, nursing homes should use staff with acquired immunity and perform frequent PCR testing of other staff and all visitors. Staff rotation should be minimized. Retired people living at home should have groceries and other essentials delivered to their home. When possible, they should meet family members outside rather than inside. A comprehensive and detailed list of measures, including approaches to multi-generational households, can be implemented, and is well within the scope and capability of public health professionals.

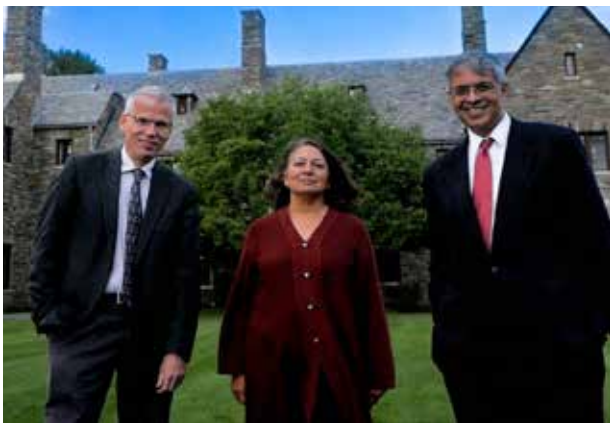
Those who are not vulnerable should immediately be allowed to resume life as normal. Simple hygiene measures, such as hand washing and staying home when sick should be practiced by everyone to reduce the herd immunity threshold. Schools and universities should be open for in-person teaching. Extracurricular activities, such as sports, should be resumed. Young low-risk adults should work normally, rather than from home. Restaurants and other businesses should open. Arts, music, sport and other cultural activities should resume. People who are more at risk may participate if they wish, while society as a whole enjoys the protection conferred upon the vulnerable by those who have built up herd immunity.

On October 4, 2020, this declaration was authored and signed in Great Barrington, United States, by:

Dr. Martin Kulldorff, professor of medicine at Harvard University, a biostatistician, and epidemiologist with expertise in detecting and monitoring infectious disease outbreaks and vaccine safety evaluations.

Dr. Sunetra Gupta, professor at Oxford University, an epidemiologist with expertise in immunology, vaccine development, and mathematical modeling of infectious diseases.

Dr. Jay Bhattacharya, professor at Stanford University Medical School, a physician, epidemiologist, health economist, and public health policy expert focusing on infectious diseases and vulnerable populations.



Left to right: Dr. Martin Kulldorff, Dr. Sunetra Gupta and Dr. Jay Bhattacharya

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FINDING THE BALANCE– REGULATION OF PRIVATE PRACTICE IN SOUTH AFRICA

Sue Tager

This paper is based on a presentation at the 27th WITS Biennial Virtual Surgical Symposium, held on the 3rd - 5th July 2020 https://conference.eventsair.com/QuickEventWebsitePortal/wits-biennial-symposium/wits2020

Any discussion around regulation of doctors in the private sector is bound to create tension between doctors and healthcare establishments. The traditional arms-length relationship between doctors and private healthcare groups does not make these conversations easy.

THE LONG AWAITED HEALTH MARKET INQUIRY (HMI) REPORT FROM THE COMPETITION COMMISSION HAS FOCUSED THE SPOTLIGHT FIRMLY ON THE PRIVATE SECTOR, WHICH IS ACCUSED OF BEING INEFFICIENT, UNSUSTAINABLE AND OVER RESOURCED.

One of the accusations levelled at the private sector in recent years is that doctors are completely unregulated, that utilization is driven by fee - for - service rather than patient need and that costs are uncontained. Patients accessing healthcare in the private sector do so without any knowledge of the outcomes of the procedures they undergo. The lack of reporting on quality and outcomes, and the failure to adhere to treatment guidelines and protocols were amongst the key findings of the HMI, and the proposed remedies for this relate very much to the introduction of regulation into the private practice environment.[1]

REGULATION OF DOCTORS IN SOUTH AFRICA ULTIMATELY RESIDES WITH THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA (HPCSA), WHICH REGULATES REQUIREMENTS FOR TRAINING AND REGISTRATION, AND IS THE BODY THAT PRESIDES OVER MATTERS OF NEGLIGENCE AND COMPETENCE IN CASES WHERE THESE ARE BROUGHT TO THEIR ATTENTION.

However, the measurement/monitoring of clinical performance is something that they do not dabble in. The HPCSA specifically refers to Physician/ Professional Autonomy for doctors as a value that must be used in the best interests of patient care, with special mention made of the fact that the patient's best interests should be served, even if these are in conflict with the personal interests of the clinician. The HPCSA also makes specific reference in its ethical guidelines, to the fact that Healthcare Professionals have a duty to comply with the regulations of the authority that presides over the specific work environment that the Healthcare Worker finds themselves in, be that in the form of an employment contract or other institutional agreement, thus opening the door to the issue

of accountability of doctors, and institutional involvement in measurement of clinical quality and outcomes.

Professional Autonomy as put forward by the World Medical Association in the Declaration of Seoul, and reaffirmed in several other declarations, refers to the fact that it is society that bestows the *privilege* of Physician Autonomy on the Medical Profession, and that along with that privilege goes a *responsibility* on the part of the Physician to self- regulate and provide transparent regulation of the profession.[2] If the Physician fails to do so, that privilege is surely misplaced. The concept of Professional Autonomy should not be misconstrued as a license to act independently without accountability.

PHYSICIAN AUTONOMY EXISTS ONLY TO PROTECT PATIENTS AND ENSURE THAT DECISIONS ARE MADE IN THEIR BEST INTERESTS. PHYSICIAN AUTONOMY IS NOT MEANT TO PROTECT THE INTERESTS OF THE PHYSICIAN.

In an ideal world, clinicians should self – regulate. This should occur at an individual level and at a collective level, with each professional body creating structures for self-regulating clinicians to participate in to ensure the delivery of high quality, evidenced based care to their patients. That regulation should come from each discipline's professional body. In this country, however, few of the professional representative bodies have taken on the role of regulating the profession from a quality and clinical outcomes monitoring point of view, with their involvement being limited to business/tariff negotiations with funders, but with little or no attempt to provide frameworks for regulation of quality of care delivered to patients. This was also highlighted in the HMI report, with one of the recommendations being a split in the academic and business functions of the Practitioner Associations.[1]

Any discussion that involves regulation of doctors within the private sector is met with the response that any such measures will impinge on the doctor's Professional Autonomy, and the conversation often ends there. If we consider that the high value placed on retention of this professional autonomy is aimed solely at protecting patients, surely this value is at odds with reluctance to participate in regulatory interventions that are aimed at improving patient care. Decades of mistrust of Hospital Groups and Funders are one of the features that underlie this resistance.

Discussions around the ethics of Professional Autonomy and the role that this autonomy plays in the clinician's ability to advocate for their patient are tempered by the fact that the medical funding industry in this country has extensively eroded this autonomy in the way it dictates what services and treatments will be funded. While not directly regulating the medical profession, the limits on medical aid funding allocations for patients significantly curtail the clinician's decision making.

Clinicians in private practice also function as independent practitioners, with little collaboration with other clinicians, and efforts to set up mechanisms to monitor quality are limited. It is not possible therefore to rely on clinicians to self –regulate without an over-arching institutional responsibility that creates a platform for individual clinicians to collaborate at an institutional level. Failure to provide this coordinating function makes monitoring of clinical quality and outcomes impossible.

Understanding the reasons for the lack of regulation must surely provide some clues as to what the potential solutions could be.

In an ideal environment, Professional Autonomy should function at an individual level and at a collective level, with each professional grouping setting up its own body to regulate all aspects of the specific profession, regulating who is registered to perform what procedures, and monitoring the delivery thereof.

A MODEL FOR COLLABORATIVE REGULATION

Private practice as we know it today is unsustainable. Value based care is where the affordable delivery of care into the future lies. This is not achievable without collaboration and regulation. Regulation, however, does not necessarily imply loss of Physician Autonomy. The two should not be thought of as mutually exclusive.

Is this simply a matter of rights and obligations? Doctors have the right to be self –regulate, but also have the obligation to submit themselves to the processes necessary to ensure that patients seeking treatment can be assured of getting the appropriate treatment, in the appropriate setting at the appropriate time, and that we have a system that is sustainable, and can provide value-based care to the maximum number of people possible.

IN ORDER TO GUARANTEE ITS PLACE IN THE HEALTHCARE LANDSCAPE OF THE FUTURE IN THIS COUNTRY, THE PRIVATE SECTOR NEEDS TO ESTABLISH A ROBUST SYSTEM OF REGULATION, THAT RESPECTS PHYSICIAN AUTONOMY AS WELL AS THE RIGHT OF THE PATIENT TO HOLD THE CLINICIAN AND THE HEALTHCARE FACILITY ACCOUNTABLE.

At Wits Donald Gordon Medical Centre (WDGMC), a Private, Academic Hospital in Johannesburg, we have some experience in how regulation can be introduced in a manner that doesn't impinge on the Professional Autonomy of the doctors involved, and

relies on voluntary self-regulation interfacing with institutional resources to facilitate the regulation process.

The above has been introduced in the context of a doctor employment model, as well as in departments where the doctors are all in independent private practices.

The private sector environment has a number of complex relationships that make collaboration between doctors and administrators difficult. These are outlined in the Figure 1. At WDGMC, we have structures in place that are aimed at overcoming the traditional arms-length, tenant-landlord relationship that characterize the doctor-hospital relationship in many private hospitals.

OTHER RELATIONSHIPS THAT FURTHER COMPLICATE THE REGULATION OF PERFORMANCE AND QUALITY IN THE PRIVATE SECTOR ENVIRONMENT NEED TO BE CIRCUMVENTED IN ORDER TO SUCCESSFULLY IMPLEMENT PROCESSES THAT MONITOR QUALITY.

Some of these are outlined in Figure 2 below.

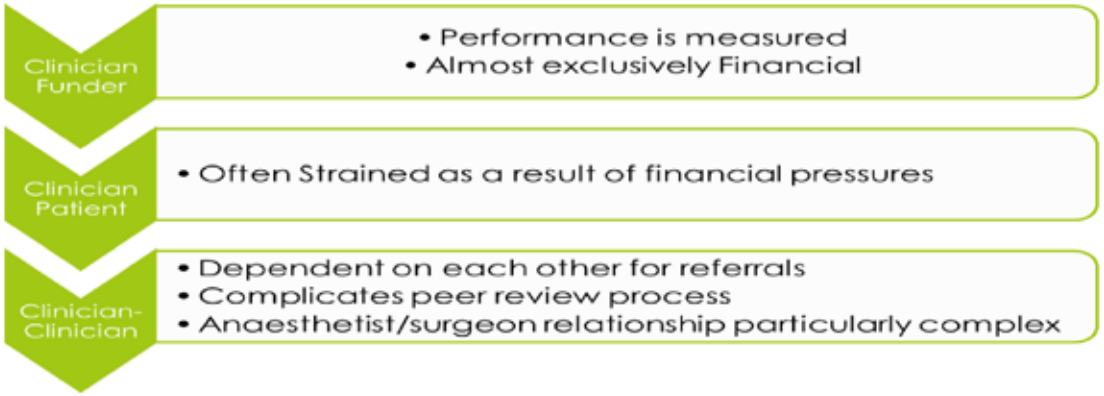
The implementation of regulation of Clinicians/ Clinician Perfomance in a private hospital environment requires fundamental foundations to be in place.

The WDGMC experience has been that the following processes are essential to the succesful implementation of regulation within the private sector.

1) A robust credentialing system needs to be in place when doctors apply for admission rights. This needs to build in a renewal process with the understanding that renewal is not automatic, and will be based on review of professional behaviour and clinical performance by a group of clinicians tasked with the oversight function.
2) A strong doctor committee that is representative of all disciplines needs to be in place, with endorsement from the doctor body and the administrators to implement and maintain the credentialing process over time.
3) The credentialing process should be enhanced as the clinical practice environmet matures and changes
4) The credentialing period must align with other agreements that are in place with the administrator, such as lease agreements, etc, so that conflict does not arise should the credentialing period not be renewed.
5) The factors that will determine successful recredentialing must be defined at the start of the process, but can be modified over time.
6) The basic processes that need to be in place in addition to the above are listed below:
    - Willingness of the doctors involved to record, review and share their data.
    - Data collection resources and systems
    - Development of and adherence to protocols
    - Measurement of compliance with these protocols
    - A culture of reporting of complications
    - Review of morbidity and mortality per discipline (Clinician driven, Institution enabled)

Figure 1. Relationship between Clinicians and Private Hospitals

Figure 2. Doctor/ Funder/Referring doctor relationships



- Multi-disciplinary Team Panels in all relevant disciplines (eg. Surgical Oncology, Renal and Liver Transplant)
- Anti-Microbial Stewardship Committee and team with implementation and monitoring of surgical prophylaxis and antimicrobial prescribing patterns
- Clinical Review Committee which oversees departments where regulatory processes have not been implemented, and provides an oversight function for those departments where self-regulation is entrenched.

WHAT CAN WE TAKE FROM THE WDGMC EXPERIENCE THAT COULD BE GENERALISED?

1) The regulatory measures that we have implemented at WDGMC have not been implemented in all units simultaneously. As with any change process, one needs to rely on the early adopters to lead the way, and this has certainly been our experience.
2) There is a plethora of information now provided by funders and hospital groups alike in in terms of measurements such as like Cost per event (CPE), readmission rates, and Defined Daily Dosage (DDDs) to measure antimicrobial utilisation. These are drawn from billing data, and if viewed in isolation, are of little value in terms of measuring quality, as they are not discipline specific. They can however be used as a basis for engaging with funders on how they can be refined to become more relevant. Failure to engage with funders on these issues can lead to decisions being made regarding a doctor's supposed efficiency or inefficiency which are fundamentally flawed. Good clinical outcomes data is required to have meaningful engagements with funders.
3) Measurement of clinical quality and outcomes actually enhances Physician Autonomy, in that Physicians who are able to provide their patients with their outcomes data are in a far better position to offer their patients the information required for truly informed consent.

REGULATION OF PRIVATE PRACTICE – THE WAY FORWARD

Regulation of private practice is essential. It should be physican –led, and institution enabled. It should work collaboratively in the interests of being able to provide patients with access to the information which they require to make informed decisions about the treatment they are offered, and it should provide them with accountability should that treatment fail them. This can be achieved by linking self-regulation at an indidivual and collective level to institution-specific regulations that ensure the provision of quality, affordable care to patients.

Professional autonomy will allow clinicians to represent themselves in forming collaborations with private hospital administrators which could result in finding affordable ways to continue to provide quality care. (Value-Based Contracting)

THE REALIZATION THAT THE FUTURE SURVIVAL OF PRIVATE MEDICINE IS DEPENDENT ON CLOSER COLLABORATION BETWEEN DOCTORS AND PRIVATE HOSPITAL ADMINISTRATORS MAY BE THE DRIVE FOR CHANGE THAT IS REQUIRED.

The biggest threat to Professional Autonomy is for doctors to leave the void that currently exists in this space within this country. A great deal of "measurement of performance" takes place within the private sector, driven by funders, who already have a big impact dictating to doctors what they can and can't do. In the absence of measuring clinical quality, this can be disastrous for patients.

Physicians have the right to autonomy. Patients have the right to accountability from the medical profession, and regulation is what is required to give them that.

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UNCERTAINTY AND, THE CERTAINTY OF THE THREAD

Claudia Campbell

Today I'm a patient, not somebody with a retrospective opinion or much 'perspective'. I write, typing on my phone with the light setting at its lowest. I'm in my bed, unable to see much through the pulsating agony in my head, working through nausea to keep anything down, attempting to not worry that my hands and feet are numb and that the world spins at the slightest movement. I need my husband to hold me up as I walk, closed eyed, the few metres from my bed to the bathroom - history has taught us too many times that if he does not do this I may very well black out. This scenario is not unfamiliar but it's not less unpleasant either.

This edition there are no creative metaphors, or deep reflections in my writing - just an explanation of being me, right now - ill.

At the beginning of 2008 a blow to my head in a car smash seemed to be the trigger for the manifestation of major PTSD and a range of NOS diagnoses. Over the following 9 years I would be hospitalised about 20 times. Admissions ranging from surgical to psychiatric to neurological to cardiac and general medical. Psychiatric symptoms, neurological symptoms, an agonising injury and searing migraines were treated - trial and error was the process. My doctors and I discovered drugs aren't really much of an option. It's a scary process as a patient and doctor to map the intolerance and allergic reactions to over 70 drugs. It's a long, gruelling process. We know now that triptans, opioids, SSRIs, SNIRs and so the list goes on cause a mess - add a dose of cortisone and suicide becomes a real option in my mind. Not ideal on any level.

However, three years ago we found a brave surgery (on the part of the surgeon and anesthetist), massive doses of an anticonvulsant and a quarterly neurological intervention hit the sweet spot. Talking therapy with my psychiatrist and psychologist chipped away at the terror of PTSD, gradually the flashbacks, panic attacks and dissociative episodes melted away. I could breathe. After 6 months I found myself describing my life as 'normal'. For the first time in over a decade my days became defined by 'normal' activities and not medical interventions. It was a private, but massive triumph.

Claudia Campbell

So, a few months back, when an unexpected event triggered the resurfacing of some PTSD symptoms it felt a bit disheartening. I also felt a bit silly for almost believing my PTSD existed in a past tense as opposed to a dormant state. Another, subsequent event would trigger a full-blown resurgence of PTSD symptoms, many worse than ever before. The intensity of depersonalised dissociation and crushing headaches was startling, but more soul-destroying was the concurrent, persistent thoughts of self-harm. These episodes are not, in any way, welcomed by my doctors or myself. Compounding the situation is that my last round of neurological treatment seems to have been largely ineffective, so those symptoms, including blindingly stubborn migraines have resurfaced with a vengeance.

IN MANY WAYS IT FEELS AS IF I HAVE BEEN VIOLENTLY YANKED BACKED INTO 2013, AND IT'S TOUGH TO NOT DEFINE MYSELF WITH TERMS LIKE RELAPSE AND REGRESSION.

Because, when I really reason it out (with patient help from my psychiatrist and psychologist), I am not in 2013, I'm in 2020. I don't have to fear those 70 drugs, because I'm not going to be asked to

take them. Killing myself is not something I'll want because there will be no cortisone. However, perhaps most importantly we know that through everything there has always existed a thread of reason in my mind - hard to find sometimes, but always there. Strengthening that thread, being reminded I can trust it, and believing it's made of some pretty strong stuff is truly the best treatment right now. My medical team know there is little hope in a blister pack for me, they also know the importance of that thread.

PERHAPS ONE OF THE HARDEST THINGS ABOUT FEELING THE WAY I DO NOW AND THE WAY I DID YEARS AGO IS THE POSSIBLE SENSE OF ISOLATION. I HAVE A HUSBAND, FRIENDS AND FAMILY WHO REALLY DO CARE AND LOVE ME. THEY SUPPORT ME IN THE BEST WAYS THEY KNOW HOW. BUT, NOBODY REALLY UNDERSTANDS THE EXPERIENCE OF MY BODY AND MIND,

and the difficulty that feeling better is an uncertain goal. Although well meant, it's immensely frustrating and discouraging to hear the words "don't worry, it'll be fine". The truth is my doctors and I don't know if "fine" is on its way soon. One of the most pervasive experiences of this feeling of total isolation happened many years ago when I was admitted to hospital for an array of symptoms and bizarre reactions to medications. Knowing what to do next wasn't clear to anyone. I'm not a person of many tears, but that day, as my psychiatrist sat across from my bed, hot tears of isolation poured down my cheeks as I looked at my hands twisting the hospital printed sheet. I remember saying something like "I have no person who 'gets' that we just don't know.... ". What he did next was one of the most powerful 'treatment interventions' I have experienced. He quietly asked me to look at him, when I did he said, in earnest "Claudia, I'll be your person". In those few words my isolation had been 'treated'. That treatment nudged me to find and hold onto my thread of reason, the thread of reason helped us eventually navigate a way through that particular episode of illness. It wasn't a clever new medicine, a detailed treatment plan, or a wealth of theoretical knowledge that effectively treated me. It was the moment my doctor didn't focus entirely on my symptoms and realised reaching a hand into that pit of isolation was far more important than a prescription.

I've never forgotten the power of that moment and I've realised that sometimes the most important thing to do is stretch my hand up and ask for help from those who have trudged this journey of mental and physical illness with me. Today I know that there is no simple way to give me a reprieve from the agony of a migraine nor the possible terror of dissociation. However, today I also know that I have a psychiatrist who realised sometimes it's more important to 'just be my person'. That without isolation both of us can hold onto that thread inside me, and that somehow we can use it to eventually 'pull me out'.

There is also a new facet to my current treatment, and one I find important. Existing in a pandemic has changed our lives in fundamental ways. I think for many of us screen fatigue is a real thing. Conference calls have been hugely important in navigating some continuity of interaction, but they continue to be a less natural way of being human. In my opinion though, there is one exception - mental health care. Over teleconsults I have found myself verbally detailing aspects of my trauma I have never been able to articulate before. The intense resurgence of my PTSD has had me experiencing elements of my trauma that have remained in total silence until now. I found myself puzzled and surprised as to what facilitated the unshackling of my tongue. This is an excerpt of an email to my psychologist last week:

"I have been giving quite a lot of thought as to what has allowed me to venture towards telling this part of my story. Surely after so many years of psychological and psychiatric treatment, with a team of talented professionals I should have been able to do this sooner? I realised that location is proving to be an important thing. Hospitals and consulting rooms, although technically providing safe spaces, are really quite impersonal and unwelcoming. Entering a reception, seeing lines of consent forms, sitting in a waiting room with other patients/clients, hearing the janitor's trolly clanking down the passage is not a nurturing experience. Although the interpersonal dynamic could be really good, the setting definitely affected how effectively I could drop my guard. Additionally, the reality is that it's not safe to drive home if I'm a dissociated, panic struck wreck. Now though, it's totally different. I love being in our home. Our couch is a really safe place. My dogs are an emotional super-structure. My bed is a dozen steps away from the couch. My husband is in the same building. My piano is just downstairs. Being surrounded by things and an atmosphere that has been created to make us feel safe, by us, is a massive thing in this process".

I don't have a clear and succinct conclusion to this piece of writing. I'm not sure what the next while will look like for me. I am sure that not feeling isolated in my experience feeds something that looks a little like courage. And I'm certain of a thread in me which, although requires patience, has never let me down. So maybe that's it, firstly 'stand' next to your patient so they are not isolated and before prescribing a blister pack, find their thread.

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

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DEPARTMENTS OF PSYCHIATRY

UNIVERSITY OF THE WITWATERSRAND

GRADUANDS

MMeds July 2020

- Dr Fiona Maynard
- Dr Mpho Bridget Tsikoane
- Dr Maria Lerato Mokwatsi

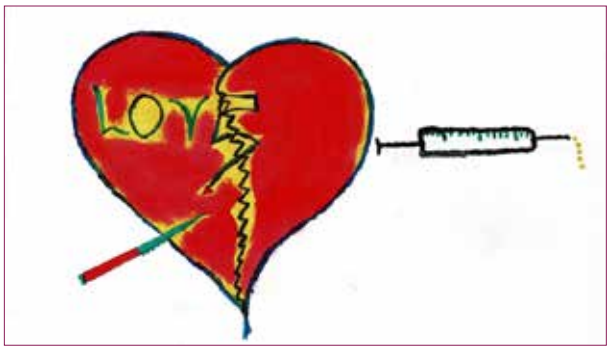
COLLABORATIONS

- **UCLA (USA)**
  Prof. Subramaney, mentor on Tirisano, Phodiso project
- **Melbourne University (Australia)**
  Study on mania to commence shortly

LUNDBECK ART PROJECT FOR MENTAL HEALTH AWARENESS MONTH.

Lundbeck SA kindly sponsored canvasses and paints to MHCUs at Sterkfontein hospital, in lieu of Mental Health awareness month. Artworks by the patients, together with an expression of what it means to them to have a mental illness will be displayed at the hospital.

Road to health



Healing heart

Bird in a cage

These, and other works, with artist content can be found at:
https://za.progress.im/en/content/art-mental-health-wellness

BOOK LAUNCH - INFANTICIDE AND FILICIDE: FOUNDATIONS IN MATERNAL MENTAL HEALTH FORENSICS

DANIE HOFFMAN

On 6th October 2020 the book entitled, "Infanticide and filicide: foundations in maternal mental health" was launched by the International Marce society conference site. Ugash Subramaney and Danie Hoffman, who had contributed a chapter based on their work at the female forensic unit at Sterkfontein hospital were on the panel at the launch, together with esteemed researchers in the field such as Dr Phillip Resnick.

The editors Gina Wong and George Parnham started with an introduction and description of the impetus of the book.

This was followed by forefathers in the field. Combining one hundred years of experience and wisdom in the area, criminal lawyer George Parnham, J.D. and psychiatrist Dr. Phillip Resnick discussed overall strategies for success in defending women who take the lives of their children as a result of maternal mental illness. Both had been involved with the famous Andrea Yates case in Texas in 2002

Next, Dr. Susan Feingold and Barry Lewis, J.D. discussed the need for compassionate and rational laws pertaining to perinatal mental illness and criminal laws in the United States.

Dr. Razali then discussed the innovative research conducted in Malaysia involving national data, interviews with incarcerated women convicted of maternal filicide, and interviews with professionals working with women at risk for committing filicide.

Dr. Barnes followed by sharing her experience of evaluating countless young women incarcerated for crimes against their children that occurred when they were in the throes of postpartum psychotic (PPP) illness.

Lastly Prof. Subramaney (Psychiatrist) and Dr. Hoffman (Psychologist) shared a clinical case of a mother in Johannesburg, South Africa who stabbed her son while in a floridly psychotic state. The authors shared how the circumstances unfolded and how the case was managed from a legal, psychiatric, and socio-cultural perspective. Although this tragic story was a grievous error of the mental health system, as the mother fell through the cracks of medical care, it is also a story of success from a legal perspective that honours the psychiatric findings. The family relations unit at Sterkfontein hospital was also highlighted in the management of female state patients

Criminal law in SA, as well as our very progressive mental health care act allows for a more human rights approach towards women that commit filicide due to mental illness. This is in strong contrast to the Western world, where a much more punitive stance is taken and women might be jailed (or in some states in the USA the death penalty is called for) with little hope of rehabilitation within the context of their families.

Since 1987, Postpartum Support International's (PSI) mission has been to increase awareness and to support public and professional communities to address the mental health needs of women and families during pregnancy and postpartum. As a leading resource centre for maternal filicide, these authors outline the early stages of the advocacy movement for women who committed infanticide and filicide. Addressing the dire need for continued education, training, and advocacy in the field of maternal mental illness and criminal justice, they underscore the work of the PSI Legal and Advocacy Committee and their resources and mobilization in this area ■

WORLD PSYCHIATRIC ASSOCIATION – HONORARY MEMBERSHIP

PROFESSOR CHRISTOPHER SZABO

Dear Christopher

It is my pleasure to inform you that, with the endorsement of the Executive Committee, I will be recommending to the WPA General Assembly taking place virtually on 16 October that you receive the award of **WPA Honorary Member.** This is to recognise your excellent service to the World Psychiatric Association.

On behalf of the WPA, your peers and colleagues, I wish to thank you for your commitment and contribution to psychiatry and mental health and offer my advance congratulations on the award.
With best wishes and regards

Yours sincerely
Helen

Professor Helen Herrman AO
President, World Psychiatric Association ■

UNIVERSITY OF CAPE TOWN

CONGRATULATIONS

THE FOLLOWING FOUR STAFF MEMBERS ARE CONGRATULATED ON HAVING RECEIVED *AD HOM PROMOTION:*

Zulfa Abrahams is a member of the Division of Public Mental Health, where she leads ASSET, a large and important multi-country health strengthening project. She has smoothly made the transition from undertaking research on nutrition to working in mental health. She has been promoted to **Senior Lecturer.**

Jackie Hoare is Head of our Consultation-Liaison Division. This Division was absolutely key clinically during COVID-19, has pioneered new curricula, and has brought in NIH grants to tackle the key issue of adolescent HIV. Jackie is recognized internationally for her work in this area (and, indeed, has just been made a Fellow of the Royal College of Psychiatrists). She has been promoted to **Professor.**

Katherine Sorsdahl is Head of our Division of Public Mental Health. This Division is recognized globally for its work in a range of areas, including establishing curricula for African scholars, interventions using community health workers, and advocacy for mental health. Katt has led multiple projects within the Division, including mentorship of many postgraduate students. She has been promoted to **Professor.**

Henk Temmingh is Head of our Research Committee. He has spearheaded clinical work on dual diagnosis, has contributed important research in this area, and is widely recognized for his contributions at Valkenberg Hospital, where he has mentored multiple registrars on their M Med projects, and where he has played a key role in a number of innovative projects. Henk has been promoted to **Associate Professor.**

AWARD

Qhama Cossie, Head of our Division of Adult General Psychiatry, is congratulated on winning the **Brain Abel Smith Prize** for Best Health Policy Dissertation at the London School of Economics ■

WORLD MENTAL HEALTH DAY 2020 WEBINAR

The Division of Public Mental Health and the South African Depression and Anxiety Support Group hosted a webinar in honour of World Mental Heath Day on Oct 9, 2020. **Prof Crick Lund** of the Division addressed the question: *"What Mental Healthcare in South Africa should look like."* He specifically talked to his colleagues' research on "Investment in Mental Healthcare" ■

"CONVERSATIONS WITH THE DEAN"

The Department of Psychiatry and Mental Health engaged with the Dean of the Faculty of Health Sciences, Assoc Professor **Lionel Green-Thompson,** on transformation matters, amongst others, on 13 October 2020. The Dean, who would often talk of "listening with compassion, walking with humility and acting with justice", has shown commitment to engaging with clinical services (e.g. Covid-related changes); with education; with social responsivity; and with transformation. The new Deanery had in addition shown particular interest in mental health, and we look forwards to working with them in this area. ■

MENTAL HEALTH MONTH: CONFERENCE

The Division of Intellectual Disability hosted an online conference on 6 October 2020, in celebration of Mental Health month, with the following theme: "Legal and Ethical Concerns regarding People with Intellectual Disability and the Law."

The keynote address, namely "Intellectual Disability in Forensic Mental Health", was delivered by Prof **Anthony Pillay,** while the following topics were addressed by the respective speakers below:

- Professor **Sean Kaliski** - "Forensic Mental Health Services and Intellectual Disability: An uncomfortable fit"
- Dr **Mo Nagdee** – "Offending Behaviour and Intellectual Disability: A review of criminogenic theories and evidence"
- Dr **Evah Mulutsi** – "The Legal and Ethical Concerns regarding People with Mental and Intellectual Disability and the Law"
- Justice **VC Saldanha** and Dr **Peter Smith** – "Achieving Justice for People living with Intellectual Disability in the Clinical Services"
- Ms **Sarah Ntaka** – "Access to Justice for Persons with Intellectual Disability" ■

WEBINAR: THE SOUTH AFRICA HIV ADDICTION TECHNOLOGY TRANSFER CENTRE (ATTC): JOURNEY, IMPACT AND LESSONS

Dr **Goodman Sibeko**, Head of the Division of Addiction Psychiatry and Co-Director of the South Africa HIV Addiction Technology Transfer Centre, presented a webinar on 17 September 2020, outlining the journey of setting up the South Africa HIV ATTC at its inception in 2017, detailing the impact and successes, and exploring lessons learned in 3 years of funding. He closed by looking at what comes next for this ATTC, as it transforms into the ITTC (International Training & Technology Centre) under a new funder ■

Dr Goodman Sibeko, MB ChB, PhD

LIVE WEBINAR: "WHITE PRIVILEGE: A CRITICAL DIALOGUE ON RACISM AND INEQUALITY IN A TIME OF COVID-19"

In the current COVID-19 context, structural racism and inequality have been amplified both globally and locally. The above live webinar on 'White Privilege' which was scheduled for 30 July 2020, thus took place at a pivotal moment, where these issues manifest in particularly direct ways in South Africa.

More than ever, we need collectively to engage, show up and do our part in seeking racial justice in our communities. The webinar format was constituted as a dialogue with Dr **Robin di Angelo**, Dr **Mandisa Haarhoff** (University of Cape Town) and Dr **Wilhelm Verwoerd** (Stellenbosch University), while the discussion was moderated by **Stanley Henkeman** from the Institute for Justice and Reconciliation.

COVID-19 has affected many students at UCT and we recognised that providing holistic support for our students is important for their academic success and wellbeing. To this end, this webinar was a public event, serving also as a fundraiser for the most vulnerable students ■

VIRTUAL SEMINAR: THE AFRICAN COLLEGE OF NEUROPSYCHOPHARMACOLOGY (AFCNP)

The African College of Neuropsychopharmacology (AFCNP) hosted a virtual seminar on 28 July 2020. The four speakers were:

David Baldwin, Professor of Psychiatry and Head of the Mental Health Group in the Clinical and Experimental Sciences Academic Unit of the Faculty of Medicine at the University of Southampton in the UK. He is an Honorary Professor in the University of Cape Town in South Africa and Visiting Professor at Shandong Mental Health Centre in Jinan, China.

Oye Gureje (MBBS, MSc, PhD, DSc, FWACP, FRCPsych) is Professor of Psychiatry and Director, WHO Collaborating Centre for Research in Mental Health, Neurosciences and Substance Abuse, Department of Psychiatry, University of Ibadan and Professor Extraordinary, Department of Psychiatry, Stellenbosch University, South Africa.

Nastassja Koen completed her medical and doctoral degrees at the University of Cape Town, South Africa; before undertaking a postdoctoral fellowship in the Department of Psychiatry and Mental Health. Currently a Senior Lecturer in the Department, she is particularly interested in genomic, transcriptomic and epigenomic biological pathways underlying the transgenerational effects of trauma- and stressor-related disorders in the South African setting.

Jon E. Grant is a Professor of Psychiatry & Behavioral Neuroscience at the University of Chicago where he directs a clinic and research lab on addictive, compulsive and impulsive disorders ■

MANDELA DAY: 18 JULY 2020

Students in the Faculty of Health Sciences responded in a rather unique way to Mandela Day, by submitting 67+ heart-warming messages to serve as encouragement! ■

CAN PSYCHOMETRIC ASSESSMENT RESULTS BE USED AS A SELECTION CRITERION DURING RETRENCHMENTS?

Mpumelelo Nxumalo, Joani van Vuuren, Shane Johnson

In a judgment* delivered earlier this year, the Labour Court considered the question of whether psychometric assessment results can be used as a selection criterion during a retrenchment process. The Labour Court found that psychometric tests can be used as assessment criteria for *filling vacant positions* during a retrenchment process.

FACTS

At the time of his dismissal, Mr Wayne Pratten (the employee) was employed by Afrizun (the employer) as its Deputy Tables Manager at the employer's Sibaya branch. During February 2014, the employer commenced with a retrenchment process under section 189 and 189A of the Labour Relations Act 66 of 1995 (LRA). The employer engaged employees on the retrenchment process through various meetings, presentations and letters. Affected employees were later advised of the proposed selection criteria to be adopted by the employer as follows -

> *"4.1. Employees employed in positions which would become redundant as a result of the restructure, would be informed of the new positions for which they qualified to apply, and would be invited to apply for appointment to such positions;*
>
> *4.2. Employees then employed in certain job categories would be selected* ***on the basis of psychometric testing****..."*

The employee was one of the employees affected by the restructuring process and he was required to apply for a new position. During the consultation process, the employee was provided with information on the new restructured positions and the minimum criteria for each position. The employee could apply for certain categories of positions. The employee applied for the positions for which he qualified to apply. The employee was required to complete various psychometric tests.

ALTHOUGH THE EMPLOYEE COMPLIED WITH THE MINIMUM REQUIREMENTS OF THE POSITIONS, HE WAS NOT OFFERED ANY OF THE POSITIONS DUE TO THE RESULTS OF HIS PSYCHOMETRIC ASSESSMENTS.

During the period between November and December 2014, the employer and employee engaged in correspondence where the employee raised certain concerns regarding his unsuccessful application. The employee particularly raised a concern relating to the role the results of his psychometric tests played in him failing to secure a position. The employer subsequently offered the employee similar positions at different branches. The employee declined the offers as his wife was employed at the Sibaya branch and accepting any of the positions would adversely affect his family location.

The employee was ultimately retrenched. The employee only challenged the substantive fairness of his dismissal at the Labour Court.

The question before the Labour Court was whether the employer's failure to appoint the employee

* Pratten v Afrizun KZN (Pty) Ltd (D439/15) [2020] ZALCD 9 (17 April 2020)

to either of the positions, due to the results of his psychometric assessments, was fair and reasonable.

Based on the evidence, the Labour Court found that –

- The psychometric tests were correctly administered and scored
- The rankings of the candidates pursuant to testing were not questionable
- The tests were valid indicators of certain personality profiles
- The employee did not rank high enough to be appointed to either of the two positions
- The personal circumstances of the employee were never considered

The Labour Court also found that the dismissal of the employee was to give effect to a requirement based on the employer's economic and structural needs. The employer in this matter elected to do away with a number of existing positions and create new positions within its existing organisational structure. Where an employer has created new positions in its organisational structure, the employer will generally prefer to fill those positions with candidates who are able to fulfil the functions attached to the new positions. Where there are more eligible candidates than available positions, it will be necessary to rank the candidates after a reliable process of assessment and then to choose the most suited candidates for the available positions.

In a previous judgment** of the Labour Appeal Court, it was held that the use of psychometric testing should not be used as a method to select employees for retrenchment. Such tests should be used only as a tool in ranking candidates for vacant positions from most suitable to least suitable for the roles.

THE REASONING BEHIND THE LABOUR COURT'S DECISION WAS SIMILAR TO THAT OF THE LABOUR APPEAL COURT IN SAB WHERE IT WAS CONFIRMED THAT THE FACT THAT AN EMPLOYEE, WHO IS DISLOCATED BY VIRTUE OF THEIR POSITION BECOMING REDUNDANT AS A RESULT OF A RESTRUCTURING EXERCISE, APPLIES FOR A POSITION AND IS UNSUCCESSFUL AND THEREFORE REMAINS AT RISK FOR DISMISSAL IF OTHER OPPORTUNITIES DO NOT EXIST, DOES NOT CONVERT THE CRITERIA APPLIED TO FILL VACANT POSITIONS INTO SELECTION CRITERIA FOR DISMISSAL.

** South African Breweries v Louw (2018) 39 ILJ 189 (LAC).

It is important to note the difference between assessment criteria used to fill vacant positions and selection criteria in the context of a retrenchment. Psychometric tests can, therefore, be used as assessment criteria for filling vacant positions during a retrenchment process provided that the test is properly administered using the correct criteria. The tests must also be consistently applied

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DEPRESSED EMPLOYEE'S DISMISSAL IS NOT AUTOMATICALLY UNFAIR

Mpumelelo Nxumalo, Shane Johnson, Kgololego Pooe,

Depression is an important issue, with about 264 million people suffering from depression according to The World Health Organisation. A recent Labour Appeal Court (LAC) decision* deals with depression as a ground for dismissal highlighting three key reminders for employers: (i) employers have a duty to consider employees' mental health; (ii) employers should exercise caution when considering disciplinary action against employees with mental health issues; and (iii) employers should be careful when determining whether an employee's conduct amounts to misconduct, ensuring that there is a shown causal link between the conduct and mental illness.

FACTS

Mr X (the employee) was employed at the Legal Aid Board (the employer) from 2007 to 2014. The employee was employed as a paralegal. For the most part, and particularly in the first few years of his employment, the employee was a high performing individual in the workplace.

During 2010, the employee was diagnosed with depression. He received several medical certificates confirming his diagnosis. The employee disclosed this to his employer.

The employee was absent from work on several occasions. The employee failed to excuse himself for most of these absences. Eventually, the employer charged the employee with four counts of misconduct and disciplinary action was instituted against the employee.

At the disciplinary hearing, the employee did not dispute the substance of the charges.

HOWEVER, HIS DEFENCE WAS THAT HE SUFFERED FROM DEPRESSION WHICH CAUSED HIM TO ACT OUT OF CHARACTER. THE CHAIRPERSON OF THE DISCIPLINARY HEARING REJECTED THIS DEFENCE AND THE EMPLOYEE WAS FOUND GUILTY OF THE FOUR CHARGES OF MISCONDUCT. THE EMPLOYEE WAS SUBSEQUENTLY DISMISSED.

The employee referred the dispute to the Labour Court claiming that his dismissal was automatically unfair.

* Legal Aid South Africa v Jansen (CA3/2019) [2020] ZALAC 37 (21 July 2020)

LABOUR COURT FOUND DISMISSAL TO BE AUTOMATICALLY UNFAIR

The Labour Court held that at all relevant times, the employer was aware that the employee was suffering from depression and that the employer failed to consider his mental state at the time of misconduct. Therefore, the true reason for the dismissal was the employee's mental illness and not the alleged misconduct. The Labour Court found that dismissal of the employee was automatically unfair in terms of section 187(1)(f) of the Labour Relations Act 66 of 1995 as amended (LRA) and that the employee had been unfairly discriminated against on the ground of suffering from depression, in terms of section 6 of the Employment Equity Act 55 of 1998 as amended.

LAC OVERTURNED LABOUR COURT'S DECISION

On appeal to the LAC, the employer's main contention was that the employee was dismissed for misconduct and not depression. The employer also argued that the employee failed to establish a causal link between his depression and the misconduct that led to his dismissal.

THE LAC STATED THAT THE KEY QUESTION TO BE ANSWERED, WHERE AN EMPLOYEE CONTENDS THAT HIS ACTIONS WERE CAUSED BY DEPRESSION, IS WHETHER THE DOMINANT OR PRIMATE REASON FOR HIS DISMISSAL WAS HIS MISCONDUCT OR HIS DEPRESSION.

The LAC commented that depression must be looked at as a form of ill health. A depressed employee may be dismissed for incapacity in terms of items 10 and 11 of the LRA's Code of Good Practice: Dismissal. Alternatively, depression may play a role in an employee's misconduct so much so that an *"employee may not be liable for misconduct on account of severe depression impacting on his state of mind (cognitive ability) and his will (conative ability) to the extent that he is unable to appreciate the wrongfulness of his conduct and/or is unable to conduct himself in accordance with an appreciation of wrongfulness"*. The employee bears the evidentiary burden to provide the factual basis of this defence.

The LAC found that the evidence showed that the employee did suffer from depression. However, the employee failed to present compelling evidence to show that he was dismissed for being depressed. Due to the nature of the employee's misconduct, the employer therefore had a legitimate reason for instituting disciplinary proceedings against him.

The LAC further found that while it might have been the case that but for his depression, the employee may not have committed some of the misconduct, he failed to present evidence to show that the cause of his dismissal was his depression. The reason for the employee's dismissal in this matter was his misconduct and not his depression.

THE DECISION OF THE LABOUR COURT THAT THE EMPLOYEE'S DISMISSAL WAS AUTOMATICALLY UNFAIR AND AMOUNTED TO UNFAIR DISCRIMINATION WAS THEREFORE SET ASIDE.

Although the LAC overturned the Labour Court's decision, the LAC nevertheless noted the following - *"Depression, sadly, is a prevalent illness in the current environment. Employers have a duty to deal with it sympathetically and should investigate it fully and consider reasonable accommodation and alternatives short of dismissal."*

This case is an important reminder to employers on two fronts -

- EMPLOYERS HAVE A DUTY TO CONSIDER THEIR EMPLOYEES' MENTAL HEALTH
- EMPLOYERS SHOULD EXERCISE CAUTION WHEN CONSIDERING DISCIPLINARY ACTION AGAINST EMPLOYEES WITH MENTAL HEALTH ISSUES

Employers should be careful when determining whether an employee's conduct amounts to misconduct or whether there is a causal link between the conduct and mental illness. This will also assist an employer in its decision on the appropriate course of action ■

From Weber Wentzel, Left to right: Mpumelelo Nxumalo, Kgololego Pooe and Shane Johnson

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TIME TO PUT PSYCHEDELICS BACK INTO PSYCHIATRY?

Christer Allgulander

PRESENTER

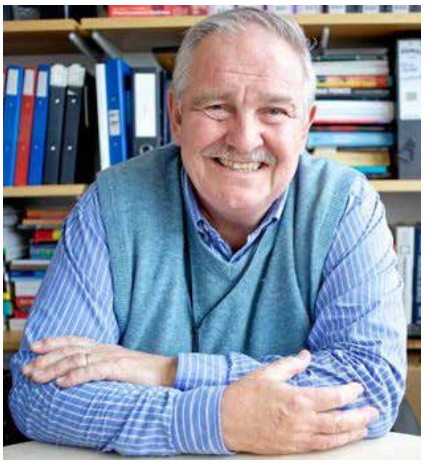
David Nutt, DM, FRCP, FRCPsych, FMedSci
d.nutt@imperial.ac.uk / profdavidnutt@twitter.com

In this Zoom presentation from 2nd October 2020 at Uppsala University in Sweden, David Nutt at the Imperical College in London captures the history and the current research status of psychedelics.

He is currently studying the effects of psilocybin in depression, coming across interesting aspects of spirituality. David Nutt is perhaps the most influential psychiatrist in Europe and this talk is truly educational and inspirational.

LECTURE LINK:

https://media.medfarm.uu.se/play/video/12751



David Nutt

WORLD FEDERATION ADHD

8th World Congress on ADHD

From Child to Adult Disorder

6 – 9 May 2021

PCC Prague Congress Center | Prague, Czech Republic

www.adhd-congress.org

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S5 Dopaquel
QUETIAPINE FUMARATE

HARMONY
IN MENTAL HEALTH

The SOUTH AFRICAN **No.1**

ANTIPSYCHOTIC OF CHOICE![1]

Dr. Reddy's

THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

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Dr. Reddy's
NEUROPSYCHIATRY
GOOD HEALTH CAN'T WAIT

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

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. 204 Rivonia Road, Block B, Morningside, Sandton. 2057. www.drreddys.co.za. ZA/01/2020-22/Dopaquel/003

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

WEBINAR SERIES

HOW COVID-19 AFFECTS YOUR PATIENT WITH BIPOLAR DISORDER

DATE PRESENTED: **3RD SEPTEMBER 2020**
SPEAKER: **DR. JP ROUX**

Dr J.P. Roux is a psychiatrist in private practice in Benoni, Life Glynnview Hospital. He is also a consultant psychiatrist at SANCA Horizon Alcohol and Drug Rehab Centre. He obtained MMed(Psych) at U.P. in 1999 and Fc(Psych) CMSA in 2000. Completed MPharm Med at U.P. in 2012, and MPhil in the Philosophy and Ethics of Psychiatry at U.P. in 2017. Special fields of interest in adult psychiatry are substance abuse disorder, psychopharmacology and molecular psychology. He is the convener for SIG for Cellular and Molecular Psychiatry at SASOP.

Dr. Roux partakes in the workshop on Pharmacogenomics and Nutrigenomics. Dr. Roux will present a few case examples, showing the benefits of knowing a patient's pharmacogenetics profile. It is mostly beneficial in predicting drug-drug interaction and to predict possible harmful adverse effects.

CHRONIC PAIN PATIENTS - HANGING BY A THREAD DURING COVID-19

DATE PRESENTED: **10TH SEPTEMBER 2020**
SPEAKER: **DR. SJ MEYER**

Dr Meyer has been working as a psychiatrist in private practice for the last 14 years. He has a passion for understanding processes that lead to illness, and a keen interest in the mind body interface.

As such,management of deliriums,anxiety disorders and the management of chronic pain are some of his favourite topics. He was an undergraduate at University of Pretoria, worked as a GP in Pietersburg for 4 years, and then did his MMed at UOFS.

He is a member of PAINSA board, and has presented at various local congresses on these topics. His passion is conveying knowledge within the medical fraternity, filling in the gaps about the mind body interface, and the wonderful world of the brain, helping with the destigmatisation of brain illnesses among doctors.

He is also the MD of Bloempsych, the company that developed Optima Psychiatric Hospital, an 80 bed facility in Bloemfontein, and is currently involved in the development of a dedicated pain unit in the Western Cape.

TO ACCESS WEBINARS

You will need to register at: www.medepro.co.za to access the site.The webinars are available on the menu. Alternatively to just view, you can go to http://medepro.co.za/webinars/

WEBINAR SERIES

TOPIC: COVID-19 AND THE ELDERLY

DATE PRESENTED: **22ND SEPTEMBER 2020**
SPEAKER: **DR. F. POTOCNIK**

After obtaining his medical degree at the University of the Witwatersrand in 1975, Felix went to Natal for five years where he obtained his Diploma in Midwifery in 1978.

Having completed stints in four of the "big five" medical specialities he migrated to the Western Cape, where he obtained his psychiatric qualification at the University of Cape Town in 1984. He started his career heading their Psychogeriatric Unit and continued in this position when he came across to the University of Stellenbosch in 1994. He is the former head of the Psychogeriatric Unit of Tygerberg and Stikland Hospitals and represents Old Age Psychiatry for the Provincial Government of the Western Cape and the South African Society of Psychiatrists.

Research interests include: Clinical Trials in Alzheimer's disease and related dementias, zinc, vitamins A and D and burden of disease, Chronic Fatigue Syndrome and Equine nutrition. He also runs a private practice in Durbanville, Cape Town.

A POSTER FOR YOU AND YOUR PATIENTS ON CARING **FOR A REUSABLE MASK**

Dear Healthcare Practitioner,

Protecting your health and the health of those around you is critical for youto carry out the essential work that you do.

With this in mind we are providing a poster on how to care for a reusable cloth mask. This poster details safe handling of the mask, not touching one's face, and the best way to clean, dry and store cloth masks.

For your convenience, this poster can be downloaded from Dr. Reddy's MEDePRO website to display in your work environment. https://www.medepro.co.za/

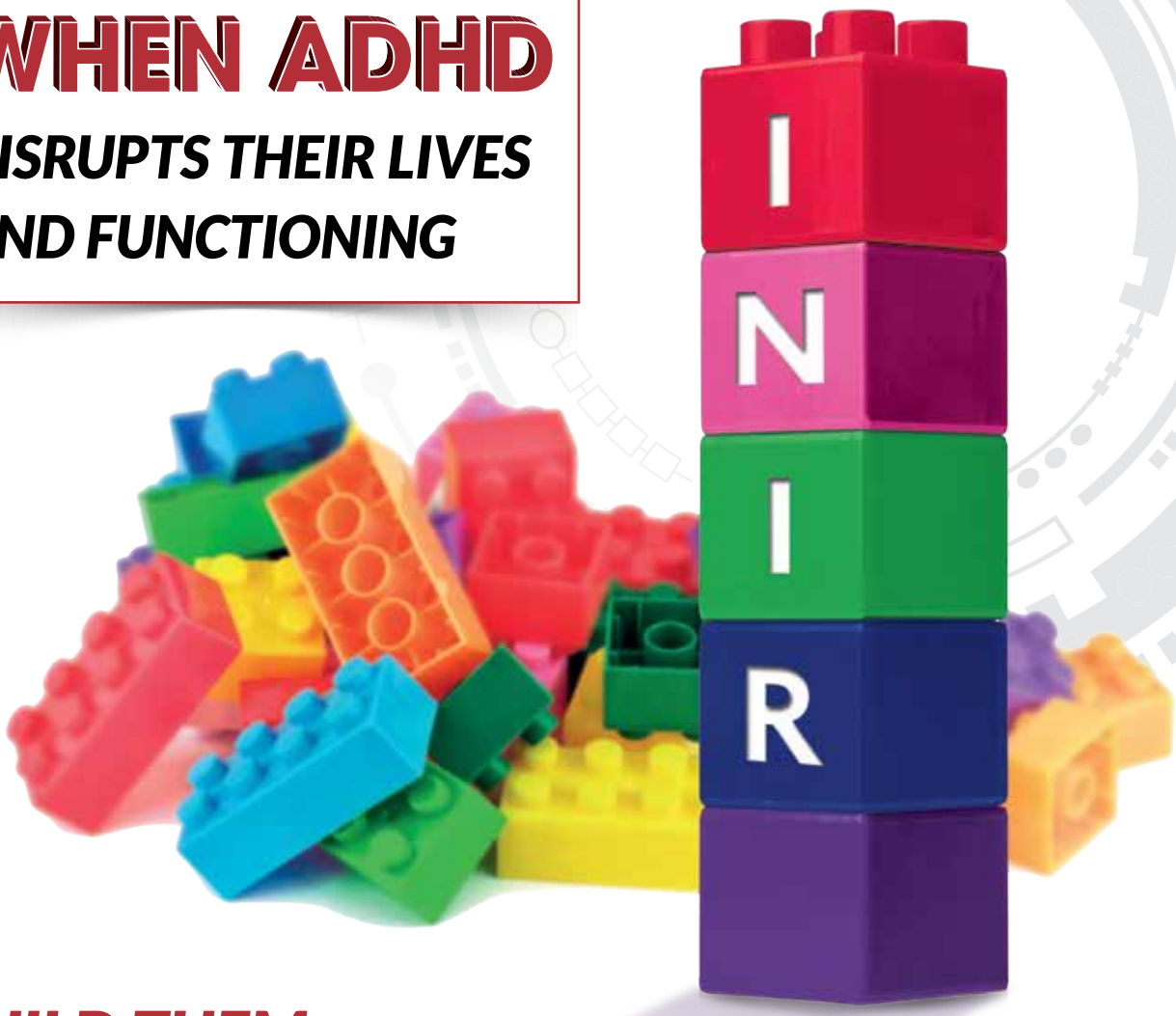
Thank you for all you are doing in helping your community through this pandemic. Stay safe, stay sane – and see you on the other side,

Yours, in the best interests of safety,

Dr Reddy's

WHEN ADHD

DISRUPTS THEIR LIVES AND FUNCTIONING



BUILD THEM UP AGAIN WITH

S5 **INIR**
atomoxetine

10 18 25 40 60

Restoring order to their lives[1,2,3]

Dr.Reddy's

References: 1. De Bruyckere K, Bushe C, Bartel C, Berggren L, Kan C, Dittmann R. Relationships Between Functional Outcomes and Symptomatic Improvement in Atomoxetine-Treated Adult Patients with Attention-Deficit/Hyperactivity Disorder: Post Hoc Analysis of an Integrated Database. *CNS Drugs* 2016; **30**:541–558. **2.** Young JL, Sarkis E, Qiao M, Wietecha L. Once-Daily Treatment With Atomoxetine in Adults With Attention-Deficit/Hyperactivity Disorder: A 24-Week, Randomized, Double-Blind, Placebo-Controlled Trial. *Clin Neuropharm* 2011; **34**:51–60. **3.** Lenzi F, Cortese S, Harris J, Masi G. Pharmacotherapy of emotional dysregulation in adults with ADHD: A systematic review and meta-analysis. *Neurosci Biobehav Rev* 2018; **84**:359–367.

Yelate
DULOXETINE HCl

HARMONY IN MENTAL HEALTH[1]

EARN CPD POINTS

Item-based analysis of the effects of duloxetine in depression: a patient-level post hoc study[2]

Dear Doctor,

Welcome to the next CPD with significant insights into depression and discussion about the sum score of the 17-item Hamilton Depression Rating Scale (HDRS-17-sum).

Item-based analyses of duloxetine trials revealed this drug to exert a robust reduction in depressed mood and other core symptoms of depression that, for several of these, was significant after 1 week of treatment.

The effect of duloxetine was not restricted to those with high HDRS-17-sum at baseline and not secondary to side effects.

Please use this MEDePRO link to access the trial and the CPD questions.

MEDePRO
www.medepro.co.za

Yours in education,

Dr. Reddy's

STRONGER TOGETHER

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Reference: 1. Galderisi S, Heinz A, Kastrup M et al. Toward a new definition of mental health. *World Psychiatry*, 2015;14(2):231-233. 2. Lisinski A, Hieronymus F, Naslund J, *et al. Neuropsychopharmacology*. 2020; 45:553-560. https://doi.org/10.1038/s41386-019-0523-4

S5 Yelate 30/60. Each capsule contains duloxetine hydrochloride equivalent to duloxetine 30/60 mg. Reg No's 44/1.2/0114;0115. Dr. Reddy's Laboratories (Pty) Ltd. Reg no. 2002/014163/07. Block B, 204 Rivonia Road, Morningside, Sandton. 2057. www.drreddys.co.za. ZA/05/2020-22/CORP/009

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

Dr. Reddy's
NEUROPSYCHIATRY
GOOD HEALTH CAN'T WAIT

S5 Yelate
DULOXETINE HCl

HARMONY
IN MENTAL HEALTH

STRONGER TOGETHER

DUAL ACTION & CONTROL FOR DEPRESSION & DPNP*[1]

Dr. Reddy's

THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

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GOOD HEALTH CAN'T WAIT

* Depression, as defined by DSM-IV Criteria; DPNP = Diabetic peripheral neuropathic pain

Reference: 1. Yelate 30/60 package insert. Dr. Reddy's Laboratories (Pty) Ltd. December 2012

S5 Yelate 30/60. Each capsule contains duloxetine hydrochloride equivalent to duloxetine 30/60 mg. Reg No's 44/1.2/0114;0115. Dr. Reddy's Laboratories (Pty) Ltd. Reg no. 2002/014163/07. 204 Rivonia Road, Block B, Morningside, Sandton. 2057. www.drreddys.co.za. ZA/01/2020-22/Yel/001

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

ALZHEIMER'S: UNDERSTAND THE 10 WARNING SIGNS AND SYMPTOMS OF DEMENTIA

VICTORIA SOROCZYNSKI on behalf of LIVEWELL

Alzheimer's Disease (AD) is the most common form of dementia, Livewell aims to encourage understanding, reduce stigma, and raise awareness around this common, yet devastating disease.

1 September 2020, Johannesburg, South Africa -- Memory loss that disrupts daily life may be a symptom of dementia, a brain disease that causes a slow decline in memory, thinking and reasoning skills. There are 10 warning signs and symptoms – every individual may experience one or more of these signs to a different degree. If you notice any of them, please see your general practitioner who can advise you on next steps.

1. MEMORY LOSS THAT DISRUPTS DAILY LIFE

ONE OF THE MOST COMMON SIGNS OF DEMENTIA, ESPECIALLY IN THE EARLY STAGE, IS FORGETTING RECENTLY LEARNED INFORMATION.

Others include forgetting important dates or events, asking for the same information over and over, and increasingly needing to rely on aides (e.g., reminder notes or electronic devices) or family members for things they used to handle on their own.

What's a typical age-related change? Sometimes forgetting names or appointments, but remembering them later.

2. CHALLENGES IN PLANNING OR SOLVING PROBLEMS

Some people may experience changes in their ability to develop and follow a plan or work with numbers. They may have trouble following a familiar recipe or keeping track of monthly bills. They may have difficulty concentrating and take much longer to do things than they did before.

What's a typical age-related change? Making occasional errors when balancing a check book.

3. DIFFICULTY COMPLETING FAMILIAR TASKS AT HOME, AT WORK OR AT LEISURE

People with dementia often find it hard to complete daily tasks. Sometimes they may have trouble driving to a familiar location, managing a budget at work or remembering the rules of a favourite game.

WHAT'S A TYPICAL AGE-RELATED CHANGE? OCCASIONALLY NEEDING HELP TO USE THE SETTINGS ON A MICROWAVE OR TO RECORD A TELEVISION SHOW.

THE 10 WARNING SIGNS AND SYMPTOMS OF DEMENTIA

4. CONFUSION WITH TIME OR PLACE

People with dementia can lose track of dates, seasons and the passage of time. They may have trouble understanding something if it is not happening immediately. Sometimes they may forget where they are or how they got there.

What's a typical age-related change? Getting confused about the day of the week but figuring it out later.

5. TROUBLE UNDERSTANDING VISUAL IMAGES AND SPATIAL RELATIONSHIPS

For some people, having vision problems is a sign of dementia. They may have difficulty reading, judging distance, and determining colour or contrast, which may cause problems with driving.

What's a typical age-related change? Vision changes related to cataracts.

6. NEW PROBLEMS WITH WORDS IN SPEAKING OR WRITING

People with dementia may have trouble following or joining a conversation.

THEY MAY STOP IN THE MIDDLE OF A CONVERSATION AND HAVE NO IDEA HOW TO CONTINUE OR THEY MAY REPEAT THEMSELVES. THEY MAY STRUGGLE WITH VOCABULARY, HAVE PROBLEMS FINDING THE RIGHT WORD OR CALL THINGS BY THE WRONG NAME (E.G., CALLING A "WATCH" A "HAND CLOCK.")

What's a typical age-related change? Sometimes having trouble finding the right word.

7. MISPLACING THINGS AND LOSING THE ABILITY TO RETRACE STEPS

A person with dementia may put things in unusual places. They may lose things and be unable to go back over their steps to find them again. Sometimes, they may accuse others of stealing. This may occur more frequently over time.

What's a typical age-related change? Misplacing things from time to time and retracing steps to find them.

8. DECREASED OR POOR JUDGMENT

People with dementia may experience changes in judgment or decision making.

FOR EXAMPLE, THEY MAY USE POOR JUDGMENT WHEN DEALING WITH MONEY, GIVING LARGE AMOUNTS TO TELEMARKETERS. THEY MAY PAY LESS ATTENTION TO GROOMING OR KEEPING THEMSELVES CLEAN.

What's a typical age-related change? Making a bad decision once in a while.

9. WITHDRAWAL FROM WORK OR SOCIAL ACTIVITIES

A person with dementia may start to remove themselves from hobbies, social activities, work projects or sports. They may have trouble keeping up with a favourite sports team or remembering how to complete a favourite hobby. They may also avoid being social because of the changes they have experienced.

What's a typical age-related change? Sometimes feeling weary of work, family and social obligations.

10. CHANGES IN MOOD AND PERSONALITY

THE MOOD AND PERSONALITIES OF PEOPLE WITH DEMENTIA CAN CHANGE. THEY CAN BECOME CONFUSED, SUSPICIOUS, DEPRESSED, FEARFUL OR ANXIOUS. THEY MAY BE EASILY UPSET AT HOME, AT WORK, WITH FRIENDS OR IN PLACES WHERE THEY ARE OUT OF THEIR COMFORT ZONE.

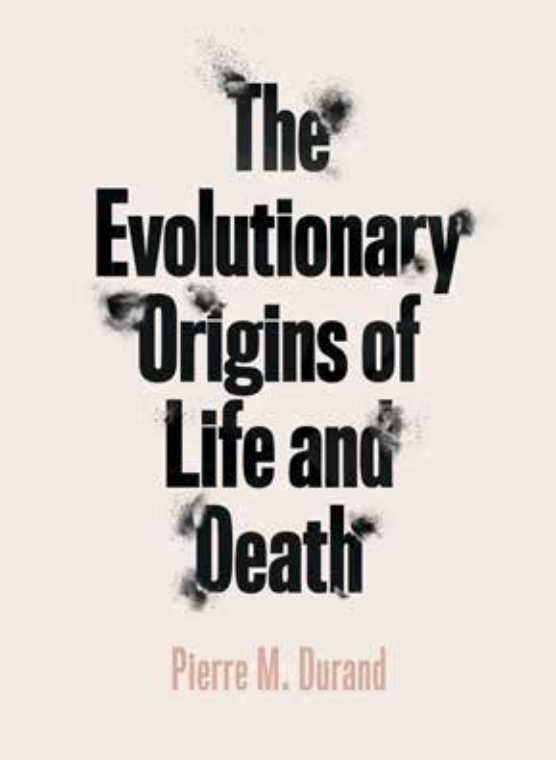
What's a typical age-related change? Developing very specific ways of doing things and becoming irritable when a routine is disrupted.

If you or someone you care about is experiencing any of the 10 warning signs, please consult with a medical professional. Early diagnosis gives you a chance to seek treatment and plan for your future. You can also join one of our upcoming dementia support groups for more information.

This list is for information only and not a substitute for a consultation with a qualified professional

Livewell™
Personalised Dementia Care

THE EVOLUTIONARY ORIGINS OF LIFE AND DEATH



Title: The Evolutionary Origins of Life and Death
Publisher: University of Chicago Press
Author: Pierre M. Durand
ISBN: 9780226747767

In biology the origin of life and the inevitable association with death is one of the greatest mysteries. Indeed, in all science and philosophy the question of why an individual would actively kill itself has long been an evolutionary mystery. Pierre M. Durand's ambitious book answers this question through close inspection of life and death in the earliest cellular life. As Durand shows us, cell death is a fascinating lens through which to examine the interconnectedness, in evolutionary terms, of life and death. It is a truism to note that one does not exist without the other, but just how does this play out in evolutionary history? These two processes have been studied from philosophical, theoretical, experimental, and genomic angles, but no one has yet integrated the information from these various disciplines. In this work, Durand synthesizes cellular studies of life and death looking at the origin of life and the evolutionary significance of programmed cellular death.

THE EXCITING AND UNEXPECTED OUTCOME OF DURAND'S ANALYSIS IS THE REALIZATION THAT LIFE AND DEATH EXHIBIT FEATURES OF COEVOLUTION. THE EVOLUTION OF MORE COMPLEX CELLULAR LIFE DEPENDED ON THE COADAPTATION BETWEEN TRAITS THAT PROMOTE LIFE AND THOSE THAT PROMOTE DEATH.

In an ironic twist, it becomes clear that, in many circumstances, programmed cell death is essential for sustaining life. For more on the contents and endorsements see https://press.uchicago.edu/ucp/books/book/chicago/E/bo68653918.html

ABOUT THE AUTHOR

Pierre M. Durand (www.pierremdurand.com) is an evolutionary biologist and molecular pathologist with an interest in evolutionary medicine. He is an alumnus of King's College, London, and the University of the Witwatersrand, Johannesburg. He is currently a reader in evolutionary biology (Wits University).

HOW TO OBTAIN COPIES OF THE BOOK FROM WITHIN SOUTH AFRICA

Bookstores stocking the book (Barnes and Noble, Waterstones, Booktopia etc) do not have branches in SA. Bulk orders from South Africa for those who wish to make use of the author discount and free courier will be placed on 1 October 2020 and again 1 March 2021. Printed copies will only arrive in SA approximately the 12th of December and again on 10 March 2021 (for orders placed between 1 October 2020 and 1 March 2021). The cost for each book with the author's discount, customs duty, VAT and international courier is R523.

To place an order please email the sales manager at durandfoundation@gmail.com for details on EFTs, book tracking and collection. E-copies and printed copies are available directly from The University of Chicago Press and Amazon

THERE IS NO HEALTH WITHOUT MENTAL HEALTH

Akeso launches online 'note to self' mental health campaign on World Mental Health Day

Mental health and well-being are integral to overall health, and the theme of this year's World Mental Health Day – 'Greater investment, greater access. Everyone, everywhere' – on Saturday, 10 October, seeks to address the barriers to accessing mental healthcare.

Akeso, which has a network of mental health facilities across South Africa, is inviting the public to share their thoughts in an online campaign to promote understanding and tackle some of the misconceptions that fuel mental health stigma.

"This year's theme highlights the significance of mental health to everyone, how important it is to ensure that each and every one of us invest in our own mental well-being, and that as a global society, we must invest more resources in mental health services to ensure equitable access for everyone, no matter where they are," says Dr Sandile Mhlongo, managing director of Akeso.

He notes that, perhaps only secondary to underfunding, the stigma around mental health remains one of the greatest challenges impacting access to care.

"THIS HAPPENS WHEN ONE WORRIES WHAT OTHERS MIGHT THINK OF THEM SHOULD THEY SEEK CARE. OFTEN THERE ARE MISCONCEPTIONS THAT MENTAL HEALTH AFFLICTIONS LIKE DEPRESSION AND ANXIETY INDICATE A LEVEL OF 'WEAKNESS' AND THAT YOU SHOULD 'JUST GET THROUGH' ANY ISSUES YOU ARE FACING," HE SAYS.

THE 'NOTE TO SELF' CAMPAIGN

With this in mind, Akeso launches a 'note to self' mental health campaign on World Mental Health Day, aiming to address some of the misconceptions around mental health, and to promote understanding of these experiences.

All members of the public are invited and encouraged to leave mental health 'notes to self' via our online platform: https://forms.gle/EGoK5fd4vtdcXKXM8. Contributors are not asked for their name, so all comments are anonymous.

This platform will be open for submissions from 10 October to 10 November. The messages received from the public will then be posted to a virtual message board at https://padlet.com/akesoclinics/u1sx3qah31ptz2q0 where individuals can look for their own notes while gaining insight by reading the notes posted by others.

"MENTAL WELL-BEING IS FUNDAMENTAL TO OUR ABILITY TO THRIVE AND REALISE OUR FULL POTENTIAL, TO THINK AND RELATE TO OTHERS, AND PERHAPS MOST IMPORTANTLY, TO EARN A LIVING AND ENJOY A MEANINGFUL PRODUCTIVE LIFE. MENTAL HEALTH IS AN INTEGRAL AND ESSENTIAL COMPONENT OF HEALTH; THERE IS NO HEALTH WITHOUT MENTAL HEALTH," DR MHLONGO ADDS.

The COVID-19 pandemic has caused an increase in the demand for mental health services due to factors

such as social isolation, anxiety and fear of illness or death, real or potential loss of income, among others. In many instances this has exacerbated pre-existing mental health conditions while in others it has brought about new mental health challenges and illnesses.

"Many of us experience daily ruminations and afflictions of a stressful life and anxiety about work or our loved ones. In such cases, mental health self-care activities can often be helpful and offer preventative and health promoting benefits that are usually sufficient to maintain good mental health," Dr Mhlongo says.

"OTHERS EXPERIENCE FAR MORE COMPLEX CHALLENGES THAT REQUIRE PROFESSIONAL AND HOLISTIC MULTI-DISCIPLINARY CARE FOR APPROPRIATE MANAGEMENT OF A MENTAL HEALTH CONDITION AND A RETURN TO OPTIMAL FUNCTIONING".

"It is our hope that Akeso's online campaign will assist in opening up conversations about capabilities and defying misconceptions while stimulating engagement on mental health matters, so that South Africans are empowered and encouraged to seek help when needed."

Assistance for mental health issues come with an array of services, which include support groups, outpatient consultations, medication and, in some cases hospitalisation.

WHEN IS IT TIME TO REACH OUT FOR HELP?

Akeso has created the following simple 'CRISIS checklist' that may help individuals to identify when they or a loved one may require professional mental health support.

- **C** Changes in your eating or sleeping patterns, or changes to your mood
- **R** Reactions to things – how are you reacting to your daily tasks and challenges? Are you getting frustrated or angrier more easily? Are you able to concentrate on a task?
- **I** Ideas that you may be better off dead or ideas about harming yourself
- **S** Symptoms of physical illness that cannot be explained e.g. chronic fatigue, persistent headaches, backaches, etc.
- **I** Interactions with others – how have you been engaging with your loved ones, your colleagues, and others? Is this different to usual?
- **S** Social withdrawal and lack of interest in things you previously enjoyed.

"IF YOU NOTICE THESE CHANGES IN YOUR LIFE, OR ARE CONCERNED ABOUT A LOVED ONE, WE URGE YOU TO SEEK HELP FROM A PROFESSIONAL NEAR YOU TO UNDERSTAND MORE ABOUT WHAT MIGHT BE HAPPENING AND HOW YOU CAN ADDRESS IT. OFTEN, THAT IS THE FIRST STEP TOWARDS BETTER MENTAL HEALTH," DR MHLONGO SAYS.

"This October, and every day, let's make a conscious effort to speak up about mental health and try to empathise with those around us. Check in with your loved ones, your colleagues and friends, and reach out to someone if you are struggling. Together, we can change the views on mental health for the better," he concludes.

ABOUT THE AKESO GROUP

Akeso is a group of private in-patient mental health facilities, and is part of the Netcare Group. Akeso provides individual, integrated and family-oriented treatment in specialised in-patient treatment facilities, for a range of psychiatric, psychological and substance use conditions. Please visit www.akeso.co.za, or email info@akeso.co.za for further information. In the event of a psychological crisis, please call 0861 435 787 for assistance.

Looking for a medical appointment? Netcare appointmed™ will make appointments with specialists practising at Netcare hospitals, GPs and dentists at Medicross medical and dental centres, and specialists at Akeso mental health facilities for you. Simply phone Netcare appointmed™ on 0860 555 565, Mondays to Fridays between 08:00 and 17:00, or request an appointment online at www.netcare.co.za/Request-a-medical-appointment

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

Dr Sandile Mhlongo, Managing Director of Akeso

Perinatal Mental Health Project
Caring for Mothers. Caring for the Future.

BREASTFEEDING AND MENTAL HEALTH

Our work with mothers experiencing symptoms of depression and anxiety and with histories of abuse and trauma, has made us realise how challenging breastfeeding can be.

Health workers may not always appreciate how these factors can affect breastfeeding and can inadvertently make the situation very distressing for vulnerable mothers. On the other hand, simple approaches can be adopted to support mothers in their feeding choices.

We have developed an issue brief to equip those working with mothers with relevant information and tools.

You can download our Issue Brief here:
https://pmhp.za.org/messages-for-mothers/m4m-mental-health-resources/

PERINATAL MENTAL HEALTH IN SOUTH AFRICA – LESSONS FROM RESEARCH, TRAINING, POLICY AND PRACTICE

Our director, Simone Honikman, was invited by the Institute of Psychiatry, Psychology and Neuroscience, King's College, London to deliver a webinar as part of their 'Family Perinatal Mental Health: A Global Perspective' series. The title of the talk was Perinatal Mental Health in South Africa – lessons from research, training, policy and practice.

Over 100 people accessed the recording within a week of the live presentation. All the recordings in the series are available at:
https://pmhp.us4.list-manage.com/track/

MESSAGES FOR MOTHERS

PMHP is a founding member of the Messages for Mothers (M4M) (https://pmhp.za.org/messages-for-mothers/) coalition of organisations which formed in response to the messaging needs of mothers during COVID-19. In the past few months, M4M has explored new opportunities to add to, improve and disseminate the messages through existing platforms with large user populations.

With our partners, we are exploring several concurrent approaches to evaluating the impact of the messaging on different beneficiary groups, expanding the language offerings and adjusting graphics for easier dissemination on social media. You can find all mental health related messages for mothers on our website:
https://pmhp.za.org/messages-for-mothers/m4m-mental-health-resources/

BEHIND THE SCENES AT HANOVER PARK

Congratulations to Liesl Hermanus who has formally been promoted to Clinical Services Co-ordinator! Liesl joined the PMHP in 2011 and this is a well-deserved promotion with added responsibilities. Further congratulations go to Thanya April, the PMHP administrator. Thanya graduated with a Bachelor's degree in Applied Social Sciences, majoring in Psychology and Counselling. Well done, Thanya! Thanya joins the clinical team as a part-time counsellor.

In response to crisis of the COVID-19 pandemic, our counselling service at Hanover Park needed to be adapted. Liesl and Thanya have been exploring new ways of engaging with clients whilst adhering to physical distancing regulations. Before the lockdown, telephonic counselling was used to check in with clients and to conduct postnatal assessments. Since then, we have expanded our telephonic service and added a digital platform to include the use of WhatsApp for keeping connected with clients.

Recently, Liesl and Thanya attended a FAMtrac course on 'Counselling in a Technology Supported Environment (e-counselling)'. They found the course useful and practical and will be adapting some of what was learnt to test an e-counselling platform for PMHP clients via Skype.

Simone also gave the opening address at the 2020 South African Mental Health & Psychology Conference on Perinatal Mental Health: What we know in South Africa and other low -and-middle-income Countries.

LATEST PUBLICATIONS

Stakeholder perspectives on antenatal depression and the potential for psychological intervention in rural Ethiopia: a qualitative study (2020)

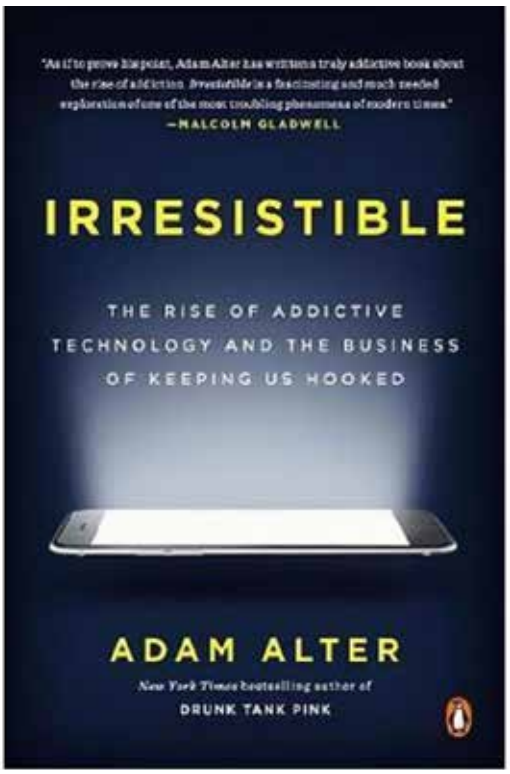
T Bitew, R Keynejad, S Honikman, K Sorsdahl, B Myers, A Fekadu, C Hanlon, BMC Pregnancy and Childbirth DOI: 10.1186/s12884-020-03069-6

Weblink:
https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-020-03069-6

IRRESISTIBLE: THE RISE OF ADDICTIVE TECHNOLOGY AND THE BUSINESS OF KEEPING US HOOKED

Koffi Kouakou

Title: Irresistible: The Rise of Addictive Technology and the Business of Keeping Us Hooked
Publisher: Penguin Press
Author: Adam Alter
ISBN-10: 1594206643 **- ISBN-13 :** 978-1594206641




Koffi Kouakou

Do you check your mobile phone every minute, if not second? Can you resist not checking the deluge of streaming social media messages that scream for your attention? Are you among the billions of hard-pressed people to give in, with little resistance, to spending long hours on the internet or watching the next titillating online soap series on Netflix or Google? Why can't most of us resist the urge to be connected to online social media gatherings?

Irresistible attempts to answer the above questions and does an excellent job of it. More importantly, it calls our attention to the rapid, omnipresent `rise of addictive technology and the business of keeping us hooked'.

THE COMMON ANSWER TO THE AFOREMENTIONED QUESTIONS IS THAT OUR LIVES ARE NOW VERY CLOSELY LINKED TO TECHNOLOGIES THAT HELP US FIND EVERY POSSIBLE MEANING, VALUES, JOBS AND EVEN HAPPINESS.

The author, Adam Alter, a native of South Africa who migrated to Australia as a child and later to the USA where he is an associate professor of psychology

and marketing at NYU, brilliantly analyses - with immense evidence - the rise of behavioural addictive technology and explains why so many of today's products are irresistible. Relying on a background in psychology and marketing, he highlights with a sharp specialist eye the danger of addiction and its link to the dark side of technology. He warns us and also provides useful remedies about the scourge of addictive technology.

THE BOOK TAKES A CLOSE LOOK AT HOW TECHNOLOGY IS INTRINSIC TO OUR LIVES.

THIS RELATIONSHIP BETWEEN HUMANS AND TECHNOLOGIES IS A MODERN PHENOMENON AND IN RECENT DECADES, THE LINK HAS BECOME DEEPER, SO MUCH SO THAT THE DECOUPLING IS ALMOST IMPOSSIBLE.

Humans have become addicted and 'hooked' as the author says. They cannot resist the continuous use of these technologies and exploit their benefits. However, as they do so, so they become more and more addicted to their use.

THE BOOK PROVIDES NUMEROUS EXAMPLES OF ADDICTIVE TECHNOLOGIES AND THEIR DAMAGING IMPACT ON THE HEALTH OF THEIR USERS. ACCORDING TO CURRENT MEDICAL STANDARDS, THE WORLD IS EXPERIENCING AN UNPRECEDENTED GLOBAL PANDEMIC OF TECHNOLOGY DRIVEN, SCREEN BASED ADDICTIONS.

The addictive behaviours of billions of people, and especially the young, using these new technologies of social media apps, gambling and online gaming, are being converted into extraordinary profits and commercial gains by companies all over the world.

But what exactly is an addiction and the new addictive technology behaviour? Is this technology addiction a healthy obsession? What does this technology mean for our health in general and mental health in particular? Why should we care? And what, if anything at all, can we do about it?

So many questions to answer. Adam Alter offers some brilliant evidence based and scientific answers to these questions and unpacks the disturbing and obsessive dangers of behavioural addictions that threaten our mental health and social relationships. ***Irresistible*** shares the critical realities of how we are psychologically locked into technology devices that have become both saviours and curses in a tech-driven age.

It powerfully flags the difference between behavioural addiction and substance addiction. It illustrates the difference in a useful comparison by linking behavioural addiction to most common issues we face in society as technology becomes an integral part of our lives where "can't-live-without-it" technology rules.

ALTHOUGH PUBLISHED IN 2017, THE SUBJECT OF THIS BOOK IS IMMENSELY RELEVANT, GREATLY ALARMING AND YET EMPOWERING. ALTER MAKES THE POINT THAT FOR OUR OWN SANITY WE SHOULD NOT BE FRIGHTENED BY TECHNOLOGY. RATHER WE SHOULD FIND BETTER WAYS TO RELATE TO IT AND USE IT TO OUR BENEFIT.

He explains how we can harness addictive products for the good, to improve our communications, strengthen our social relations, reengineer the boundaries between work and play and reduce their negative effects on health, well-being and happiness.

The impact of this book will last a long time. The provocative idea that argues that new technology causes new addictions is scary. But it should not make technology a monster nor turn us into frightened users at the mercy of an unknown ogre in our lives. It is a cautionary tale for all, adults and youngsters, who constantly use ubiquitous and addictive technology.

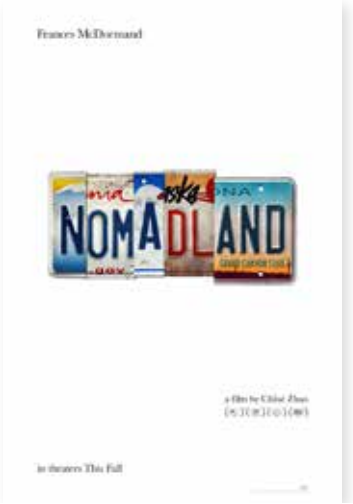
This book lives up to its title, equips us with understanding and suggests ways to help us to deal with this irresistible new world.

Koffi Kouakou is a senior lecturer at the Wits School of Governance, where he teaches strategic government communications and scenario planning. He is the former director of the Unilever Mandela Rhodes Academy for Communications and Marketing (UMRA), a Storyteller, Social Commentator, Business Strategist, Author and Futurist. He specialises in information communications technologies for development and telecommunications adapted to environmental issues in Africa. He has been a regular contributor to international, local media and business magazines on the BBC, VOA, Deutsche Welle, The People Daily, eNCA, Africa 360 degrees, SAFM, 702 Radio, Power FM, China, Brainstorm, The Media, CIO.COM and Intelligence in South Africa. He co-authored a book titled AfricaDotEdu: IT Opportunities and Higher Education in Africa, 2003. **Correspondence: koffizulu@gmail.com**

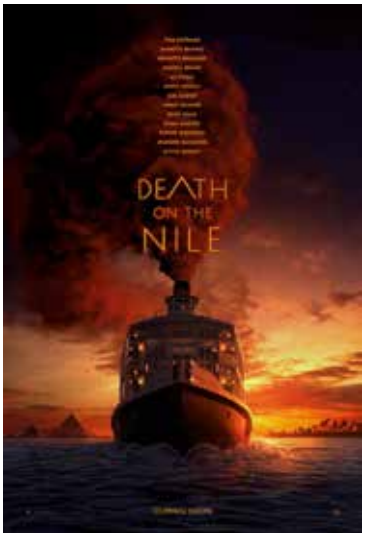
MOVIES

Six Minutes to Midnight stars the *Victoria and Abdul* duo Eddie Izzard, Academy Award winning Judy Dench and directed by Andy Goddard from *Downton Abbey* fame. Set in the summer of 1939, and based on true events, the film follows a secret agent Thomas Miller who takes up a teaching position at a school for German girls on the eve of World War II. The British drama also stars Jim Broadbent and James D'Arcy and releases at Cinema Nouveau on 20th November.

What if you saved a souvenir from every failed relationship? Certified as "Fresh" on Rotten Tomatoes *The Broken Hearts Gallery* is a charming romantic comedy about an art gallery assistant, recently dumped by her boyfriend that creates an exhibit of souvenirs from past relationships. Starring Geraldine Viswanathan and Dacre Montgomery releasing 20 November at Cinema Nouveau this ode to relationships is not to be missed.



Academy Award winner Francis McDormand takes the lead in the drama *Nomadland* and follows a woman in her sixties who embarks on a journey through the American West after losing everything during the recession. *Nomadland* releases 4 December at Cinema Nouveau.



Death on the Nile is an upcoming mystery thriller directed by Kenneth Branagh and based on the 1937 novel of the same name by Agatha Christie. While on vacation on the Nile, Hercule Poirot must investigate the murder of a young heiress. The star-studded cast includes Kenneth Branagh as Hercule Poirot, Gal Gadot, Letitia Wright, Armie Hammer, Annette Benning and Russell Brand to name a few. *Death on the Nile* is sure to entertain you and releases 18 December at Ster-Kinekor and Cinema Nouveau theatres ■

ON TURNING SIXTY

David Swingler

I was well prepared.

There were three valedictory lectures set out for the last week of June. The first a journal club reviewing developments in schizophrenia over the thirty five years of my psychiatric practice, the second a set of 'Ten Things I Wish Somebody Had Told Me When I Started Out' as a parting gift of bon mots to junior colleagues in the Departments of Psychology and Psychiatry at 2 Military Hospital.

THIRD AND LAST WAS A PRESENTATION TO THE WHOLE HOSPITAL MORBIDITY AND MORTALITY MEETING – MY 'BABY' FOR THE LAST DECADE – TITLED 'THE SUICIDES OF MY CAREER'.

There were as many events to mark my 60th birthday in July that precipitated this mandatory retirement. An intimate nuclear family dinner, my annual 'Cellar Rationalisation Party' for extended family and friends in its 31st consecutive year, and a weekend away in the Koue Bokkeveld to explore the finest wine in the world with twenty best mates.

And then there was COVID-19. For which nobody was prepared…

Joostenberg Bistro

The Koue Bokkeveld? My French Chef friend Christophe Dehosse of Joostenberg, The Vine Bistro at Glenelly and latterly The Postcard Cafe at Stark-Conde and always up for a decent plate of food with a good glass of wine, suggested we secure the use of The Truffle Lodge. This is the epicentre of Volker Miros' Woodford Truffles Black Perdigord – tuber melanosporum – farming partnership company on the family's Groenfontein Private Nature Reserve in the Koue Bokkeveld north east of Ceres/Prince Alfred Hamlet/Op die Berg. It's not in commercial use but has restaurant quality walk-in fridges and freezers, a kitchen to weep for, and sleeps twenty. With plenty of space to dine as a group.

David Swingler

The generous Miros family were most accommodating and we planned a menu that could be prepared mostly in advance with only final finishing touches – so nobody got lost behind a stove – along with some wines. This was a 60th recall, with my twenty best mates, most of whom are either in the wine or hospitality industries. And while local goods have my energetic support, this one was also about engaging with classic benchmarks, the greatest wines of the world.

Pieter Ferreira Brut

Monro Brut

So, what would we have enjoyed? Friday night's 'coq au vin' attracted the theme 'Magnums'; we'd all be excited to see one aother, and thirsty after the long drive. Villiera's Monro Brut and Pieter Ferreira's Blanc de Blancs – both producers present – would keep pace with Lanson 2005, then Hamilton Russel Vineyards Chardonnay and Newton Johnson Family Vineyards Pinot Noir would lead out Sadie Family Columella and Kanonkop Paul Sauer.

NOT BEING A FAN OF 'STICKIES', PERHAPS A GLASS OF BOPLAAS 'PORT' WITH A PIECE OF CHEESE TO CLOSE THE MEAL.

Saturday morning's repast was planned to be low-key refuelling as lunch was due to be long and liquid. The theme for it was 'Burgundy'. While this famous region's white grape chardonnay has travelled well, its red grape pinot noir – 'a minx of a vine' – hasn't. There is nothing quite like the flavour without weight, the power without force, of the greatly finessed red wines emanating from a little patch of dirt, the Cote d'Or – golden slope – just south of Dijon in north eastern France. My two favourite vineyards (I've been blessed with many generous friends) are Musigny and Chambertin and we would be having these.

Chambertin

The proposed meal included many of my favourite things; pate 'en croute' with pistachio, pan-fried duck breast, 'oeuf en muerette' (eggs poached in red wine sauce served on sourdough toast with roasted bone marrow – sensational), slow cooked brisket with truffle sauce, and cheese, including the excellent local Dalewood. Like 'stickies', I'm not one for desserts.

THERE WOULD BE NO NEED FOR SUPPER.

Woodford Truffles

Gaja Barbaresco

Sunday morning would ring in a brunch of yoghurt & fruits followed by scrambled eggs with truffles. The wine theme would be obvious: Piedmont, in northern Italy. Home to both the finest white truffle of Alba, it is also host to the nebbiolo grape in Barolo and Barbaresco.

Barbaresco

Barolo

THESE WINES ARE MY SECOND FAVOURITE, ONLY A WHISKER BEHIND RED BURGUNDY BUT FOR THE SAME REASON: SUBTLETY, GRACE AND FINESSE RATHER THAN RAW, BRUTE FORCE.

And Sunday night supper was scheduled to be a *braai*. One can't have a 60th birthday weekend away without a *braai*. This wine theme was also obvious. Leftovers. Were there any…

COVID-19 came and will, hopefully, go. And while I may well deliver 'The Suicides of My Career' at a SASOP meeting at some stage, I'm not sure that celebrating a 61st at The Truffle Lodge next year will be quite the same.

The Vine Bistro at Glenelly

http://woodfordtruffles.co.za/

https://joostenberg.co.za/

https://glenellyestate.com/vine-bistro/

https://stark-conde.co.za/pages/postcardcafe

David Swingler is a writer and taster for Platter's South African Wine Guide for over 21 years to date. Dave Swingler has over the years consulted to restaurants, game lodges and convention centres, taught wine courses and contributed to radio, print and other media. A psychiatrist by day, he's intrigued by language in general, and its application to wine in particular. **Correspondence: swingler@telkomsa.net**

CAPE TOWN IS OPEN FOR BUSINESS - AND IT WON'T HURT YOUR POCKET TO VISIT

With the easing of lockdown regulations to Level 1 restrictions, South Africa's borders are open to a number of international travellers and Cape Town is ready to welcome these guests and domestic travellers with open arms. And if you think that a visit to Cape Town will break the bank, think again.

"Everyone is fighting for a piece of the tourism pie, but we have already seen that, locally, we are still a very popular destination to visit. The Mother City offers a little bit of everything - beach, mountains and nature, and there are many ways to enjoy Cape Town without breaking the bank," says Briony Brookes, PR & Comms Manager for Cape Town Tourism. "Cape Town is a world-class destination and we predict that, instead of going overseas for a top travel experience right now, South Africans will look closer to home and see that Cape Town has as much to offer as other cities around the world, if not more."

Below, Brookes shares her tips on how to enjoy a pocket friendly Cape Town.

1. Use the 50 things to do for under R50 list

This list has been doing the rounds for a number of years now and, every year, the team at Cape Town Tourism updates it to ensure that these items are still valid or, if not, swaps it out with something that fits the bill. Highlights include hippo spotting, eland viewing and bird watching at Rondevlei Nature Reserve, a visit to the gardens at Babylonstoren, strawberry picking and so much more.

Find the list at: https://www.capetown.travel/50-things-to-do-for-under-r50-in-cape-town/

2. Enjoy free Cape Town

Did you know that there are so many free things to make use of in Cape Town? The Free Walking Tours, for example, give you the chance to learn more about the history of the city, significant sites and more - all at no cost to you. Other free activities include hiking up one or more of our stunning mountains or along one of the many beach promenades, lounging on our gorgeous beaches, picnicking in the Green Point Urban Park, an audio tour of Groot Constantia - and so much more.

3. Take advantage of local offers

Attractions all around Cape Town have local-only offers that allow for free or discounted entry to South African residents. Table Mountain and the Two Oceans Aquarium, for example, have birthday specials for locals who are able to enjoy these iconic attractions for free on or in the week of their birthday - and if your birthday was during lockdown, you can still claim your free ticket! The Table Mountain National Park also has a Green Card that costs R167 for South African residents of Cape Town and allows the holder of the card 12 entries into any of the Table Mountain National Park's pay points: Cape of Good Hope (Cape Point); Boulders Penguin Colony, Oudekraal and Silvermine, as well as to the braai and picnic areas at Tokai, Newlands and Perdekloof.

4. Research, research, research when it comes to accommodation and eating out

Accommodation is often one of the biggest costs when travelling. However, right now leading up to the festive season, there are many establishments that are running excellent promotions and deals. All it takes is an extra bit of research to find these deals and discover great value and discounts on accommodation in Cape Town. The same can be said for eating out. To offset the losses that occurred during lockdown, many of Cape Town's top restaurants are running meal specials to secure lots of bookings. Take some time to research local restaurants and see which ones have deals that fit your budget. There are also the amazing Cape Town markets where food is often cheaper than in restaurants and each offering is something truly unique

5. Book early for cheaper flights

Flights can be a major cost in travelling, but the earlier you book, the better. Booking now for a few months ahead means that you save on costs as many airlines push up their prices for last-minute bookings. Get in there early to avoid disappointment or price hikes

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

AGM 2020 SUMMARY

In keeping with current virtual meeting formats, the South African Society of Psychiatrists held their Annual AGM via Zoom on the 20th of October 2020.

The meeting commenced with an acknowledgement of and a moment of silence for all the psychiatrists we have lost in 2020, with a special mention of the untimely passing of the immediate Past President and Director on the SASOP BoD, Professor Bernard Janse van Rensburg earlier this year.

THE BOD HAS FELT THE HUGE BURDEN OF COVID-19 PERSONALLY, AS WE RECOLLECTED THE CHALLENGES AND LOST BATTLES THAT HAVE FOLLOWED PSYCHIATRISTS DURING THE PANDEMIC

The meeting started with a brief presentation by Dr Kagisho Maaronganye* addressing the current medication shortage crisis in Public Sector Services.

He highlighted some of the main reasons driving the medication shortages – these include:

- Patents running out and a lag period of years needed for generic companies to produce on an economically viable scale
- The shrinkage of the capacity to produce active pharmaceutical ingredients limiting this ability to only a very few countries in the world
- Increased scope and demand of products that can be produced by major drug companies at the expense of drugs that have long been in use and are still effective but now carry low profit margins
- The need to produce massive amounts of drug within a "short period of time, without a corresponding expansion in manufacturing capacity" as could happen during the COVID-19 pandemic.

DR MAAROGANYE ALSO EXPLAINED THE MULTI-LEVEL CHALLENGES FROM MEDICATION PROCUREMENT, SOURCING AND LACK OF SENIOR LEVEL REPORTING AND AUDITING OF SUPPLIES IN MANY STATE FACILITIES IN SA. HE ALSO DISCUSSED THE SUGGESTIONS IN IMPROVING THESE SYSTEMS AND DELIVERIES OF MEDICATIONS.

As a concluding slide, he presented SASOP's position on the way forward:

1. Official letter to the DG and Minister of Health seeking answers, confirmation of the stock outs, requesting a resolution and timeline for the process, including the alternative approaches that are feasible
2. Letter to all pharmaceutical companies requesting an explanation from their perspective on the shortages
3. Engagement with advocacy groups such as the National Mental Health Alliance, TAC and S27 in approaching SAHPRA and learning from their experience with similar human rights issues
4. Formation of a subcommittee in PUBSEC to address specifically to put the above mentioned plan into action.

* a copy of this presentation is available to members on the membership section of the SASOP website.

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The President Professor Bonga Chiliza then led the AGM through the agenda with the following as some of the highlights:

1. Feedback on the establishment of the **Public Sector Executive**

- The PUBSEC Exco is headed by Dr Kagisho Maaroganye and has been involved in several key areas over the past year of its establishment
- These included addressing patient advocacy, human resource issues in state services, inputs into the national strategic processes
- MOST RECENTLY THE PUBLICATION OF COVID-19 SPECIFIC GUIDELINES FOR THE INPATIENT MANAGEMENT AND ADMISSION OF MENTAL HEALTH CARE USERS WHO ARE PUIs IN PSYCHIATRIC FACILITIES.

2. **The Private Public Partnership**

- Has been active since February 2019 under the guidance of Prof Rita Thom and Bernard JV Rensburg to increase cooperation between private and public sector psychiatrists
- PART OF THE AGENDA HAS BEEN TO STRENGTHEN PUBLIC SECTOR WORK, AND TO EXPLORE NEW BUSINESS MODELS FOR PSYCHIATRY
- The following is a list of the papers that speak to this drive:
    - Psychiatrists in South Africa: A situational analysis of numbers, distribution and functions of psychiatrists to meet mental health care needs of the country
    - Situational review was undertaken by the College of Psychiatrists and the South African Society of Psychiatrists to inform the development of a strategy to increase specialist training and examination capacity in South Africa.

3. **HealthCare Workers Care Network**

- Several psychiatrists have volunteered and been instrumental in the support and care of HCWs during the time of COVID
- Prof Rita Thom and Antoinette Miric were key in driving and coordinating the network

4. **Focus on Early Career Psychiatrists**

The president highlighted the initiatives in place for support of Early career psychiatrists including the Registrar Finishing School, CMSA registrar workshop, the Public Mental Health Forum and the PsychMG roadshows

5. **Strengthening African Psychiatry**

SASOP has partnered with the African Global Mental Health Institute that aims to address the contemporary challenges of mental health disorders through education, training, research and policy development.

The AGM also tabled the updated financials and adopted the resolution to not increase the annual SASOP fees for the next year, given the current COVID challenges. Independent auditors were appointed for the next 12 months. Financials are available on request from SASOP via their administrative partner Healthman.

The AGM also considered and tabled a resolution to extend the term of the current SASOP Board until the next AGM in 2021. This resolution was supported by the membership present.

The AGM concluded with a reminder to the membership of the 20th National SASOP conference which has now been moved to the 20th-24th of October 2021, to be held at the Champagne Sports Resort in central Drakensberg.

Dr Anusha Lachman
Honorary Secretary

SAVE THE DATE

www.sasop2021.co.za

SASOP

20th National Congress
of the
South African Society of Psychiatrists

20 - 24 October 2021

Champagne Sports Resort
Central Drakensberg

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

MENTAL HEALTH OF HEALTHCARE WORKERS IN THE CONTEXT OF COVID-19

A webinar was hosted by the South African Society of Psychiatrists on Thursday 20th August 2020. A recording of the webinar is available

The featured ***speakers*** were:

Cassey Chambers
Operations Director, South African Depression and Anxiety Group (SADAG); Partner on Healthcare Workers Care Network (HWCN)

Noeline Nakasujja, MBChB, MMed Psych, PHD
Associate Professor & Chair, Department of Psychiatry, School of Medicine, Makerere University College of Health Sciences

Roopa Mathur, Do, MS
Consultant-Liaison Psychiatrist, Department of Psychiatry, Boston Medical Centre, Instructor of Psychiatry, BU School of Medicine

The ***moderators*** were:

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

Michelle P Durham, MD, MPH
Adult, Child & Adolecent Psychiatrist and Residency Training Director, General Psychiatry, Boston Medical Center, Assistant Professor of Psychiatry, BU School of Medicine

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

COVID-19 HCW MENTAL HEALTH SURVEY

Dear Colleagues, COVID-19 has impacted on the mental health of many, especially health care workers.

In order to better understand the impact of COVID-19, we are surveying health care workers in 3 middle income countries (Phillipines, South Africa and Turkey). This survey is aimed at all categories of health care workers in South Africa and is not limited to doctors or hospital staff.

We would greatly appreciate it if you would spare 15 minutes of your time to complete the survey. This can be done via a computer or mobile phone. Similarly, we would be thankful if you would forward this on to your networks in order to assist us to gather data from a diverse and large sample of health care workers.

See information sheet (below) for details regarding ethical approval by the University of the Witwatersrand and resources for accessing mental health assistance.

Should you have any questions, please do not hesitate to contact me.

Keep Safe!

Dr Atiya Mosam

Public Health Medicine Specialist
Senior Researcher: PRICELESS SA - SAMRC/Centre for Health Economics and Decision Science

Tel: 083 237 5380
Email: atiya.mosam@wits.ac.za

HEALTHCARE WORKERS CARE NETWORK
Caring for the Carers by the Carers

INFORMATION SHEET

UNDERSTANDING ANXIETY IN HEALTH CARE WORKERS DURING THE COVID-19 PANDEMIC IN FOUR MIDDLE INCOME COUNTRIES

Good Day Colleague

The COVID-19 pandemic has resulted in considerable anxiety. This may be especially pronounced in healthcare workers directly involved in patient care. We are a group of researchers from 3 different countries (Phillipines, South Africa and Turkey) aiming to understand the effect of the new coronavirus pandemic on the anxiety levels of health care workers.

If you are a health care worker involved in patient care (COVID and Non-COVID patients), we would greatly appreciate it if you would spare 15 minutes to participate in this study by completing a short online survey

Your participation in this study is entirely voluntary. The survey is completely anonymous. Your name cannot be linked to your answers and you will not be identified in the final research report. There will be no consequences if you choose not to participate or if you end the survey before completion.

Clicking "Yes" to the question, "I Agree To Participate In This Survey", constitutes informed consent and you will be allowed to proceed with the survey. If you do not wish to agree to participate, you may close the survey page without fear of any consequence.

The survey is focused on your current work and life circumstances as well as your experience of anxiety

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symptoms. It will only take 15 minutes of your time and can be answered using your mobile phone. You may also end the survey at any time, should you not wish to continue.

Permission to conduct this research study has been granted by the relevant country ethics review boards and ethics permission for South Africa has been granted by the Human Research Ethics Committee of the University of the Witwatersrand.

Due to the anonymity of the survey, the research team is unable to contact or offer support to any individuals who may be experiencing mental health difficulties. However, resources (including emergency helplines) can be found on the following websites:

- Health Care Workers Care Network (https://healthcareworkerscarenetwork.org.za)
- South African Depression And Anxiety Group (http://www.sadag.org/)

Should you have any questions, you may contact the following people:

Principal Investigator (South Africa)
Dr Atiya Mosam
(C) 083 237 5380
(E) atiya.mosam@wits.ac.za

Secretary to the University of Witwatersrand Human Research Ethics Committee
Ms Mapula Ramaila
Administrative Officer
Human Research Ethics Committee (Medical), Biobanks and Biosafety Ethics Committees
(C) 011 717 2656
(E) mapula.ramaila@wits.ac.za

Thank you for taking the time to assist us with this research.

Yours Sincerely
Dr A Mosam

POSITION

HCU: FORT ENGLAND HOSPITAL

POST: **HEAD CLINICAL UNIT REF NO: ECHEAL/HCU/FEH/01/09/2020** (2 Posts)

SALARY: **R 1 728 807 — R 1 834 890 per annum (OSD)**

CENTRE: **Sarah Baartman District, Fort England Psychiatric Hospital**

REQUIREMENTS:

Appropriate qualification that allows registration with the Health Professions Council of South Africa (HPCSA) as a Medical Specialist. A minimum of 3 years' appropriate experience after registration in Psychiatry. Ability and practical experience to set up and provide training program for under and post graduates.

DUTIES:

- Running the Department of Psychiatry in an effective manner. Responsible for training & guidance of Medical Officers, Medical Interns, Community Service Medical Officers, Medical Students & other categories in the Department of Psychiatry.
- Ensure that the department is compliant with National Core Standards & Ideal Hospital Realization Framework.
- Coordinate and compile Medico-Legal aspects & attend to all legal issues pertaining to the Department of Psychiatry.
- Develop operational plans, quarterly & annual report of the Department of Psychiatry.
- Perform Clinical Audits.
- Conduct Departmental Mortality & Morbidity Meetings.
- Liaise with other stakeholders & ensure efficient outreach to dIstrict hospitals

Enquiries: **Ms. Nazo**
Tel no 046 602 2300

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

GLOBAL STUDY ON THE IMPACT OF COVID-19 ON MENTAL HEALTH PROFESSIONALS: INVITATION TO PARTICIPATE

GCP.NETWORK
World Health Organization

The **World Health Organization Global Clinical Practice Network (GCPN)** invites you to join the network and participate in a global study on the impact of the COVID-19 pandemic on you and on your professional practice.

Since 2011, over 15,500 GCPN members from 159 countries have been collaborating with the WHO Department of Mental Health and Substance Abuse. The GCPN's main focus has been to assess and maximize the clinical utility and global applicability of the diagnostic guidelines for mental disorders in the new version of the International Classifications of Diseases (ICD-11).

COVID-19: A GLOBAL HEALTH CRISIS

Participation begins with you joining the Global Clinical Practice Network (GCPN). Thank you in advance for your important contribution.

The Global Clinical Practice Network (GCPN) is an international and multilingual network of healthcare professionals providing mental health services. Originally, GCPN was established by the World Health Organization's Department of Mental Health and Substance Abuse as a core mechanism for the development of the diagnostic guidelines for Mental, Behavioural and Neurodevelopmental Disorders included in the latest version of WHO's International Classification of Diseases and Related Health Problems (Eleventh Revision; ICD-11).

Since its inception in 2011, GCPN members have shared their clinical expertise by providing feedback on the development of the ICD-11 through participation in internet-based field studies assessing the clinical utility, reliability and global applicability of the ICD-11 diagnostic guidelines. Insights gained from GCPN members directly informed WHO's decisions about the structure and content of the new classification system, which in turn will affect mental health service delivery and the activities of health professionals worldwide.

BEYOND THE ICD-11, THE GCPN'S LARGE INTERNATIONAL SAMPLE AND CAPACITY TO CONDUCT STUDIES IN MULTIPLE LANGUAGES PROVIDE AN UNPARALLELED POTENTIAL TO CONDUCT PRACTICE-BASED RESEARCH RELEVANT TO MENTAL HEALTH PROFESSIONALS AROUND THE WORLD.

In June 2020, we began implementation of a groundbreaking study on the impact of the COVID-19 pandemic on the clinical practice and occupational well-being of mental health professionals. This study is ongoing and will collect data at three time points to assess the evolving impact of COVID-19.

The GCPN includes over 15,600 health professionals who represent various disciplinary backgrounds, all WHO global regions and 159 countries. Any mental health or primary care professional who has completed their training and is qualified to practice in their country is eligible to participate. GCPN registration takes approximately 10 minutes to complete. As a GCPN member, you will be asked to participate in research initiatives focused on understanding what clinicians worldwide are actually seeing in clinical practice no more than once per month, and each survey or study will require about 30 minutes of your time. You will never be asked to provide identifying information about your patients.

To register for the GCPN, please use the link below:
http://www.globalclinicalpractice.net/

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

Dear SASOP Member

Please find below the current SASOP Guidelines to the **Management of Impairment Claims on Psychiatric Grounds.**

As you will note that these guidelines are from 2017 and will need urgent updating to incorporate the current changes brought about by COVID and the implementation of Telepsychiatry. We are looking for SASOP members who are keen and willing to assist with the updating of these guidelines as part of a team headed by Prof Christoffel Grobler.

If you are interested please can you email Prof Grobler directly: dr.stof@mweb.co.za

SASOP GUIDELINES TO THE MANAGEMENT OF IMPAIRMENT CLAIMS ON PSYCHIATRIC GROUNDS

THIRD EDITION 2017

Issued by the South African Society of Psychiatrists (SASOP)

Compiled by members of a task team appointed by SASOP: Dr G Grobler, Prof C Grobler, Dr FA Korb, Dr G Lippi, Dr S Zilesnick, Dr E Allers.

- They have read and understood the terms and conditions of the informed consent document.
- Refusal to answer specific questions may influence the assessment and may be reported to the referral source.

THE INDEPENDENT PSYCHIATRIC IMPAIRMENT ASSESSMENT

All available sources of information should be used in an assessment.

Taking into account the details of the specific case, the psychiatric assessment should include the following, where appropriate:

- A full psychiatric history (including highest level of education) and mental status examination
- Full occupational history and current occupational duties.
- Collateral information – from family members, employers, or any other appropriate sources
- Perusal of previous medical documentation
- Appropriate special investigations (e.g. neuro-imaging and neuropsychological testing in cases of dementia or other cognitive disorders)

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- It should be made clear to the patient that the purpose of the interview is to perform a psychiatric assessment. This will form the basis of a psychiatric report, which will be forwarded to the insurance company who requested the assessment. The patient must be alerted that any information divulged may be included in the report.
- In cases where the psychiatrist deems it necessary to discuss aspects of the case with another party (such as the treating doctor, or an employer), prior informed written consent must be obtained from the patient.
- Patients are entitled to a copy of your report. However, the report should be requested through the insurance company and only released with the psychiatrist's written permission.

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- The emphasis of the treating physician should be on return to work, based on the recovery model.

Furthermore, the independent psychiatrist:

- Will be perusing all previous medical documentation including a full psychiatric report by the treating psychiatrist(s) and all other documentation thought relevant by the insurer.
- May contact the treating mental health care professionals for additional information.

ASSESSING THE DEGREE OF IMPAIRMENT

The 2001 SASOP Guidelines were based on the 5th edition of the AMA Guides to the Evaluation of Permanent Impairment and the current edition is based on the 6th edition. In the 6th edition of the AMA Guides to the Evaluation of Permanent Impairment, there is a paradigm shift adopting a contemporary model of disablement: it is simplified, functionally based and internally consistent. Also, it uses the terminology and conceptual framework of disablement of the International Classification of Functioning, Disability and Health (ICF), a World Health Organization document.

The newest (6th) edition of the AMA Guides to the Evaluation of Permanent Impairment aims to be more diagnosis and evidence-based and attempts to optimize inter-rater and intra-rater reliability. Rating percentages are functionally based. It stresses conceptual and methodological congruity within and between organ system ratings and it has as its primary purpose the rating of impairment to assist adjudicators and others in determining the financial compensation to be awarded to individuals who, as a result of illness or injury, have suffered measurable physical and/or psychological loss.

The relationship between impairment and disability remains complex and difficult, if not impossible, to predict. In some conditions there is a strong association between level of injury and the degree of functional loss expected in a patient's activity for example mobility and activities of daily living.

But the same level of injury is in no way predictive of an affected individual's ability to participate in major life functions (including work) when appropriate motivation, technology and accommodations are available. Disability may be influenced by physical, psychological and psychosocial factors that can change over time.

In assessing impairment for a mental disorder, the first critical step is to make a definitive diagnosis based on the DSM. The presence of a diagnosis does not necessarily suggest the patient is impaired. Despite the wide range and availability of psychological tests and ratings scales, the patient interview, review of records and mental status examination remain the foundation for evaluation of the patient and determining impairment.

In order to assess the degree of functional impairment, it is necessary to make a detailed exploration of all of the symptoms, and the effects that they have on the patient.

The American Medical Association Guides to the Evaluation of Permanent Impairment suggested method for assessing the severity of functional impairment in patients with psychiatric disorders uses three rating scales namely:

1. The Brief Psychiatric Rating Scale
2. The Global Assessment of Functioning Scale
3. The Psychiatric Impairment Rating scale

SPECIAL CONSIDERATIONS

- Attention must be given to the effects of medication on signs and symptoms and ability to function (e.g. benzodiazepines may be responsible for such symptoms as drowsiness, lethargy, impaired concentration and memory and impulsivity)
- Unemployment and its resultant inactivity may be confused with psychiatric symptoms such as lack of motivation, listlessness, reversed sleep-cycle, and poor self-esteem
- The assessment of motivation is problematic. It is often difficult to distinguish from mental impairment, e.g. anhedonia. Underlying personality traits may be a major determinant of motivation. For many patients with poor motivation, proper rehabilitative programs may significantly improve function.

ASSESSING WHETHER IMPAIRMENT CAN BE REGARDED AS PERMANENT OR NOT

- Permanency is where the impairment becomes static or well stabilized and is not likely to remit in the future despite medical treatment. Decisions regarding the permanence of impairment cannot be made lightly. Impairment can only be regarded as permanent after optimal treatment has been applied; i.e. sufficiently high doses of the most effective medication for a long enough period of time, plus appropriate psychotherapy by a suitably qualified therapist and sufficient time allowed for recovery during which continued vocational rehabilitation took place administered by an occupational therapist.

A patient should not be considered permanently ill until all reasonable treatment options have been exhausted. Treatments applied need to be those generally recognised as appropriate for the psychiatric disorder in question, and known/acceptable treatment algorithms for treatment resistance be followed. These days, there are many lines of treatment that can be explored that are effective in treating even refractory patients and for this reason, as mentioned earlier, treating psychiatrists are encouraged to make use of the SASOP Treatment Guidelines for Psychiatric Disorders.

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Patient compliance is also important – a patient who does not keep psychotherapy appointments, or who does not take medication regularly, cannot be said to be non-responsive to treatment.

Sometimes patients cannot afford expensive private prescription medication, especially when these are not covered by their medical aid options. In such cases reasonable optimal treatment should be evaluated in terms of the medication available at local government institutions.

THE PSYCHIATRIC REPORT
TREATING PSYCHIATRIST'S REPORT

Care should be taken in drawing up the psychiatric report, as important decisions are made based on the information provided. It needs to be kept in mind that the report may be scrutinised by, among others, the patient, insurance company claims assessors, other doctors and legal representatives. The report should be comprehensive, objective and accurate. Financial advisors are not entitled to receive the report directly from the author. The report will only be released by the insurance company to the patient if the author has given consent for release in line with prevailing legislation.

The following psychiatric interview template is recommended for use by the treating psychiatrists:

PSYCHIATRIC IMPAIRMENT ASSESSMENT INTERVIEW TEMPLATE

Member Name:

Date of Birth:

Marital Status:

Occupation:

Last Worked:

Scheme Name and Code:

Treating Psychiatrist:

Primary-Care Doctor:

Date of this examination:

Date of first consultation with the claimant:

Appointment schedule over the past year e.g. 4-weekly:

What is the psychiatric diagnosis for which the patient had been treated prior to referral for independent psychiatric opinion?

Current psychiatric symptoms?

Chronological history of events leading up to cessation of work:

What is the Claimant's current job? Describe responsibilities briefly.

What does the Claimant find particularly stressful about the work?

Which work responsibilities would the Claimant have difficulty with and why?

Which work responsibilities would the Claimant not have difficulty with?

Employment history:

Does the Claimant get along with superiors/ colleagues at work?

Has the Claimant ever been involved in any disciplinary hearings?

When last did the Claimant work? How long has the Claimant been on sick-leave?

Please comment on any occupational therapy assessments or functional capacity assessments received:

What kind of vocational rehabilitation measures has thus far been implemented to assist the Claimant to return to work?

Has the Claimant's made any requests for or been offered reasonable accommodation at work?

Which reasonable accommodative measures would the Claimant like to see being implemented at work to decrease pressure on the claimant? (Examples include a phased return to work, restructuring jobs, adjusting working time and providing support in the workplace)

Current treatment and response thereto. Please specify names and dosages of all medication and provide details of all adjuvant therapy.

Does the Claimant know the names and dosages of all their psychiatric medications?

Does somebody else administer their medication?

Does the Claimant experience any side-effects on their psychiatric medication?

Clinical examination / mental state examination findings (please record general appearance, mood, anxiety, psychotic features, mental state, cognitive and social functioning etc.).

Please comment on any psychological treatment received, consultations with psychologists etc.:

Please comment on the Claimant's compliance with treatment (medication, follow ups with psychiatrist, consultations with psychologist etc.)

Please provide details of any hospitalizations over the past 12 months. Please indicate the dates of admission and discharge, provide the name of the hospital to which the claimant was admitted and the reasons for admission.

Past psychiatric history:

Past Treatment

Pre-morbid functioning:

Motivation for recovery and return to work:

Medical history:

Allergies, diabetes, epilepsy, asthma, TB, tested for HIV (and results), hypertension, hypercholesterolemia, head injuries and surgical procedures.

Substance history (habits):

Type of substances (cigarettes, alcohol, cannabis, OTC pain tablets e.g. Adco-Dol etc). Pattern of use, longest periods of abstinence and use of self-help or professional resource.

Family history of mental illness:

Educational history and highest level of education:

Results of any relevant rating scales or bedside cognitive assessments e.g. the Brief Psychiatric Rating Scale (BPRS), Psychiatric Impairment Rating

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Scale (PIRS), Global Assessment of Functioning Scale (GAF) or Montreal Cognitive Assessment (MOCA).

Results of any special investigations or specialist consultations. Only provide copies of results available on file.

Your comment on how the claimant's condition has progressed over the last 12 months. Has there been any improvement / deterioration? Please provide details.

Is any further treatment planned or anticipated? Please provide details.

Please comment on the claimant's ability to look after him/herself and perform everyday tasks:

Grooming and personal Hygiene:
Bathing/ showering:
Brushing teeth:
Dressing:
Sexual activity:
Health management:
Relationships:
Care of others / Child rearing:
Preparing meals and other domestic tasks:
Shopping:
Travel and Driving:
Leisure activities:
Physical exercise:
Social interaction:
Managing finances:
Communication device use:
Final diagnosis.

What are the chances of this Claimant returning to work?

	Excellent	Good	Fair	Poor
3 months				
6 months				
1 year				
1years				

Reasons for your opinion;

Have all treatment options been exhausted?

If not, why?

In your opinion, what aspects of the impairment may influence the Claimant's current job specifically and what would you suggest to address those problems?

Any other comments you feel may be of assistance to prevent permanent disability from occurring?

Signature: Date:
Name (please print): Qualifications:
Contact Number:

Confidentiality

As with all medical reports, confidentiality is of paramount importance and the contents are never disclosed to unauthorised parties. They may only be disclosed to a third party with the consent of the client. Should a claimant wish to obtain a copy of the psychiatric report they may apply to the insurer who will release it to them in accordance with procedural requirements as per the Protection of Personal Information Act.

It must be noted that because of the necessity for a close therapeutic relationship between doctor and psychiatrist, a second opinion from an independent psychiatrist may be sought. This is done to alleviate pressure on this relationship and is in accordance with international practice.

Future directions for becoming an independent psychiatric medical assessor

- Psychiatrists interested in becoming independent psychiatric examiners are encouraged to do the Foundation for Professional Development's (FPD) Short course in the evaluation of permanent medical impairment rating (based on the AMA Guides' 6th edition).
- In future it is envisaged that a curriculum for a psychiatry-specific course will be drawn up by SASOP.
- It remains the prerogative of the insurance companies as to whom they approach for independent opinions.

Closing remarks

At least twenty per cent of employees will experience some form of mental illness during their working lives. On balance, work is linked to good health rather than ill health and is good for psychological wellbeing. The effects of loss of work on the other hand can include social isolation, poverty, deterioration in physical- and mental health, and increased mortality.

The longer a person is off work, the less likely they become to ever return to work and once a person commences on certified work absence, they commonly start down a slippery slope that could end in longterm worklessness. Recovery is often faster and more successful if people can do some work while recovering.

Psychiatrists are encouraged to manage the impairments associated with mental illness that may result in cessation of work and do everything possible to prevent permanent disability from developing. This goal can be reached through:

- Frequent communication with all stakeholders including the insurance case manager, the employer and all members of the multidisciplinary team
- Effectively addressing the psychiatric condition

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- Educating patients regarding the benefits of staying at work or returning to work as soon as possible.

Current available evidence undeniably points towards the benefits of keeping people productively employed. It stands to reason that everything possible should be done to avoid the unfortunate outcome of permanent cessation of work and psychiatrists are well positioned to play a leading role in managing the impairments associated with mental illness and preventing permanent disability.

Suggested reading

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INSTRUCTIONS TO AUTHORS

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

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

LETTERS TO THE EDITOR

* Novel experiences
* Response to published content
* Issues

FEATURES

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

REPORTS

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

PERSPECTIVES

* Personal opinions written by non-medical contributors

NEWS

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

ANNOUNCEMENTS

* Congresses, symposia, workshops
* Publications, especially books

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

REVIEW / ORIGINAL ARTICLES

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

* A 300 word abstract that succinctly summarizes the content will be required.
* Referencing should preferably conform to the Vancouver style i.e. superscript numeral in text (outside the full stop with the following illustration for the reference section: *Other AN, Person CD. Title of article. Name of Journal, Year of publication; Volume (Issue): page number/s. doi number (if available);* Harvard style or variations of either will also be acceptable
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Give your patients the benefit of a psychotropic that adapts to their needs[1]

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Is indicated for the treatment of depression; and mixed anxiety and depression[2]

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Demonstrates **comparable antidepressant** activity to TCAs, SSRIs and SNRIs **without the tolerability issues of SSRIs** i.e. **insomnia, anxiety and sexual dysfunction[5]**

SARI = serotonin antagonist and reuptake inhibitor; TCA = tricyclic antidepressant; SSRI = selective serotonin reuptake inhibitor, SNRI = serotonin-noradrenaline reuptake inhibitor

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For full prescribing information refer to the professional information approved by the Regulatory Authority.

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