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JANSSEN PHARMACEUTICA SOUTH AFRICA

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Dear Reader,

Welcome to the 3rd issue of South African Psychiatry. A great failing is to err and not to acknowledge, so as Editor-in-Chief it is incumbent on me to acknowledge that there were a number of errors in the last issue – February 2015. Specifically, there were quite a few typographical errors, none of which detracted from the content or look and feel of the issue but nonetheless were not pleasing to me or the team. All noted errors have been amended in the electronic version of the February 2015 issue www.southafricanpsychiatry.co.za. As a consequence it has made us review our editorial processes, and hopefully such errors will be eliminated.

Having said that, I do need to note a specific query from one of the authors published in the February 2015 issue. Christa Kruger raised a specific query in relation to the title of her article on dissociation. She noted that the title should have read “Training of dissociation…” rather than what was published i.e. “Training of dissociation...”. This has been amended in the electronic version of the February 2015 issue.

The current issue has a very specific focus in terms of Feature content, namely projects related to leadership and mental health. These projects relate to a public-private partnership that has sought to develop skills, competence and confidence in advancing services within the public sector. Each project comprised a multi-disciplinary membership, with a focus on community orientated services. The content in this issue reflects almost 2 years of mentored progress, with mentorship providing a unique component. The experiences of the mentors will be reflected in the August 2015 issue of South African Psychiatry. Aside from the development of individuals and the benefit to patients, the process itself has been one that has provided a much needed dose of optimism for the participants – all of whom are state employed, with some University affiliated – and demonstrated what should be possible outside of this initiative. Hence it was very interesting to note a recent development at Groote Schuur Hospital where R900 000 was allocated to clinician initiated projects aimed at improving services. The funding came from within the institution. This is precisely what the current initiative has been – clinician initiated projects that advance and improve patient care. I would like to think that the initiative has been silent in the vanguard, with a focus on Psychiatry and mental health at sites across the country. As a consequence of the success of this initiative, further funding was secured for a Public Mental Health Forum that is due to take place in Johannesburg in October 2015. Public Mental Health is an emerging discipline within Psychiatry and although not conceived as such – the mental health leadership initiative that these projects emanate from stepped squarely into this territory. A recent edition of World Psychiatry (February 2015) devoted a significant portion of content to Public Mental Health and it appears prudent for local Psychiatry and allied disciplines to familiarize themselves with what I believe will in due course become a further area of sub specialist training having been included in the FCPsych II curriculum. One of our other Feature articles relates to an exciting collaboration between the Departments of Psychiatry at the University of the Witwatersrand and the University of British Columbia in Vancouver, Canada. Over the past 18 months staff from the University of the Witwatersand and the University of Pretoria have received formal training and clinical supervision in Neuropsychiatry with the content of the article describing the programme. As usual we have Departmental news and reports as well as announcements of events from around the country. I believe that with each issue we consolidate the role we strive to fulfill, as a hub for communicating important information about the discipline of Psychiatry in South Africa. As always, I invite you to think about what you could say related to what you do and what is happening in your neck of the woods – we’re not only listening, we want to receive and share. I look forward to hearing from you. Enjoy the issue!

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AN ASSERTIVE COMMUNITY TREATMENT PROGRAM IN THE DEPARTMENT OF PSYCHIATRY AT CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL

A variety of community based models have been suggested to aid the comprehensive management of psychiatric out-patients. Unfortunately, there is a lack of literature which puts these models on trial in South Africa, as well as a scarcity of indigenous and originally developed models from South Africa itself.

Zamo Mbele and Jacqui Edgar

Assertive Community Treatment, or ACT, is an intensive and highly integrated approach for community mental health service delivery. Basic tenets of the ACT programs include but are not limited to; “assertive engagement, in vivo delivery of services, a multidisciplinary team approach, continuous responsibility and staff continuity over time, caseloads with high staff-to-client ratios, and brief but frequent contacts (high service intensity)” (Scott and Dixon, 1995, p.1). The ACT teams are also required to provide close liaison with the client’s support systems and treatment is focused on alternate activities (Taube et al. 1990). An ACT program comprises of several interventions including telecommunication with patients, family support groups and outpatient groups.

Several studies have demonstrated the effectiveness of Assertive Community Treatment in the management and rehabilitation particularly of patients recovering from a first episode mental illness and admission (see Verhaegh, Bongers, Kroon, & Garretsen, 2007; Peterson et al., 2005; Jorgensen, et al., 2000; Penn et al., 2005 for example). The overall endeavour of the program is to improve compliance with treatment, thereby reducing the probability of relapse and readmission following an index admission and diagnosis with a mental illness.

CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL & THE DEPARTMENT OF PSYCHIATRY

Chris Hani Baragwanath Academic Hospital (CHBAH) or Bara, is situated and services the South Western Township (SOWETO) of Johannesburg, Occupying around 173 acres (0.70km²), with approximately 3200 beds and about 6 760 staff members, Bara is the largest hospital in the Southern hemisphere. The Department of Psychiatry is responsible for the treatment and management of all psychiatric patients at Bara, offering both inpatient and outpatient services.

THE DEPARTMENT CURRENTLY HAS FOUR ADULT PSYCHIATRIC WARDS WITH A TOTAL OF 105 BEDS. BED OCCUPANCY RUNS AT APPROXIMATELY 100% AND THERE IS AN AVERAGE OF 15 ADMISSIONS PER DAY.

The Department also boasts three specialized outpatient clinics of which the adult outpatient clinic sees about 400 patients per month.

The Department of Psychiatry is responsible for the treatment and management of all psychiatric patients at Bara, offering both inpatient and outpatient services.

The Department currently has four adult psychiatric wards with a total of 105 beds. Bed occupancy runs at approximately 100% and there is an average of 15 admissions per day. The Department also boasts three specialized outpatient clinics of which the adult outpatient clinic sees about 400 patients per month.
THE CHBAH ACT PROGRAM

The CHBAH ACT program is an adaptation of the original Assertive Community Development principles, modified for the current stage of the overall project at Bara. This program was designed through a collaboration of psychological literature and occupational therapy principles.

PSYCHOLOGY

(The psychological program was developed by Tyrone Edgar M.A. Clin.Psyc.)

The psychological component of the CHBAH ACT PROGRAM (CAP), aims to provide the index psychotic patient with a foundational management of mental illness. It combines aspects of the Unified Protocol (UP) for Transdiagnostic Treatment of Emotional Disorders (Barlow, Farchione & Fairholme et al., 2011), Cognitive Processing Therapy (CPT): Veteran Military Version (Resick & Monson, 2008), Mood Charts (Miklowitz, 2008), daily routines (Beck, 2011), and 8 steps to mental wellness (Bentley, 2013).

The CAP has 6 sequential components. Each component encourages the integration of 8 steps to mental wellness (Bentley, 2013) into a daily schedule.

The 8 steps to mental wellness involve:

1. Seeing a doctor
2. Taking Medication
3. Understanding the Illness
4. Healthy eating
5. Exercise
6. “Doing”
7. Relating to others
8. Nurturing oneself

In addition to a daily routine, the patients are encouraged to complete a mood chart and relate any fluctuation in mood to deviations in the 8 steps. Matching mood states with the 8 steps is intended to provide patients with a foundation in which to monitor psychological stress effectively.

Distilling the UP’s components of ‘emotional experience’, the CAP introduces the concept of ‘emotion driven information’ (EDI). The term EDI is taken to mean ‘any information, direction or guidance an emotion generates to guide behaviour’. The intention of the term EDI was to introduce a simplified awareness that emotional information can guide behaviour. To aid this process, six main emotions, outlined in CPT, are used to help patients gain insight into what kind of EDI can be expected from which emotions. The patients are encouraged to challenge EDI utilizing the 8 steps to mental wellness.

Subsequently, the link between EDI and EDB’s is highlighted to help patients pause before adopting non-adaptive emotional actions. Patients are encouraged to challenge EDB’s by comparing EDI with information derived from the 8 steps for mental wellness. Patients are encouraged to report on their progress through their daily routines and mood charts. In this respect, the aim is for patients to begin adopting a foundational way of managing mental illness.

‘PSYCHOEDUCATION’ IS ALSO AN ESSENTIAL PART OF THE PROGRAM, WITH A COLLABORATIVE APPROACH BEING ADOPTED WITH PATIENTS BEING ENCOURAGED TO PARTICIPATE IN THE PROCESS OF ‘GETTING TO KNOW THEIR DIAGNOSIS’ AND ‘GETTING TO KNOW THEIR TREATMENT’

OCCUPATIONAL THERAPY

(The occupational therapy program was developed by Jacqui Edgar)

Stress management is the primary focus of the occupational therapy sessions as stress is a major cause of relapse in patients with mental illness. The program addresses the following areas:


- Patients are assisted to identify “resources” at their disposal. Resources are individuals, activities or structures that reduce stress levels for the patient. For example, talking to a loyal and supportive friend, doing an activity that they find enjoyable or consulting with a professional that they have established rapport with. Once resources have been identified, the patients are encouraged to identify things in their lives that do not reduce their stress levels even though it may seem that these things should be useful. For example, socializing with friends that uses substances; shopping that leads to debt, excessive sleep etc. Patients are encouraged to access their resources while reducing the frequency of activities/people that have been identified to be harmful.

- The difference between positive and negative coping strategies is addressed. Patients are
encouraged to identify the negative strategies that they have been implementing and substitute them with more positive, healthy coping strategies.

• The importance of a solid support structure is highlighted and patients are required to identify people in their lives that they are able to obtain support from.

• Leisure exploration is facilitated and patients are required to identify leisure activities that they are able to perform with their resources at home for example exercise, sport activities, crafts, reading etc. The leisure tasks are incorporated into the daily routines of the patients to promote constructive use of time.

• Lastly, constructive use of time is addressed and patients are educated on the importance of a balanced routine in order to prevent relapse (Cynkin and Robinson (1990) - Activities Health Model)

EXPERIENCES

The multidisciplinary team frequently evaluates aspects of the program in order to improve adherence to the program, internalization of information and subsequently prevent relapse. At the end of each rotation, the patients are also requested to provide feedback on their experiences. The following notes the aggregate of the opinion vis-à-vis ‘what worked’ and ‘what did not work’.

WHAT HAS WORKED...

The multidisciplinary team approach to the program has yielded positive results. The design of the six week program and the implementation relied on a multidisciplinary team as it represents a convergence of occupational therapy and psychological theory and practice. During the implementation of the program, psychiatry was also consulted extensively in a bid to improve the overall management of the patients.

Recruiting family in treatment is a key intervention with community treatment and particularly assertive community treatment plans. When family members have been available to participate, the prognosis of the patient has been assessed to improve and the family members have presented themselves as protective factors in the dynamic formulation.

Allocating case managers for each patient has increased the consistency in the overall management of the ACT patients, with patients expressing their appreciation of a known person who they can develop rapport with and contact when necessary.

Regular contact with patients has allowed for increased assessment of their progress and early detection of symptoms ahead of a relapse.

‘Tea and scones’ were provided for patients compliments of the MDT. This gesture was visibly appreciated by participants and was associated with both abstract and physical nurturance. The time spent sharing in the ‘tea and scones’ allowed participants to interact which improved the overall rapport of the group, fostering group cohesion.

WITH REGARD TO AN EVALUATION OF THE PROGRAM, THE FOLLOWING WAS NOTED;

• The practical implementation of leisure, relaxation and social activities in the group program has shown to be effective in improving the ability of patients to reduce stress, improve mood and their constructive use of time.

• The patients were introduced to 6 primary emotions and were encouraged to identify these emotions in themselves and others throughout the 6 weeks. This knowledge seemed to generate a more objective awareness of emotional content, providing the patients with a less subjective and overwhelming experience of emotion. In addition, the notion of emotion driven behaviour (EDB) seemed to help the patients understand the connection between emotional information and behaviour. This provided the patients with some insight into the connection between managing emotional content in such a way that it produces healthy outcomes.

• It became fairly clear, after the conduction of the first group program, that the volume of information the patients were expected to internalize was unrealistic. Patients were being made aware of many techniques, however, the program did not allow for true internalization and therefore the skill to implement the strategies into their daily lives. It was evident that a more repetitive, basic program would allow for better application of skills.

• The content of the program was reduced to focusing on stress management and the link between emotion driven behavior and the 8 steps to mental wellness.

• The initial program was 8 weeks in length and it was agreed by the MDT that this was too long as patients were unable to commit to attending all sessions as a result of logistical and practical limitations such as financial constraints. The length of the program was therefore reduced to 6 sessions to improve attendance.
CHALLENGES

Finances:
The patient population identified for the purposes of this pilot program is known to belong to the lower-class of the socio-economic standard. Compliance with treatment is hindered by logistics such as transport costs. In a bid to eliminate these confounding variables, the program aims to provide transportation costs for the ACT groups starting in 2015.

Lack of human capital as a resource:
Initially, few staff members were involved in the project, resulting in a high work load for the ACT team members, occasionally impacting on the effectiveness of the service being provided. However, the team has been expanded to include three occupational therapists and 2 psychologists conducting the program. This has allowed staff to conduct the groups on a rotational basis, allowing for better utilization of human resources. The project hopes to recruit other essential members as dedicated members of the team, including a psychiatrist, a psychiatric-nurse, and a social worker, all of which are necessary for the delivery of a quality and comprehensive service.

Looking forward:
As the program only serves as a foundation in the management of mental illness, it is important that patients are given the opportunity to continue therapy once they have completed the program based on their needs. Therapy may be in the form of individual psychotherapy and occupational therapy or referral to an identified group such as a coping skills, vocational skills etcetera, as well as partnering with additional stakeholders for further referral.

The program has an opportunity to produce research outcomes in line with the academic institution. In this regard, a data base containing basic patient information was established for future research possibilities. Furthermore, an occupational therapy outcome measurement tool, the APOM (Activity Participation Outcome Measure) developed by Prof. Daleen Casteleijn, is currently utilized to measure the therapeutic outcomes at the end of every group.

The patients’ performance in 8 domains (Communication skills, Self esteem, Balanced Lifestyle, Life skills, Role performance, Process skills, Motivation and Affect) is assessed prior to the program and after the patients’ completion of the program. The aim of the assessment is to identify the main areas of function that the program has served to improve, while taking note of aspects that are not a focus of the program. Further, patients also have an opportunity to benefit from feedback produced in the pre-and-post assessment through the APOM.

CONCLUSION

Two years into the ACT program the team is more confident of having developed an acute therapeutic process which is beneficial to the patient population identified, improves prognosis and reduces relapse rates - as demonstrated in data collected. The assertive nature of the program is resource intensive, currently employing five fulltime members to administer and manage the program and one part-time consultation post for training purposes. Further, this staff complement is likely to increase as the research and academic opportunities are developed.

The ACT team has considered expanding the program beyond the acute six-week group program by partnering with intermediate and long-term facilities and institutions. Overall, the investment in outpatient management and treatment of the selected patient population has been demanding, however it has also been rewarding as demonstrated by the data. Importantly the appreciation and gratitude expressed by the individuals who have been part of the program has been noteworthy.
As a member of one of the six groups who proposed projects and participated in the Sanofi Mental Health Leadership Initiative, developed by Christopher P Szabo (Department of Psychiatry, University of the Witwatersrand) and Jennifer Fine (SANOFI Senior Medical Advisor), I collaborated with Craig Bracken (psychiatrist, Helen Joseph Hospital – HJH), Florence Makobonyane (Deputy-Director, Nursing, City of Johannesburg District - COJ) and Salome Mashile (Deputy-Director, Gauteng Directorate of Mental Health. Our allocated mentor was Shan Naidoo (School of Public Health, University of the Witwatersrand). Our project was entitled “Improving access, referral and service delivery of mental health and psychiatric care in the Joburg Metro District - Helen Joseph Hospital Catchment Area, Gauteng Province”. The project adopted both a broad and narrow scope. The broad scope, implying a top-down process, proposed the development of a COJ (Joburg Metro) and HJH catchment area action plan. The first step of this process was to compile a state of affairs report. The narrow scope, implying a bottom-up process, focused on the referral of patients between HJH and the four main referring community psychiatry clinics. This required collaboration and improved communication between the hospital and these clinics regarding down-referral (from HJH to community clinics) and up-referral (to HJH for admission and for outpatient assessment). Activities included proposed monthly liaison meetings in which patient information was reviewed regarding discharge and referral, and to identify patients lost to follow-up.

The development of this project was motivated in terms of the following real life challenges:

- Increasing numbers of patients, of whom many were being readmitted continuously and with more than 600 outpatients attending HJH Psychiatric OPD at the time, which resulted from an increasing demand, but also from the extent of fragmentation of the referring community based services.

- Irregular supplies of psychiatric medication, poor adherence to treatment and lack of follow-up, as well as the inherent pervasive stigma towards mental health care users and providers, which all further exacerbated the already challenged service delivery situation.

- The lack of funds available to appoint staff due to the limited allocation of funding to psychiatry and mental health in general.

- The urgent need to effectively translate policy to effective service and academic programs in terms of the HJH psychiatric unit’s assigned mandate within the regional referral system. This requires facility and provincial commitment to ensure the appropriate allocation of resources, as well as the introduction of support systems and regular progress reviews.

- The lack of a long term commitment to additional funding and the improved prioritization of psychiatric and mental health care, to effective and cost-effective service delivery as an outcome, as well as to the improvement of the mental health status of people living in the hospital’s catchment area.
In terms of the broad scope of view, the following seven options for resolution were proposed:

1. Consultation and liaison between service levels on a regular basis.
2. Inclusion of a psychiatrist in the proposed NHI district clinical specialists support teams.
3. Mental health care costing and designated budgets.
4. Strengthening of district specialist mental health teams.
5. Implementing the adopted principles for the referral of care users in Gauteng.
6. Psychiatric units in general specialist hospitals in terms of the eight objectives of National Mental Health Action Plan.
7. Implementing a mental health and psychiatric information system.

The following stakeholders were identified in this regard:
- The central hospital in the referral cluster (Charlotte Maxeke Johannesburg Academic Hospital).
- Helen Joseph Hospital (as the tertiary hospital in the cluster).
- The two specialized hospitals (Tara and Sterkfontein hospitals).
- The different secondary hospitals (Rahima Moosa, Tambo Memorial, Natsalspruit, Far East Rand and Edenvale hospitals).
- As well as the more than 20 ambulatory specialist psychiatry clinics, district hospitals (Berta Gxowa, South Rand and Heidelberg), community health centers - CHC (Hillbrow, Discoverers and Alexandra) and at least 33 primary health care clinics in the COJ and Ekurhuleni districts.

Specific challenges to the resolution of the stated problems included:
1. The lack of translation of existing policy into practice and measurable service action plans.
2. Staff and services not being orientated regarding logical geographical catchment areas for the different levels of referral system.
3. With regard to the referral within the central hospital cluster to which HJH belongs, line functions of clinician responsibilities do not currently include the management of services at this level, and as such, attempts to do so may be overreaching individual clinicians’ responsibilities.
4. Poor access of clinicians to decision-making structures at all levels, which could possibly be improved through the collective access of the SASOP’s regional and national structures.
5. The limited number of available psychiatrists and the need to consider appropriate “skills transfer” and training.
6. Poor access to and poor maintenance of databases, including updating information and developing capacity to provide regular and reliable reports (which will have significant implications for the successful implementation of the NHI).
7. The need to complete the “mapping” of existing services and referral patterns, as well as to establish routine planning cycles on all levels.

The goal of developing an action plan for the COJ (Joburg Metro)/HJH catchment area was not achieved during the period of the project, but the following could be a way forward:

- Continued participation in cluster coordination meetings to collate and map the information on service provision and patient referral.
- Liaison between the University of the Witwatersrand’s Departments of Family Medicine and Psychiatry on referral principles, standard treatment guidelines and prescriber levels of available medication.
- A proposed workshop with staff from HJH and specialist community clinics, CHC’s and district hospitals in HJH catchment area.

THE NATURE OF THE PROJECT WAS SUCH THAT SIMPLY DELINEATING THE PROBLEMS, THE ROLE PLAYERS AND A PROPOSED PLAN OF ACTION TO ADDRESS THE PROBLEMS WAS VIEWED AS PROGRESS IN SO FAR AS PROVIDING A FOUNDATION FOR ACTION. WHILST THE SANOFI MENTAL HEALTH LEADERSHIP INITIATIVE HAS FORMALLY CONCLUDED, THE WORK THAT HAS COMMENCED WILL CONTINUE.
Involvement with the SANOFI Mental Health Leadership Initiative led to the development of the “HIV Paediatric Project”. As can be seen from Figure 1 below, there were a number of components. Improved adherence to Anti Retroviral Treatment (ART) has been a major objective with a range of related activities to facilitate such an outcome.

Rene Nassen and Anbrenchia Moos

1. GROUP INTERVENTIONS

A notable outcome has been occupational therapists developing a programme to provide craft groups as a supportive space and also to possibly detect neurocognitive problems. Family sessions have been initiated by the Lentegeur social worker. Drumming groups will be initiated at Lentegeur Hospital.

2. HIV MENTAL HEALTH CLINIC

Focus groups were held with users (parents and adolescents) as well as providers (clinicians running ART sites in DOH, City and Medecin Sans Frontiers MSF - i.e. ‘Doctors Without Borders’). There was consensus that mental health and neurocognitive problems greatly impact on Anti Retroviral Treatment adherence and may be resulting in treatment failure rates as high as 30% (MSF). A decision was made to start a dedicated HIV/paediatric neuropsychiatry clinic. A potential site for the clinic was identified and will be Khayletisha District Hospital. Meetings were held with managers and paediatric colleagues.
involved with HIV care and it was agreed that a dedicated meeting would be held to plan the clinic. This clinic will run in collaboration with 2 medical officers at the hospital and will receive referrals for a wide range of neuropsychiatric problems, including (but not exclusively) paediatric HIV. This initiative will form part of the Lentegeur Child and Adolescent Mental Health outreach and skills transfer initiative.

3. HIV SYMPOSIUM

The symposium, which was reported on in the February 2015 issue of South African Psychiatry, was successfully delivered in November 2014.

POSITIVE FEEDBACK WAS RECEIVED FROM ATTENDEES WHO COMPLETED EVALUATION FORMS AS WELL AS EMAILS FROM CONGRATULATING THE LENTEGEUR TEAM ON EXCELLENT CONTENT BUT ALSO A PROFESSIONAL EVENT COORDINATION.

An administrative assistant, Shannon O’Rourke was appointed to assist with the planning/organisation of the symposium. She has an undergraduate degree in medical anthropology (University of British Columbia) and is about to embark on a Masters in anthropology at UCT (2015). One of the emails received highlighted the uniqueness of the event in that the attendee (a subspecialist trainee in child psychiatry), for the first time experienced clinicians and researchers from all levels of care, contributing to discussions about the topic (see content below).

The speakers consisted of CAMH clinicians (from Lentegeur), a child psychiatrist from a tertiary hospital, a neurodevelopmental paediatrician (tertiary), a HIV doctor (primary level), a researcher (Stellenbosch University) as well as the country director for the Children’s HIV Association (CHIVA).

Attendees comprised clinicians, health professionals, researchers and trainees at all levels of care and the NPO sector and included well published researchers in the field of HIV (eg the CHER Project). There was an appeal for similar type training initiatives as it is much needed. Contact has been made to request that the screening tools be incorporated in the HIV directorate assessment packs in paediatric HIV clinics. There has also been contact from a Stellenbosch University affiliated NPO called SOUTH TO SOUTH, requesting training input from the Lentegeur team to their programmes as well as a congratulatory email from the director of medecins sans frontiers.

The symposium was funded through donations from the South African Society of Psychiatrists HIV Special Interest Group as well as SANOFI through the Mental Health Leadership initiative.

FEEDBACK FROM AN ATTENDEE

Dear Dr Nassen

I am writing to thank and congratulate you for organizing the HIV Symposium, which ran on 13 and 14 November 2014, at the College of Medicine in Cape Town. I attended both days of the symposium, and found it to be both academically enriching and enjoyable.

I was particularly struck not only by the wide range of disciplines represented at the symposium, but also by the range of contexts and working platforms represented. It was refreshing and interesting to me to hear first hand what projects are being run in the community, and by whom, and to learn about the variety of assessments, interventions and support being implemented for children and adolescents with HIV. I think the symposium also served as an excellent networking platform in this regard.

It was great to receive the box of screening tools, rating scales and journals. I am particularly excited by the HAND screening tool, and will be watching this space regarding its further development and validation.

While I enjoyed the more academically slanted presentations too, I found the presentations on drumming, storytelling and the talk regarding the body-mapping artwork on display, particularly refreshing. I think that they managed to foster in the attendees a sense of richness of experience and a sense of unity and communitarianism.

Thank-you again and congratulations,
PLANS FOR 2015

- Validation of HAND tool
- Engage with ART sites to pilot use of screening tools
- Establish craft group at MMCHC
- Establish paediatric neuropsychiatry clinic at local district hospital
- Follow-up meeting with HIV clinicians in Khayelitsha area (DOH and MSF).

PERSONAL REFLECTIONS ON PARTICIPATION IN THE SANOFI MENTAL HEALTH LEADERSHIP INITIATIVE:

Anbrenthia Moos:
Attendance of the leadership programme and witnessing the fruition of the project has resulted in huge personal growth in relation to developing leadership skills, project management, and acquiring knowledge in the field of HIV. My involvement in the leadership programme has resulted in the development of a screening tool for HIV associated neurocognitive deficits (HAND), which is culturally appropriate for the South African context but has spurred me on to improve my research/academic outputs by embarking on a Masters in public Health at the University of the Western Cape (UWC).

I AM PLEASED TO REPORT THAT I HAVE SUCCESSFULLY COMPLETED THE MANAGEMENT MODULE (AS PART OF FULFILLING DEGREE REQUIREMENTS) AND PASSED WITH DISTINCTION! I ALSO PLAN TO VALIDATE THE TOOL AND LOOK FORWARD TO THE PUBLICATION AND ROLL OUT OF THE TOOL.

I was also granted the opportunity to participate in the development of the first paediatric guidelines (published in SA HIV journal, in September 2014), as a co-author. I have recognised the value of being receptive and open to this opportunity to participate in the programme at short notice as it has resulted in huge personal and professional growth. I have firsthand experienced the growth of leadership within myself but also the inspiration that leadership can galvanise.
Rene Nassen:

I have experienced the content of the leadership programme, interaction with attendees and mentor as personally and professionally enriching. This has been a great leadership opportunity to construct and implement a programme which will significantly impact on the care of HIV+ children. Regarding the HIV symposium: I designed the programme and liaised with speakers. My intention was for speakers to be from primary, tertiary and research sectors which was a huge strength of the programme. There were significant challenges in navigating different sectors/systems i.e. DOH, university and CMSA.

One of the challenges was the financial aspect i.e. managing the financial bequest from Sanofi and completion of the contractual agreement, whether money should be deposited in the Facilities Board of the hospital versus the University. Eventually ‘red tape’ could not be overcome and SASOP stepped in to assist and administered the funds. The learning curve was about navigating that interface, delegation of tasks, trust and motivation of the team, moving on despite mistakes, and willingness to learn from them and accept negative feedback by seeing the positive. I understand how important it is to remain motivated and determined to persevere despite difficult territory to navigate and to recognise that ‘change management’ needs to be a focus if one wishes to implement something innovative or ‘different’. It is also important to be familiar with the governance, regulations and procedures within each institution, e.g. policy frameworks such as leave, consent from employer etc.

On a positive note, despite the challenges we have actually reached completion and stayed ‘on track’. Our time management has been excellent as we set ourselves manageable tasks, with an action list which was updated regularly at planning meetings. During the final 3 months prior to the Symposium, we were able to employ an admin assistant without whom we would not have coped. She still has to be remunerated as per our agreement (that she will be paid in 2015). Our other achievements are that both Anbrenthia and I have created locally applicable HIV screening tools, I was first author for the paediatric HIV guidelines (she co-authored) and I believe that we have impacted in a tangible way based on hugely positive feedback and requests to engage with various colleagues involved with HIV care. We anticipate collaborations which will be more integrated and have emphasised the value of mental health clinicians, to HIV care.
THE DEVELOPMENT OF A NEUROPSYCHIATRIC PROGRAMME AT THE UNIVERSITY OF THE WITWATERSRAND

Neuropsychiatry was recently promulgated and accepted as a sub-specialty of psychiatry within the Health Professionals Council of South Africa (HPCSA) and the Colleges of Medicine South Africa (CMSA). The Department of Psychiatry at the University of the Witwatersrand therefore needed to meet the requirements as set out by the College of Psychiatry within the CMSA.

Two universities leading in this field are the University of Cape Town and Stellenbosch University, both of whom have established Neuropsychiatry Masters in Philosophy programmes. As there were no trained Neuropsychiatrists at the University of the Witwatersrand we needed to develop expertise within this sub-specialty and establish rotations at hospitals serving the academic complex. This necessitated identifying trained psychiatrists with an interest in neuropsychiatry and currently working within the field at the relevant hospitals. Formal training within Neuropsychiatry therefore demanded inviting experts and sub-specialists to teach and train these identified psychiatrists on site. Our aim was for the identified psychiatrists to register as Neuropsychiatrists within the HPCSA, enabling adequate training of registrars and finally training sub-specialists in the future. HPCSA rules necessitate that two psychiatrists, registered in the sub-specialty together with an accredited unit be available before training of sub-specialists is allowed. Once constituted, the Department of Psychiatry (University of Witwatersrand) would then be able to form a Division of Neuropsychiatry within the Department developing and training Neuropsychiatry within Gauteng province. The hope being retention of skills within the province and the University.

We therefore needed to partner with specialists in the field, particularly those overseas with a reputation for Neuropsychiatric excellence. The partnership with the University of British Columbia’s Neuropsychiatry programme was established and Prof Trevor Hurwitz, a qualified Neuropsychiatrist and head of the Neuropsychiatry programme at the University of British Columbia in Vancouver Canada formally became our educator. Prof Hurwitz is an internationally renowned expert in the field of Neuropsychiatry and is the editor of the Casebook of Neuropsychiatry, (American Psychiatric Publishing, 2013). We needed to devise a cost effective long distance programme together with on site supervision. A curriculum was developed and a teaching programme which involved two, one week on site teaching opportunities and video conferencing teaching sessions which involved formal teaching and presentation of cases, where the relevant supervision was to be received. Meeting the teaching and training needs of future specialists required funding. Funding opportunities were applied for through the University of the Witwatersrand and the Department of Education but were unfortunately not successful. We were however able to create and develop a short course through the University without funding opportunities. The aim of the short course was to enhance the knowledge and competence of specialists in the diagnosis and management of common Neuropsychiatric disorders. Dr Sue Tager, (CEO, Wits Donald Gordon Medical Centre) was approached, who was extremely interested in getting involved in training sub-specialists and contributing to retention of skills within South Africa. This would ultimately bring improved clinical knowledge and care and create an area of research expertise, adding to the Wits Donald Gordon medical centre’s aspirations. Funding was therefore granted and the project initiated, supported by Professor Christopher Paul Szabo (Head of Department of Psychiatry, University of Witwatersrand) and Professor William Honer (Head of the Department of Psychiatry, University of British Columbia).

This unique and innovative project began in May 2014 and to date we have had two on site teaching opportunities where Prof Hurwitz has travelled to South Africa and supervised this process. The two week
on site teaching opportunities included didactic lectures and case presentations at different hospitals, covering a wide range of conditions/disorders within Neuropsychiatry. Monthly case conferences and video conferences are held, using the innovative and progressive “video conferencing” platform at the Wits Donald Gordon Medical Centre. The platform allowed secure case presentations and discussions to take place, with review of neuroimaging findings where appropriate. This has allowed multiple consultants at different locations (within Johannesburg and in Vancouver) to join together using technology to connect and acquire knowledge, essentially making geography ‘irrelevant’.

This project is unprecedented in South Africa by virtue of the collaboration of interested individuals at multiple hospital sites, the involvement of other experts from related disciplines including, Neuropsychology and Neuroradiology and supervised and trained by Prof Hurwitz who is the medical director of The BC Neuropsychiatry Program (BCNP). The BCNP is accredited by the United Council of Neurologic Subspecialties (USA) as a training program for Behavioral Neurology and Neuropsychiatry, thus accessing a training program in the subspecialty of Neuropsychiatry that is currently not available in South Africa.

We have formed a geographically distributed network of consultants willing to help and learn from each other with the goal of improving clinical neuropsychiatric services and establishing this subspecialty as an academic and clinical discipline in the Gauteng province. Retention of skills and creation of a critical mass of such tertiary specialists is vital if Neuropsychiatry is to survive as a clinical discipline in South Africa. Research provides the academic framework for this subspecialty and our project has established the infrastructure for multi site project partnerships that will further the development of the science of Neuropsychiatry. Research has already begun and we are currently collaborating on two research projects with the University of British Columbia’s Neuropsychiatry programme and anticipate many more in the future. We also envisage exchange programmes between international Universities and the Universities of Gauteng.

Once adequately trained, supervision will be ongoing through videoconferencing with the British Columbia’s Neuropsychiatry programme through the expertise led by Prof Hurwitz. The initial goal of the project is the grandathering of relevant specialists with the necessary clinical exposure, knowledge and skills to create a Neuropsychiatry sub-specialist programme charged with the mandate to further this subspecialty in South Africa via training, the creation of dedicated posts within a resource restricted environment and the establishment of HPCSA accredited subspecialty units.

This project has also demonstrated the viability of public private partnerships where collaboration allows for the growth and the development of skills and expertise that would be difficult to accomplish by a resource constrained public sector acting alone. Lastly this project demonstrates the dawn of a new era of telemedia facilitated international collaboration in science and education where geography is rendered meaningless all to the benefit of the patients we serve.

The Neuropsychiatry team includes consultants from the University of the Witwatersrand and the University of Pretoria:

Gregory Jonsson is a psychiatrist based at Chris Hani Baragwanath Hospital and a lecturer in the Department of Psychiatry, University of the Witwatersrand. He has a special interest in HIV and is currently undertaking a PhD in a related field. Correspondence: Gregory.Jonsson@wits.ac.za

Christopher Paul Szabo is a psychiatrist and Head, Department of Psychiatry at Charlotte Maxeke Johannesburg Academic Hospital as well as Head, Department of Psychiatry, University of the Witwatersrand. Correspondence: Christopher.szabo@wits.ac.za

Trevor Hurwitz is a neuropsychiatrist and Professor of Psychiatry at the University of British Columbia, Vancouver, Canada. Correspondence: t.hurwitz@ubc.ca

Sue Tager is a neurologist and the Chief Executive Officer at the Wits Donald Gordon Medical Centre in Johannesburg. Correspondence: sue.tager@mediclinic.co.za

William Honer is a psychiatrist and Jack Bell Chair in Schizophrenia, Professor and Head, Department of Psychiatry as well as Director, Institute of Mental Health University of British Columbia, Vancouver, Canada. Correspondence: honer@mail.ubc.ca
Both exercise and meditation are beneficial for patients with depression. Neuroimaging and biochemical studies have demonstrated that both interventions are associated with structural changes in the brain and biochemical effects in the central nervous system and body that modulate mood and sense of wellbeing.

ARE CURRENT TREATMENT OPTIONS FOR DEPRESSION ACHIEVING OPTIMAL RESULTS?

Remission rates with current antidepressant pharmacotherapies are low. Even among those who do respond to initial treatment, approximately 50% will relapse within 1 year.

The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study evaluated the effectiveness of antidepressant treatment among outpatients with major depressive disorder. Initial monotherapy with a selective serotonin reuptake inhibitor (SSRI) achieved remission in only just over one quarter of patients. Among the remaining patients, approximately 30% achieved remission after augmentation with bupropion or buspirone, and switch to another SSRI, serotonin-noradrenaline reuptake inhibitor (SNRI), or bupropion achieved remission in approximately 25%. Further augmentation for nonremitters with lithium or triiodothyronine, or switch to mirtazapine or nor triptyline achieved remission in fewer than 20% of patients. A fourth treatment period including either medication augmentation or switch improved remission rates by less than 15%.6

Reasons for low rates of remission and high rates of relapse in responders are unclear, but there is clearly a need for nonpharmacological approaches to management of patients with depression.

MANAGEMENT FOR DEPRESSION NEEDS TO GO BEYOND TREATING MOOD

Mood disorders are intricately linked to behavioural parameters, including exercise, sleep, substance misuse and smoking, and also to other medical conditions such as systemic inflammation, coronary artery disease, obesity and insulin resistance, osteoporosis and pain.

In the light of this observation, when treating depressed patients it is appropriate to not only consider mood, but also to address ‘wellness’, taking into consideration the patient’s overall health, sense of wellbeing and positivity, and physical and mental functionality.

I) EXERCISE IN THE MANAGEMENT OF DEPRESSION

SUMMARY

- Exercise is associated with structural and biochemical changes in the central nervous system and body that influence mood, attitude, the activity of the immune system and the stress response.

- Exercise improves mood in depressed patients and augments the effect of antidepressant medication.

- In order to ensure that patients safely embark on an exercise programme that they will adhere to, they will need to be educated about the benefits of exercise, how to perform it and how to include it into their lifestyle.

THE NEUROBIOLOGY OF EXERCISE

Voluntary physical activity influences metabolic and neurochemical pathways in skeletal muscle, the spinal cord and the brain. Exercise influences brain plasticity by facilitating neurogenerative, neuro-adaptive and neuroprotective processes. It also enhances executive functions of cognition and some types of learning, including motor learning in the spinal cord. These adaptions in the central nervous system may be associated with positive effects that are relevant to the prevention and treatment of a wide array of medical conditions, including obesity, cancer, depression, age-related cognitive impairment, Parkinson’s and Alzheimer’s diseases, ischaemic stroke and head and spinal cord injury.

Chronic physical activity also has central effects that regulate and attenuate the stress response and peripheral sympathetic activity. These processes
may be beneficial in clinical disorders, such as hypertension, heart failure, oxidative stress and suppression of immunity.

Exercise may impact on mood, memory and anxiety through its actions on three different physiological systems, namely neurotrophins (growth factors) in the brain, the parasympathetic nervous system and the inflammatory response. It may also have a direct antidepressant effect through its influence on the endogenous cannabinoid and opioid systems.

* Physical exercise directly and positively impacts on the neuroanatomical structures involved in mood regulation

Studies have demonstrated that exercise directly stimulates growth and development of new cells in the hippocampus. These effects are observable as early as 10 days after initiating an exercise program. Furthermore, there is a direct relationship between peak oxygen uptake in tissues (VO2 peak) as a measure of fitness and hippocampal volume (left and right sides).

Conversely, hippocampal volume shrinks in people who do not exercise. Through this mechanism, because the hippocampus inhibits the activity of the hypothalamic-pituitary-adrenal axis, exercise may also influence the neuroendocrine stress response and related inflammatory cascade.

In animal studies, brain derived neurotropic factor (BDNF) in the hippocampus was increased after physical activity regardless of the age of the test subject, so it appears that these positive effects may be present in both young and old individuals.

* Exercise positively impacts on inflammation

Interleukin 6 (IL6) is a biomarker of systemic inflammation that correlates with disease and disability in older individuals. In a 12-month study of subjects aged 70 - 89 years, in comparison to a successful aging health education intervention, physical exercise (including aerobic, strength, balance and flexibility exercises) was associated with a significant reduction in IL6 at both 6 and 12 months.

However, exercise may have either anti-inflammatory or proinflammatory effects depending on which tissue is examined. In another animal study, 6 hours after exercise, pro-inflammatory cytokines were not increased in muscle tissue, but were increased in adipose tissue. This proinflammatory effect in adipose possibly contributes to the weight loss associated with exercise.

Macrophages, which are the first line of response in the inflammatory process, are also influenced by exercise. In women, both moderate (45 minutes at 55% VO2 max) and intense exercise (60 minutes at 70% VO2 max) were associated with increased chemotaxis, phagocytosis, and microbicide capacity of neutrophils, which lasted for up to 24 hours.

* Physical exercise is a biological ‘wellness’ intervention

Positive psychological effects of exercise are well described and can also be demonstrated objectively by measuring endogenous cannabinoid (CB) or opioid signalling activity. In animal studies, in comparison to sedentary controls, 8 days of voluntary exercise significantly increased CB1 receptor site binding density.

In human athletes, visual analogue scale (VAS) scores taken before and after exercise indicated significant increases in happiness and euphoria after running, which were associated with reductions in opioid receptor availability in prefrontal and limbic/paralimbic brain structures.

CLINICAL STUDIES OF EXERCISE AND DEPRESSION

In 2009, the Cochrane institute reviewed data for the effect of exercise on depression and updated this report with more recent data in 2013. They concluded that exercise improves symptoms of depression and its effects are comparable to those achieved with psychotherapy and pharmacotherapy.

In summary, results from the Cochrane analysis and other studies allow the following recommendations about the benefit of exercise in depressed patients:

• Both aerobic exercise (cardiovascular training) and resistance training are beneficial, but the benefit of both combined is greater than for either alone.

• Higher intensity exercise (>75% VO2 max) is more beneficial than low-moderate intensity exercise (61-74% VO2 max).

• The optimal duration of an individual exercise session is 20-30 minutes, with no apparent increase in benefit after 60 minutes.

• The optimal frequency of participation in exercise is 5-7 days per week.

• The antidepressant benefits increase with adherence to an exercise program over weeks to months.

• Exercise should be continued in the longer term for antidepressant benefits to be maintained.

• Exercise augments and extends the efficacy of antidepressant medication.

• Exercise may reverse treatment failure in some patients who do not initially respond to pharmacotherapy.

• Unsupervised exercise at home may have comparable efficacy to supervised exercise. Weight loss is not necessary to achieve psychological benefits with exercise.
Dropout rates for exercise, however, are high and similar to those observed with psychotherapeutic and drug interventions. Because of this, it is very important to explain the benefits of exercise to patients and educate them so that they know what to do, how to do it and for how long. In addition, providing them with written information and exercise logs helps them to understand the benefits, address questions that might arise later, to monitor their progress and to be aware of their own personal gains (e.g., improvement in mood) that may be subtle, gradual and that might otherwise go unrecognised.

A template of a booklet for this purpose has been developed by Professor Jain and is available from Pfizer (Tracy Kielly: Tracy.Kielly@pfizer.com).

**PRACTICAL ADVICE FOR ENCOURAGING PATIENTS TO EXERCISE**

1. Seek assistance from patients who have already experienced benefit from exercise to talk to, guide and encourage new patients.

2. Explain the neurobiological evidence underlying the benefits of exercise. Figure 1 may be useful.

3. Use pictures to illustrate how exercise influences hippocampal volume and affects immunity.

4. Explain the evidence that demonstrates exercise augments and prolongs the efficacy of anti-depressant medication. Exercise not only helps to relieve depression, but it is also associated with an improved sense of wellbeing and wellness (pleasure).

5. Explain practical implementation of an exercise program (FID):
   - **Frequency**: Exercise every day.
   - **Intensity**: Start low and work up to moderate to high intensity (“you should not be able to hold a conversation while exercising”). Optimal exercise should achieve at least 65% of maximum heart rate (HRmax), where HRmax may be calculated by: 220 - age. For example, HRmax for a 50 year old man is 170 beats per minute. He should aim for a heart rate of 110 to reach 65% HRmax during exercise.
   - **Duration**: Start with 5 minutes and build up to a total duration of 30 minutes to 1 hour per session. “Don’t give up. Allow exercise to become part of your daily routine for the rest of your life.”

6. Advise them to do both aerobic and resistance training. Walking is also valuable exercise as long as it is at the right intensity. Thirty minutes of brisk walking per day (3 km per day at 6 km/hr speed) is adequate.

7. Advise them to monitor their activity and track their progress. Keep a daily log of:
   - Activity and duration
   - Mood before and after exercise

(Figure 2)

- Use an App for cell phone or tablet; e.g., myfitnesspal, which tracks food, calorie intake and exercise energy expenditure.

8. Prescribe activity. Write down the exercise plan that the patient has agreed to (Figure 3).

**EXERCISE PRESCRIPTION**

1. We agree to exercising. I will exercise for the following times a week:
   - 1/week
   - 2/week
   - 3/week
   - 4/week
   - 5/week
   - 6/week
   - 7/week

2. We agree to the following type of exercise:
   - Aerobic exercise
   - Weight lifting/Resistance training
   - Mixed (both)

3. We agree to the following minimum number of minutes of exercise on the day of exercise:
   - Less than 15 minutes
   - 15-20 minutes
   - 20-30 minutes
   - 30-45 minutes
   - 45 minutes-1 hour
   - More than an hour

4. Other notes on the exercise prescription:

(Figure 3: Exercise prescription)

**II) MEDITATION IN THE MANAGEMENT OF DEPRESSION**

**SUMMARY**

- Meditation is a powerful clinical intervention leading to better outcomes in patients with depression.
- Meditation is not just a ‘feel good’ intervention, but is supported by strong neurobiological findings.
- Meditation is easy to incorporate into a busy clinical practice using a variety of different resources.

**MEDITATION VS. MINDFULNESS**

Meditation has been used for centuries to focus attention and awareness. It is a mental exercise aiming to create a mind-body interaction that induces a relaxed bodily state and calm state of mind with awareness of, and full concentration on the present moment. In addition to reducing stress, meditation can have a significant effect on how people perceive and process the world around them and can alter the way they regulate attention and emotion.
TARGETING MORE THAN ONE MECHANISM TO EFFECTIVELY TREAT MAJOR DEPRESSIVE DISORDER

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Mindfulness may be defined as “the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment.” It involves a consciousness of sensations, perceptions, emotions and thoughts and is the attentional state that underlies all forms of meditation.

**DEPRESSION AND MINDFULNESS: MINDFULNESS-BASED COGNITIVE THERAPY**

Depressed people focus predominantly on past experiences and adopt a judgemental attitude towards thoughts. In this context, the emphasis of mindfulness on the present and adopting a non-judgemental attitude is very relevant to helping them escape from this disabling state of mind. Combining mindfulness with cognitive behavioural therapy (CBT) to create a mindfulness-based CBT (MBCT) is a practical way to teach depressed patients to incorporate these principles into their daily lives. It teaches mindfulness through group-based programs with daily homework.

**EVIDENCE FOR STRUCTURAL AND PHYSIOLOGICAL CHANGES INDUCED BY MINDFUL MEDITATION**

Magnetic resonance imaging studies have demonstrated that regular mindfulness meditation has neuroplastic effects that influence brain structure. In comparison to nonmeditating matched control subjects, meditators had volumetric changes in numerous areas of the brain involved in cognitive control and affective regulation, including regional gray matter, the amygdala and hippocampus.

The stress response and inflammatory activity may also be affected by mindfulness. Kiecol-glaser and colleagues showed that, in comparison to novices, expert yoga practitioners had a markedly attenuated stress response, indicated by lower interleukin-6 (IL6) plasma levels and lower heart rate both before and after being exposed to stressful stimuli. Furthermore, after exposure both of these indicators returned to baseline levels faster in the expert group. Yoga sessions were also associated with increases in positive affect scores. These data suggest that regular yoga practice may reduce inflammation below levels predicted by such key risk factors as age, abdominal adiposity, cardiorespiratory fitness, and depressive symptoms.

**EVIDENCE-BASED MINDFULNESS IN CLINICAL PRACTICE**

Mindfulness is both teachable and effective. Clinical studies in which patients with psychopathology have been exposed to MBCT have produced promising results. In patients with generalised anxiety disorder, MBCT was associated with improvement in scores for anxiety and depression, and somatic and psychic symptoms. In patients with panic disorder who were already treated with pharmacotherapy, after only 2-8 weeks MBCT significantly reduced scores for both anxiety and depression.
Segal and colleagues randomised depressed patients who were in remission with maintenance antidepressant pharmacotherapy to one of three groups: discontinuation of medication plus placebo, continuation of medication, or discontinuation of medication plus eight weekly group sessions of MBCT. Among unstable remitters (defined as occasional elevations of score on the Hamilton Depression Rating Scale >7 during remission), those remaining on medication and those receiving MBCT were significantly less likely to relapse than those receiving placebo, with no difference in relapse rates between the medication continuance and MBCT groups (adjusted relapse rates 27% in the maintenance group, 28% in the MBCT group and 71% in the placebo group).

Goafrin and van Heerigen randomised 106 recovered depressed patients with a history of at least 3 depressive episodes to continue with treatment as usual (TAU) or to receive MBCT in addition to TAU. MBCT improved time to first relapse by 35%, with mean time to first relapse post study of 39 weeks for TAU and 54 weeks for TAU plus MBCT. Dalen and colleagues provided 6 weekly two-hour group classes and two monthly follow-up classes in MBCT to obese individuals with a mean body mass index (BMI) of 37 kg/m2.

THE CLASSES INCLUDED TRAINING IN MINDFULNESS, MEDITATION, MINDFUL EATING, AND GROUP DISCUSSION, WITH EMPHASIS ON AWARENESS OF BODY SENSATIONS, EMOTIONS AND TRIGGERS TO OVEREAT. IN COMPARISON TO BASELINE, PARTICIPANTS SHOWED SIGNIFICANT INCREASES IN MEASURES OF MINDFULNESS AND COGNITIVE RESTRAINT AROUND EATING, AND DECREASES IN EATING DISINHIBITION, BINGE EATING, DEPRESSION, PERCEIVED STRESS, PHYSICAL SYMPTOMS, NEGATIVE AFFECT AND C-REACTIVE PROTEIN.

Body weight and BMI were significantly reduced by 4 kg and 1.3 kg/m², respectively (P<0.01).

Training in MBCT does not necessarily need to be face to face. Online training reduces costs and allows patients to complete courses in their own comfortable, familiar surroundings.

An online mindfulness course consisting of 10 sessions, guided meditation videos and automated emails, with elements of mindfulness-based stress reduction and MBCT, completed at a pace to suit the individual (minimum length 4 weeks) was associated with significant reductions in perceived stress, anxiety and depression at course completion, and with further reductions at 1 month follow up. The effect sizes for these improvements were comparable with face to face cognitive behavioural therapy for stress.

**PRACTICAL APPLICATION OF MBCT TRAINING**

1. MBCT should be discussed with the patient, explaining the neurobiology and health benefits of regular mindful meditation.

2. Provide handouts on the benefits of mindfulness and meditation. Booklets and pictures are useful. A template of booklet for this purpose has been developed by Professor Jain and is available from (Tracy Kielly: Tracy.Kielly@pfizer.com)

3. Provide patients with a list of resources and encourage the use of meditation apps for cell phone or tablet.

   - A selection of mindfulness apps are described with links for download at: http://www.mindful.org/mindful magazine/mindfulness-apps
   - An online MBCT course is available at: http://www.bemindfulonline.com

   Professor Jain recommends the following books and audio sets to guide clinicians and patients:

4. Introduce patients to mindfulness by guiding them through an example.

5. Refer patients to clinicians who specialise in meditation.

6. Mindful meditation requires ongoing effort to develop and refine. It cannot be effectively taught to others by a clinician who does not have experience of it him/herself. Therefore, clinicians are encouraged to learn and try mindful meditation before attempting to convince patients to try it.

7. An 8-week MBCT training program with a mindfulness facilitator would typically include the following:
   - Classes for 2 hours a week for 8 weeks.
   - 1 all day session between weeks 5 and 7.
   - Daily homework using CDs.
   - Talk about experiences with home practices and obstacles, and how to deal with them.

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Rakesh Jain is a psychiatrist and Clinical Professor in the Department of Psychiatry, Texas Tech School of Medicine, Texas, USA. References and suggested reading can be obtained from Rakesh Jain: Correspondence: jaintexas@gmail.com
THE SASOP SOUTHERN & NORTHERN SUBGROUPS HOSTED A PUBSEC CPD SEMINAR AT SANOFI HEADQUARTERS IN MIDRAND

“Community Psychiatry in the Context of Public Health”

ON THE 18TH OF APRIL 2015 WITH THE FOLLOWING PROGRAMME:

<table>
<thead>
<tr>
<th>Time</th>
<th>Programme</th>
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<tbody>
<tr>
<td>08:00 - 08:30</td>
<td>Registration and coffee</td>
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<tr>
<td>08:30 - 08:40</td>
<td>Presentation by Sanofi</td>
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<tr>
<td>08:40 - 08:45</td>
<td>Welcome and opening – Dr Anusha Rama (SASOP – PubSec)</td>
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<tr>
<td>08:45 - 09:15</td>
<td>Public Mental Health and Public Health Psychiatry</td>
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<tr>
<td></td>
<td>Prof L Rispel (Head: Wits School of Public Health)</td>
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<tr>
<td>09:15 - 09:30</td>
<td>A model of Community Psychiatry and the Southern Gauteng Service</td>
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<td></td>
<td>Dr Lesley Robertson (SASOP – PubSec)</td>
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<td>09:30 - 09:45</td>
<td>Mental Health Policies and Community Psychiatry in Northern Gauteng</td>
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<td></td>
<td>Dr Funeka Sokudela (University of Pretoria, Dept. of Psychiatry)</td>
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<tr>
<td>09:45 - 10:15</td>
<td>Treating mental illness in primary care – the Family Physician’s perspective</td>
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<td>Prof J Hugo (Head: University of Pretoria, Dept. of Family Medicine)</td>
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<tr>
<td>10:15 - 10:45</td>
<td>Panel Discussion – Prof C Szabo (Head: Wits Dept. of Psychiatry)</td>
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<td>10:45 - 11:30</td>
<td>Tea</td>
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<tr>
<td>11:30 - 12:00</td>
<td>Public Health Psychiatry: How can we provide medication to a nation?</td>
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<td>Dr Janine Munsamy (Essential Drugs Programme)</td>
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<td>12:00 - 12:15</td>
<td>Closing the Mental Health Treatment Gap; Costs and Cost-effectiveness</td>
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<td>Prof Rita Thom (SASOP)</td>
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<td>12:15 - 12:45</td>
<td>Panel Discussion – Chair Dr Gerhard Grobler (Head: SBAH Psychiatry Unit,</td>
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<td>University of Pretoria, Dept. of Psychiatry)</td>
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<td>12:45 - 12:50</td>
<td>Close – Dr Carla Kotzé (University of Pretoria, Dept. of Psychiatry)</td>
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**DOPAQUEL (QUETIAPINE)**

**INDICATIONS**

Dopaquel is indicated for the treatment of schizophrenia and manic episodes associated with bipolar disorder.
This started in most of the first world countries in the early 1990’s with the process of deinstitutionalization resulting in a reduction of available acute and sub-acute psychiatric beds worldwide. South Africa and in particular the Western Cape was no different. The Western Cape, in line with national government, implemented policies and strategies expediting a move to community based psychiatric care and treatment. The underlying intention was to improve the quality of care of the mental health care users in the broad communities in the Western Cape. There have been several publications highlighting the short comings, sequelae and impact on individuals having to live and cope in our communities with the existing services at hand. In addition to the worldwide economic downturn and less available resources from government the added burden on care givers having to support often very difficult patients in overcrowded decentralized primary health setting is difficult. The persistent demand and pressures on acute psychiatric beds from within the primary health care and district hospital setting is more often than not relegated to the local psychiatric nurse. The options are limited and the mental health gap keeps widening. There have been some good publications highlighting the presence or absence of poor support networks, persistent challenging social environments, ongoing substance misuse on the mentally ill and the impact on social well being.

On ground level the notorious “high frequency users”, revolving door patients whom repeatedly present to our primary health care facilities (PHC) and our district hospitals, often out of hours, are but a symptom of the community based services that are inadequate and failing our patients. This situation perpetuates the stigma surrounding mentally ill patients whom often are on the receiving end of the proverbial short stick. Paarl hospital and our surrounding community are no different from any other community. Our group identified the need to identify the higher risk patients and align them with existing resources in our communities.

**BACKGROUND**

Paarl provincial hospital is a 380 bed regional (level 2) hospital in a rural region of the Western Cape. The hospital provides specialist psychiatric services to two geographical services areas (GSA) namely the West Coast with five district hospitals (Malmesbury, Piketberg, Citrusdal, Clanwilliam and Vredendal hospital) and a portion of the Winelands with one district hospital (Stellenbosch hospital and two community district clinics.

The levels of poverty and the percentage of uninsured patients are indicated in Table 1. Paarl hospital psychiatric unit was first a 4 bedded unit in 2010, but due to persistent bed occupancy ratios exceeding 140% our official bed status has increased to the present 16 beds. This is still inadequate to service the population in the West coast and Winelands as indicated in Table 1. From the start our clinical staff complement, Table II, indicates one fulltime hospital based psychiatrist and eight professional nurses (PN) for both the areas.

<table>
<thead>
<tr>
<th>Table I: Western Cape census data</th>
<th>2013</th>
<th>2015</th>
<th>% uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape Winelands</td>
<td>796 034</td>
<td>823 773</td>
<td>77%</td>
</tr>
<tr>
<td>Western Coast</td>
<td>324 952</td>
<td>334 978</td>
<td>83%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>5598 164</td>
<td>5240 703</td>
<td>78%</td>
</tr>
</tbody>
</table>

The face of community psychiatry in South Africa has changed considerably over the last twenty years.
Paarl and in particular the West Coast covers a vast geographical area. Due to our persistent bed occupancy rate exceeding 100%, scattered availability of seclusion rooms in the district hospitals, a readmission rate 5% worse than the provincial target set at below 10% and limited access to specialist psychiatric input area wide - our group decided to pilot a model with existing resources. In line with the literature the majority of our admissions are precipitated by periods of non-adherence to prescribed drugs, poor follow up strategies, ongoing substance misuse, premature discharges with no proper planning and no consultation with relevant family members.

Our group were of the opinion that the type and the severity of the mental disorder had an impact on the service utilization or entry into the service and as a consequence the long term functioning. For a number of our patients the existing community psychiatry services were inadequate and contributed to the revolving door syndrome at district and regional level. Our group looked into providing an enhanced assertive community based solution different from traditional community psychiatry and different from the originally described ACT teams) in the United Kingdom. Our model would also be less intensive as the established ACT teams at tertiary hospitals. However, we did retain some of the key elements:

1. Patients were seen in the community
2. Patient were engaged and followed intensively
3. Each patient had a dedicated worker
4. Treatments was individualized between patients and over time
5. Care was continuous over time and across functional areas
6. Smaller case load per keyworker

We commenced by conducting an audit of patients, from Paarl hospital, with a specific clinical profile i.e. 3 or more admissions to any of our district or regional hospitals; an established diagnosis of bipolar mood disorder, schizo-affective disorder or schizophrenia; a family member willing to participate. Patients were subsequently excluded if there was: no willing family member to participate, a forensic history or patient refusal to participate. We identified 12 individuals, 5 males and 7 females with an average age of 38 years. 72% (8/12) had an primary diagnoses of schizophrenia, 18% (2/12) had a diagnoses of bipolar mood disorder and 9%(1/12). In the 12 months prior to our ACT the cohort had a total of 33 admissions to either district or regional hospital. Subsequent to establishing the group of patients, each was allocated to a keyworker but it was decided to limit the numbers to a maximum of three patients per keyworker. The keyworker actively reviewed patients clinically as well as consulted and had meetings with caregivers as clinically indicated. Each keyworker would formally present each patient to the psychiatrist in a ward round every fortnight for 12 months.

<table>
<thead>
<tr>
<th>Table II: Staffing 2010-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winelands</td>
</tr>
<tr>
<td>Psychiatrist</td>
</tr>
<tr>
<td>PN</td>
</tr>
<tr>
<td>District Hospital</td>
</tr>
<tr>
<td>CHC</td>
</tr>
</tbody>
</table>

OUR PRIMARY AIM WAS TO SEE IF WE COULD DECREASE THE TOTAL ADMISSIONS WITH OUR ENHANCED COMMUNITY PSYCHIATRIC APPROACH COMPARED TO THE SAME PRIOR TO ENROLMENT. THE SECONDARY AIM WAS TO QUANTIFY THE TIME AND TRAVELLING IN ORDER TO PRODUCE A REDUCTION IN ADMISSIONS.
There were two main outcomes with the approach adopted:

1. The first was a reduction from 33 admissions to 1 admission which was significant even in such a small sample. The reduction was expected, but we were pleased at the magnitude of the reduction. The continued feedback from patients and the subsequent interviews with family and caregiver all highlighted the patient centred experience (PCE) and in total the improved quality of life of remaining in the community.

2. The second was quantifying the time and effort required from mental health staff to measure what they usually do. We were surprised by the data as travelling and spending time with patients in the community is sometimes perceived by our peers as not being medical or not deemed treatment and often not factored in. The data in Table III reflects the time and effort to achieve the reduction in admissions.

DISCUSSION

The PACT model in a rural setting with limited resources does have an impact on readmission to hospitals. We were limited in resources in terms of core clinical staff and available acute psychiatric beds, but had relative unlimited resources in terms of time allowed visiting patients at home.

Our group demonstrated that time and effort in the company of patients and their nominated carers is effective. We also demonstrated that time discussing patients on ward rounds with the right people was effective. Our secondary aim was surprising and poses several interesting questions pertaining to community psychiatry.

We did demonstrate that there is a cost implicated in achieving a reduction from 33 admissions to 1 admission. The question is whether this model is cost effective i.e. the patient day experience (PDE) of saving 32 admissions in Rands and Cents vs the conversion of Table III into Rands and Cents?

Our group feels that the converted monetary value is realistic and that the way to improve the cost effectiveness is to increase the number of patients on PACT and ultimately increase the denominator in the cost per patient equations.

Table III:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time/Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward rounds with Psychiatrist</td>
<td>535 minutes (8.9 hours)</td>
</tr>
<tr>
<td>Psychiatrist traveling</td>
<td>1587 km</td>
</tr>
<tr>
<td>Keyworker travelling</td>
<td>376 km</td>
</tr>
<tr>
<td>Keyworker time travelling</td>
<td>436 minutes (7.3 hours)</td>
</tr>
<tr>
<td>Keyworker on phone</td>
<td>136 minutes (2.3 hours)</td>
</tr>
</tbody>
</table>

Charl Prinsloo is a psychiatrist working at Paarl Provincial Hospital and affiliated to the Department of Psychiatry at the University of Stellenbosch. A list of related reference material can be obtained from Charl Prinsloo.

Correspondence: Charl.Prinsloo@westerncape.gov.za Emily Smith is a Professional Psychiatric Nurse working at TC Newman Hospital in the Drakenstein sub district. Elmarie de Lange is a Professional Psychiatric Nurse working in the Matzikama District. Pat Mayers is an Associate Professor and Acting Head, Division of Nursing and Midwifery, Faculty of Health Sciences, University of Cape Town. Correspondence: pat.mayers@uct.ac.za
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- Suboxone® - Suitable for office-based treatment.

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buprenorphine/naloxone

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References:
A CHILD AND ADOLESCENT
MENTAL HEALTH INITIATIVE:
Child and Adolescent Mental Health Services (CAMHS) in South Africa are under resourced at all levels of care (primary, secondary and tertiary).

Wendy Vogel, Zaida Damons and Willem de Jager

Children and adolescents make up about 40% of the population with approximately 17% having a major psychiatric disorder. At present in the Western Cape there are limited child and adolescent mental health services at primary and secondary care levels. The majority of children and adolescents with mental health problems are either not seen at all or are referred to tertiary services. This may be an inappropriate use of resources (i.e. using tertiary level resources for a mental health problem that could be dealt with at a primary care level). The lack of services at primary and secondary care clinics means that the development of care pathways within CAMHS is challenging to implement. Tertiary level services are required to provide clinical services, teaching, and research, as well as provide outreach and support to primary and secondary care services.

The Department of Health 2020 guidelines highlight the following approach:

1. Patient-centred quality of care
2. Outcomes based approach
3. Primary health care philosophy
4. Strengthening district health services
5. Equity
6. Affordability
7. Building strategic partnerships

Currently, many tertiary CAMHS are inaccessible and not affordable by the majority of the population. Often specialist child and adolescent services see children with mental health difficulties who could easily be seen at their local clinic if appropriate services were available. Due to the lack of such services, children and adolescents may also be followed up within a tertiary setting, leading to blockages within the care pathway.

The intended outcomes of participation in the Sanofi Mental Health Leadership initiative were to strengthen mental health services at primary and secondary levels of care and develop care pathways. In so doing, we hoped to address items 1, 3, 4, 5, 6, 7 of the Healthcare 2020 guidelines.

We aimed to achieve this by doing the following:
1. Review existing referral criteria into the tertiary service. Develop care pathways into and out of the tertiary service to ensure a smooth flow through the service, and encourage more appropriate and accessible access to care.

In order to do this, outpatient staff have been reviewing current referrals at level 3 to meet service delivery requirements as determined by L1/2/3 acute hospital packages of care. We have introduced basic care pathways into the service to ensure that all cases are seen by the mental health teams at the local clinics prior to being referred to a tertiary service. We have improved communication and flow through the service by ensuring that discharge forms are sent to referrers, as this was not always done routinely. Stable patients requiring routine monitoring are being devolved to local CHCs for follow up.
2. Obtaining feedback from patients (parents/caregivers and children and adolescents) is a priority.

Patients are being encouraged to fill in the complaints and compliments forms distributed by the hospital in order to obtain feedback. This has enabled us to highlight areas where our services are doing well and to deal with complaints timely. Some patients have complained about the long queues at the CHCs and an intermittent medication supply. Attention needs to be given to the clinic space. Children need to be seen in a quiet and containing environment, which is not always possible in the community clinics. Being seen as part of a busy psychiatric clinic with psychotic adults can be extremely intimidating for children and adolescents and may exacerbate their anxieties. We also hope to introduce other questionnaires, such as the Experience of Service Questionnaire (ESQ).

3. Improve waiting list times and flow through the tertiary child and adolescent psychiatric services by learning from other models, such as the Choice and Partnership Approach (CAPA) model.

We have reduced the waiting list time at CAMHS and continuously look at demand and capacity. We review case loads on a regular basis and devolve stable cases back to the CHCs. We have not implemented the CAPA model in its entirety and are using parts of it that are appropriate for our context.

4. Meet with service providers in a variety of settings such as district hospitals, community health centres, tertiary hospitals, educational and social development services in order to find out about existing services and assess the need for outreach and support.

CAMHS outpatient staff have been supporting the development of child and adolescent mental health services at district hospitals and community health centres (CHCs). We have been offering monthly supervision and support for psychiatric nurses working at CHCs. We also intend to offer workshops for nurses and other primary care workers in children’s homes and education services to offer support, teaching and training on common mental health problems.

We have had many face to face meetings with our colleagues in primary and secondary care to discuss care pathways and need. We have met with general psychiatrists, medical officers, family physicians, nurses, psychiatry registrars and psychologists offering services at level 2 community health centres and district hospitals, in order to assess needs and offer support. We have also met with referrers from the education department and social development. We offer daily telephonic support and advice when required (over and above emergency referrals).

Some of the difficulties that have been encountered include inadequate staff numbers at the CHCs to meet the need. The overwhelming numbers of adult patients with severe mental illness who require treatment leave staff with little time to spend with children with mental health problems. There are inadequate facilities for seeing children and adolescents with mental health problems at the CHCs. There is a need for more therapists to provide input within the educational setting and many of the children’s educational needs are not being met resulting in progressively worsening behavior. Social services are also often not able to meet the demand on their services. Ongoing training initiatives are taking place.

5. Ensure accurate data collection.

Ensure that all new cases, discharges and follow ups are properly documented on the hospital data base (clinicom).

Ensure that all cases have ICD 10 codes on the data base.

Establish and maintain a research database at CAMHS. This is an ongoing process.

In summary, the SANOFI Mental Health Leadership Initiative enabled us to reflect on our service delivery and make improvements where indicated. It was helpful meeting colleagues beyond “our patch” and sharing our aims as well as our frustrations. Having two CAMH services as part of the programme added to the overall benefits. We all have much to learn from each other. Although there were only two of us on the programme, the head of OPU, W.de Jager and the rest of the CAMHS OPU team were actively involved in the process and implementation. Immediate benefits to the patients were shorter waiting times.

The formal programme with guest speakers was informative and enriching. We would like to thank Prof Zabow, Dr Fine, Prof Szabo and all our colleagues who contributed to the programme.

Wendy Vogel is a Child and Adolescent Psychiatrist. She is Head: Division of Child and Adolescent Psychiatry,Red Cross War Memorial Children’s Hospital, and a Senior lecturer in the Department of Psychiatry and Mental Health, University of Cape Town. References can be obtained from Wendy Vogel. Correspondence: wendy.vogel@uct.ac.za

Zaida Damons is a nursing sister and Operational Manager: Division of Child and Adolescent Psychiatry, Red Cross War Memorial Children’s Hospital.

Willem de Jager is a psychologist and Head of Clinical Psychology and OPU, Red Cross War Memorial Children’s Hospital and a Senior lecturer: in the Department of Psychiatry and Mental Health, University of Cape Town.
HEALTH Minister Aaron Motsoaledi has launched an independent investigation of allegations against the Health Professions Council of SA (HPCSA), including maladministration and fitness of its managers to lead it.

The HPCSA is a statutory body established in terms of the Health Professions Act. Its responsibilities include dealing with complaints from the public about medical practitioners, and accreditation of doctors and training institutions.

The Minister has oversight of it. The independent panel will be chaired by the head of the University of Cape Town’s department of medicine, Prof Bongani Mayosi, and has 60 days to report back. It consists of experts in medicine, law, IT and administration from both the public and private sector.

The panel will probe the competency of CEO Buyiswa Mjamba-Matshoba and chief operating officer Tshepo Boikanyo to manage the HPCSA. It will also investigate the procurement process followed in awarding an information systems contract to technology company Oracle.

The value of this contract was not disclosed but Motsoaledi said Oracle had been rejected by the National Department of Health.


Motsoaledi said he had instituted the investigation after numerous complaints about the HPCSA’s management, and the pursuit of whistle-blowers who were forced to leave the institution. He said Prof Mayosi’s panel would determine whether the top officials in question needed to be put on special leave for the duration of the investigation and whether a forensic probe would be required. It will meet later this week.

Referring to the issue of the rising number of costly lawsuits for medical malpractice that dominated a summit on medico-legal litigation this week, MOTSOALEDI SA NEEDS A VERY STRONG, COMPETENT, EFFICIENT HEALTH PROFESSIONS COUNCIL TO DEAL WITH THE PROBLEMS FACING THE HEALTHCARE SECTOR, ESPECIALLY IN VIEW OF THE ISSUES RAISED IN THE SUMMIT. PRESENTATIONS MADE AT THE SUMMIT ON MONDAY SHOWED DOCTORS WERE BEING FOUND GUILTY BY THE COUNCIL ON CHARGES OF NEGLIGENCE, INCOMPETENCE, INSUFFICIENT TREATMENT, MISDIAGNOSIS AND OVERCHARGING THEIR PATIENTS. THIS RAISES QUESTIONS OF ETHICS AND THE TRAINING OF DOCTORS.

HPCSA president Sam Mokgokong supports the investigation. He has received 30 submissions from staff complaining about a variety of issues at the organisation.

Prof Mokgokong said the council would continue to operate and adjudicate cases before it as this was done by professional boards, not by management. He said the Minister did not see the need to dissolve the council and appoint a curator.
"... control is the single most important determinant of **good quality of life** ..."
The bodies and minds of babies in relationship: Dialogues in a multidisciplinary context

Call for Papers

It gives us great pleasure to invite you to submit an abstract for the Gauteng Association for Infant Mental Health (GAIMH) conference to be held at University of the Witwatersrand, Johannesburg, South Africa 30 – 31 October 2015

The conference is supported by DST-NRF Centre of Excellence in Human Development and hopes to attract a multidisciplinary audience. International and local presenters from disciplines such as paediatrics, psychiatry, psychology, occupational therapy, nursing, social work, speech and audiology, physiotherapy and early education are welcome to send abstracts for submission.

Abstract submission deadline: Monday 20 July 2015
Abstracts are invited under the following themes:

- Antenatal and perinatal matters
- Attachment and adversity
- Clinical interventions with infants and their parents/caregivers
- Early education and development
- Emotion and regulation disturbance
- High risk Infants
- Infancy
- Infant mental health: Assessment and diagnosis
- Neuroscience and attachment
- Parental mental health/ Caregiving contexts
- Training of infant mental health practitioners

Authors are requested to conform to the following guidelines for submission of abstracts:

- Abstract should be no more than 300 words (excluding title)
- Centre the title in capital letters at the top of the page
- Thereafter state your names and affiliation (upper and lower case)
- Thereafter type the body of the abstract, using single spacing
- If possible, please use Times New Roman, font size 12
- Please leave 2.5 cm margins on all sides

On a separate page please let us have your full name, title, address, telephone, mobile, fax and email

Please indicate if you are submitting your abstract for an oral or poster presentation

Please email your abstract as an attached file in MS Word to Bridget Peterson at conference@onscreenav.co.za or submit your abstract online via the website www.gaimh.co.za
Bring life with ADHD into focus
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janssen

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methylphenidate HCI

Medical Info Line: 0800 10 71 12. Reference: 1. TUM data September 2012. 2. Concerta® 18, 36 or 54 mg extended-release tablets containing 18 mg, 36 mg or 54 mg of methylphenidate respectively. Reg. Nos. 17/11/2012; 4271/2012/2; 17/12/2013 and 17/12/2014.
PM22/CONCERTA/S0094a
The overarching theme of the congress was ‘Excellence in Psychiatry: Practice, Education, Research’, and this was evidenced by the content in the scientific program, which included the latest developments from basic and clinical research, and the application to evidence based practice in diagnosis and education. The congress was attended by approximately three thousand delegates, from all corners of the globe.

In line with our continuing medical education objectives, Janssen sponsored six delegates, from both the public and private sector to attend this event. The other South African in attendance, Prof Bernard Janse van Rensburg, was there in his World Psychiatric Association (WPA) Congress committee capacity, promoting the 2016 congress, which will be held in Cape Town next year.

Feedback from delegates regarding some of the lectures attended is outlined below:

Dr Thebe Madigoe
(Clinical head: Tara Hospital)

THE EPA FORUM

Dr Shekhar Saxena (Director, Mental Health & Substance Abuse, WHO) discussed the WHO Mental Health Action Plan 2013 – 2020 (MHAP).

This plan was formulated for the following reasons:

- To correct the omission of Mental Health from the 2011 WHO Declaration on Non Communicable Diseases.
- Mental disorders (excluding substance and suicide) account for 10% of the global burden of disease, and one third of all disability. Mental disorders reduce life expectancy by 20 years for males and 15 years for females.
- In spite of these facts, the budgets allocated for Mental Health services are disproportionately low across the globe.
Purpose:
To lead member states in pursuing 4 objectives:
• The development of Mental Health & Social Care Services
• Mental Health Leadership & Governance
• Mental Health Promotion & Prevention
• Information Management Systems & Research

Clear & specific targets for 2020 have been set, e.g.:
• The development or revision of national mental health laws and policies
• Reduction of suicide by 10%

Outcomes:
There are encouraging reports showing that some of the above objectives are being fulfilled. E.g.:
• Mental Health services have been scaled up in Ethiopia
• Expansion of Mental Health services in Sri Lanka since 2004, especially at primary care level, with a notable reduction in hospital admissions
• China has promulgated a new mental health law
• Expansion of community based services in Brazil, allowing for a 50% reduction in institutional beds over the past 14 years.

Way Forward:
• In 2016, the WHO will host Finance Ministers from all member states for a symposium on Depression.
• Psychiatrists & Mental Health professionals in all member states should actively lobby their governments & hold them accountable to their commitment to the MHAP.

THE NEXT EPA CONGRESS WILL BE HELD IN MADRID, SPAIN FROM 12 – 16 MARCH 2016.

Lisa Selwood, Medical Scientific Liaison: CNS Portfolio Janssen Correspondence: lselwood@its.jnj.com

SELECTED REPORTS FROM ATTENDEES:

Dr Nai’m Moola
(Psychiatrist: Life Riverfield Lodge)

THE NEED FOR NEW NOMENCLATURE FOR PSYCHOTROPIC DRUGS

Surveys have suggested that many clinicians have found the available nomenclature system inadequate, as it does not reflect the latest scientific development and knowledge and hence there has been a drive to come up with a new nomenclature system. Clinicians also report that it is confusing for both themselves and their patients i.e. antipsychotics used to treat depression, antidepressants used to treat anxiety.

The development of a new nomenclature system has been initiated by the major colleges of neuropsychopharmacology (ECNP, ACNP, Asian CNP and CINP together with IUPHAR), and aims to help clinicians select the best and most appropriate medication for their patients.

The template for this new system comprises of four axes for each generic medication:
1) Pharmacological target/ mode of action
2) Approved indications
3) Efficacy and side – effects
4) Neurobiology

A free app is available on the iOS App Store and Google Play Store, called NbN.

Dr Vinusha Juggath
(Specialist Psychiatrist: Akeso Clinic Alberton)

SYMPOSIUM: TREATMENT PATHWAYS AND EXPERT CLINICAL RECOMMENDATIONS IN ADULT ADHD PATIENTS

3 case studies were presented:
• An adolescent previously diagnosed with ADHD who has ‘fallen into the gap’
• ADHD and co-morbid depression
• ADHD symptoms that present only in adulthood
Conclusions:
• ADHD persists into adulthood in many patients
• It has a broad impact, and a variety of features and affects many domains of life, including social relationships and work
• It is often associated with co-morbid disorders such as anxiety, depression, personality disorders and substance use disorders
• Pharmacological treatments have been shown to be effective in adults with ADHD

Dr Marius Pretorius
(Psychiatrist: Denmar Hospital)

SYMPOSIUM: SUICIDE AND THE BRAIN

Neurocognitive impairments include:
• Inability to discriminate between safe choices and risky decision making
• Impaired ability to perform corrections
• Heightened sensitivity to negative social stimuli
• Reduced verbal fluency

Neuroanatomical basis for vulnerability:
• Smaller volumes shown in left caudate nucleus, the left sup. temporal gyrus and the OFC
• Dysfunction in cingulate gyrus

CSF Biomarkers of suicidal behaviour:
• Low 5 HIAA
• Low Oxytocin
• High Interleuken 6

Epigenetic changes in the suicidal brain:
• Early adverse life events
• Changed gene expression
• Myelination impaired

Dr Neil Yorke
(Psychiatrist: Private Practice, Cape Town)

DIABETES MELLITUS AND BRAIN HEALTH IN BIPOLAR DISORDERS

In imaging studies of bipolar disorder, when looking at brain changes, some studies found atrophy in many brain areas, some studies showed nil change and still others showed enlargement. A major influence was diabetes or insulin resistance.

Patients with bipolar disorder have three times the risk of diabetes than the general population. In a registry of bipolar patients:
• 13% had known diabetes
• 8% previously undiagnosed
• 31% pre-diabetic (most not previously diagnosed)
• >50% insulin resistant and diabetes combined
• 75% not previously diagnosed

Co-morbid diabetes showed:
• Worse outcomes
• More mixed episodes
• Poorer response to lithium therapy
• Lower N-acetyl aspartate levels
• Lower GAF scores,
• Smaller hippocampal volumes
• Accelerated neuroprogression

Causality is not known, it could be that brain changes make patients more impulsive which may lead to over eating, insulin resistance, diabetes, further brain damage and lower functioning.

Lisa Selwood, Medical Scientific Liaison: CNS Portfolio Janssen
Correspondence: lselwood@its.jnj.com

“Much of the meaning of having a mental disorder is having a period of life that does not make sense along one's life narrative.”

Luis Madeira

Dr Marius Pretorius
Psychiatrist: Denmar Hospital

Symposium: Suicide and the Brain

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Epigenetic changes in the suicidal brain:
• Early adverse life events
• Changed gene expression
• Myelination impaired

Dr Neil Yorke
Psychiatrist: Private Practice, Cape Town

Diabetes Mellitus and Brain Health in Bipolar Disorders

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Correspondence: lselwood@its.jnj.com

“Much of the meaning of having a mental disorder is having a period of life that does not make sense along one’s life narrative.”

Luis Madeira
Help shape a future for your patients with Schizophrenia

- Symptom improvement as early as day 4
- Oral supplementation not required at initiation
- Long-term positive and negative symptom improvement
- Reduces risk of relapse and rehospitalisation
- Convenient once-monthly administration

Xepion® is a long-term treatment option for patients with schizophrenia, providing sustained and consistent symptom control

References:

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Preventing relapse, enabling futures
The PMHP have recently collaborated with the Perinatal Education Programme (PEP), who have long been involved with the continued training and education of health professionals, and produced a textbook Maternal Mental Health published under the Bettercare label. PEP have provided educational opportunities to over 60,000 health professionals over the past 20 years (Woods, Attwell & Ross, 2012) which have been shown to result in significant improvements in knowledge, clinical skills and care practices (Woods & Greenfield, 2010).

The Bettercare Maternal Mental Health book is ideal for doctors, nurses and social workers involved with supporting and caring for mothers during the perinatal period. The book is available online or in print copy (Bettercare). The content included practical approaches to the identification and referral of mothers with mental health problems as well as guidance for first-line management.

Those practitioners who achieve at least 80% in the optional post-test are eligible for a certificate of completion.

The textbook can be read online or purchased in print from the Bettercare website.
Special Issue for 2015: Journal of Child and Adolescent Mental Health

Call for Submissions

Theme: Community-Based Interventions for Child and Adolescent Psychiatric Disorders in Low Resource Settings

Dear prospective author,

We would like to bring your attention to an upcoming special issue of the Journal of Child and Adolescent Mental Health and invite you to submit a manuscript for publication. The focus of this special issue will be on community-based interventions for child and adolescent psychiatric disorders in low resource settings.

Your manuscript will be due by the 30th of May 2015 and undergo a rigorous peer-review process. The anticipated release date of this special issue is October 2015.

When submitting your manuscript online, please indicate in the space provided that your manuscript is for consideration for the special issue. Please also indicate this in your cover letter. You can submit your manuscript using our online submission system:
http://mc.manuscriptcentral.com/rcmh

As of October 2014, the Journal of Child & Adolescent Mental Health is officially indexed on Medline®. Produced by the U.S. National Library of Medicine, Medline is considered to be one of the top medical bibliographic databases in the world. Medline indexes almost 6000 journal titles, with 19 million records. Inclusion in the database is an affirmation of the journal’s standing and the journal has recently seen an expansion in frequency to accommodate the rising number of submissions.
The *Journal of Child & Adolescent Mental Health* aims to contribute towards the development of a robust and inclusive knowledge base for child and adolescent mental health across diverse contexts. To this end the *Journal* seeks to promote coverage, representation and dissemination of high quality work that is located in or addresses lower-resource contexts, such as those of the Global South regions.

We look forward to receiving your manuscript.

Sincerely,

Professor Soraya Seedat  
Editor-in-Chief, JCAMH  
*sseedat@sun.ac.za*

Dr Georgina Spies  
Editorial Manager, JCAMH  
*ggiocos@sun.ac.za*
MAKING THE MOST OF LIMITED RESOURCES IN A RURAL SETTING

After having spent the best part of a year providing an Outreach and Support service to District hospitals in the rural areas of the Western Cape I came to an important realisation: We have first world legislation in terms of the Mental Health Care Act but we are nowhere near being able to implement it.

Jannes Bornman

There has not been a commitment on a primary care level to provide the human - and structural - resources to bring essential mental health care closer to home. In most, but not all settings, stigma amongst health care professionals about mental illness is still common place. It takes the form of treating mental illness as a separate entity from the rest of medicine. The excuse that mental health care is too time consuming for a busy clinic is also heard much too often. The expectation, of years gone by, that only the mental health nurse and the community psychiatrist should be looking after the patients is ongoing. In my particular catchment area the previous community psychiatrist had sadly passed away several years before, leaving nothing to fall back on. We needed to start over but this time make sure that we focused our energy on establishing a sustainable service, appropriate for the burden of disease.

CENSUS 2012 TELLS US THAT THE CAPE WINELANDS EAST TOGETHER WITH THE OVERBERG DISTRICTS HAVE A POPULATION OF ROUGHLY 638 000 PEOPLE. WITH 2 PSYCHIATRISTS APPOINTED THERE IS 0.3 PSYCHIATRISTS PER 100 000 PEOPLE. THIS STANDS IN COMPARISON TO THE UK FOR EXAMPLE WHERE THERE ARE AN AVERAGE OF 19 PSYCHIATRISTS PER 100 000 PEOPLE. INTERNATIONALLY IT IS ACCEPTED THAT THERE SHOULD BE AT LEAST 10 PSYCHIATRISTS PER 100 000 PEOPLE.

Looking at our inpatient statistics (in particular the number of admissions annually) at Worcester Regional Hospital and comparing that to Crick Lund’s statistics of the likely incidence of severe mental illness and the percentage of those needing admission annually, we find that we only admit around 25% of the total to be expected. It is therefore clear to see that we are nowhere near providing the service to the community that we need to and yet, at the time at least, our bed occupancy rate was 140% (with only 8 inpatient beds).

WHEN I HEARD THAT SANOFI WAS OFFERING A SERIES OF SEMINARS ON LEADERSHIP IN MENTAL HEALTH I REALISED THAT AS HEAD OF DEPARTMENT I NEEDED HELP TO IMPROVE MY LEADERSHIP SKILLS.

I also asked an important ally in my efforts, our only mental health nurse in the local sub-district, Francois Pietersen, to join me. The task ahead of us was a hefty one: provide a better service but without any additional resources. With the guidance from our mentor, Pat Mayers, we decided that the first step in our project would be to start only in our local subdistrict. The aim was to establish a mental health outpatient clinic at the local community health centre (CHC) where doctors would rotate. The idea was that all doctors should gain some experience in mental health care and hopefully it will also assist in eradicating some of the stigma amongst medical practitioners. It would be a clinic where the appointment slots are of a longer duration and the doctors would have a consultant available for
telephonic advice, as well as monthly Outreach and Support visits. At these visits they can present the more difficult cases and perhaps even see them with the consultant. Mr Pietersen would also be able to refer cases to the mental health clinic when medical input is needed. The monthly Outreach and Support visits would be attended by all members of the multidisciplinary team. We arranged a meeting with the multidisciplinary team including the Family Physician who is the head of the clinic. The response we received was an all too familiar one: they would not be able to start yet another clinic as they were already overburdened by the additional infectious diseases clinic due to the prevalence of HIV and TB. There appeared to be no room for negotiation.

It was back to the drawing board. We shifted our focus to things within our control and continued to support each other in improving on what we were already doing. Hopefully our enthusiasm and our efforts would set an example for others to follow. We would focus on our inpatient- and outpatient services as well as on forming collaborative partnerships within the local community and getting volunteers involved by means of training community care workers (CCW’s) in mental health. Our measurable outcome would be our inpatient unit’s re-admission rate (the percentage of the total monthly admissions who are re-admitted within 3 months of being discharged). The different components we planned to address were the following:

- improved communication by virtue of a more comprehensive discharge summary with particular attention given to details around reasons for non-adherence to the treatment plan upon discharge.
- focus on patients with frequent re-admissions: to request for transfer back to our unit from the Psychiatric hospital when they are ready for discharge so that we can put in place a comprehensive discharge plan in consultation with care givers.
- the functional level of patients, as assessed by Occupational Therapy, which would strongly inform our discharge plan.
- to commence an additional urgent outpatient clinic where patients who are at risk of being admitted can be seen more assertively and also to pick up those patients who may have been turned away by the Emergency Centre as being not ill enough for admission and then lost to follow-up.
- to focus on building and strengthening our relationships with any NGO’s in our area who are involved in mental health care in some form or another. We identified the Association of People with Disabilities (APD).
- training of CCW’s by Francois Pietersen.
- Francois Pietersen to look at starting a community project to serve as a form of sheltered employment for patients.

Although these different components of the project had achieved varying levels of success we were pleasantly surprised to see that our outcome measure had shown a significant and sustained improvement. We’ve done well in achieving the target set by the Western Cape Department of Health of a re-admission rate of < 15% (Figure 1).

So much has come from this project that we now have renewed energy and motivation to continue in the same vein. We’ve established an additional collaborative relationship with the Worcester Business Forum and hope to receive funding for a project to involve children and adolescents in education about drug abuse and mental health. We have also identified expert patients to initiate a Mental Health Forum at our local CHC. This will give our patients and their families a much needed voice, which we believe is critical in advocating for a better service.

Even though our initial project did not succeed locally we have seen that at two district hospitals in our catchment area a mental health outpatient clinic had indeed been established. We hope that in time this will happen at all district hospitals and even in our own sub-district.

We would like to use this opportunity to thank SANOFI, Prof. Szabo, Dr. Fine, Prof Mayers and all the other speakers involved in this Mental Health Initiative. You’ve been truly inspiring and we’ve also learned a lot from our fellow attendees and have drawn inspiration from other projects and realised we’re not alone in our fight for better mental health care in South Africa.

Jannes Bornman is a consultant psychiatrist at Worcester Regional Hospital and is affiliated to the Department of Psychiatry at the University of Stellenbosch. References can be obtained from Jannes Bornman. Correspondence: Jannes.Bornman@westerncape.gov.za Francois Pietersen is a Chief Professional Nurse working in Worcester in community psychiatry for the Department of Health, Western Cape Government.
Through its support of this workshop, Servier Laboratories was involved with the initiation of the annual registrar’s exam preparation workshops and has supported this event, as well as the College Council and examiner’s meetings linked to the workshop, for the last 6 years via an unrestricted educational grant and logistics support. Approximately 400 delegates (including registrars, Council members of the College and speakers) have had the opportunity to attend the event over the years. The workshop has evolved over time to cover exam content refreshers (involving didactic teaching related to selected topics) as well as exam approach and techniques.

The Council of the previous triennium (2011-2014) determined the topics to be covered for the triennium 2014-2017, noting that different topics will be covered each year.

The aim is to afford all registrars preparing for the Part II exams an opportunity to be part of the workshop - once - with heads of departments nominating the relevant delegates from each university on an annual basis.

This year the meeting was held at the ORT Southern Sun Hotel in Johannesburg and once again the meeting was well attended by invited registrars who will be writing exams in the current or next semester. The feedback from registrars is that the opportunity to meet colleagues and interact directly with senior colleagues (and potential examiners) is of great value during the crucial months before writing.

Verbatim comments from the feedback included:

‘Good interaction with our examiners & consultants without being judged; Supportive, encouraged to think out of the box and provided with supporting documentation’

‘Clear understanding of areas to be studied; Useful & thoughtful discussion on cultural implications when managing of pts’

‘Excellent presentation of latest and exam oriented information; Encouraging and builds interest in further reading’

‘Yes - very informative for exams in general’

‘The practical examples were excellent’

Servier Laboratories, in collaboration with the College of Psychiatrists, remains committed to the ongoing funding of the workshop and related meetings.

Judith Herald is Senior Product Manager: VALDOXANE, Servier Laboratories SA (Pty) Ltd. Correspondence: Judith.Herald@za.netgrs.com
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The College of Psychiatrists and Servier Model: A Pharma-Psych Partnership

Servier, a leading French independent pharmaceutical company, describes itself as having no shareholders and distributes no dividends from its turnover. However, reflecting the company’s dedication to its research mission of innovation and discovery to treat unmet medical needs, it reinvests 25% of its annual turnover into Research & Development.

The College of Psychiatrists has been privileged to be one of the beneficiaries of Servier’s investment in the professional development of psychiatrists and in furthering the aims of academic psychiatry in South Africa.

In 2009, Servier committed itself to an academic partnership with the College of Psychiatrists towards funding an annual examination workshop. This has become not just an annual event but an event that is both prized and popular among registrars countrywide.

Through its support of the college examiners’ meetings, Servier Laboratories was involved with the initiation of the annual registrars’ examination preparation workshops and has supported this event as well as the college council and examiners meetings linked to the workshop for the last 6 years via an unrestricted educational grant and logistics support.

The aim of the project is to afford all registrars an opportunity to be part of the workshop once during their training and thus heads of department nominate their senior registrars preparing for their FC Psych Part II examinations to attend.

Approximately 400 delegates (including registrars, examiners and speakers) have had the opportunity to attend the workshops since its inauguration. The workshop has evolved over time to include College council meetings, curriculum and examination workshops for examiners, a written and oral examination technique session for registrars who are on the threshold of sitting their final examinations, as well as informative updates on a series of key topics in psychiatry. The registrars benefit from exposure to a range of experienced clinicians and academics from around the country, as well as experts and opinion leaders from both the private and public sectors.

Apart from the academic merits of the forum, the workshop serves as an excellent platform for registrars to network with fellow-registrars from other academic centres, exchange notes, meet the ‘dreaded’ examiners in a less-formidable setting and establish future professional collaborations. Registrars get an opportunity to rub shoulders with prominent senior specialists and future role-models.

Academics and examiners benefit from sharing a unique platform solely dedicated to the training and examining of specialists in our country. The pharmaceutical industry is also formally introduced to the next crop of young specialists-to-be.

This year the meeting was held at the ORT Southern Sun Hotel in Johannesburg from 12-14 February and was well attended by registrars and specialists from all nine universities as well as from the private sector.

Suvira Ramlall and Soraya Seedat
GOOD CLINICAL PRACTICE STARTS WITH THE ESTABLISHMENT OF A SINGLE, ROBUST, PLATFORM OF ACADEMIC EXCELLENCE. SERVIER’S PARTNERSHIP WITH THE COLLEGE OF PSYCHIATRISTS IS AN EXCELLENT MODEL OF A PUBLIC-PRIVATE/BUSINESS-ACADEMIC COLLABORATION THAT IS AN INVESTMENT IN ACADEMIC PSYCHIATRY. THE COLLEGE OF MEDICINE IS THE OFFICIAL NATIONAL EXAMINING BODY FOR SPECIALISTS IN THE COUNTRY AND SUCH COLLABORATIONS AUGUR WELL FOR THE ULTIMATE EVOLUTION TO A NATIONAL PLATFORM FOR REGISTRAR EDUCATION AND TRAINING AS WELL AS FOR THE CONTINUING PROFESSIONAL AND ACADEMIC DEVELOPMENT OF SPECIALISTS. INDEED, THEREIN LIE THE DIVIDENDS!

Suvira Ramlall is a psychiatrist affiliated to the Department of Psychiatry, University of Kwa Zulu Natal and the current Secretary of the College of Psychiatrists in the Colleges of Medicine of South Africa. Correspondence: Ramlalis4@ukzn.ac.za

Soraya Seedat is a psychiatrist and Professor/Head of the Department of Psychiatry at the University of Stellenbosch. She is the current President of the College of Psychiatrists in the Colleges of Medicine of South Africa. Correspondence: sseedat@sun.ac.za
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UCT DEPARTMENT OF PSYCHIATRY AND MENTAL HEALTH

Invitation to the

“SELF HARM – SUICIDE SYMPOSIUM”
For Psychiatrists, General Practitioners and other Mental Health Professionals.

The River Club, Liesbeeck Park Way, Observatory, Cape Town

05 August 2015

LONDOCOR EVENT MANAGEMENT
Faliza Pearce: Email Faliza@londocor.co.za TEL: 021 393 5950 or 083 255 3666
Sonja du Plessis: Email Sonja@londocor.co.za TEL: 011 954 5753 or 082 455 7853
We have pleasure inviting you to the Self-Harm / Suicide Symposium which will be held on Wednesday, 05 August 2015 at The River Club, Liesbeeck Park Way, Observatory, Cape Town. The organising committee expects at least 150 Psychiatrists, General Practitioners and other Mental Health Professionals at this meeting.

See below draft programme and registration form for your information. Please note, this symposium has applied for 6 clinical and 4 ethics points. CPD certificates will be issued on the day.

We look forward to your participation in this one day symposium.

Yours sincerely

Graeme Hendricks
Symposium Co-ordinator

**SCIENTIFIC PROGRAMME (subject to change)**

**Suicidal phenomena and self-injurious behaviour, assessment, interventions and ethical considerations.**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker/Authors</th>
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<tr>
<td>07:00 – 08:00</td>
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| 08:00 – 08:10 | Welcome                                                                  | Dr Sharon Kleintjes
|               |                                                                          | Head: Psychologist, Valkenberg Hospital               |
| 08:10 – 08:50 | Suicidal phenomena in general medical settings-meanings and epidemiology in South Africa | Dr Jason Bantjes                                      |
| 08:50 – 09:30 | Ethical and Medico-legal issues relating to self-jurious and suicidal phenomena | Prof Tuvia Zabow                                      |
| 09:30 – 10:10 | Is suicide *non*-prevention ever morally justified?                      | Prof David Benatar                                    |
| 10:10 – 10:40 | TEA/COFFEE BREAK                                                         |                                                     |
| 10:40 – 11:50 | Assessment of patients, risk factors, risk assessments and significance of therapeutic alliance | Dr Jason Bantjes                                      |
| 11:50 – 12:30 | Psychopharmacological interventions                                      | Dr Kerry Louw                                         |
| 12:30 – 13:00 | Evidence based brief and cognitive interventions- efficacy of 'no harm' contracts and safety plans | Dr Jason Bantjes                                      |
| 13:00 – 14:00 | LUNCH                                                                    |                                                     |
| 14:00 – 14:40 | Dialectical Behaviour therapy interventions                              | Ms Hayley Julius                                      |
| 14:40 – 15:20 | Mindfulness based interventions                                           | Ms Lameze Abrahams                                    |
| 15:20 – 16:00 | Practitioners issues in the management of suicidal and self-harm phenomena | Ms Louise Frenkel and/ Ms Ereshia Benjamin            |
| 16:00 – 16:30 | Referral pathways                                                        | Dr Peter Milligan                                     |
Dr. Andreas Schreiner, a certified psychiatrist and neurologist who currently holds the position of Vice President Medical & Scientific Affairs CNS and Pain at Janssen-Cilag Europe, Middle East and Africa, gave a guest lecture in the Department of Psychiatry at the University of the Witwatersrand on the 8th April 2015. He spoke on the topic of “Schizophrenia - The impact of relapse, hospitalization and treatment decisions on patient outcomes”.

Dr. Schreiner frequently lectures and has given more than 500 scientific presentations at national and international meetings. He has also published more than 60 peer-reviewed manuscripts in national and international journals, has written several book chapters and has presented more than 350 abstracts at national and international meetings.
UNIVERSITY OF WITWATERSRAND

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FELLOWSHIP

TEACHING ADVANCEMENT AT UNIVERSITY (TAU) FELLOWSHIP PROGRAMME

The TAU Fellowship Programme Committee received your nomination to participate in this programme and wish to thank you for your application. It is impossible to inform you that your candidacy was successful. You are invited to participate in the TAU Fellowship Programme.

The programme will consist of:
- one day of initial contact session from 13 to 16 July 2013;
- a second four day contact session from 18 to 21 January 2014;
- a third four day contact session from 1 to 4 July 2014;
- as well as an annual number of on-line communications and assignments.

The programme will culminate with the presentation of short research and development reports by groups of nominees. All participants who successfully complete the programme will receive a certificate and will become TAU fellows, and remain members of the TAU network. Travel and accommodation expenses will be met by the TAU fellowship programme, and each participant will receive a small grant to carry out a group teaching or research project.

Please confirm your acceptance of this invitation to participate in the TAU Fellowship Programme before Friday, 22 February 2013 to info@tau.ac.za. This is essential in order to make arrangements for accommodation and travel.

Yours sincerely,

Dr. Yvonne Duval

TAU FELLOWSHIP PROGRAMME MANAGER
tau.fellowship@wits.ac.za

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SYMPOSIUM

held their first Neuropsychiatry Symposium

NEUROPSYCHIATRY SYMPOSIUM 2015

With presentations focused on various aspects of Traumatic Brain Injury:
- RAF Assessments, Cognitive Rehabilitation related to function, Neuropsychiatric complications in TB. Lived experience of Traumatic Brain Injury, Community Resources for Traumatic Brain Injury, Ethical issues surrounding curaesthesia, interesting case studies.
A major neurosciences initiative has been launched at UCT’s Faculty of Health Sciences in partnership with Groote Schuur academic hospital complex. The Neurosciences Initiative will bring together clinicians and researchers from a wide range of specialities, fostering collaboration in the treatment of a number of neurological disorders, including stroke, central nervous system infection and trauma, among others.

J Block at Groote Schuur Hospital, where the Neurosciences Initiative will be headquartered, has been identified. The facility will be developed to include the academic departments of key neuroscience disciplines, laboratories, a neuroimaging facility, and specialised, multidisciplinary clinics, which will complement and enhance the existing clinical activities at Groote Schuur.

The CEO of Groote Schuur Hospital, Dr Bhavna Patel said: “Groote Schuur Hospital is proud to be a part of this initiative in providing a clinical neuroscience service to its patients. We would like to thank the university for the contribution to this hospital facility, which will be world-renowned in clinical service, teaching and research. Our partnership can only grow in strength going forward.”

The initiative will advance care and transform research and teaching in the neurosciences in Africa by drawing together an array of expertise in neurosurgery, neurology, neuropsychology, neuropsychiatry and neuroimaging. It will also partner with other disciplines such as engineering, the arts and disability studies, creating a facility where patients can access the highest quality of care and the most cutting-edge treatment options.

Interim dean of the Faculty of Health Sciences, Prof Gregory Hussey said: “Neurosciences is the new frontier of medical research at UCT. Through this initiative, we aim to make a contribution not only in South Africa, but in Africa and globally. The initiative will address the needs of our continent’s people and open new ways for Africa to contribute to the global body of knowledge in this rapidly advancing field.”

The vision of the Neurosciences Initiative has been made reality through a R25-million financial donation from UCT alumnus David Barnes and his wife Ursel Barnes, and fundraising efforts will continue in order to finance the development of this state-of-the-art facility.

Head of the Division of Neurosurgery, Prof Graham Fieggen said: “The majority of people suffering from common neurological disorders live in low and middle-income countries. There is a need to understand these disorders within the context of our own continent. We cannot simply import models from the Global North.”

UCT Deputy Vice-Chancellor Prof Danie Visser said: “UCT is excited that this initiative will integrate the laboratory, clinic and community, so that clinicians and researchers can collaborate to offer rapid translation of contemporary treatment options.”

The launch of the Neurosciences Initiative in Cape Town on 23 March was hosted by UCT Vice-Chancellor Dr Max Price and attended by the University of Oxford Vice-Chancellor Prof Andrew Hamilton and a delegation of leading researchers from both universities. UCT researchers have been meeting with their University of Oxford counterparts in Cape Town to discuss a range of collaborations that could make valuable inroads in research, from neurosciences and malaria, to land reform and HIV.

Posted on 23 March 2015 | 1:11 pm

Sanofi has been sponsoring the “SANOFI PSYCHIATRY DEVELOPMENT AWARD” for three consecutive years. The sponsorship is in partnership with the Heads of academic Departments of Psychiatry at the Universities of Cape Town, Free State, KwaZulu Natal, Limpopo (Medunsa Campus), Pretoria, Stellenbosch, the Witwatersrand and the Walter Sisulu University.

The Award (R50 000, in part or full amount) is open to all registrars at any of the aforementioned institutions and to junior consultants within 3 years of specialist registration. The purpose is to support research and research-related activities. The basis of financial support includes completion of higher degree research projects, attendance at conferences to present such research, or participation in workshops to facilitate skills acquisition relevant to the research.

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

APPLICATIONS ARE OPEN FROM JUNE 2014 AND CLOSE ON JUNE 30 2015.

For further details contact: Greg Sinovich, 082 449 9844
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Janssen has a historical, longstanding and continued commitment to neuroscience, and medical education within this disease area. We have an overarching aim to enhance patient care by providing local healthcare professionals with accurate and reliable information, so they are empowered to make fully informed recommendations, in the best interests of their patients.

Prof Sergeant is the Emeritus Professor and Chair of Clinical Neuropsychology at the Vrije Universiteit in Amsterdam. Not only was he the chairperson of the European Network for Hyperkinetic Disorders (EUNETHYDIS) until January 2015, but he has been Knighted by Her Majesty, Queen of the Netherlands, to officer in the Order of Oranje-Nassau, which recognizes people who deserve appreciation and recognition from society for the way in which they have carried out their activities.

He teaches from an undergraduate through to a postgraduate level on the neuropsychology of childhood disorders, neuropsychological assessment, and psychodiagnostic education. He is also the editor and reviewer of a number of journals and has been described as ‘one of the forefathers of ADHD’.

Four events were held in Durban, Cape Town, Johannesburg and Pretoria respectively, and were attended by a total of 152 specialists, including psychiatrists, paediatricians, neurologists, and GPs with a special interest in ADHD.

Prof Sergeant presented two presentations over the course of the evening. The first covered information relating to the updated EUNETHYDIS guidelines on the management of ADHD. The complex management of pre school children, quality of life in patients with ADHD, comorbidities and the practical management of adverse events were discussed. Both pharmacological and non pharmacological management measures were presented, reinforcing the importance of holistic management of the ADHD patient.

Based on feedback received from experts in the field, the second part of his presentation covered a contentious and much debated topic that has been presenting itself in ADHD circles recently – emotional dysregulation in the context of ADHD.

Prof Sergeant attempted to answer the question:

‘IS EMOTIONAL DYSREGULATION BETTER EXPLAINED BY ADHD, COMORBIDITIES, OR OTHER AFFECTIVE DISORDERS’

By presenting clinical information on emotional predictors and neuropsychological and neuro imaging data. He also gave practical examples of symptom differentiation between bipolar disorder and ADHD, which often present clinically in a very similar manner. Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) were also touched on.

Some feedback from attendees included the following:

Wonderful speaker, stimulating discussion and very insightful

Wonderful and excellent caliber presentation and speaker

Thank you to Janssen for arranging the lectures by Prof Sergeant. It was a privilege to hear an academic of his stature speak to us. The commitment of Janssen to education is highly commendable and valuable

Prof Sergeant’s talks were excellent and so worthwhile to have been at. The next day I was immediately able to use some of his information in my clinical practice.

Many thanks to Janssen for bringing him to SA.

Lisa Selwood, Medical Scientific Liaison: CNS Portfolio Janssen Correspondence: lselwood@its.jnj.com
L to R: Prof. Sergeant, Kim Searle (National Sales Manager),
Sean Searle (Head of Medical Affairs)

Prof. Sergeant, Durban Event

Pretoria Event

Johannesburg Event