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Dear Reader,

the publication of this the third issue of 2016 means that the year is swiftly moving to a close. The fourth and final issue for the year will be published in anticipation of the World Psychiatric Association International Congress 2016 in November. It also means that one has to begin preparation for the first issue of 2017 in February. Each issue provides me with a sense of pride, not only in relation to the publication itself, but most importantly related to the extent and quality of contributions. The current issue sees the availability of pdfs for each article available from the website contents page. This highlights the commitment to responding to reader requests for development of the publication.

Whilst not - yet - a Department of Higher Education and Training (DoHET) accredited publication, the Feature articles provide a range of content worthy of academic acknowledgement at a standard that certainly both informs and challenges the readership. Next year will mark the 3rd year of publishing *South African Psychiatry*. The importance of the milestone is that at the end of the 3rd year of consistent publication we become eligible to apply for DoHET accreditation. To this end 2017 will see a shift in terms of introducing open peer review in the form of invited commentary for Feature articles as well encouraging registrars (and supervisors) with successfully examined MMed research reports to submit the literature review as a 5000 word article – peer review being by virtue of successful examination by 2 examiners. A University letter confirming successful examination and award of the degree will be a requirement for acceptance. Such an approach would be novel, but with sufficient rigor, it will also provide both incentive to publish and ultimately financial reward in the form of subsidy for Departments. This serves as an invitation to registrars and supervisors. I trust that Heads of Departments will support the initiative and I will shortly communicate directly with them. Instructions to authors will in due course reflect these developments.

In essence, there is progress and a vision for the future. As always the support of all who constitute *South African Psychiatry* is the key to success. I trust you will enjoy this issue.

Christopher P Szabo

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Healthcare. We Care.
Most medical codes of ethics have historically focused on not doing harm, not taking life, not engaging in sexual acts with patients, and not revealing secrets. Little attention has been given in the past to the importance of doctors giving full and accurate information to their patients.¹

In the Hippocratic Oath, doctors are cautioned to practice with purity and holiness, which may imply veracity. At the same time they are expected to act in ways that are beneficial, with little consideration given to situations where perhaps beneficence and truth may be in conflict. The Declaration of Geneva of 1947, a modern version of the Hippocratic Oath, ignored the problem of truth all together and focused on the health of the patient which it put forward as the doctor’s primary consideration.²

In the later years of the twentieth century, there has, however, been a bioethical shift from medical paternalism in which doctors attempt to protect patients from the truth, to respect for patient autonomy and their participation in treatment-related, decision-making.³ In 1981, the World Medical Association, in the Declaration of Lisbon, explicitly conveyed that patients had the right to accept or refuse treatment after receiving adequate information.⁴ This may be largely attributed to the fact that most of the research on truth-telling in relation to diagnoses has been with regard to cancer literature.⁵ In 1961, 90% of doctors researched by Oken⁶ did not reveal diagnosis. By the time Novack et al⁷ conducted their study in 1979, the trend had reversed so that 98% reported adhering to a policy of disclosure.

Deciding between disclosure and non-disclosure may, however, be justified from both ethical points of view. The rights-based belief that the value of truth-telling is to be viewed fundamentally as a prerequisite for the choice of treatment, is reinforced in the ethical guidelines of the World Psychiatric Association’s Declaration of Hawaii (1977/1983)¹¹ which stated that psychiatrists needed to inform patients of the nature of their respective conditions and of the therapeutic procedures available. According to this document, the patient is to be told the truth so as to be given the opportunity to choose between appropriate and available methods of therapy.¹² The principle involved is that of respect for the patient’s capacity to make informed choices with regard to treatment.
In many instances, however, as may be the situation in certain psychiatric cases, a patient’s diminished cognitive capacity and judgement may render him or her incapable of participating effectively in medical decision-making. This acknowledgement has led to the argument, therefore, that truth-telling is to be forfeited as a right in cases of reduced mental ability. Non-disclosure has also been considered to be ethically defensible, from this rights-based, Kantian perspective, in instances where a patient explicitly requests not to be told.

On the basis of a consequentialist approach, a doctor may also decide that a patient is best served by being made aware of his or her diagnosis. However, there may be instances where being truthful is likely to cause significant distress, anguish, depression, pain and a loss of hope so that the patient’s psychological health is seriously compromised. In such cases, deception may be viewed as the more helpful and benevolent choice.

However, it must be recognised that consequentialism requires not only a short-term consideration of what might or might not be beneficial, but also a reflection of the implications of disclosure or non-disclosure in the future. In order for deception to be morally justifiable, it has been contended that it must be an action of last resort; it must be justifiable to the public; and the practitioner must be sufficiently cognisant of potential damage done to patient trust and clinician trustworthiness in the long-term.

**VALIDATION, STEREOTYPES AND STIGMA**

As psychiatrists experience on a daily basis however: the motivation to behave in a respectful way with regard to the autonomy and rights of the patient; the imperative of guaranteeing a long-term sense of trustworthiness; the need to maintain a therapeutic alliance with a patient; as well as the requirement that the patient be assisted therapeutically, often in contexts of personal, interpersonal and familial chaos, places them frequently in difficult situations with regard to disclosure.

Their area of medical concern relates to the difficulties people bring with regard to their understandings of reality, the world and themselves in the world. Furthermore, in certain instances, when people come to psychiatrists for help, they seek validation for their point of view. Presenting them too soon with a diagnosis which calls into question their view of reality may, in some instances, result in their leaving treatment prematurely. Flexibility and sensitivity is required with regard to how to disclose and when to disclose.

This is true in all areas of medicine; however a person with a heart difficulty can separate their sense of themselves and their view of themselves in the world from their problematic organ. A cancer can be viewed as an illness that has happened to a person. However the nature of a person’s consciousness corresponds with their psychiatric disorder.

Psychiatric patients also often have to grapple with negative stereotypes associated with their respective disorders. In South Africa, stigma in response to mental illnesses such as schizophrenia remain prevalent and influential. A particularly cautious approach is thus necessary when presenting a diagnosis that is associated with social misunderstanding and prejudice. A study carried out on the impact of a diagnosis of mental illness on stereotypes, prejudices and discrimination with a German sample, found that while a label of major depression had no effect on public attitudes, a label of schizophrenia came with attendant negative stereotypes and was associated with more negative than positive social responses.

**TELLING A PERSON THEY ARE SCHIZOPHRENIC SHOULD THEREFORE BE ACCOMPANYED BY A GOOD DEAL OF EMOTIONAL SUPPORT AND AWARENESS OF THE SOCIAL IMPLICATIONS OF THIS LABEL. TELLING A PERSON THEY HAVE A LIVER DISEASE IS NOT ACCOMPANIED BY A SIMILAR ASSAULT ON A PERSON’S SENSE OF SELF.**

It has been pointed out that the advantage of giving patients a psychiatric or psychological diagnosis is that it may help people to understand themselves, their temperaments and their personalities. It may guide people towards thinking about their strengths and their weaknesses, about how they react in certain situations, what they should avoid, what they should do more of and how they can live in a healthy and pleasurable way with themselves and others. The disadvantage of a diagnosis is that it may be associated with stigma, it may be used to blame the patient for his or her misery or it may become an excuse for the patient or family to avoid taking responsibility for their actions.

**THE RELEVANCE OF THE RIGHT STAGE OR MOMENT**

With regard to disclosure, deliberation needs to be taken concerning the stage of the disorder that the patient is suffering from. If a patient suffering from a dementia is to be told the truth, this needs to happen while he or she still has the capacity to retain information and to take necessary steps with regard to future care and financial planning. A person suffering from a psychotic disorder is usually in no position, while in the throes of psychosis, to appreciate and utilise truthful information regarding his or her
condition. Constructive disclosure is, in such cases, best attempted once the psychosis has resolved. On the other hand, conveying to a depressed patient that their hopeless view of the world and themselves may be attributable to their condition rather than to an inherently bleak reality, may, in many instances, encourage compliance with treatment. Truth-telling may be similarly helpful where distressful sensory disturbances, such as may be related to seizure activity, are ego-dystonic rather than ego-systonic.

DIAGNOSTIC DISCLOSURE AS FEEDBACK

It may be useful in the context of psychiatry to view the disclosure of diagnosis as a form of therapeutic feedback. Feedback is used in psychotherapeutic settings to convey information about past behaviour while influencing the likelihood and nature of its re-occurrence.\(^1\) It can be descriptive, as when a psychiatrist comments: “it seems that despite the fact that there are a number of improvements to your life in the pipeline, you still feel discouraged and hopeless”. It can be evaluative, as in the following: “you appear to have difficulty concentrating on the tasks presented to you and you struggle to complete them”. It can be interpretive as in: “you appear to be generalising your bad experiences with Jane to other women”. Feedback may also be self-disclosing as when a therapeutic practitioner comments: “when you speak so fast I have difficulty understanding what you are trying to tell me”.

-discussion of the relevant diagnosis may then, in time (when the moment is right in terms of the receptivity of the patient and the certainty of the psychiatrist) become a part of the general process of feedback.

The timing, form and manner of feedback are all important. Feedback, whether in the form of diagnosis or not, requires judgement as to when it is to be delivered and in what situation. Emotional processes surrounding feedback exchange are critical with regard to its reception, acceptance and incorporation. The emotional state of the patient needs to be taken into account at all times so that potentially troubling information is only fed to a patient when he or she is in a position to deal with it with equanimity.

All feedback is more likely to be constructively digested within the context of a strong therapeutic alliance. Feedback in general is more likely to be accepted if it has an influential source, combining expertise, credibility and personal relevance.\(^2\) Negative feedback of any kind, such as that which a serious psychiatric diagnosis may represent, is best presented alongside some sort of affirming commentary on the patient. Resistance to negative data is less likely if it is preceded by positive information.\(^2\),\(^3\) Diagnostic feedback should therefore be presented in the context of a discussion of the patient’s strengths, resilience factors and weaknesses, with mention of their strengths preceding the negative aspects of their condition. All of this is especially relevant if the patient in question has a Narcissistic Personality Structure as such individuals are more likely to question negative feedback and to view the doctor who presents it is as less than competent.\(^2\)
THE CONSTRUCTION OF DIAGNOSTIC FEEDBACK

Psychiatrists, furthermore, need to construct diagnostic feedback by tailoring it to the cognitive abilities of the patient involved; sensitively identifying symptoms; explaining the underlying biological and perhaps psychological processes involved; providing education which explains the role of medication and whatever other therapies are indicated as useful; and maximising the positive possibilities.

DISCLOSING TO FAMILIES

It has been suggested (at least with regard to Alzheimer’s patients) that the ideal situation for disclosure is in a joint meeting with patient and family together, in which facts about the disease are followed by a discussion of resources and plans for future care. In a South African psychiatric context, in which stigma with regard to mental illness is rife, it is suggested that, where possible, patients be consulted with regard to whom they would like diagnostic information shared with. In addition to stigma, many patients come from family contexts dominated by a lack of resources, inadequate housing, overburdened family members and a plethora of interpersonal antagonisms and the frequent trauma that often characterise such situations.

THE UNCERTAINTY PRINCIPLE

Finally, an important tenet with regard to disclosure also needs to be born in mind: this is the uncertainty principle. Absolute truth and hence absolute certainty is rarely achieved in medicine. Psychiatry is no exception. Much change is taking place, at present, with regard to understandings surrounding various disorders of mental health.

Precision medicine is revealing that biotypes do not correspond to the traditional diagnostic entities of Schizophrenia, Bipolar and Schizoaffective Disorders.

Current diagnostic categories, not only relating to the psychoses, but also relating to Autism Spectrum Disorders, Attention-Deficit Hyperactivity Disorder, Depression and Anxiety are in the process of being revealed to be imprecise and more biologically heterogeneous than they had hitherto been understood to be.

COLLABORATION

With this in mind, an open, honest presentation of information as it is perceived and known, is to be advocated.

A COLLABORATIVE RELATIONSHIP SHOULD BE CREATED IN WHICH FEEDBACK REGARDING DIAGNOSIS IS VIEWED AS UNBIASED, IS CLEARLY FORMULATED, TAILORED TO THE PATIENT’S SUBJECTIVE EXPERIENCES OF HIS OR HER DIFFICULTIES AND DELIVERED IN A CLIMATE OF FREE CHOICE SO THAT IT MAY BE RECEIVED, CONSIDERED AND PROCESSED.

It may be that several attempts will need to be made with regard to conveying diagnostic feedback. Receiving less than optimistic information may represent the demise of a sense of well-being and hope and patients may pass through various stages of denial, anger, bargaining, grief and acceptance - not necessarily in this order. Assistance with additional support and coping strategies in relation to the potential personal and social consequences of the diagnosis should be provided by referring the patient for individual psychotherapy and family therapy, if this is appropriate. Good support groups, where they exist, should always be utilised to help patients gather more information, share stories of similar experiences with others and develop a sense of emotionally-strengthening connection and identification with people grappling with comparable predicaments.
Child and Adolescent Psychiatry in South Africa is frequently practised in resource constrained settings. These constraints commonly extend from the patient’s living environment to the point of healthcare delivery. Such constraints are often aetiologically related to the presenting problems and may predispose patients to a multiplicity of diagnoses. Psychiatrists working in these burdened settings are often challenged to integrate new diagnostic entities in an already crowded diagnostic space. The current paper provides an overview of the diagnostic validity and clinical utility of Disruptive Mood Dysregulation Disorder (DMDD) given that this new DSM-5 inclusion may require due consideration in routine practice.

**DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD)**

DMDD is a new diagnosis in DSM-5 characterised by a persistently irritable or angry mood with intermittent temper outbursts (Table 1). The relationship between early chronic irritability and later depressive disorders is consistent with findings that irritability symptoms in childhood such as losing temper, becoming annoyed easily, predict later depression. These findings provided the foundation for the diagnosis of DMDD and its inclusion within DSM-5 Depressive Disorders, which emphasizes the disorder’s mood component and its distinction from the bipolar disorders.

The diagnosis of Bipolar Disorder amongst children and adolescents has generated much debate in recent years with diagnosis thereof increasing much faster than in adults. This has contributed to an escalating prescription of antipsychotic drugs for this patient group. While this increase could be supported by a real increase in prevalence and improvement in case identification, some researchers have attributed the high rates as stemming from mainly irritability in children being used to support the presence of a manic episode as opposed to traditional manic symptoms which are lacking.

**THE DIAGNOSIS OF SEVERE MOOD DYSREGULATION ORIGINATED MORE THAN A DECADE AGO AND HAS BEEN SUPPLANTED BY DISRUPTIVE MOOD DYSREGULATION DISORDER IN DSM-5. IT DESCRIBED CHILDREN & ADOLESCENTS WHO PRESENT WITH HYPER-AROUSAL TOGETHER WITH CHRONIC NON-Episodic IRITRABILITY AND FREQUENT TEMPER OUTBURSTS.**
APPLYING DSM-5 – DIFFERENTIAL DIAGNOSES, COMORBIDITIES AND VALIDITY

The symptoms described in Table 1 are consistent with those of Severe Mood Dysregulation, with a notable omission of hyper-arousal. Severe, chronic irritable mood in children has long presented a challenge to those working in child psychiatry because of its poor diagnostic specificity and its inclusion in numerous mood, anxiety, and disruptive behaviour disorders. Consequently Bipolar Disorder has been diagnosed in children with chronically irritable mood and thereby promoting the disorder as non-episodic. It is likely that this approach added to the outstanding rise in Bipolar Disorder diagnoses in paediatric patients noted earlier. Visits for Bipolar Disorder in this population group, in the United States, rose from an estimated 25 per 100,000 in 1994–95 to 1,003 per 100,000 in 2002–2003. The typical mood of DMDD is consistently irritable or angry, while that of Bipolar Disorder varies across euthymia, depression, and mania.

RESEARCH SUGGESTS THAT BIPOLAR DISORDER AND SEVERE MOOD DYSREGULATION HAVE A DIFFERENT COURSE.

The former (and not the latter) correlated with the development of lifetime Bipolar Disorder and the latter with the development of other psychiatric disorders, notably Major Depressive Disorder, Generalised Anxiety Disorder and Dysthymia.

Other diagnoses are distinguished from DMDD on the basis of outburst characteristics alone or in combination with irritability and include Intermittent Explosive Disorder (IED) and Oppositional Defiant Disorder (ODD). IED and DMDD differ in frequency of outbursts (twice a week for 3 months for IED; three times a week for 1 year for DMDD). Outstandingly, persistent irritability is not a criterion of IED, although it may be present. This suggests that IED may be a variant of DMDD. Thus, criteria may be met for both disorders. In such instances, DSM-5 specifies that DMDD takes precedence over IED. However, IED may be appropriate when the duration is less than 1 year. Both DMDD and ODD criteria include irritability and temper outbursts. However, the disorders differ in three respects:

1. **Severity**: outbursts must occur three times a week in DMDD, but only once a week in ODD (for individuals 5 years or older);

2. **Duration**: 12 months for DMDD and 6 months for ODD;

3. **Pervasiveness and impairment**: in DMDD, function must be impaired in two of three settings, and it must be severe in one setting, while ODD has no such requirement.

More children with DMDD will therefore meet criteria for ODD than the reverse. In this respect, in two large community samples, approximately 70% of children with DMDD met criteria for ODD, but less than 40% with ODD met criteria for DMDD. According to DSM-5, individuals whose symptoms meet criteria for both DMDD and ODD should only be given the diagnosis of DMDD.

The clinical validity of DMDD has been estimated from existing data sets. Axelson and colleagues generated DMDD diagnoses from previous interviews of children in the Longitudinal Assessment of Manic Symptoms study. They contrasted two groups, one with elevated parent ratings of mania (N=621), the other without (N=86). DMDD was twice more prevalent
among children with elevated ratings than those without. DSM-5 states that if an individual has ever experienced a manic or hypomanic episode, the diagnosis of DMDD should not be assigned. This suggests that Bipolar Disorder must be excluded before making a diagnosis of DMDD.

Axelson and colleagues reported that children with DMDD also have significantly higher rates of Attention Deficit Hyperactivity Disorder (ADHD), ODD, and Conduct Disorder than those without. Specifically, 96% of youths with DMDD had ODD or Conduct Disorder, and 77% had ADHD and ODD or Conduct Disorder.

The validity of DMDD as a diagnostic entity continues to be questioned based on the extent to which features are comorbid or associated with a range of other disorders.

APPLYING DSM-5 – RELIABILITY

Reliable assessment precedes the establishment of a new diagnosis and subsequent treatment guidelines. This is especially noteworthy for DMDD and related settings in which clinicians have conceptualised these children in different ways giving rise to multiple diagnoses.

In the DSM-5 field trials, inter-clinician reliability varied markedly by setting – acceptable in in-patient setting using Cohen’s kappa (k=0.49) and unacceptable in outpatient settings (k=0.06-0.11). Similarly, symptoms of DMDD are more frequently endorsed by parents than by hospital staff. However, this may reflect a diminution in irritability on admission to an inpatient setting.

BRAIN ACTIVITY

The behavioural responses to frustration in children with severe, chronic irritability are mirrored by abnormal neural responses. Deveney et al report that brain regions implicated in emotion, spatial attention, and reward processing show “less activation” after “negative feedback” in frustrating situations among children with severe mood dysregulation than among healthy children. Children with severe mood dysregulation also exhibit difficulty in shifting attention. Research utilizing such paradigms and populations may facilitate the development of novel interventions. Ryan points out in an editorial related to Deveney’s work that the findings may apply to other disorders, since irritability spans multiple diagnoses.

OUTCOMES

Axelson et al demonstrated that only 19% of children initially diagnosed with DMDD maintained the disorder across 12- and 24-month follow-ups, suggesting that the disorder has relatively low stability but remains chronic in a small proportion of children.

This finding is consistent with retrospective formulations of Severe Mood Dysregulation in the Great Smoky Mountains Study by Brozman et al, which found that, among children who met criteria for Severe Mood Dysregulation, 82.5% did so in only one of four waves of assessments. The lifetime prevalence of Severe Mood Dysregulation dropped dramatically (from 3.3% to 0.4%) when criteria had to be met in two consecutive waves. In previously ascertained community samples, including the Great Smoky Mountains Study cohort, Copeland et al found prevalence estimates of about 1% for DMDD in children over age 6 - comorbidity was the rule.

DMDD WAS ASSOCIATED WITH HIGH LEVELS OF SOCIAL IMPAIRMENT, SERVICE USE, AND SCHOOL SUSPENSIONS, AS WELL AS FAMILY POVERTY, SUPPORTING THE CLINICAL IMPORTANCE OF THE DIAGNOSIS.
MANAGEMENT OF DISRUPTIVE MOOD DYSREGULATION DISORDER

Roy and colleagues point out that in light of DMDD being a relatively new diagnosis, trial directed clinical guidelines are unavailable. However, they have proposed that rational clinical guidelines may be constructed from treatment studies involving disorders with overlapping overarching inclusion criteria with DMDD. In doing so, recommendations can be made based on research involving children with Severe Mood Dysregulation, ODD, or aggressive behaviour. A number of psychosocial interventions focussing on successful parenting have demonstrated effectiveness in children with oppositional behaviour – notably so in younger children as opposed to adolescents in whom cognitive behavioural therapy is favoured.

The significantly high frequency of irritability co-occurring with severe temper outbursts in children with ADHD has resulted in the evaluation of the effects of stimulants on these symptoms. Meta-analyses demonstrate moderate to large effects of these agents on aggression in children with and without ADHD.

Valproate, an anticonvulsant used as an anti-manic agent, may be useful for treating mood dysregulation of the type seen in DMDD. It may furthermore serve as adjunctive treatment to stimulants and behavioural interventions when managing ADHD and aggression in children. The possible suggestion that valproate’s anti-manic properties influence outcome in settings like those described is offset by trial-work demonstrating that lithium did not benefit children with Severe Mood Dysregulation. In-patient management alone has also yielded significant improvements in a similar patient population group. This suggests that containment within a structured, predictable setting is therapeutic.

Atypical antipsychotics may improve symptoms of DMDD, such as irritability and aggression. Side-effects, even with short-term treatment, may limit their widespread use however. Whilst controlled trials are still awaited in DMDD, treatment decisions would be based on studies of related psychopathology, such as aggression and irritability, in other paediatric samples.

Atomoxetine, approved for ADHD, has not shown a reduction in aggression in children with ADHD. Alpha agonists, such as clonidine, are used as augmentation treatment for ADHD but demonstrate limited effects on primary conduct symptoms and exhibit significant side effects. Studies examining these agents in the treatment of ADHD are awaited.

Based on the literature, a first level approach is most likely stimulant treatment as it enhances children’s resilience and frustration tolerance and reduces aggression with an acceptable side-effect profile.

It is also suggested that there is an addition of psychosocial interventions, such as parental guidance for young children and individualised cognitive behavioural therapy for older children. If insufficient improvement occurs with combined stimulant and psychosocial treatment, a mood stabiliser such as valproate should be considered. An atypical antipsychotic is a further consideration thereafter but one should remain mindful of its possible side-effects.

The complexity of the clinical presentations of children with DMDD is frequently highlighted with all the negative consequences of the disorder like a decline in family function and child-parent relationships.

CONCLUSIONS

DMDD is a new DSM-5 diagnosis. Despite the experts in the field of Severe Mood Dysregulation contributing extensively towards the evolution of DMDD, the validity of the entity and criteria adopted remain in question. Scientific validity of psychiatric diagnoses continues to be questioned as diagnostic systems like the DSM evolve.

Psychiatrists working with such systems in various psychiatric settings often enquire about the origins of diagnostic entities (on scientific grounds) which then support all that follows during the management of such a case. Psychoeducation has become more interactive between patients, their parents, caregivers and clinicians – validity often being brought into question by those better informed who are being subjected to various management strategies.

A number of concerns underlie the issue of validity:

1. Discrepant inter-rater reliability, notably in outpatient populations that are significantly larger than the inpatient population groups;

2. Phenotyping irritability that in itself spans multiple diagnoses and by attempting to create another phenotype (DMDD), related to irritability, it could be argued that the range of possibilities has been widened further without increasing diagnostic precision;

3. Stability of the DMDD diagnosis;

4. Management approaches that have not been supported by specific studies.

The inclusion in DSM-5 of DMDD, poses many challenges, which will necessitate further research. Concerns regarding its validity as a diagnostic entity could impact on utility, both internationally and locally.
The health system in general is characterised by a lack of accountability at multiple levels. As illustrated in the diagram (Figure 1), the South African Government has attempted to meet these challenges through a range of responses that have been intended to improve quality, efficiency and accountability. This has culminated in the establishment of the Office of Health Standards Compliance.

**CHALLENGES**

There are a number of challenges that South African health services face in a country of 52 million people served by 411 public hospitals, approximately 3,500 public clinics and 222 private hospitals. However, there is a disparity in the health service spend since the public health sector covers 83% of the population and spends approximately USD 11 Billion per annum, whereas the private health sector covers 17% and spends approximately USD 10 Billion per annum.

The challenges faced by the health services in rural and peri-urban areas include severe access problems, as depicted in the picture to the right illustrating the type of difficulties that rural patients face in accessing clinical services.

Other challenges include poor housing and over-crowding with a large proportion of the population living below the poverty line.

**PROBLEMS ASSOCIATED WITH THE SOUTH AFRICAN HEALTH CARE SYSTEM**

There are a number of underlying problems that affect a large proportion of healthcare establishments which include, unacceptably poor quality and unsafe health services.

The public health system is characterised by poor outcomes. It is under resourced and over-burdened, fragmented, highly variable, poorly managed with weak clinical governance and there are concerns regarding the knowledge and skills and competence of staff. Private health care is inefficient and costly.
THE VISION OF THE OHSC IS TO PROVIDE
“SAFE AND QUALITY HEALTHCARE FOR ALL SOUTH AFRICANS”.

ITS MISSION IS TO,
“ACT INDEPENDENTLY, IMPARTIALLY FAIRLY AND FEARLESSLY IN GUIDING,
MONITORING AND ENFORCING HEALTH CARE SAFETY AND QUALITY STANDARDS
IN HEALTH ESTABLISHMENTS TO SERVE THE PEOPLE OF SOUTH AFRICA”.

QUALITY IN HEALTH CARE

Quality and safety in healthcare is the expected norm and is frequently taken for granted; however, quality is never an accident. It is always the result of high intention, sincere effort, intelligent direction, and skillful execution and represents the wise choice of many alternatives (Willa A. Foster, Source Unknown).

Quality in the provision of patient care is defined as the degree to which the probability of desired outcomes is increased and undesired outcomes is reduced, (Board of Commissioners, Joint Commission, USA).

Making quality certain means getting people to do better all the worthwhile things they ought to be doing anyway, (Philip B. Crosby, Quality is Free).

REGULATED QUALITY STANDARDS

To avoid situations like this the decision was taken to develop regulated standards for health establishments (HE), defined as:

“the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services”

The OHSC regulations are not intended to, nor do they regulate the health professionals who work in HEs.
Their purpose is to:

- Develop a common definition of quality of care which should be found in all health establishments as a guide to the public, to managers and to staff at all levels.
- Establish a benchmark against which health establishments can be assessed, gaps identified and strengths appraised.
- Provide a framework for the national certification of health establishments.

The content of the NCS is to embody what managers (clinical and administrative) are expected to deliver in health establishments and reflect the policy context based on:

1. Legislation, policies, guidelines and protocols
2. Requirements of:
   - Treasury
   - Department of Public Service Administration
   - King guidelines on corporate governance.
3. Clinical governance, for example, guidelines, protocols
4. Clinical systems requirements, for example medical devices, pharmacy, diagnostics.

THE CONCEPT OF DOMAIN

The WHO has defined domains as areas within HE where there is a risk of quality problems occurring. Hence by setting quality standards that reduce the risk of poor quality in domain areas, the probability of safe quality patient care being provided is increased. Seven cross-cutting Domains were selected as risk areas in HEs.

Domains 1 - 3 focus on the core business of delivering quality health care to patients and include:

1. Patient Rights,
2. Clinical Governance and Care

Domains 4 - 7 focus on support systems that ensure the HE system delivers its core business:

4. Health Promotion and Disease Prevention,
5. Leadership & Corporate Governance,
6. Operational Management and
7. Facilities & Infrastructure.

All data used in evaluating the compliance of the NCS is obtained from the evaluation of the measures. Should the measure be non-compliant, they are classified according to risk categories defined below:

- Vital measures are those that ensure that the safety of patients and staff are safeguarded so as not to result in unnecessary harm or death (Weighting: 50%).
- Essential measures are those considered fundamental to the provision of safe, decent, quality care (Weighting: 30%).
- Developmental measures are those elements of quality of care to which health management should aspire to, in order to achieve optimal care. (Weighting: 20%).

Table I: Functional Areas in a hospital

| M 01 - CEO / Hospital manager |
| M 03 - Communications PRO |
| M 04 - Facility infrastructure |
| M 05 - Financial management |
| M 06 - HR management |
| M 07 - Infection control |
| M 08 - Management of information |
| M 10 - Procurement |
| M12 - Occupational Health and Safety |
| M 14 - Clinical management group |
| M 16 - Case Management |
| P 01 - A+E |
| P 02 - Outpatients |
| P 03 - Maternity |
| P 04 - Medical ward |
| P 05 - Surgical ward |
| P 06 - Paediatric ward |
| P 07 - Generic wards |
| P 08 - Physiotherapy |
| P 09 - ICU / HCU / Burns / speciality ward |
| P 10 - Operating theatre incl. cath labs |
| P 11 - Psychiatric ward |
| P 12 - Occupational therapy |
| P 13 - Speech therapy |
| C 01 - Blood services |
| C 02 - Lab services |
| C 03 - Health technology services |
| C 04 - Pharmacy |
| C 05 - Radiology |
| S 01 - CSSD |
| S 02 - Cleaning services |
| S 03 - Food services |
| S 04 - Laundry services |
| S 05 - Maintenance services incl. garden services |
| S 06 - Record archive |
| S 07 - Waste management |
| S 09 - Transport services |
| S 09 - Security services |
| S 10 - Entrance reception and help desk |
| S 11 - Patient administration |
| S 12 - Mortuary services |

M = Management, P = Patient Care, C = Clinical support, S = Support Services
METHODS USED TO EVALUATE THE COMPLIANCE OF MEASURES

Document review and analysis –
• check for availability of a document, policy or protocol e.g., patient records, personal files, policies or guidelines.
• review content of a document to serve as evidence that the standard has been fulfilled e.g., minutes of meetings, reports and plans.

Observation
– directly observe staff carrying out their duties or performing certain functions e.g. observe infection control and hand hygiene practices, performance of procedures or the way patients are counseled.

Patient interview
– one on one interviews with a small sample of patients to ask specific questions using a structured checklist.

Staff interview
– one on one interviews with a small sample of staff to ask specific questions using a structured checklist.

Patient record assessment
– review of the content of the patients records to serve as evidence for compliance.

EVALUATING THE COMPLIANCE OF MEASURES IN HE

The departments and services within HEs are called Functional Areas, as shown in Table I (Previous Page):

Standards, with measures that define the requirements for the standards, are set for each Functional Area. The aim of the standards is to reduce risk, specified by the domains, in relevant Functional Areas of HEs.

To facilitate the evaluation process, the standards and their measures that directly impact on relevant Functional Areas have been grouped together into separate questionnaires. Hence there is one questionnaire for each Functional Area to evaluate the domain risk areas specific to each Functional Area.

In this way, by complying with the measures set out in the questionnaires, the risk of adverse incidents will be reduced and patient safety and efficiency will be enhanced in HEs.

SUMMARY OF THE INSPECTION PROCESS

The inspection, evaluation and reporting processes are not enough. It is only when non-compliant standards are improved and all standards are met and maintained that safe quality care is assured. Quality does not just happen, it is always the result of, “high intention, sincere effort, intelligent direction, and skillful execution”.

REQUIREMENTS FOR QUALITY IMPROVEMENT

A number of specific requirements will have to be met if the majority of South African HEs are to improve to a situation where they are able to provide safe quality services to the citizens of the country. These are set out below:

1. Team work, including:
   • Public enterprises at national, provincial and local levels with the associated involvement of all public stakeholders including the National Department of Health and other social services such as Social, Housing and Public Works Departments.
   • Private Health Sector.
   • Regulatory Bodies.
   • Non-governmental Organisations
   • Public
   • Media
2. Well-designed continuous improvement programmes in all HEs.
3. Time for HEs to understand and implement quality improvement processes required to bring about the necessary fundamental changes required for substantial improvement.
4. Discipline in cases of continued non-compliance with the regulated standards.
Yelate (Duloxetine)

Indications:

Yelate is indicated for the treatment of:
- Depression as defined by DSM-IV Criteria
- Diabetic peripheral neuropathic pain (DPNP)

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Stuart Whittaker, founder and former Chief Executive Officer of the Council for Health Service Accreditation of Southern Africa, pioneered the concepts of a facilitated accreditation programme and graded recognition to assist disadvantaged hospitals in Southern Africa and other developing countries to comply with professional standards and conducted research and the testing of adverse event monitoring systems for Southern Africa. He has published widely and he has presented at numerous international and national conferences. As a temporary consultant to the World Health Organisation he participated in projects to assess the impact of accreditation on national health systems and choosing Quality Approaches in Health Systems. Appointed by the Minister of Health in 2013 to serve on the Board of Directors for the Office of Health Standards Compliance (OHSC) in South Africa. He is a Visiting Professor at the School of Public Health and Medicine at the Faculty of Health Sciences at the University of Cape Town and Extraordinary Professor in the School of Health Systems and Public Health, Faculty of Health Sciences, University of Pretoria. Correspondence: stuart@mqh.co.za

Facilities that meet the National Core Standards will be certified. Certification will be a pre-requisite for funding through the proposed National Health Insurance Fund. The diagram below summaries the functions of the OHSC.

In cases of continued non-compliance with the regulated standards, OHSC inspectors may issue a notice of non-compliance to person in charge of establishment to reflect:

- any prescribed norm and standard that have not been complied with;
- details of the nature and extent of non-compliance;
- any steps that are required to be taken and the period over which such steps must be taken; and
- the penalties that may be imposed in the event of continued non-compliance.

If the person in charge of the HE fails to comply with the requirements of the notice of non-compliance, the required response takes into account the nature, extent, gravity and severity of the contravention and consequently the OHSC may:

- issue written warning with a prescribed time frame to achieve compliance
- require from establishment a written response
- recommend to the relevant authority any appropriate and suitable action, including disciplinary proceedings
- recommend to the Minister the temporary or permanent closure of facility if it constitutes a serious risk to public health or to health service users;
- impose upon that person or health establishment a fine
- refer the matter to the National Prosecuting Authority for prosecution.

SUMMARY OF REGULATORY POWERS AND FUNCTIONS OF THE OHSC AS REQUIRED BY THE ACT.

FUTURE DEVELOPMENTS

At the present, the OHSC only has standards for hospitals and primary care HE, however it is planned to develop standards for Family Practitioners and Specialists.
A simple question was voiced by an in-patient before the last general elections; “Doctor, what arrangements are being made so that we can vote?”

At the time, unaware of the legislation regarding registration on the voter’s role and implications for the mentally ill, a quick response was that arrangements would be made for voting to take place. I then discovered that the Electoral Act (73 of 1998) as it currently stands denies the mentally ill the right to be registered on the voter’s role in two circumstances, firstly, if they have been “declared by the high court to be of unsound mind or mentally disordered”, and secondly if they are “detained under the Mental Health Care Act, 2002 (Act 17 of 2002)”. I subsequently began to question this piece of legislation which deals with a founding principle of the South African constitution, “universal suffrage” for all adult citizens of the Republic of South Africa. Essentially though, a group of individuals are excluded from voting on the grounds of mental illness.

The right to vote has long been denied to various groups of people around the world, considered for one or other reason by the powers that be to be incapable of voting. Historical reasons for exclusion from suffrage include gender, religion, race, criminality, social class or wealth status, knowledge or educational level. Age is still considered an acceptable criterion for determining eligibility for franchise, as is holding the appropriate nationality. These historical exclusions were “justified” at the time by “philosophical” ideas regarding certain groups being incapable of applying their mind to the task of voting, or perhaps incapable of voting in line with what those in power felt was appropriate, with loyalty questioned in religious groups. The extreme South African example denied the right to vote to non-white South Africans during the apartheid era. It was for this reason that the right to vote was a founding principle of the new constitution adopted by post-apartheid South Africa in 1998.

Anecdotally, from my experience, the overwhelming first response by the lay public as well as mental health professionals, to the question “should the mentally ill be allowed to vote?” Is, “of course not”.

This highlights the overwhelming stigma still associated with mental illness. The label of “mental illness” is broad encompassing a variety of psychiatric illnesses, of varying severity. The reasons behind excluding the mentally ill from voting in the Electoral Act have not been expressly stated, but one can surmise that the assumption is that the mentally ill cannot make a sound and rational judgement as to who should be leading the government based on delusional beliefs or cognitive impairment.
The mentally ill are, however, not a homogenous group, with globally impaired cognitive functioning, as seems to be suggested by the electoral act. To suggest so is essentially stereotyping the “mentally ill”, and is in my opinion discriminatory on the ground of mental illness. I use the term “mentally ill” in inverted commas because there are obviously concerns with the use of this term. One could argue that the act is not referring to all mentally ill patients but to just a group of patients with “severe mental illness”. Again, however, those with severe mental illness are not even a homogenous group.

In line with global trends to destigmatise mental illness and make treatment less restrictive and more inclusive with community involvement, the South African legislation governing the treatment of those with a mental illness was amended in 2002.

The Electoral Act does not take into account the most recent developments in the Mental Health Care Act of 2002. It is unclear what “detained under the mental health care act” refers to, voluntary, assisted or involuntary admissions, or just to involuntary Mental health care users (MHCU)? Also, would those who have been “declared of unsound mind by a high court” be “state patients”? Perhaps the act refers only to involuntary admissions, to a group of patients who are either posing a danger to themselves or to others by refusing treatment and are unable to see the need for their own treatment, and to state patients, who have committed a crime and been found not responsible or unfit to stand trial on the grounds of a mental disorder or defect?

Admission to hospital as an “involuntary MHCU” or as a “state patient” does not imply that there is global cognitive impairment, although there may be a small subgroup of patients who are cognitively impaired.

Cognitive impairment may impact on who one chooses to vote for, or may leave a person vulnerable to coercion. Likewise, there are some “involuntary MHCU” or “state patients” who have delusions, and delusional beliefs may impact on who a person decides to vote for.

Depression may impact on motivation and drive and thus impact on the voting process. Cognitive impairment, delusional beliefs and depression are found in patients with varying degrees of severity in terms of functional impairment, even among those admitted to hospital for treatment. There are also a number of people in the community with cognitive
impairment, delusions and depression, who are not admitted under the MHCA or declared by a high court to be of unsound mind or mentally disordered.

“Capacity” is task specific; a health care professional assessing a patient for “capacity” has to determine the degree of functional impairment in the patient, and which functional domains are affected and how this impacts on the task at hand.

THE HEALTH CARE PROFESSIONAL NEEDS TO DETERMINE IF THE PATIENT UNDERSTANDS THE TASK AT HAND, AND CAN MAKE A REASONABLE DECISION BASED ON ASSIMILATING THE RELEVANT FACTS, WEIGHING THE PROS AND CONS AND DETERMINE THE ADVANTAGES AND DISADVANTAGES OF A DECISION. TAKING THIS INTO ACCOUNT, HOW THEN WOULD ONE DETERMINE WHETHER A PERSON HAS CAPACITY TO VOTE? SOME MAY SUGGEST THAT A SIMILAR PROCESS TO DETERMINING CAPACITY FOR DECISION MAKING IN TERMS OF FINANCIAL MATTERS SHOULD BE FOLLOWED. WOULD THIS ENTAIL ASKING WHO A PATIENT INTENDS TO VOTE FOR? OR PERHAPS ASKING THE REASONS FOR A PARTICULAR VOTING DECISION? THIS ASSESSMENT WOULD BE HIGHLY SUBJECTIVE IN TERMS OF DETERMINING WHETHER THE RESPONSES WERE RATIONAL AND APPROPRIATE.

It is important to remember that the average voter registered on the voter’s roll does not have to give any justification for their voting decision, they are not required to prove that they have any understanding of the voting process, the pros and cons of voting for a particular political party or the consequences of voting.

There is also no intellectual requirement for registration on the voter’s roll. There is no requirement that the voter should familiarise themselves with the manifesto of each political party and therefore make a rational decision.

It is my opinion that the exclusion of the mentally ill in the Electoral Act as it stands is unfair and discriminatory and should be challenged. Any adult who expresses the desire to vote should not be denied that right through legislation.

Dr Yvette Nel is a psychiatrist at Tara hospital, and is a joint appointee at the University of the Witwatersrand’s Department of Psychiatry. References available from the author. Correspondence: yvette.net@wits.ac.za
“How beautifully leaves grow old. How full of light and colour are their last days.”

COGNIMET (MEMANTINE HYDROCHLORIDE)

INDICATIONS¹

For moderately severe to severe Alzheimer’s disease.

Efficacy has not been established beyond 6 months.

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‘STEP UP’
A GREAT LEAP FOR MENTAL HEALTH ADVOCACY
Suvira Ramlall

Annually, July is observed as National Mental Health Awareness Month. To kick start the month this year and to raise awareness about mental health, the KZN Mental Health Advocacy Group, planned a morning of healthy walking and information sharing on Durban’s beachfront on Saturday 2 July 2016.

Mental health care patients, caregivers, practitioners, public and private sector service providers, non-profit organizations and benefactors launched the Mental Health Advocacy Movement with the first ‘Step up for mental health’ activity.

Proving the resilience and mettle of those affected by and working with mental illness and substance abuse, a 350+ strong group – ranging from babies in prams to senior citizens - braved one of Durban’s coldest mornings with gusty winds to walk the talk for the Cinderella of Health. Participants gallantly walked the distance and were rewarded with medals for their participation.

A vibrant group of organizations engaged with participants providing much needed information, advice, pamphlets and displaying the creative handicrafts of chronic mental health care users. Mental well-being is fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens.

Mental health activities enhance peoples’ well-being and functioning by focusing on their strengths and resources, reinforcing resilience, reducing risks and enhancing external protective factors.

Mental illness causes a huge burden to individuals, families and the country as a whole. It is a major contributor to absenteeism and lost productivity in the workplace. By 2020, clinical depression will be the leading cause of disability worldwide. Mental illness often co-exists with and complicates the outcome of many common physical disorders such as diabetes, hypertension, cardiac disease and HIV.

Furthermore, substance use disorders and mental illness often co-occur, making treatment of both conditions more difficult. The onset of mental illness is most commonly in youth with persistence into later life. In South Africa mental illness and behavioural disorders are the leading cause of disability in persons between the ages of 10 – 29 years. In addition, the behavioural, substance use and socio-economic problems associated with mental illness all predispose an individual to HIV infection. In turn, HIV infection causes and exacerbates mental illness, and mental illness worsens treatment outcomes of HIV/AIDS.

The Mental Health Advocacy Group aims to change the major structural and attitudinal barriers to achieving positive mental health outcomes. It plans to take action to help and support people affected by mental illness to voice their needs, secure their rights, represent their interests and obtain services required thus helping to promote social inclusion, equality and social justice.
The objectives of the advocacy group are to:

- Raise awareness about mental health, mental illness and substance abuse
- Empower consumers, families, NGOs
- Organize programmes to reduce stigma and discrimination
- Collaborate with the media to inform and educate the public
- Promote prevention programmes
- Motivate and inform decision-makers
- Influence policies

Some of the health benefits of exercises such as walking are:

- Relieves stress
- Improves memory
- Helps you sleep better
- Boosts your mood
- Positively impacts on depression, anxiety, PTSD and ADHD
- Improves self-esteem and emotional resilience
- Improves energy levels
- Boosts the immune system
- Helps to control body weight
- Improves the control of cholesterol, blood pressure, blood sugar

The mental health advocacy group is an initiative of the mental health care practitioners based at King Dinuzulu Psychiatric Hospital in Durban and is supported by the KZN Department of Health, the South African Society of Psychiatrists, the Psychological Society of South Africa, the South African Depression and Anxiety Group (SADAG), Discovery Health, Sanofi Aventis, Akeso Psychiatric Clinics and the Durban Practicing Psychologists Group.

Organizations and institutions represented at the Beachfront Walk on 2 July 2016 were SADAG; Nurture, Alzheimer’s SA, Durban and Coastal Mental Health Society, Rehabilitation and Upliftment Foundation (RAUF), Healing Hills and Akeso Psychiatric Hospitals, Ekuhlengeni Provincial Hospital, Alcoholics Anonymous (AA), Bessie Makhatini Foundation for Dementia Care in Lamontville and UKZN Howard College’s Student Society of Psychology, supported by the KZN Branch of PsySSA.

The Mental Health advocacy Group plans to make this an annual, and possibly national, event. Other activities planned for this year are a symposium, which will include a session devoted to caregiver support, the establishment of a central mental health resource centre as well as outreach activities to communities to increase awareness of mental health, mental illness and substance abuse and to empower communities to improve their mental health. They may be contacted at MHadvocacygroup@gmail.com

Suvira Ramlall is Bio-clinical Head of Psychiatry-King Dinuzulu Hospital Complex; Lecturer-Department of Psychiatry, UKZN; Secretary- Council, College of Psychiatrists; Member of KZN mental health advisory committee. References are available from the author.

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On the 8th of June 2016 the Department of Psychiatry from the University of the Witwatersrand hosted its Annual Research Day at the Sunnyside Park Hotel in Johannesburg. This was the 28th year of the event. It provides an invaluable opportunity for graduating psychiatry registrars, psychologists and allied health professionals to present their research. Registrars in their second year of training organise this annual event with the guidance of Associate Professor Janse van Rensburg. The scene was set with the keynote speaker, the eminent Dr Pierre Durand presenting a captivating topic, “Evolution and the Molecular Basis for Psychiatry”. Dr Pierre Durand is group leader of the evolutionary medicine laboratory in the department of Haematology and Molecular Medicine, University of the Witwatersrand, and holds honorary positions in the Evolutionary Studies Institute and at the University of the Western Cape. Subsequent presentations stimulated interest in a number of current topics in the field of child and adolescent psychiatry along with adult psychiatry. Dr Sheila Lutaaya, supervised by Dr Belinda Marais, stood out with the winning topic titled “Effectiveness of a Structural Behavioural Communication Intervention at Tara Outpatients Clinic” and was awarded a prize sponsored by the SASOP Southern Gauteng Subgroup.

The event promulgated the exchange of knowledge and ideas between those already qualified and those still in the process of completing their studies and research along with serving as medium for networking between researchers, aspiring researchers and industry.

**Sponsors:**
We would like to thank our sponsors, without whom this would not be possible:
Thomas Edison, the famed patentee/inventor, believed that little people lived inside the brain (the Broca area according to him), working in shifts, and were largely responsible for the storing and retrieval of memories (Edison, 1885/1968).

Of course this line of reasoning is prone to the difficulty of infinite regress in which these little people have little people of their own, who in turn have further little people, ad finitum. This idea served as the premise for Pixar’s animated feature film Inside Out (Rivera, 2015).

In this story we are invited into the developing mind of a young girl (Riley) who has 5 personalities who personify primary emotions (Joy, Sadness, Anger, Fear, and Disgust).

The viewer is welcomed into a world in which memories are stored and serve in the creation of personality structures, including an amusing side-adventure into the subconscious. Initially within the narrative the role of Sadness is unclear and emotions are largely kept separate within their areas of expertise, for example Fear has the role of keeping the protagonist safe.

However, as the plot unfolds the integration of emotions emerges. This theme of emotional integration has been identified as important within the therapeutic context (Greenberg, 2004).

After the viewing a discussion was led querying the relevance and application of emotional integration within the context of Sterkfontein Psychiatric Hospital. One problem identified was that psychosis is commonly a defence mechanism against intense emotions.

Therefore, the difficulty within our context is to allow for emotional integration through the therapeutic exploration of emotions while avoiding inducing relapse through this very exploration. The staff were encouraged to be aware of these emotional elements and to initiate individualised intervention strategies.

Paul Warby (Clinical Psychologist in Community Service), References available on request: warbypaul1@gmail.com
Dr Danie Hoffman (HOD, Principal Psychologist at Sterkfontein Psychiatric Hospital)
SYMPOSIUM ON MENTAL HEALTH AND SCIENTIFIC PUBLICATION
- WPA 2016 REGIONAL CONFERENCE TBILISI, GEORGIA. APRIL 27-30

The symposium featured four speakers: Natalia Petrova – Russia (speaking on behalf of Peter Morozov), Armen Soghoyan – Armenia, Christopher Paul Szabo* – South Africa and Michelle Riba – United States of America. The symposium brought together perspectives and initiatives on promoting publishing of mental health content as well disseminating such content. Natalia Petrova reported on Peter Morozov’s programme that facilitates the development of young psychiatrists, as writers.

The process involves attendance at international congresses with subsequent, under guidance, writing of review pieces related to congress material for publication in local journals for local psychiatrists. Armen Soghoyan (current WPA Secretary for Finances) presented a report on a Russian version of World Psychiatry, noting that under the editorship of Mario Maj, the publication is ranked 3rd amongst psychiatric publications in terms of impact factor (as noted in Michelle Riba’s presentation). The implication of non-English versions of the publication is greater access to WPA content, with similar versions in both Arabic and Spanish.

Christopher Paul Szabo provided a perspective on scientific publishing in Africa with a specific focus on the issue of developing world data generated by developing world researchers and published in credible developing world journals. The concern expressed was that local policy needs a local database to ensure appropriateness.

Michelle Riba (current WPA Secretary for Publications), presented content related to some of the work of the operational committee of the section with a specific mention of one of the current agendas i.e. providing guidance on how to get published.

Subsequent discussion focused on the link between sections within the WPA, specifically Education and Scientific Publications (current WPA Secretary for Education, Edgard Belfort, being at the symposium). Such collaborative work would be important in developing researchers, disseminating research and addressing scientific capacity of developing world countries within the WPA.

A similar symposium is anticipated at the forthcoming WPA meeting in Cape Town, South Africa (Nov 2016).

Christopher Paul Szabo is a Member, WPA Operational Committee on Scientific Publications

UNIVERSITY OF STELLENBOSCH

APPOINTMENT

BONGA CHILIZA (Centre photo above) was appointed as a Professor in the Department of Psychiatry.
TIRISANO TRAINING PROJECT (TTP) - TWO-YEAR SCHOLARSHIP

Lameze Abrahams, clinical psychologist, was awarded a two-year scholarship from Tirisano Training Project (TTP), which is a collaboration between University of California, Los Angeles (UCLA) and several South African Universities and Institutions including faculty from the University of Cape Town (UCT), the University of Stellenbosch (US), the Human Sciences Research Council, and North West University (NWU).

COLLABORATION – GRANT FUNDING

Associate Professor Jackie Hoare will be working with Caroline Kuo, an Honorary Lecturer in the Department, and others at Brown University, on an NIH R21 grant to explore conditional economic incentives as a strategy to boost ARV adherence in teens living with HIV. They will be collaborating with members of the Department of Paediatrics as well as KidzPositive.

DR NASTASSJA KOEN
GRANT AWARD

A post-doctoral fellow and part-time lecturer, working on the Neuro-GAP project, has obtained a grant from the Harry and Dora Crossley Foundation for her work on trauma and gene expression aspects.

DR.PIETER NAUDE
GRANT AWARD

Dr Pieter Naude, a post-doctoral fellow, working on the Drakenstein Child Health Study, has also obtained a grant from the Society of Biological Psychiatry to work with Prof John Joska on neuro HIV/AIDS and neuroinflammation.

LARA VAN NUNEN
OPPENHEIMER FELLOWSHIP AWARD

Lara van Nunen, a PhD student, with Dr Samantha Brooks, has been awarded an Oppenheimer Fellowship for her work on interventions for methamphetamine dependence.

DR EUGENE DAVIDS
POSTDOCTORAL RESEARCH FELLOW

The Adolescent Health Research Unit (AHRU) in the Division of Child and Adolescent Psychiatry has appointed Dr Eugene Lee Davids, the unit’s first postdoctoral research fellow. He has also been awarded the Donald J Cohen Fellowship for International Scholars in Child and Adolescent Mental Health, to attend the IACAPAP (International Association for Child and Adolescent Psychiatry and Allied Professions) Congress in Canada in September 2016.

MRC FUNDING

Dr Fleur Howells has won MRC funding for a study on the neurobiology of schizophrenia; co-investigators include Drs Henk Temmingh and Pieter Naude. Dr Howells has also been appointed as the Sarah Turoff Senior Lecturer in Neuroscience in the department and is a winner of the Claude Leon Merit Award.

PROF CRICK LUND
TW KAMBULE AWARD OF THE NATIONAL SCIENCE & TECHNOLOGY FOUNDATION

Prof Crick Lund been awarded the TW Kambule Award of the National Science & Technology Foundation, for his contributions over the past 5-10 years; he is the first psychologist to win this award. He will also be working with Jurgen Unutzer at the University of Washington and Inge Petersen at UKZN on a substantive CDC grant that aims at implementing and scaling up a collaborative care intervention locally.

DR SHAUN SHELLY
OPEN SOCIETY FELLOWSHIP AWARD

Dr Shaun Shelly, a PGDip (Addictions Psychiatry) student has been awarded an Open Society Fellowship to further the work he has been doing on moving towards a more progressive drug policy for South Africa.
Dr Pierre Malherbe chaired the event with the theme: Trauma and Mental Health. Londocor assisted with the event management and feedback has been overwhelmingly positive. The symposium was well attended with 14 industry sponsors. Presentations were of the highest standard, comprising a range of invited speakers.

PROF PIERRE JOUBERT: POSTTRAUMATIC STRESS DISORDER (PTSD) AND ACUTE STRESS DISORDER (ASD): DSM-IV TO DSM 5

Prof Joubert expressed the opinion that the developments around PTSD / ASD present an example of psychiatrists trying to get a better understanding of a complex phenomenon. It is done to the exasperation of disciplines and individuals idealizing constancy. What we are seeing is the scientific process in action over relatively brief periods of time.

He highlighted the changes in diagnostic criteria from DSM-IV to DSM 5 in a very clear and concise manner and provided the following summary for PTSD changes:

The traumatic event(s) is better described; Re-experiencing symptoms are now called intrusion symptoms and there are small changes involving better definitions; Symptoms of avoidance have their own category; Symptoms of changes in cognition and mood have their own category and include changes from DSM IV-TR; Symptoms of arousal and reactivity include reckless or destructive behaviour.

For ASD: The traumatic event(s) is better described; No immediate reaction of intense hopelessness etc., or dissociation is required; The traumatic event(s) involve the only criteria that must be met.

He concluded with the idea that psychiatrists should not get stuck on cherished opinions – if the facts, even just for a period of time, properly point in a different direction, we must go with the facts in the true spirit of science.

DR ANDROULA LADIKOS: IMPACT OF CHILDHOOD TRAUMA

Dr Ladikos gave an in depth discussion about the way in which children’s early social experiences shape their developing neurological and biological systems. Stressful and traumatic experiences undermine their health, social competence and their ability to succeed academically as well as in life.

Stable attachment bonds are essential for an infant’s continuing neurobiological development and form the basis of a child’s coping strategies and later adult mental health. It also affects the individual’s style of engagement and seeking out of supportive relationships later in life. Attachment is a process that continues throughout the later stages of life and early trauma has immediate as well as long term consequences. It is not only trauma within the first two years of life that is psycho-pathogenic. Long term trauma such as having an abusive father can also have a very negative effect on the developing child.

On the positive side, positive environmental influences, such as social support can ameliorate genetic and environmental risk for psychopathology and promote resilience. There is evidence that effective psychotherapy interventions can be made in traumatized two year olds. In order to understand...
and make sense of the effect of trauma in childhood, one has to understand the underlying mechanisms that have an effect on the developing brain. Early intervention and identification of the negative events of early childhood trauma is everyone working in mental health’s business.

PROF UGASVAREE SUBRAMANEY: PTSD CONTROVERSIES AND DETECTION OF MALINGERING

Prof Subramaney focused on 2 aspects of PTSD: Firstly, she discussed issues surrounding the clinical utility of the diagnosis. It is the only disorder for which the diagnostic criteria specify a clear cause/precipitant. Whereas PTSD was once conceptualized as a normal response to an abnormal event, it is now increasingly viewed as an abnormal response to events that turn out to be relatively common. Belief systems and how people make sense of what happens to them may impact on how trauma is experienced and PTSD is expressed. While controversy about PTSD is understandable given that it can be used for purposes of compensation, there is continuing evidence that PTSD is characterized by specific psychobiological disturbances, and that this condition deserves increased recognition and improved treatment.

The second half of the talk concentrated on the detection and management of malingering. People might mangle for financial reasons, to avoid criminal responsibility, in order to justify their level of functioning to others, or to gain the attention and respect of fellow comrades/veterans. Detection of malingering is typically a probabilistic judgement and one should combine all available evidence and determine whether the bulk of the evidence points toward a particular conclusion. A recommended starting point is the Miller-Forensic Assessment of Symptoms (M-FAST; Miller 2001), combined with a diagnostic interview and collateral information. It is important to spend time studying the mind of the claimant and to remember that no single finding from a clinical assessment is sufficient to definitively identify malingering.

DR RICHARD SYKES: PSYCHOPHARMACOLOGY FOR TRAUMA-RELATED DISORDERS

Dr Sykes highlighted the neurobiological changes and discussed some of the psychopharmacological dilemmas in PTSD. These include the high rate of comorbidity, different responses based on the types of trauma, that no agent has been developed specifically for PTSD, with few double-blind trials and poor response and remission rates. There are many different treatment guidelines available and they all acknowledge pharmacological and psychotherapeutic approaches. It is recommended that psychotherapy should be used before pharmacotherapy when possible.

First-line pharmacotherapy is SSRIs, with the best evidence for paroxetine, sertraline and fluoxetine. The SNRIs, especially venlafaxine, are also considered first-line options, but do not improve hyperarousal. Other medications with some evidence for improvement of certain symptoms include, phenelzine, moclobemide and mirtazapine. Trazodone and gabapentin may help for insomnia. Carbemazepine can help with flashbacks, insomnia, irritability and impulsivity, while valproate can improve hyperarousal and avoidance. Topiramate and lamotrigine can improve insomnia, re-experiencing and irritability. Lithium is helpful in reducing irritability and anger. Antipsychotics, including risperidone, olanzapine and quetiapine can also be used in severe, treatment-resistant PTSD. Benzodiazepines have limited value in treating the core symptoms of PTSD.

The take-home message was that PTSD is a complex, multi-dimensional neuropsychiatric illness, with a high probability of chronicity and comorbidity. SSRI’s and SNRI’s have the most evidence as first-line agents in combination with psychotherapeutic treatments. Current treatments fail to address all the dimensions of the illness. Adrenergic inhibiting agents, especially as early intervention treatments, provide promising results. There is an investigative drive underway and currently there are more than 30 randomized controlled clinical trials testing novel agents for the prevention and treatment of PTSD.
DR FANE BALE:
HYPNOTHERAPY FOR TRAUMA IN PSYCHIATRY

Dr Bale gave a brief history of hypnosis and highlighted some of the misconceptions. He briefly discussed the hypnotherapy process, which includes the pre-induction phase, trance induction and deepening phase, termination phase and post-hypnotic phase. The APA has said the following about hypnosis: ‘Hypnosis is not in itself a therapy, but rather is a state of aroused, attentive, focal concentration with a relative reduction in peripheral awareness that can be utilized to facilitate a variety of psychotherapeutic interventions’.

During the hypnotherapy process a full psychiatric history, including the organic work up is important, before initiation of the hypnotherapy process. Afterwards a post-hypnotic interview is done and therapy is continued. Hypnotherapeutic and hypno-analytic techniques applicable in psychiatry after trauma exposure were discussed with the focus on regression hypnotherapy and ideomotor signals. The abreaction-therapeutic process of releasing intense emotions while recovering buried memories was also discussed. Abreaction is a highly emotional reliving of an experience, which frequently becomes a catharsis. The purpose is to transform unfinished stuck places/memories/suggestions/beliefs that have been continuing to negatively affect the patient’s current life.

Dr Bale concluded with a case presentation that demonstrated one of these techniques used in a psychiatric patient. Hypnotherapy augmentation to pharmacotherapy in the management of some psychiatric conditions like PTSD has been reported to have some value in some studies.

DR CARLA KOTZÉ:
ELDER ABUSE:
ETHICAL AND LEGAL ASPECTS

Dr Kotzé discussed the increase in the older population and elder abuse as a global public health, criminal justice and human rights problem. The phenomenon of elder abuse is understudied and clear evidence of the prevalence and scope of the problem is unknown, partly due to problems with the exact definition of what constitutes abuse. Older people have reported that they perceive marginalization and exclusion as a result of structural deficits and social transformation as a violation of their human rights.

The Older Persons Act of 2006 was discussed in the context of the historical background, its main objectives and limitations with implementation. Some ethical dilemmas, such as the duty to report, protection and safety vs. confidentiality, victim autonomy and right to self-determination were also addressed. There is a legal obligation to report suspected abuse, but the overriding concern must always be the safety of the patient and prevention of unnecessary suffering.

AS A CONCLUSION THE NEED FOR MORE RESEARCH INTO THE PHENOMENON OF ELDER ABUSE WAS HIGHLIGHTED. HEALTH PROFESSIONALS SHOULD CONSIDER ROUTINE SCREENING FOR ABUSE, ESPECIALLY IN HIGH-RISK POPULATIONS, AND PATIENT-CENTERED TREATMENT AND PREVENTION STRATEGIES SHOULD BE IMPLEMENTED. THERE SHOULD BE COORDINATED EFFORTS AT NATIONAL LEVEL TO PRESERVE AND PROTECT THE HUMAN RIGHTS OF VULNERABLE AGING POPULATIONS. THE PROBLEM OF ELDER ABUSE CANNOT BE PROPERLY SOLVED IF ESSENTIAL NEEDS ARE NOT MET. WE MUST CREATE AN ENVIRONMENT IN WHICH AGEING IS ACCEPTED AS A NATURAL PART OF THE LIFE CYCLE AND WHERE OLDER PEOPLE ARE GIVEN THE RIGHT TO LIVE IN DIGNITY – FREE OF ABUSE AND EXPLOITATION – WITH OPPORTUNITIES TO PARTICIPATE FULLY IN EDUCATIONAL, CULTURAL, SPIRITUAL AND ECONOMIC ACTIVITIES.
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South African Society of Psychiatrists

National Health Insurance for South Africa White Paper of December, 2015:
Response and Position Statement of the South African Society of Psychiatrists (SASOP)

Dr Lesley Jane Robertson, FC Psych (SA); MMed Psych (Wits)
SASOP National Convener of Public Sector Psychiatrists

Introduction

SASOP is the only representative body for psychiatrists in South Africa and represents approximately 75% of psychiatrists working in South Africa. As South African psychiatrists, working in both the public and private sectors, we are grateful to have this opportunity to respond to the NHI white paper which was published in December, 2015. This response is primarily concerned with the white paper as it relates to the provision of mental health care from a clinical perspective. The SASOP private sector group has made a separate submission regarding the NHI model and its financing via the South African Private Practitioners Forum (SAPPF). Therefore, such matters are only discussed in this document where they are of general concern to all SASOP members.

The vast majority of people with mental illness in South Africa currently do not receive treatment of any kind.\(^1\)\(^2\) However, mental illness has significant public health and social implications.\(^3\)\(^5\) As with all measures that will close the treatment gap for the mentally ill, SASOP fully supports Universal Health Coverage (UHC) and the integration of mental health into primary care. Mental illness is closely linked to poverty as it often leads to unemployment and poor socio-economic circumstances for the individual sufferer and their families.\(^2\)\(^5\) A consequence of this is that the severely mentally ill, already a marginalised group in society, are unable to access health care which requires employment-linked insurance or out of pocket payment.\(^6\) They are thus dependent on the public health sector for quality care. We therefore commend and support the Honourable Minister of Health, Dr Motsoaledi, in his endeavours to achieve equal access to quality care for all South Africans. We hope that we may be of service in reaching this goal. Our comments on the white paper are made in this light.

* PLEASE NOTE: The full text is available electronically as a pdf on the website www.southafricanpsychiatry.co.za.
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Exsira significantly improves work impairment in major depressive disorder, by reducing absenteeism and increasing productivity.\(^1,2\)

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

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

References:

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PP-EXD-ZAF-0007
On 29 May 2016 Sunday Times reported on the non-medical use of ADHD medication (specifically methylphenidates (MPH) such as Ritalin and Concerta) as “smart-drugs” and possible “gateway drugs”.

The title of the article “‘Kiddy cocaine’ lets students aim for the highest marks” with a sub-title “Milder forms of tik” prescription drug is highly sought after, but experts warn of its danger” clearly can contribute to the stigma surrounding ADHD as a diagnosis and the treatment thereof.

In this article, Francois Steyn’s (from the department of Social Work and Criminology, University of Pretoria) research was highlighted with regard to the prevalence of non-medical use of MHP by undergraduate students (SAJP, 2016). In his study 818 students completed a survey in which 1 in 6 (17.2%) of respondents indicated past MPH use, although only 2.9% has been diagnosed with ADHD. Nearly a third (31.7%) of users obtained the MPH products illegally.

DR PIERRE VIVIERS (STELLENBOSCH UNIVERSITY’S CAMPUS HEALTH SERVICES) SAID THAT THEY HAVE TREATED STUDENTS WHO HAD BECOME “EXTREMELY ADDICTED TO THE DRUG”, WHILE DR JACQUES MALAN (PSYCHIATRIST WITH A SPECIAL INTEREST IN SUBSTANCE ABUSE) DESCRIBED RITALIN AS A “MILDER FORM OF TIK” AND THAT GENERAL PRACTITIONERS AND PSYCHIATRISTS WERE WRITING PRESCRIPTIONS WITH “VERY LITTLE PROPER ASSESSMENT”.

SASOP believes in the comprehensive diagnostic assessments by an adequately-trained and skilled healthcare professional, preferably a psychiatrist, prior to initiating drug treatment. Such an assessment should include a diagnostic interview, appropriate assessments by an educational psychologist and/or occupational therapist, and collateral information from family members and/or the employer. Rating scales can aid in the diagnosis.

A diagnosis of ADHD should be made according to established diagnostic criteria (APA, 2013), ADHD is characterised by severe and impaired levels of inattention, hyperactivity and impulsivity, with symptoms already evident in childhood.

Early diagnosis and intervention, and ongoing treatment (which includes compliance to treatment) are crucial in preventing complications (including psychiatric comorbidity such as substance abuse, mood- and anxiety disorders) and long-term costs for individuals with ADHD (Schoeman, 2016).

International guidelines recommend the use of stimulants (MPH derivatives) and non-stimulant medication (e.g. atomoxetine) as first-line treatment (e.g. BAP, 2007; NICE, 2013). These treatments are effective and, although side-effects may be present, if used judiciously, is not harmful to individuals with ADHD. Psychotherapy and social skills training should also form part of treatment. South African guidelines are being developed.

THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS (SASOP) WOULD LIKE TO INDICATE THE FOLLOWING:

- SASOP do not support the cosmetic use of medication, i.e. to treat patients in the absence of a diagnosis. This implies that the use of MPH as “smart drugs” or cognitive enhancers is not supported.

ADULTS WITH ADHD...
SASOP WOULD LIKE TO ADVISE PATIENTS TO CONSULT THEIR PSYCHIATRISTS PRIOR TO STOPPING ANY MEDICATION. FOR THOSE PATIENTS WHO ARE UNDER THE CARE OF A GENERAL PRACTITIONER, THEY SHOULD DISCUSS THE MATTER WITH HIM/HER AND IF THEY ARE UNABLE TO GET AN ADEQUATE RESPONSE THEY MAY CONTACT MEMBERS OF SASOP. INDIVIDUALS IN WHICH THE DIAGNOSIS OF ADHD HAS NOT BEEN ESTABLISHED ARE ADVISED TO CONSULT A PSYCHIATRIST WELL-Versed IN THE DIAGNOSIS AND TREATMENT OF ADHD.

A balanced report should have included interviews from psychiatrists with a special interest in ADHD who belongs to the SASOP Special Interest Group for adult ADHD.

Furthermore, the misuse/abuse of MPH by individuals without ADHD is a personal choice and not supported by SASOP. Medical health care professionals have a professional duty to do a comprehensive assessment (most likely something that cannot be done in the average fifteen-minute GP consultation) and establish an accurate diagnosis prior to prescribing any medication used for the treatment of ADHD.

SASOP - POSITION STATEMENT

ON BEHALF OF SASOP
Dr Renata Schoeman (Co-convenor, SASOP adult ADHD SIG) Renata@renataschoeman.co.za
Correspondence: www.renataschoeman.co.za
If you are living with ADHD, are a parent, teacher or family member associated with ADHD, **MY ADHD** brings you a rich resource of information on how to cope, manage and excel in living with ADHD.

**MY ADHD**

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- An interactive, daily refreshed Facebook page
- Innovative unique new ADHD blog page - quality content by ADHD specialists and patients
- Appropriate and informative content about dealing with ADHD in all age groups and daily situations
USB’s TOP MBA STUDENT SELECTED AS FINALIST FOR BUSINESS WOMAN OF THE YEAR

DR Renata Schoeman, USB’s Top MBA Student for 2015, has been named a finalist in the Business Woman of the Year Awards, presented by The Businesswomen’s Association of South Africa (BWASA) for her work in adult ADHD as well as leadership development. The gala evening is on the 26th of August 2016, where the winner will be announced.
My home office – indeed, my home! – is awash with wine as I write. There are full cases just delivered in the entrance hall, awaiting reconciliation.

There are bottles lined up on the central island to be tasted. There are ‘left overs’, open bottles short of about 35 ml which were tasted, awaiting collection by grateful student nieces and nephews. There are empties, all packed in cardboard cases in the garage, destined for recycling...

It’s ‘Platter Season’, an eight-week period in winter when a band of wine writers taste and reduce to words (which, hopefully, conjure the taste for you as you read them) nearly 8000 wines for Platter’s South African Wine Guide, for which 2017 will be the 37th edition when launched in November. Neither the 2* Chardonnay’s ‘ripe citrus fruit tensioned by bright seam of acid in 2015’ nor the 280-character write-up of 5* ‘Regal Red 2013’, are idle thumb sucks. They are carefully considered vignettes, created after tasting the wine in conjunction with its individual technical analysis sheet, and within constraints of time, space and editorial directives. And the end result of a significant logistic exercise.

It was a little less complex and somewhat more home-spun when John and Erica Platter launched the Guide – then called John Platter South African Wines – in 1980. Angela Lloyd – still busy tasting, writing and managing the ever-growing index – joined the couple shortly thereafter to review all (yes, all) the then-cooperatives. Yours truly is now in his 19th edition on the trot.

The owners have changed along with the complexity over the years, each contributing particular character. John & Erica sold the title to their then printers Creda, who subsequently moved it on to a former Creda director Andrew McDowall (under the aegis of Newsome McDowall). Diners Club snapped it up when Andrew retired three years ago and it is now published by JP Rossouw, creator of Rossouw’s restaurant guide, also in the Diners’ stable.

What has remained consistent though, are the Guide’s ‘USP’ being its comprehensive inclusion – by invitation – of every SA wine bottled or bagged for sale, its balance of honest fairness to both producer and consumer, and its inherent integrity. Of positive disposition, Platter’s celebrates the upside of a wine, rather than carping about any downside.

The production chain goes something like this. Taster writers are allocated portfolios which evolve with time – a producer is reviewed for three years before reallocation, to both retain consistency and inject fresh views – and any conflicts of interest are declared and managed. Each and every known producer, 900 of them from a garagiste making one barrel in the, well, garage through to large corporate producing wholesalers, is invited to submit wines, and given an opportunity to request alternative tasters if there is demonstrable conflict of interest. Unlike all other wine shows or competitions, there is no charge for inclusion. Updated contact details and producer news is submitted along with two bottles of each wine to a central winelands warehouse, where a clutch of Stellenbosch University students (fondly known as The Elves) reconcile the submission against the previous edition – consistency is crucial – and follow up on any discrepancies. Of which there are many! Once resolved under supervision of a wine coordinator, the submission is then sent to the designated taster.

Tasters again confirm the correct reconciliation and go about the business of reviewing the wine, and writing it up. This happens on a web-based intranet, with multiple communications between numerous role-players to prevent errors or omissions. After rafts of debate, both internal and public, the Guide uses the sighted method – the wine’s identity is known – rather than tasting ‘blind’. The potential downside of undue influence of the label is offset by additional richness sighted tasting brings to the copy. ‘Blind’ elements are used though: second opinions that are mandatory if the star rating changes excessively from one year to the next, and the Wines of the Year Panel Tasting, are all ‘blind’ in nature. Once tasted and written up, the wines are centrally indexed and the copy then edited.
With tooth enamel tenuous and tongues somewhat stained, the tasters know the end is in sight in late August, when the top wines are reviewed at the Wines of the Year tasting. All 4* wines – some 640 last year, less than 10% of the total – are tasted unsighted by panels over two days, for 5* status and to seek the Wines and Producers of the Year in various categories. Last year 83 – 1% of the total review – achieved coveted 5* status. Then it’s final editing and off to the printers for launch in November.

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

Correspondence: swingler@telkomsa.net

Over 1.4 million hard copies have been sold over the years, and the Guide has won the Louis Roederer International Wine Writers’ Award, the Lanson Le Prix du Champagne, and the Wine and Drinks category of the Gourmand World Cookbook Awards. The future, though, is digital, and available apps for both iPhone and Android ‘put Platter’s in your pocket’.

http://www.wineonaplatter.com/
It has been a while since I had the opportunity to view a romantic film of substance in addition to being in a privileged position to write a review about it. Brooklyn, a film based on the novel by the same name written by Colm Tóibín, not only presented me with an opportunity to view an exceptional film, but it also allowed me to experience the complexities and magic of love portrayed in the film on an emotional level. Lately it is very rare to come across a piece of cinematography in the romance genre that can stir the soul as this film is able to do.

Set in the early 1950’s, the film portrays the life of Eilis Lacey, a young Irish girl living with her sister and mother in Enniscorthy, County Wexford. As compared to her sister, Eilis (played by Saoirse Ronan) struggles to make a decent living for herself. She works in the supply store of Ms. Kelly (played by Brid Brennan), a very difficult and mean-spirited old gossipmonger, referred to as “nettles Kelly” by those who work for her. Eilis is very uncertain about her future, and her sister Rose (played by Fiona Glascott) makes contact with a Catholic priest, Father Flood (played by Jim Broadbent) in America who agrees to sponsor Eilis’ immigration to the United States in order to improve her prospects. Eilis’ departure from Enniscorthy is not easy as she is very close to her mother and especially so to Rose.

The voyage across the Atlantic proves to be a very difficult experience for Eilis, the details of which I will leave for you to discover, suffice to say that it would seem that one should never eat a full meal when the seas are rough... Luckily Eilis’ bunkmate comes to her aid and sees to it that she recovers from her ‘ordeal’. Eilis arrives in America and finds a place to stay at the all-female boarding house of Mrs. Kehoe (played by Julie Walters). She starts working at a department store but Eilis is desperately homesick. Father Flood enrols Eilis in bookkeeping night classes at Brooklyn College and together with her supervisor at the department store they try their best to encourage Eilis and sooth her longing for Ireland.

One night whilst escorting a new lodger out to a dance, Eilis meets the sweet and gentle Tony Fiorello (played by Emory Cohen) who falls hopelessly in love with her. As Eilis and Tony’s relationship develops, she starts settling down in Brooklyn and the change in her mood and appearance is most notable! It is at work one day where Father Flood informs Eilis of the sudden death of her sister Rose. Eilis is shattered by the news and as she finishes her trans-Atlantic telephone conversation with her mother, she knows that she has to go back to Ireland for a month or two. Tony takes Eilis to an open plot of land on Long Island where he tells her about his dreams for their future together. Shortly after this Eilis informs Tony of her decision and he insists that they get married before she goes to Ireland to see her mother. They get married at City Hall and Eilis journeys back to Ireland.

In Ireland Eilis visits her sister’s grave and she talks to her sister about Tony and how she wished that things could have been different. Everyone and everything in Ireland seems to be conspiring together to keep Eilis from returning to America and Tony. Eilis goes out on a date with a well to do suitor despite being a married woman - although no one in Ireland is aware of her marriage. It is at this point where it would be good to leave the rest up to you to discover. My review thus far has only included highlights of a film with so much more for you to see, to experience – the most important being the magic of true love. I have advocated to all who are willing to listen that Brooklyn is the best love story that I have seen in some time. The emotional dynamics of the developing plot leaves one breathless, and I salute Finola Dwyer, the film’s producer, for her effort in ensuring that Tóibín’s complicated novel came to life in an outstanding manner on the big screen. Brooklyn was received with critical acclaim after being premiered at the Sundance Film Festival in January 2015 and the film also received three Academy Award nominations.
With the recent departure of Pauline Timothy, Brand manager for the “Long-Acting Injectables Portfolio” from Janssen, I wish to inform you that Melissa Du Toit, our Concerta® Brand Manager, will add these products to her current ADHD portfolio and duties, thus broadening her portfolio to include these innovative products. Lisa Selwood, our Medical Scientific Liaison for Neurosciences will also be sorely missed, as she moves onto an interesting new role in the health funding industry.

Melissa, who holds a BSc degree in Physiology (Biochemistry & Genetics), started out at Janssen as a Sales Representative in the CNS team in 2007 in Pretoria in the areas of ADHD, Schizophrenia, Epilepsy and Alzheimer’s. She was extremely successful in this role, and was the CNS Divisional Representative as well as the overall Janssen Representative of the Year in 2009.

In 2010 she moved into Sales Management of our Inland CNS team, leading a team of 13 Representatives successfully.

After three years in this role, Mel moved to lead our Company flagship Brand, Concerta®, as Brand manager. Prior to working at Janssen, Mel worked at Boehringer Ingelheim in the Cardiovascular franchise.

Melissa has a deep interest and longstanding passion for Neurosciences, and also people leadership.

We wish to thank Pauline & Lisa for their dedication and commitment to Janssen and the Neurosciences in particular, and welcome Mel to this exciting area of Psychiatry. Lisa’s replacement will be announced shortly.

Di Crossman
Neurosciences Business Unit Director
Janssen
dcrossma@its.jnj.com
ANNOUNCEMENT

An Introduction to the

Practice of Psychiatry in Africa

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AN INTRODUCTION TO THE PRACTICE OF PSYCHIATRY IN AFRICA

ISBN: 978-9966-007-50-6
AUTHORS: DR. PHILIP RENISON OPOONDO
PUBLISHED: 2016 NO.OF PAGES:230
FORMAT: PAPERBACK. PORTRAIT.150MM X 205MM

ABOUT THE BOOK

This book is a handy introduction to the practice of Psychiatry especially in resource limited settings in Africa. It covers the basic conditions one is likely to come across at the primary care level and gives practical hints on their diagnosis and management. Its pocket size enables one to carry it around as a quick reference and revision guide.

It’s easy and readable non-technical style makes it suitable for anyone interested in a basic understanding of psychiatric conditions and their management.

ABOUT THE AUTHOR

Dr. Philip Opondo is Assistant Programme Director, Department of Psychiatry, Faculty of Medicine at the University of Botswana and Adjunct Assistant Professor of Psychiatry in the Associated Faculty of the Perelman School of Medicine, Department of Psychiatry, University of Pennsylvania. He has had extensive experience practicing and teaching psychiatry both in Kenya and Botswana. This book arose out of his experiences practicing psychiatry in the public sector and teaching medical students and is aimed at medical officers, medical students, clinical officers and Psychiatric nurses both qualified and in training.

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Message from the Secretary General

Dear Colleagues and Friends,

Heartfelt greetings to you! The first visit of the SG in the 2nd year of hermann to WPA Secretariat Geneva was organized between April 10th-13th, 2016. As you know, our Secretariat is based in the campus of the Geneva University Psychiatric Hospital. One of the highlights was my meeting with the Director General B. Levart which was very cordial and fruitful. The DG has extended all possible support and help to the WPA Secretariat. We also had a visit by François Ferreyre, the former HOD of Psychiatry at HUG, whose time, WPA Secretariat had started working at the current premises.

The WPA Regional Conference, Thethi, April 27-30, 2016 was a highly successful event with the theme: ‘Mental health, directions and challenges’. Our hearty congratulations to Eka Okonjo, President of the Society of Georgian Psychiatrists and her team. We are looking forward to the WPA International Congress, Cape Town November 16-22, 2016. Theme: ‘Psychiatry: Integrative Care for the Community’. Kindly do attend.

Our newly designed website www.wpanet.org has gone live. Please visit the website and send us your valuable comments. If you notice any error or failure to update any of the pages, kindly bring it to our attention.

We thank WPA President Dinesh Bhugra and the EC for their support and guidance.

Thanking you,

Roy Abraham Kallivayalil
Secretary General
World Psychiatric Association

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Message from the President

Dear Colleagues,

Data from a global survey from 193 countries on discrimination against people with mental illness has been completed and the report is being written up as we speak. The report will be launched on the Second World Mind Matters Day on 4th September 2016. We are assessing levels of discrimination in social, political, economic and personal dimensions. Early results are shocking as how individuals with mental illness are treated by various societies and cultures.

WPA-Lancet commission on Psychiatry has started its data analysis. Over 2400 responses were received. Early next month we will start writing the report and hopefully be able to launch it either later this year or early next year. Thank you all for responding and circulating it to your members. With Carciif an educational charity we are looking at well-being. Please respond on the web based survey and also circulate it widely. The link is https://www.surveymonkey.co.uk/r/care/well-being.

The work on setting up Diploma in Psychological Medicine aimed at psychiatrists and a Diploma in Mental Health for other health professionals continues apace. Curriculum has been agreed. We are still looking for examples of good curricula please do send them to me. We are also looking at assessments methods. We are hoping that all the assessment and learning will be web-based.

WPA has an International Congress in Cape Town from 18-22 November. Please put the dates in diary. This will be an exciting conference with eminent speakers and range of symposia and workshops.

Look forward to seeing you and hearing your opinions and valuable thoughts.

Please check the website regularly and get involved.

Dinesh Bhugra, CBE
President
World Psychiatric Association

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Spiez is a town and municipality on the shore of Lake Thun in the Bernese Oberland region of the Swiss canton of Bern. Nestled between hills and vineyards and dominated by a magnificent medieval castle that dates from 15 and 16 century, Spiez is a great attraction for tourists who often visit.
Do your patients suffer from:

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

Revive Normality
FROM THE EDITOR

We always knew that 2016 was going to be a big and busy year for SASOP, and in this issue we report primarily on an important fixture in the Society – the annual Dr Reddy’s PUBSEC weekend, recently held in Swakopmund. Whilst the event may be remembered for peculiar reasons (a spectacular dinner in the desert, psychiatrists being stranded at Walvis Bay Airport on their return, and speakers having to abandon their presentations due to an emergency evacuation of the hotel), it turned out to be a productive and visionary event as far as public sector psychiatry, and how it dovetails with private practice, to address the challenges of practicing psychiatry in an ever-changing environment, is concerned. It was yet another important milestone on our road to the “big one” – the WPA International Congress in Cape Town in November 2016.

Dr. Ian Westmore

FROM THE PRESIDENT

A successful Dr Reddys/Pubsec annual meeting was held in Swakopmund, Namibia, in April. There were complaints about the program having an emphasis on public sector matters and leaving private practice psychiatrists with nothing to attend. My impression is that the program dealt with the politics of medicine irrespective of the vocation. This is an area that also needs attention from SASOP. The PsychMg annual meeting will be held in August, 2016. Progress is being made in getting the Pubsec and Private Psychiatry Vocational Groups working even more closely and tackling projects together. It is also expected that the leadership of these Vocational Groups will mutually attend each other’s meetings.

There is no further engagement between SASOP and the Gauteng DOH with regards to Life Esidimeni patients. (In March patients were discharged to the Takalani Facility in Soweto. SASOP, SADAG, SAMHF and Section 27 attempted to obtain a high court interdict against the discharging of patients from Life Esidimeni to Takalani. Unfortunately we lost the case. The key issue is that the Judge could not understand that patients could be discharged and still require care). SASOP together with other stakeholders have subsequently met and decided to form a “South African Mental Health Alliance”. In the meantime, SASOP and PsySSA have been tasked with producing a position statement on “Discharge”. There is still ongoing media interest in this issue. I have had several interviews with journalists and there have been several publications in the print media. Recently I was interviewed for a possible documentary that will be screened on ENCA’s Checkpoint.

AFRICAN PSYCHIATRY

The African Association of Psychiatrists and Allied Professionals (AAPAP) hosted a meeting in Addis Ababa, Ethiopia in June 2016. SASOP did not attend this meeting. I have been briefed by Prof D. Stein that AAPAP has tasked the African Presidents of the various societies to lead the process of the review of the AAPAP constitution. The president of the Kenyan Psychiatry Association is leading the process and I am in liaison with him.

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

My meeting requests to Mr S. Phakathi were not successful earlier in the year. Attempts are being made to secure a meeting again after liaison with Prof M. Freeman when we met at a Congress in June. It has now been confirmed that SASOP will present to the Ministerial Advisory Committee on the 10th of August 2016.

INTERNATIONAL LIAISON

I attended the annual APA meeting in Atlanta in May 2016. It was a successful meeting. I had a meeting with Dr Saul Levin and we discussed the APA’s support of the 2016 WPA International Congress. We also discussed the SASOP/APA membership.

I was also able to attend the Africa Discussion Group meeting organised by Samuel Agbo where I met the South Sudan Psychiatrist who is the only psychiatrist in her country. I had brief discussions on the Cape Town congress with the WPA President Prof Dinesh Bhugra.

The meeting of the English Speaking Colleges (APA, The Canadian College of Psychiatrists, the Royal Australia New Zealand College of Psychiatrists, The Royal College, SASOP/College of Psychiatrists) was held on 16 May 2016 at the APA annual meeting. The theme for this year was “differential attainment”. We hope to meet again in Cape Town at the WPAIC.

Dr Mvuyiso Talatala  
President

3. FROM THE EASTERN CAPE SUBGROUP  
DR THUPANA SESHOKA

- We are experiencing a serious challenge with the shortage of acute beds in the Nelson Mandela Metro. We are getting lots of complaints from the general hospitals about having lots of patients awaiting acute beds in their casualties and units that are conducting the 72 hour observations, as they cannot get their patients admitted in the designated psychiatric hospitals. We are busy addressing the issue with the EC DoH and the designated psychiatric hospitals within the province to see how best we can alleviate this crisis. Our next meeting is on the 27/07/2016.

- We had a visit from the HPCSA for the accreditation of Registrar posts and our Registrar posts were increased from 18 to 26, and may even increase more when they will be visiting us again in 6 months, which is good news for us. There have been suggestions that registrars rotate between different centres and this is being considered.

4. STRIKE ACTION AT FORT ENGLAND HOSPITAL

It has come to the attention of SASOP that, in July, there was a tense situation at Fort England Hospital in Grahamstown, when some of the hospital staff went on strike, creating a situation where clinical staff, including doctors, ended up having to assist with e.g. preparation of meals for patients to prevent compromise of patient care.

Grocott’s Mail (20th July 2016) reports that, “Striking staff at Fort England Hospital returned to work yesterday afternoon following a meeting with Department of Health officials. This came after two days that saw specialist clinical staff in the kitchens preparing meals for patients under police guard, as strikers threatening to close down the facility unless CEO Roger Walsh was axed”. The Eastern Cape Subgroup will continue to keep the SASOP Board of Directors informed of further developments.

Read more at http://www.grocotts.co.za/content/hospital-staff-return-work-20-07-2016-1

5. THE WESTERN CAPE SUBGROUP  
DR NEIL HORN (CHAIRPERSON)

AGM 2015 was attended on 17th October 2015 by around 40 members and Dr Gerhard Grobler representing the President. The SASOP WC Distinguished Service Award was made to Prof Denise White, Psychiatrist and leader of SAMA. Two Registrars presented their research and awards were also made to them. Two new members of the Committee were announced (Dr Domingo and Dr Moodley). The Acting Chair Dr Horn, the Acting Hon Secretary Dr Freeman and the Hon Treasurer Dr Potocnik were elected to a further term of office. The WC subgroup has met 3 times. Lively discussion about the function and governance of the subgroup, membership, and relations with Pharma have taken place.

The subgroup has identified 3 main functions:

1. CPD meetings.

Most of our members are in the private sector and these meetings might be thought to mainly serve the private sector but are poorly attended. In 2015 two CPD meetings and the AGM were Pharma sponsored
and on 2 occasions the sponsor abused the process, once by promising to pay then leaving SASOP with the bill, and once by manipulating the content of the programme and refusing, at the last minute to sponsor speakers who were not speaking on their preferred topic.

The Committee has decided that we should run an Ethics meeting without Pharma sponsorship in 2016 (some speakers have made an ethical decision not to speak at Pharma sponsored meetings) and we await to see how well attended this will be. (We have also requested that SASOP National develop a pro forma agreement for sponsors to sign ahead of sponsored meetings. This issue was raised in the 2014/15 report and response is awaited).

CPD meetings were held in February sponsored by Pfizer (Joint Neurology meeting) and May (Psychotherapy meeting) sponsored by Cipla. Attendance at the latter meeting was dismal with around 30/140 members attending. This may be because so many other CPD meetings like the CINP and PsychMG meetings provide CPD points.

2. Engage with young Psychiatrists.
In early 2016 a Dinner for Registrars lead by Drs Allen and Vythilinghum was convened, sponsored by Pharmadynamics. This was well attended, but few Registrars are members. WC SASOP also sponsored seven Registrars to the Biological Psychiatry congress in 2015, and made two Research awards. The Committee requests that space be provided at the WPA for oral presentation of the top Registrar research projects.

In order to address the membership issue Reg reps recruited a further 10 members but were disappointed to learn that no acknowledgement of membership came from SASOP after paying a subscription. It was also noted that the Healthman database had 20 members listed as Registrars but this is year’s is out of date.

WCSASOP requests that:

i) Healthman provide up to date membership lists to subgroups annually and inform subgroups of membership changes 3 monthly.

ii) New members receive a welcome letter. SASOP consider issuing members with Business cards - Registrars might value these.

3. Represent the Speciality.
It is noted that members receive requests from the media to comment on Mental Health issues. It is unclear how such requests should be handled locally or what SASOP’s position is on media liaison.

The Subgroup also noted with concern the lack of communication from National. Minutes of National meeting are not available to subgroups. The website seems under-utilised and out of date. CPD points not on the website from SASOP congresses.

Examples of useful updates are: placing information about SASOP designated experts in particular fields who are mandated to represent SASOP in the media; providing contact information of members and Public sector mental health services to assist when patients need to be referred to another area.

Editor’s note: the concerns raised by the Western Cape subgroup were tabled and discussed at the recent Board of Directors meeting on 23.07.2016. Recommendations about updating the database even further and acknowledgement of receipt of membership application were made to Healthman; relations with Pharma and CPD meetings were discussed and will be taken back to the subgroup; better utilization of the media, website and internal communication as well as recruitment and retention of young psychiatrists was also discussed and will be reported on in subsequent Headline editions.

6. THE CHILD AND ADOLESCENT SPECIAL INTEREST GROUP
DR SUE HAWKRIDGE (CONVENOR)

A meeting of the CAP SIG was held at the Lord Charles Hotel, Somerset West, on 25th September 2015. Dr Wendy Duncan stepped down as convenor and was replaced by Dr Sue Hawkridge.

CURRENT ISSUES AND ACTIVITIES:

a. Limits on prescription of methylphenidate at primary health care level:
This matter is still receiving attention in most provinces. Drs Nassen and Mpinda have developed and piloted a training course for primary health care physicians in the Khayelitsha-Eastern substructure of the Cape Town metro to support the recently requested extension of
prescription of methylphenidate to medical officer and family physician level. This is still being considered by the W. Cape provincial PTC and it is hoped that the training will be rolled out in other substructures as soon as possible.

b. Appropriate admission facilities for psychiatrically ill adolescents:
The position statements (SASOP CAP SIG, SA ACAPAP and the College of Psychiatrists) proposed at the meeting of CAPSIG in 2015 have not yet been collated. This will be addressed as soon as possible. In all provinces adolescent psychiatric patients are still being involuntarily admitted to adult wards in violation of their constitutional rights and at significant personal and medico-legal risk.

c. Loss of child and adolescent psychiatry beds in the Free State:
The Free State Department of Health is under administration and some progress has been made. Signatures are reportedly still outstanding on the appointment of an additional child and adolescent psychiatry consultant and were some time ago promised “within a week” but this has not yet materialised. Renovations to the wards to allow for separate facilities for adolescents will reportedly begin soon. In the interim, admission of adolescents to adult psychiatry wards continues, and colleagues are being encouraged to submit serious adverse event forms when young patients are admitted in these circumstances.

d. Forensic child and adolescent psychiatry:
Developments in this area are being tracked and addressed by members who are also part of the Forensic Psychiatry SIG. Criminal capacity assessments have been the major focus but changes in the Criminal Procedures Act affecting children and adolescents have also required attention. A national benchmarking of the criminal capacity assessment process is needed and will be carried out in collaboration with the Department of Justice.

e. The Mental Health Care Act:
The position of involuntary patients who are children or adolescents and whose parents/guardians are unavailable or oppose admission under the MHCA remains ambiguous. A recent High Court order in the Western Cape provided some clarity but implementation of the law seems to differ across provinces and a national guideline remains necessary. Consultation with the Centre for Child Law at the University of Pretoria is under way.

f. Private sector:
Funding for children and adolescents with psychiatric disorders remains a challenge. Some medical aids refuse to fund treatment of depression in children and will not pay for antidepressant treatment as they regard it as “off label”. We request that this matter be taken up by the relevant SASOP structures.

g. National training curriculum and examination standardisation:
This process is under way with the College subcommittee chaired by Dr Lynda Albertyn.

h. Six month training in child and adolescent psychiatry for registrars:
This matter has been raised at Council level in the College of Psychiatrists but there remains resistance to the formalisation of the 6 month requirement. In the interim, WSU has reduced its CAP training time to 4 months owing to budgetary constraints (the training is out of province). Dr Lynda Albertyn continues to address the matter at Council level in the College of Psychiatrists.

FORTHCOMING CHILD & ADOLESCENT PSYCHIATRY CONFERENCES:

i. The SA ACAPAP Congress 2017 (in association with the African Association for Child & Adolescent Psychiatry, PANDA-SA and SAISI) will be held on 7-9 September 2017 at Spier, Stellenbosch.

ii. The 22nd Conference of the IACAPAP will be held in Calgary in September 2016. The CAP SIG will be unofficially represented by Dr Sue Hawkridge.

7. THE FORENSIC PSYCHIATRY SPECIAL INTEREST GROUP
DR INDRHRIN CHETTY

The Forensic SIG Exec Committee consists of: Prof Mo Nagdee (Chair), Prof Ugash Subramaney (Secretary) & Dr Indhrin Chetty (Treasurer).

Regional representatives are to be co-opted in due course as required.

- **Forensic subspecialty:** the Regulations and Portfolio of Learning have been posted on the College website. Accreditation of subspecialty training centres is progressing and subspecialty programmes have commenced in a number
of centres. Increasing numbers have registered as forensic subspecialists (Weskoppies - 3, Sterkfontein - 1, Fort England - 3, Valkenberg - 2 & Fort Napier – 1; private sector - 2). The M.Phil in Forensics program is under development and consideration in some centres.

- **National forensic mental health professionals contacts database** is well utilized by psychiatrists doing forensic work (both state and private sector) for communications of forensic interest.

- **Review of tariffs payable to psychiatrists & psychologists in terms of section 79 of the Criminal Procedures Act.** The Dept. of Justice & Constitutional Development has circulated proposed amendments of tariffs payable to psychiatrists and psychologists for forensic work (i.e. psycho-legal evaluations under the CPA, expert testimony, and capacity evaluations of children under CJA)

- **Proposed amendments to the Criminal Procedure Act**

  Feedback from the Forensic SIG has been provided to the Inter-Sectoral Task Team re:
  - Constitution of panels for psychiatric observation reports/role of psychologists.
  - Day visit / outpatient observations & waiting list issues.
  - Recommendations for CPA amendments.
  - Criminal Procedure Amendment Bill – was recently received and forwarded to all forensic practitioners for comment.

- **Psychiatric disability assessments**

  Prof Stoffel Grobler from the Forensic SIG is on the SASOP task team – the SASOP Guidelines for the assessment of Disability (3rd edition) have been circulated for comment to Forensic SIG members.

### 8. OLD AGE PSYCHIATRY SPECIAL INTEREST GROUP

**DR CARLA KOTZÉ (SECRETARY)**

The increasing number of elderly (of whom 70% will at some stage require psychiatric intervention), necessitates the re-appraisal of the distribution of the allocated health resources to meet this need. The unique psychopathology and social circumstances demand specialized knowledge and skills, not readily transferable from having worked with younger adults.

Some 20 years ago we had 7 dedicated units across South Africa, mostly attached to universities that provided at least part-time dedicated psycho-geriatric services. Unfortunately, these units melted away over time and have only recently started to resurface. We now have at least 3 dedicated units and growing enthusiasm from recent graduates.

Stikland Hospital, though, is the only accredited training facility with two subspeciality training posts, but the posts are not funded. We thus source internally and also advise candidates to seek funding from external sources such as Discovery Health. In spite of these difficulties, we do now have three qualified Old Age Psychiatrists grandfathered by the HPCSA.

We both applaud and encourage the pharmaceutical industry in lowering the price of the cognitive enhancers registered for Alzheimer’s disease. These medications are known to also benefit patients with vascular dementia, Lewy body dementia and Parkinson’s disease, while their use in HIV patients demonstrating neuropsychiatric deficits warrants further exploration.

Care-giver support organizations (such as DementiaSA and the Alzheimer’s Association of SA) and pharma, among others are actively engaging the relevant authorities with establishing Alzheimer’s disease as a PMB and making at least one cognitive enhancer available at State health level.

(Dr Lina Groenewald will start her training for an M.Phil in Old-Age Psychiatry at the beginning of next year).

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**RECENT AND FORTHCOMING FORENSIC EVENTS**

- Forensic Inter-Sectoral Conference, 16-17 March 2016, Gauteng
- WPA International Congress, 18-22 November 2016, Cape Town (Numerous symposia of forensic interest scheduled thus far).
- National forensic mental health conference 2017, Valkenberg Hospital (TBC).
9. MEMORANDUM OF UNDERSTANDING ON COLLABORATION BETWEEN THE ROYAL COLLEGE OF PSYCHIATRISTS, SASOP AND THE COLLEGE OF PSYCHIATRISTS OF SOUTH AFRICA.

Over the past four years, SASOP has been engaging with the Royal College of Psychiatrists, and now a draft MOU has been drawn up and is being considered by the three parties. This draft MOU seeks:

- To establish close collaboration in all relevant fields through the African International Division of the Royal College of Psychiatrists.
- To enable the exchange of information between all three psychiatric institutions in all areas relating to training and teaching activities.
- To promote joint research projects in areas relevant to psychiatry.
- To study the viability of establishing assistance to professionals who wish to undertake periods of training in either of the countries that are the object of this agreement.
- To study ways of working together that will lead to greater participation for both bodies in other psychiatric institutions worldwide.
- To establish all measures with respect to support and exchange that may assist the institutions in fulfilling their statutory objectives with more ease.
- Collaborating and exchanging expertise in initiatives to balance patients’ and carers’ rights for care, treatment.
- To share experience in raising understanding of advocacy about mental health with our respective governments.

Discussions will continue between the three parties before it is signed.

10. PUBLIC SECTOR MATTERS

DR LESLEY ROBERTSON
(NATIONAL CONVENOR PUBSEC)

As the SASOP Board of Directors convened on Saturday, 23rd July, I realised I did not have a PubSec report to submit – I had had no communication with the subgroup PubSec reps. Life had taken over in the three months since we all met at Swakopmund. However, reading the previous Headline, I see how I emphasised the need to communicate, to be coordinated and cohesive. And some words of Mvuyiso Talatala’s: “We must accept that government has no interest in hearing the voice of SASOP”.

If we are to find effective ways to lobby government for mental health needs, we will have to make time to communicate and encourage one another’s efforts. Greater use of Headline presents an optimal means of disseminating information, and so I encourage all members to submit their news to Ian and myself each quarter.

Thupana Seshoka reported on the Eastern Cape to the Board: some good news, despite the extreme service delivery stressors due to lack of personnel and lack of beds. The HPCSA has increased the number of registrars from 18 to 26. However, while some posts have been allocated, others still have to be created accordingly. In addition, Zuki Zingela’s post in Umtata is still not finalised.

The subgroup though is persevering with meetings with their DOH, and consultations are ongoing. In the Western Cape, demands on acute psychiatric services hit a pitch in the last quarter as one district hospital had to close its casualty to medical and surgical patients, due to the high number of psychiatric patients needing attention!

Through all our negotiations with government, in each province, the need to develop community-based services is paramount. In Gauteng, with the termination of the contract with Life Esidimeni, renovations of Sterkfontein, Weskoppies and Kalafong hospitals have taken place to accommodate patients; a move towards increased institutionalisation. Several hundred patients have been placed in ill-equipped NGO residential homes.

Overcrowded conditions at one NGO have resulted in three patients being admitted to CHBH – one with confirmed Salmonella Typhoid, the other two suspected. Whilst NGO residential and day care facilities are a core component of community-based services, they cannot be pressurised to take more patients than they can manage, and they need to be adequately funded.

We have a duty to our patients to link with advocacy groups in lobbying for better mental health services. We are not able to achieve this as individuals.
10. REMEMBERING DR ANN BARRETT (1938-2016) – BY DR LENNART ERIKSSON

Ann Barrett was born in London and went to India at the age of two. After moving to South Africa, she was schooled at Roedean School in Johannesburg. She obtained her medical degree from UCT and graduated in 1961. She has two daughters, Sue and Jenny.

She joined Addington Hospital in 1979 with Drs Levin, Patterson, and Schlebusch and with mentors Drs Valjee and Gilmer in attendance. Ann served as the Chairperson of the KZN subgroup of SASOP for many years. She worked in private practice until she could practice no more!

In my 39 year contact with Ann the following aspects of her devotion and character stood out for me: Inspiration, moral values, her dedication to SA Psychiatry, and her dedication to patients.

What I have valued most about Ann was her capacity to engage and share a laugh, as well as her capacity for EMPATHY versus COMPASSION. Empathy is mainly reflection and can be quite non-committal whilst compassion is a much deeper and personal sharing with the patient. That, in my opinion, is what Ann was all about. A very special person indeed.

I want to describe the very exceptional quality that was Ann. Ann, whom i came to know at the end of 1979, was, during those difficult registrar times, a lone beacon of loving kindness.

Ann held strong Christian beliefs. Her capacity for loving kindness is, for me, however, best described by the following Buddhist text:-

“THERE IS A CONSTANT FLOW BETWEEN WISDOM WHICH REQUIRES “LETTING GO” AND THE PRACTICE OF COMPASSION WHICH ENCOURAGES “EMBRACING”.

KITTASARO 2014

Ann was able to separate her clinical wisdom – which was solid enough – in a way that allowed her to “let go” of clinical wisdom and compassionately embrace the struggles of her patients.

It is true that we may all master empathy – hearing and reflecting the pain and suffering of our patients. Compassion, on a deeper level, means having empathy with your own suffering and the suffering of others. To achieve this depth of connection is a rare quality.

IN ALL MY INTERACTIONS WITH ANN, AND HEARING THE REFLECTIONS FROM THE MANY PATIENTS I CAME TO REFER TO ANN, CONFIRMED THIS RARE QUALITY. ANN WAS INDEED AN EXCEPTIONAL PERSON.

11. CONGRATULATIONS TO PROF BONGA CHILIZA!

On behalf of SASOP, we congratulate Bonga Chiliza, the current SASOP Honorary Treasurer on being appointed Professor in the Department of Psychiatry at the University of Stellenbosch.

Well done Bonga!
INSTRUCTIONS TO AUTHORS

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

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

LETTERS TO THE EDITOR
- Novel experiences
- Response to published content
- Issues

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

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

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

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

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

All content should be forwarded to the editor-in-chief,
Christopher P. Szabo - Christopher.szabo@wits.ac.za

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