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Oral Presentations

ANTIPSYCHOTICS IN ANXIETY DISORDERS

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In 1970 antipsychotics (haloperidol, levomepromazine, thiothixene) were recommended in Sweden as the first-line treatment of anxiety in organic brain syndromes, psychoasthenia and substance abuse. The benzodiazepines came to dominate treatment of anxious patients in the 1970s and are still appreciated for their rapid anxiolytic effect, low clinical toxicity and low price. Evidence-based guidelines, however, recommend the SSRIs, venlafaxine, duloxetine, and pregabalin as first-line treatment in anxiety disorders.

Studies are currently ongoing to assess the utility of new antipsychotics in primary anxiety disorders: quetiapine, risperidone, aripiprazole, ziprasidone, and olanzapine. This is justified in the light of that a large proportion of these patients, about one-third, do not respond to first-line treatments or discontinue because of adverse drug effects. Single or augmentation therapy with antipsychotics may enhance response rates. Primary anxiety disorders, particularly PTSD, may include psychotic symptoms such as dissociation, or severe insomnia, that may be targeted with these medications.

Another important patient category is those with substance use disorders, particularly alcohol, among whom there are few or no controlled studies of conventional anxiolytics. Anxiety is also common among patients with psychoses, bipolar disorder, ADHD or borderline personality disorder, and few controlled studies have addressed that issue.

Emerging controlled studies show that new antipsychotics may be useful as first-line therapy, as augmenters, and in patients with anxiety caused by psychoses and bipolar disorder. In this educational update, the results of these studies regarding symptoms, adverse effects and restoration of function will be discussed.

ANXIETY IN SOMATIC DISORDERS

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Anxiety is a frequent companion to patients with chronic somatic diseases, particularly neurological, cardiovascular, respiratory and endocrinological diseases. Such patients are routinely excluded from phase III studies of anxiolytic medications, so there are no guidelines for them. Yet these patients are numerous and costly in primary care and in nursing homes. There is virtually no literature on how anxiety impacts on such diseases, and whether treating anxiety *per se* improves the outcome of patients with chronic somatic disease.

This presentation reviews the available studies of patients with stroke, epilepsy, traumatic brain injury, pain states, Parkinson's disease, MS, heart disease, chronic obstructive respiratory disease, diabetes, and irritable bowel syndrome.

Anxiety may be an acute reaction to having developed a somatic

disease, a coincidental primary anxiety disorder, or secondary to the social, physical, and mental impact of the somatic disease. Somatic medications, e.g. beta-stimulants and corticosteroids, may cause or aggravate anxiety symptoms. Anxious patients tend to misinterpret and overstate their physical symptoms.

The specialty dealing with this crossroad is psychosomatic medicine (formerly consultation-liaison psychiatry). Collaborative care programmes are currently being tested in the Netherlands and in the USA, within the emerging concept of care effectiveness research (CER). Such studies combine guidelines, results of randomised trials and common sense in developing stepped care and collaborative care programmes based on algorithms, and usually governed by a case manager.

The emerging challenge in many societies is the ageing population. Much more research is needed to understand the aetiology of emotional disorders in the elderly, and how to best deal with them.

COMMUNITY REHABILITATION OF THE SCHIZOPHRENIC PATIENT

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Community rehabilitation programmes for schizophrenic patients have been studied in specialised psychiatric literature since the early 1970s. Under that name various approaches have been the subject of controlled studies, such as the assertive community treatment (ACT) model of case management, family interventions, supported employment, skills training and illness self-management, cognitive interventions and integrated treatment of substance use disorders and severe mental illness.

One of the problems researchers have found in so-called community rehabilitation programmes is that some of them take place in the community, but there is no real community participation in the process. This usually has negative consequences for a patient.

Real community rehabilitation programmes begin with a comprehensive identification of the client's skills, strengths and deficits in relation to the skill demands required in the particular environment/s in which the patient would like or needs to function. In such a programme the patient is involved in all the phases of the treatment and the rehabilitation plan goes through clear delineated steps that the patient needs to complete in order to achieve the rehabilitation goals.

The ACT of case management is the most comprehensive model and could include some of the others in its approach. The objective of this talk is to summarise the present state of knowledge on the topic and exchange some ideas on how to adapt it to the South African context.

DUAL DIAGNOSIS: A THEORY-DRIVEN, MULTIDISCIPLINARY APPROACH FOR INTEGRATIVE CARE

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The co-occurrence of substance use disorders with other psychiatric conditions influences the presentation of difficulties, time frames of treatment, treatment contexts, treatment responses and relapse risk.

Psychiatric conditions may present as risk factors for addictive behaviours, as 'self-medication' may alleviate symptoms of these difficulties and become conditioned responses. Addictive behaviours may also develop into psychiatric disorders in themselves or be causally linked to other psychopathology. Multiple treatments and co-morbidity become meaningfully related over time, and substance use may precipitate and exacerbate pre-existing conditions. This paper argues that dual diagnosis treatment should not only be based in evidence-based medicine but should also have a sound basis in theory. Treatment of dual diagnosis mental health problems can follow one of three models, sequential, parallel and integrated, and the illness model of addiction is positioned alongside other models for understanding co-morbidity. The concept of the 'addictive personality' is critiqued and the systems theory of Patrick Carnes is presented as a feasible basis for understanding addictive behaviours, addictive personality 'shift' and recovery-orientated treatment programming. The clinical relevance of theory is presented as crucial to intervention programmes, and case vignettes illustrate the need for intervention that is evidence based and has a credible theoretical foundation

THE EMOTIONAL LANGUAGE OF THE GUT - WHEN 'PSYCHE' MEETS 'SOMA'

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Recurrent abdominal pain (RAP) in children is a common presentation to generalists and paediatricians. About 5 - 10% of patients have an organic cause for the pain. The rest are often defined as having functional abdominal pain (Rome criteria, 1999) which, although often seen as benign, is not so in terms of the child's ongoing distress, frequent doctors' visits, multiple, often invasive, investigations, school absenteeism, associated anxiety and depression, and family disruption and distress. The paediatrician will approach the pain as a physical symptom for which an underlying physical cause must be found (or at least excluded), to facilitate a physical treatment. When no physical cause is found, often after repeated sets of investigations and multiple consultations with doctors, the child may then be sent to a child psychiatrist for evaluation of a psychological cause for the pain.

This pain is often called 'psychosomatic', a label that defines the 'psyche' and the 'soma' – the mind and body – as separate entities. This is, however, not the case. The mind and body are not separate entities, but coexist as part of the whole person. The 'brain-gut' link has now been shown not to be merely conceptual but to have its basis in physiological mechanisms that link the psycho-emotional state with gastro-intestinal function. The gastro-intestinal and central nervous systems are derived from the same tissues embryologically, and this has particularly been demonstrated in the role of the serotonergic system. This implies that the central nervous system and the emotions are intricately connected to the gastro-intestinal tract and that the understanding of the symptoms of RAP is based on a partnership between the physical and emotional approaches.

This understanding has led to the development of a bio-psycho-social model for functional abdominal pain that presents it as a product of biological, psychological and social subsystems interacting at multiple levels, which need to be approached in a parallel fashion by the involvement of members of a cross-specialty multidisciplinary team from the beginning of the evaluation. The child is managed as part of the family and the pain within the context of emotional factors, particularly

anxiety and depression, both in the child and in the caregivers (who may predispose their child to the cause of the pain, as well as perpetuate it through their response to it). RAP presents real, often silent distress in our children. through the experience of real physical symptoms emerging from the gut. As with all forms of communication, if we understand the language – we understand.

THE PSYCHOTHERAPY OF BIPOLAR DISORDER

Franco Colin

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Bipolar disorder is generally considered to be strongly biologically determined. Psychotherapy has however demonstrated that it has profound effects on improved outcomes and sustained compliance. This talk will review the evidence but also refer to the 'how to' of the treatment.

DEVELOPING AND ADOPTING MENTAL HEALTH POLICIES AND PLANS IN AFRICA: LESSONS FROM SOUTH AFRICA, UGANDA AND ZAMBIA

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INTRODUCTION: In Africa, 76% of countries have a national mental health plan, while only 52% have a mental health policy, many of which have not changed for decades. The Mental Health and Poverty Project (MHaPP) put in place a number of steps aimed at developing and adopting a provincial mental health plan in South Africa, and national mental health policies and plans in Uganda and Zambia. Based on these case studies, this paper identifies facilitators and constraints to the successful development and adoption of mental health policies and plans.

METHODS: Taking a participatory action research (PAR) approach, each MHaPP intervention was evaluated with a combination of both qualitative and quantitative measures, including direct observation and documentation of meetings, semi structured interviews, and evaluation using the WHO Checklists on Mental Health Policy and on Mental Health Plans.

RESULTS: During the course of the interventions, a draft provincial mental health plan was developed in the Northern Cape in South Africa, a national strategic plan was formally adopted in Zambia, and a national mental health policy was developed in Uganda. A number of barriers and facilitating factors were identified. Barriers included limited funding; limited capacity for plan and policy development; non-commitment and lack of support from senior policy-makers; bureaucracies within government; and a low priority for, and negative attitudes towards, mental health. Facilitating factors included routine mental health service data; support from important decision-makers; active participation of relevant stakeholders, especially civil society; and regular consultation with such groups.

CONCLUSION: Developing and adopting mental health policies and plans is not an easy task, having a number of technical, economic and political obstacles. Concrete recommendations are provided for the successful development and adoption of comprehensive and realistic mental health policies and plans in African countries. These include gaining a high level of political mandate and strong leadership; actively identifying and involving relevant stakeholders; awareness-raising and lobbying of mental health; equipping workers in the mental health sector with the necessary skills for policy and programme development; remaining flexible and being patient; and obtaining strategic posts.

THE IMPORTANCE OF RELAPSE PREVENTION IN SCHIZOPHRENIA

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The first 2 - 5 years after diagnosis are critical in setting the parameters for longer-term outcome in schizophrenia. This is the period of maximum risk of disengagement, relapse and suicide. It also coincides with major developmental challenges of forming a stable identity, peer network, vocational training and intimate relationships. Major challenges that we face in treating early psychosis include intervening as early as possible, providing the most effective treatment with the minimum side-effects, achieving symptomatic and functional remission, and re-integrating into society with restoration of individual autonomy and optimal quality of life.

However, the challenge is not so much *getting* patients better – it's *keeping* them better. Patients generally respond well to treatment in the early phase of the illness, but at the same time relapse rates are high and overall recovery rates are low. We assessed the clinical consequences of antipsychotic discontinuation by offering patients who had been successfully treated for 2 years after a single psychotic episode enrolment in a follow-up study in which medication was discontinued and patients carefully followed up. Treatment was immediately re-instituted when relapse was identified. Results indicate a 97% relapse rate after 3 years. Generally relapses occurred suddenly, without early warning signs. Patients returned rapidly to levels of psychopathology were similar to those observed during the first psychotic episode. These findings have important clinical implications, suggesting that antipsychotic discontinuation after 2 years of treatment may not be in the best interests of the majority of patients.

MENTAL HEALTH CARE ACT: FACT OR FICTION?

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INTRODUCTION: A new Act regulating mental health services and other aspects pertaining to mental illnesses and defects was signed by the State President on 6 November 2002 (Mental Health Care Act 17 of 2002).

METHOD: The Act is systematically reviewed, and areas where the reality on the ground looks different to what the Act stipulates are highlighted. Examples for alternative implementation are given.

RESULTS: It has become clear that health care institutions are unable to cope with some aspects of the Act, and that the implementation has become idiosyncratic, depending on the facilities available.

CONCLUSION: This talk serves as an introduction to the Act for those

not familiar with it, and as an introduction for the workshop to be held the next day. Some suggestions regarding modifications of the Act and its regulations will be discussed.

DOES A DEDICATED 72-HOUR OBSERVATION FACILITY IN A DISTRICT HOSPITAL REDUCE THE NEED FOR INVOLUNTARY ADMISSIONS TO A PSYCHIATRIC HOSPITAL?

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The G J Crookes Hospital is a district hospital on the south coast of KwaZulu-Natal. Since 2002, on the promulgation of the MHCA 2002, the clinical and administrative management of involuntary admissions to a dedicated psychiatric hospital proved a difficult-to-manage process, resulting in many patients being treated and cared for in an open medical ward. This unsatisfactory situation was resolved by establishing a dedicated extension to the male medical ward that was designed to function as a stand-alone 72-hour observation facility. This 9-bed facility, Ethembeni, which includes 2 seclusion rooms, is contained within a high-security area of the hospital.

This presentation will report on the experience of establishing a 72-hour observation facility in a district hospital. It will also highlight advantages for a district hospital of having in place a 72-hour observation facility, such as: (i) nil, to date, transfer of involuntary admissions to a psychiatric hospital; (ii) improved medical as well as psychiatric management of mentally ill members of our community; (iii) containment of the mentally ill in a facility separate from the medical units; and (iv) early and continued contact with family and community, resulting in improved clinic attendance and medication compliance.

CONCLUSION: The decision to establish a 72-hour observation facility within a district hospital has dramatically improved the medical, administrative and human rights management of the mentally ill.

THE INCIDENCE AND RISK FACTORS FOR DEMENTIA IN THE IBADAN STUDY OF AGEING

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INTRODUCTION: Even though dementia is a growing problem in developing countries, few incidence studies have been conducted in these countries. A previous report among Yoruba Nigerians suggested a comparatively low rate.

METHOD: A cohort study of elderly persons (aged 65 years and over), residing in eight contiguous predominantly Yoruba-speaking states in Nigeria, was conducted between November 2003 and December 2007. Of the baseline sample of 2 149, 1 408 (66%) were successfully followed up after approximately 39 months. Face-to-face in-home assessments were conducted with two ascertainment tools with demonstrated cultural applicability and validity. Incident dementia was determined among persons who were free of the problem at baseline (1 225).

RESULTS: At the 3-year follow-up, 85 persons had developed dementia. With a total sum of risk years for the sample of 3 888, the estimated incidence of dementia was 21.85/1 000 person years (95% confidence interval 17.67 - 27.03). Compared with males, the age-adjusted hazard ratio (HR) for females was 2.12 ($p < 0.002$). The incidence increased linearly with age such that, compared with persons aged 65 - 74 years,

the HR (adjusted for sex) for persons aged 75 - 84 years was 2.84 ($p < 0.001$) and for those aged 85 years and over 4.13 ($p < 0.001$). An increasing incidence of dementia was found with increasing rural location of respondent's residence. Compared with persons in the highest socio-economic status group, those in the low groups were at significantly increased risk of having incident dementia. Persons with poor social engagement at baseline had a 2-fold elevated risk for new onset of dementia.

CONCLUSIONS: The rate of dementia among Yoruba Nigerians is higher than previously reported. Indices of social isolation are risk factors for incident dementia in the population.

IS DEPRESSION A DISEASE OF INFLAMMATION?

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Epidemiological studies have repeatedly confirmed the co-morbidity between depression and cardiovascular disease. The presence of depression is associated with a poor prognosis for coronary artery disease (CAD). The high co-morbidity may relate to chronic mild inflammation and increased platelet activation, suspected to be present at least in more severe forms of depression. Stress-related psychiatric disorders (e.g. major depression, bipolar disorder, anxiety disorders and post-traumatic stress disorder) have been variably associated with pervasive loss of homeostasis in the autonomic nervous system. This loss, often referred to as allostatic load, leads to dysregulation of the autonomic nervous system with sympathetic overdrive and vagal tone diminution. An efferent vagal pathway has been identified, the anti-inflammatory cholinergic pathway (CAIP), which is believed to exert an anti-inflammatory action. When vagal tone is diminished, inflammation becomes disinhibited and one would expect specific inflammation biomarkers to become elevated in the brain and the periphery. This provides a plausible mechanism for elevated blood levels of pro-inflammatory cytokines and chemokines previously reported in depressed patients compared with healthy controls by other groups and ours. When pro-inflammatory cytokines become chronically elevated, endothelial dysfunction eventually ensues, ultimately leading to atherosclerosis and atherothrombosis. Of interest is whether this pro-inflammatory status of depression can be reversed by antidepressant treatment and/or whether the pro-inflammatory changes normalise when the depressed mood is alleviated. In this presentation I will provide strong evidence that major depressive disorder is accompanied by pro-inflammatory status. Additionally I will present evidence that antidepressant treatment may not normalise biomarkers of inflammation within the time frame that patients regain a euthymic state.

PAEDIATRIC BIPOLAR DISORDER: MORE HEAT THAN LIGHT?

Sue Hawkrigde

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INTRODUCTION: The increasing rate of diagnosis of bipolar disorder in children in many parts of the world, including South Africa, has raised concern in several quarters. There are researchers and clinicians who regard the condition as well established and requiring pharmacotherapy, usually with multiple drug classes; there are also those who fear that a large number of children with difficulties in the realm of affect regulation are being both stigmatised and possibly over-medicated, as well as sometimes being denied appropriate psychological, educational and

family assessment and the psychosocial interventions that may be indicated. This is particularly a danger when the diagnosis is made according to symptom checklists and by persons with no professional background in child mental health.

AIM: This paper attempts to summarise the history and provenance of the entity paediatric bipolar disorder (presenting in children under 18 years), and to shed some light on the controversies that exist around it. It also contextualises the issues for a South African paediatric mental health service, and suggests some guidelines around the assessment and management of children and adolescents who do or do not meet the criteria for bipolar disorder in resource-scarce countries.

METHOD: A selective review of the scientific literature pertaining to paediatric bipolar disorder and paediatric bipolar spectrum disorder was undertaken with a focus on historical emergence, diagnostic criteria, proposed treatment modalities and long term outcomes.

RESULTS: An overview of the history of the disorder gives an indication of the determination with which attempts were made to make the diagnosis of bipolar disorder fit the children in question. Diagnostic criteria were adjusted and expanded, terminology was redefined, and clinical trials of various mood stabilisers, second-generation antipsychotics, stimulants and antidepressants were undertaken. However, studies have recently been published suggesting that the disorder as conceptualised in the looser spectrum approach is not continuous with adult bipolar disorder, and a DSM-V category of temper dysregulation disorder with dysphoria has been proposed in order to find a more suitable classification for this group of children and adolescents with serious psychopathology, relatively poor outcomes and equivocal responses to most psychotropic medications. There may be some overlap with diagnoses such as borderline disorder of childhood, multiple complex development disorder, etc.

CONCLUSION: While bipolar mood disorder in children and adolescents remains a significant, troubling and often difficult-to-treat psychiatric disorder, it would seem that expanding the meaning and scope of the diagnosis has not been of benefit to the patients researchers sought to classify. The prudent course would appear to be to adhere to rigorous diagnostic assessments by suitably qualified professionals and evidence-based multimodal treatment. In resource-scarce countries, this may entail telepsychiatry and/or extensive outreach services by child and adolescent psychiatrists.

EBM: ANOVA CONUNDRUM

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The explosion of published scientific knowledge in the past decades has left a significant proportion of practising psychiatrists with a difficult task: balancing daily work demands with continuing medical education responsibilities.

The presentation is in the form of an interactive workshop, aiming to help with the translation of medical evidence into everyday medicine and attempting to find a user-friendly face of statistics.

TRACKING THE LEGAL STATUS OF A COHORT OF INPATIENTS ON DISCHARGE FROM A 72-HOUR ASSESSMENT UNIT

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INTRODUCTION: Principles that were incorporated in the Mental Health Care Act, No. 17 of 2002, include the protection of human rights; procedures for care in the least restrictive environment; transfer of

the administration of the Act from the Justice to the Health Department; and the establishment of Mental Health Review Boards to oversee procedures. The process for the legal admission of an assisted or involuntary user is described in Chapter 5 of the Act, requiring that documentation must be submitted to the review board within 7 days and approval of an admission must be received within 30 days.

METHOD: A retrospective clinical record review was undertaken of a cohort of mental health of care users discharged from the acute 72-hour assessment unit at Helen Joseph Hospital (HJH) during 2007. The purpose of the study was to track the progress and legal status of these users in the first 12 months. The available data from HJH and the different facilities and services where these users were referred to, were compared with the information on these users from the responsible review board.

RESULTS: During 2007, a cohort of 565 users were admitted and discharged from HJH. These users were referred to: HJH outpatients, the H Moross Centre (Tara), Sterkfontein Hospital (SFH), community psychiatric services and Life Health Esidimeni. Of these, 263 users were admitted as voluntary users, 178 as assisted and 115 as involuntary. It was found on discharge from HJH, in 46% of the assisted group and 61% of the involuntary group, that the necessary documentation on the change of their legal status that occurred was not available. Tracking this cohort of users after discharge showed that, in addition, no information was available on the legal status of a further 55% of the 51 users referred to and discharged from Tara, and a further 44% of the 89 users referred to and discharged from SFH. An attempt to obtain data on the legal status of users referred to the community psychiatric services was not successful. Data on this cohort of users obtained from the responsible review board was totally incompatible with the information that was obtained from the three hospitals.

CONCLUSION: In order to fulfil their role as protectors and overseers of the human rights of mental health care users, review boards rely on the data submitted to them by health care facilities in their area of jurisdiction. The extent to which the information on the legal status of this cohort of inpatients discharged from one 72-hour assessment unit has been compromised, raises an urgent question about the capacity to effectively track users through the different facilities and services they are being referred to.

DUAL DIAGNOSIS UNITS IN PSYCHIATRIC FACILITIES: OPPORTUNITIES AND CHALLENGES

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Substance abuse is the most common (50%) and clinically significant (high rates of relapse and hospitalisation) co-morbid disorder in patients suffering from mental illness. Separate mental health and substance abuse treatment systems deliver fragmented and ineffective care. Often patients are excluded from services in one system and are shunted from one service to the other. Hence the need for an integrated service such as that offered in a dual diagnosis unit. Effective dual diagnosis programmes combine psychiatric and substance abuse interventions that are tailored to the complex needs of such patients.

Some of the challenges to the establishment of dual diagnosis units in psychiatric facilities include convincing policy makers of the need for such services, financial support for infrastructure and human resources, training of clinicians, creation of additional psychiatry subspecialties, and

providing education to patients and their families on the need and benefits of and integrated approach to the problem.

The lack of dual diagnosis units in South Africa affords psychiatrists the opportunity to advocate for mental health policy changes, to set up such units, and to monitor and conduct research on the positive outcomes of such services. The multidisciplinary approach in a dual diagnosis unit also allows for close collaborations with other stakeholders such as physicians, social services and rehabilitation centres. This may result in improved adherence to psychiatric treatment, abstinence and a reduction of the burden on health resources.

A dual diagnosis unit was established at Chris Hani Baragwanath Hospital 2 years ago. A workable model has been developed for both inpatient care and sustained outpatient attendance. There is an opportunity to refine this model and duplicate it at other psychiatric facilities and community-based psychiatric services.

ALCOHOL-INDUCED PSYCHOTIC DISORDER: A COMPARATIVE STUDY ON THE CLINICAL CHARACTERISTICS OF PATIENTS WITH ALCOHOL DEPENDENCE AND SCHIZOPHRENIA

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OBJECTIVE: Alcohol-induced psychotic disorder (AIPD) is a rare complication of excessive alcohol use for which limited comparative studies are available. The aim of this study was to prospectively investigate demographic and psychopathological characteristics in patients with AIPD, schizophrenia and uncomplicated alcohol dependence. We postulate that AIPD is a discrete clinical entity that can be differentiated from schizophrenia and uncomplicated alcohol dependence by means of standardised clinical assessments.

METHOD: Twenty-eight patients with AIPD, 21 with schizophrenia and 20 with uncomplicated alcohol dependence were assessed utilising psychiatric rating scales including the Positive and Negative Syndrome Scale (PANSS).

RESULTS: Patients with AIPD had a significantly lower educational level, later onset of psychosis, higher level of depressive and anxiety symptoms, fewer negative and disorganised symptoms, better insight and judgement and less functional impairment compared with patients with schizophrenia.

CONCLUSION: This study provides further supportive evidence that AIPD can be clinically distinguished from schizophrenia.

Jordaan GP, Nel D, Hewlett RH, Emsley R. Alcohol-induced psychotic disorder: A comparative study on the clinical characteristics of patients with alcohol dependence and schizophrenia. *J Stud Alcohol Drugs* 2009;70(6):870-876.

ANXIETY DISORDERS: THE FIRST EVIDENCE FOR A ROLE IN PREVENTIVE PSYCHIATRY

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Anxiety disorders have been somewhat neglected within the field of psychiatry, but now there seems to be a potential that anxiety disorders may have a quite unique 'preventative role' in psychiatry.

Furthermore, our current understanding of co-morbid disorders, between the various anxiety and mood disorders in particular, seems to confuse our interpretation of the illnesses and which diagnosis to manage. Published rates of co-morbidity seem far higher than our clinical experience. I hope

to define true co-morbidity, look at some related sub-definitions, and examine the consequences this has on the treatment options and outcome of anxiety disorders.

Recent epidemiological data demonstrate a clear connection between the anxiety and mood disorders and also a link from depression to dementia.

New biological and epidemiological evidence of anxiety disorders points to a potential for preventative psychiatry with the anxiety disorders. These data and theories will be presented.

THE END OF RISK ASSESSMENT AND THE BEGINNING OF START

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Actuarial risk assessment scales have not quite fulfilled the expectation that objective rating schemes would assist in identifying individuals at high risk of acting violently. Such scales tend to sample a relatively small number of risk factors, and often exclude other, often rarely occurring, factors that may be as important in particular individuals. Actuarial scales also do not assess how risk factors interact, or for how long they are valid. None takes into account the possible influences of protective factors. There is a new generation of instruments, represented by the Short-Term Assessment of Risk and Treatability Scale (START), developed in Vancouver, which attempts to address these shortcomings and to provide an individualised approach to assessing risk.

PSYCHIATRIC DISORDERS AND PSYCHOSOCIAL CORRELATES OF HIGH HIV RISK SEXUAL BEHAVIOUR IN WAR-AFFECTED EASTERN UGANDA

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BACKGROUND: Studies from developed countries have shown psychiatric disorders to be a risk factor for HIV infection, with one of the suggested pathways being through increased risky sexual behaviour. There are few data on this association from sub-Saharan Africa and an absence of programming to address this risk factor in HIV prevention on the continent.

OBJECTIVES: To investigate the psychiatric and psychosocial risk factors for high-risk sexual behaviour in a vulnerable population in war-affected Eastern Uganda.

METHODOLOGY: A cross-sectional survey was carried out in 4 sub-counties in two districts in Eastern Uganda. 1 560 randomly selected respondents (15 years and above) were interviewed. The primary outcome was a derived variable 'high-risk sexual behaviour' defined as reporting at least one of 13 sexual practices that have been associated with HIV transmission in Uganda. Multivariable logistic regression was used to assess factors associated with high-risk sexual behaviour in this population.

RESULTS: Males were more likely to have at least one 'high-risk sexual behaviour' than females (14.0% v. 11.6% in the past year). Sex outside

marriage was the most common 'high-risk sexual behaviour', reported by 12% of married participants in the past year. Factors independently associated with 'high-risk sexual behaviour' among males were being a victim of intimate partner violence (OR 3.34, 95% CI 1.97 - 5.66), having a major depressive disorder (OR 1.93, 95% CI 1.19 - 3.12), and being in the middle tertile poverty index (OR 2.12, 95% CI 1.11 - 4.03 compared with the lowest tertile). Among females these factors were previous exposure to war-related sexual violence (OR 1.96, 95% CI 1.17 - 3.28), previous exposure to war-related physical trauma (OR 1.73, 95% CI 1.05 - 2.87), and having a gynaecological problem (OR 2.49, 95% CI 1.53 - 4.05).

CONCLUSION: In both genders, psychiatric and psychosocial risk factors were significantly associated with high-risk sexual behaviour, although directions of causation cannot be inferred from this cross-sectional study.

RECOMMENDATIONS: HIV/AIDS prevention programmes in conflict and post-conflict settings should address the psychiatric and psychosocial wellbeing of these communities.

1. Collins P, Holman AR, Freeman MC, Patel V. What is the relevance of mental health to HIV/AIDS care and treatment programs in developing countries? A systemic review. *AIDS* 2005;20:1571-1582.

ONE YEAR OF FORENSIC PSYCHIATRIC ASSESSMENT IN THE NORTHERN CAPE: A COMPARISON WITH AN ESTABLISHED ASSESSMENT SERVICE IN THE EASTERN CAPE

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INTRODUCTION: Occupying the largest land mass of South Africa's nine provinces, the Northern Cape is also the least populated, with 1.1 million people. In 1994 the N Cape became a separate province. This development necessitated the establishment of an autonomous health department, including the treatment of state patients and assessment of accused persons referred for psychiatric observation by courts. A forensic psychiatric service tasked with the assessment of accused persons was established in 2008.

METHODS: This study is retrospective and descriptive in design. The period of study extends from 2008 to July 2010. As data on all cases over this period are available, no cases were excluded. Data contained on the *forenSys* database were used. The descriptive parameters on the accused referred for psychiatric assessment and selected for inclusion in the study were as follows: biographical – age, gender, marital status, financial support, highest level of education; legal – index offence; clinical – Axis I, II and III diagnoses; assessment findings: ability to follow proceedings (able or unable), criminal capacity (responsible, diminished responsibility and not responsible).

Similar data from the forensic service at Fort England Hospital, Grahamstown, E Cape, comprising 1 000 cases assessed during the period September 2004 - July 2010 were obtained and statistically compared with the Northern Cape data using a chi-squared approach. Eastern Cape data were obtained from the Fort England *forenSys* database.

The selected data parameters were obtained by means of an SQL-query in Microsoft Access. Statistical analysis was performed using Statistica software at the Department of Statistics, Rhodes University, Grahamstown. Consistency in descriptive approach and diagnosis was strengthened because one of the authors (CV) had been involved in both the Eastern and Northern Cape assessments.

RESULTS: During the first year of operation, 52 accused were assessed. The majority of accused were charged with violent offences. In the Northern Cape, accused were mostly young adult males, in their twenties, relied on relatives or social grants for their finances and had limited schooling. Two-thirds of cases had no diagnosis on either Axis I or II. Of those with positive psychiatric diagnoses, schizophrenia, mental retardation and dementia were the commonest diagnostic findings. Substance abuse was common to those with mental illness as well as those without. The minority of cases were assessed to be unable to engage and follow court proceedings or lacking criminal capacity. Murder cases were found more frequently among cases with no Axis I diagnosis. Positive Axis I diagnoses occurred more frequently in accused charged with property crimes. When present, mental retardation was diagnosed more frequently in rape than other cases.

CONCLUSION: The forensic psychiatric profile of accused persons in the Northern Cape corresponded with those in the Eastern Cape.

MENTAL HEALTH SERVICE USER PRIORITIES FOR SERVICE DELIVERY IN SOUTH AFRICA

Sharon Kleintjes¹, Crick Lund¹, Leslie Swartz², Alan Flisher¹, and the MHaPP Research Programme Consortium

¹Department of Psychiatry and Mental Health, University of Cape Town; ²Department of Psychology, Stellenbosch University, W Cape

INTRODUCTION: Inclusion of the voices of mental health care users in policy-related decision-making can benefit users' recovery process and positively impact on the relevance of mental health policy directions for service development. South African mental health care users' influence on the scope and directions for policy and service development has been limited during the 16 years of democracy in South Africa. The aim of this presentation is to present 40 South African mental health care users' views on mental health care service priorities to support their recovery.

METHODS: Snowballing was used to identify mental health care user advocates in the nine provinces (N=20), and users of public mental health services in one urban (N=10) and one rural (N=10) district in two provinces. Respondents' views were collected during semi-structured interviews. The interviews were conducted in English, except for the 10 rural district interviews which were conducted in isiZulu. Interviews were recorded with respondents' permission. English interviews were transcribed verbatim. The isiZulu interviews were translated and transcribed into English by the interviewer, and back-translated by an independent bilingual speaker. Thematic analysis of the data was guided by a coding scheme derived using a framework analysis approach to defining, categorising, mapping and interpreting the textual data. Framework analysis was developed for use in applied policy research directed at obtaining information that can inform actionable recommendations and is well suited to the focus of this study. Transcripts were multi-coded on the basis of coding frame themes using NVivo 7 qualitative data analysis software, with additional themes added to the frame as determined by the data. Informed consent was obtained from participants and confidentiality assured by removal of identifying material from interviews. Permission for the study was obtained from the Research Ethics Committee of the Faculty of Health Sciences, University of Cape Town.

RESULTS: User priorities for service supports spanned a wide range of needs, including equality needs (citizenship, participation, acceptance, respect), material supports (state benefits, income generation, employment), basic living needs (housing, water, sanitation, transport) personal development (education, skills development), social needs (family support, help with child care, intimate relationships) and treatment

needs (medication, accessible treatment, psycho-education, support for family carers).

CONCLUSION: Mental health care user views on service requirements to promote their recovery include traditional health care for symptom management, but go beyond treatment to supports that will encourage their efforts to return to valued life roles such as that of citizen, family member, neighbour, friend, lover, co-worker and learner. An intersectoral public policy and service provision approach is needed to adequately address the challenge of comprehensively supporting the recovery of mental health care users.

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THE NATURE AND EXTENT OF OVER-THE-COUNTER AND PRESCRIPTION DRUG ABUSE IN CAPE TOWN

Liezl Kramer

Private Practice

OBJECTIVES: This study aims to investigate the nature and extent of over-the-counter (OTC) and prescription drug abuse in Cape Town, with a view to informing policy formulation associated with reducing OTC and prescription drug abuse. This study was performed as part of an MSc in Drugs and Alcohol, Policy and Intervention through the University of London.

METHOD: Ten key informants working throughout Cape Town participated in a semi-structured interview. Content analysis of the responses was performed according to a number of specific themes. Recent findings by South African authors and the South African Community Epidemiological Network on Drug Use (SACENDU) were reviewed to triangulate the study findings.

RESULTS: The study revealed high levels of OTC and prescription drug abuse in the non-treatment-seeking population in Cape Town. Benzodiazepines and codeine-containing analgesics were most commonly abused. There is a lack of awareness regarding the risks associated with OTC and prescription drug abuse. Available treatment services, policies and regulations are inadequate to address the current problem.

CONCLUSION: Policy recommendations to address such inadequacies should include further research, widespread education of the public and professionals, a national real-time computer database accessible to all service providers which records various contacts, prescriptions and OTC medications issued, and stricter legislation on the availability of OTC and prescription drugs, specifically the re-scheduling of codeine to prescription-only status.

PHYSICAL HEALTH ISSUES IN LONG-TERM PSYCHIATRIC INPATIENTS: AN AUDIT OF NURSING STATISTICS AND CLINICAL FILES AT WESKOPPIES HOSPITAL

Christa Kruger

Department of Psychiatry, University of Pretoria

INTRODUCTION: Maintaining physical health in the presence of severe mental illness has remained a challenge. The aim of this study was to identify the most pressing physical health issues faced by long-term psychiatry inpatients, as part of a larger multi-phased programme

evaluation project to improve clinical service delivery and quality of care to the long-term patients in Weskoppies Hospital.

METHODS: Regular nursing statistics on infections, vital data, injuries and undesirable incidents, as well as clinical file data on general medical conditions diagnosed on routine or emergency physical examinations, were collected for 207 long-term inpatients at Weskoppies Hospital over a 6-month study period. Undesirable incidents (including verbal or physical aggression, oppositionality or non-compliance with hospital rules, harassing fellow-patients, and cannabis or other substance abuse) were recorded because of their physical health-related sequelae and psychiatric nursing implications. Subgroups of patients were compared with respect to the variables of interest using two-way tables and Fisher's exact tests, or Mann-Whitney U and Kruskal-Wallis tests.

RESULTS: Overall, the most frequent physical health issues were respiratory tract infections, physical aggression, falls and lacerations. When analysed by subgroups, younger patients (<45 years) and male patients were statistically significantly more prone than their counterparts to physical aggression and other undesirable incidents, as well as to injuries due to fighting or assault. Older patients (>45 years), male patients and patients suffering from cognitive disorders (dementia or mental retardation) were significantly more prone than other subgroups to respiratory tract infections. Moreover, patients with cognitive disorders were significantly more likely than patients with other diagnoses to contract any kind of infection or to sustain any type of injury, especially accidental injuries and injuries due to falls that result in lacerations and abrasions. Furthermore, the body weight of the older patients (representing around two-thirds of the study population) was significantly less than that of the younger patients. Although the mean blood pressure of the patients who suffered from hypertension (nearly a third of the study population) was statistically significantly higher than that of the rest of the patients, it was well controlled (i.e. it was well within the normal range and the difference was not clinically significant).

CONCLUSIONS: In managing the above physical health issues, two subgroups of long-term psychiatric inpatients might benefit from particularly intensive nursing: the younger and male patients who are prone to physical aggression and its sequelae, as well as the patients with cognitive disorders who are vulnerable to accidental injury and infections. The established practice of routine influenza vaccination should be continued to help alleviate the burden of respiratory tract infection in long-term psychiatric inpatients.

SUICIDE RISK IN SCHIZOPHRENIA – 20 YEARS LATER, A COHORT STUDY

Gian Lippi, Ean Smit, Joyce Jordaan, Louw Roos

University of Pretoria

INTRODUCTION: This study re-evaluated, after a period of 20 years, a cohort of patients with schizophrenia who had been considered to be at high risk for suicide. The outcome and social factors associated with their suicide risk over the two decades, as well as the symptomatology and pharmacotherapy over this period, were investigated.

METHOD: Subjects were contacted and interviewed face to face using a questionnaire devised for evaluating suicide risk and factors likely to have an influence on suicide risk in this population. The Beck Hopelessness Scale was administered and ratings were compared with those from the original study. The Calgary Depression Scale for Schizophrenia was also administered. Cross-tabulations were then performed to identify factors associated with increased suicide risk. A psychological autopsy was

performed for those subjects who had committed suicide since the original study.

RESULTS: Fourteen of the original 33 high-suicide-risk schizophrenia patients were traced. Three subjects had committed suicide during the 20-year period. Among the living subjects, risks for suicide were found to be lower than those 20 years earlier. Hopelessness and depressive symptoms correlated with independently evaluated suicide risk. Male gender, poor social support, early age of illness onset, current admission to or recent discharge from hospital, and a higher level of education were all factors associated with increased suicide risk. Subjects who presented with social withdrawal, blunting of affect and delusions had associated elevated risks of suicide. Good insight into illness and a history of previous suicide attempts coincided with elevated risk. Cannabis abuse and poor or periodic adherence to treatment, as well as weight gain, akathisia and parkinsonian adverse effects on said treatment, were all associated with an increase in risk of suicide. Formal thought disorder, avolition and cognitive impairment were associated with a lower risk of suicide.

CONCLUSION: Hopelessness, depression, certain positive symptoms and adverse effects of medication were found to be associated with increased suicide risk among the schizophrenia subjects in this study. Certain demographic factors and those related to illness course were also found to be associated with increased risk of suicide in this population. These findings are in accord with those reported in the literature. Despite current knowledge about this subject, suicide remains notoriously and ominously unpredictable in patients with schizophrenia.

DEVELOPING MENTAL HEALTH INFORMATION SYSTEMS IN SOUTH AFRICA: LESSONS FROM PILOT PROJECTS IN THE NORTHERN CAPE AND KWAZULU-NATAL

Crick Lund¹, S Skeen¹, N Mapena², C Isaacs³, T Mirozev⁴, and the Mental Health and Poverty Research Programme Consortium Institution

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INTRODUCTION: Mental health information is a low priority in health information systems in low- and middle-income countries. In a 2005 report, just over 57% of African countries surveyed had a reporting system tracking health system functioning and budget allocation for mental health. In South Africa, there is only one mental health indicator collected at primary health care (PHC) level in the District Health Information System (DHIS), namely 'mental health visit'. Little is known about the process of developing mental health information systems (MHIS) at primary care level in this country. The aim of this study was to assess the process and the preliminary impact of integrating mental health indicators into the DHIS in 2 districts in the Northern Cape and 3 districts in KwaZulu-Natal.

METHODS: Researchers at UCT collaborated with data management and mental health programme staff in the Department of Health in the Northern Cape and KwaZulu-Natal, using methods of participatory action research. The steps in developing the system included establishing a task team in each province; conducting a situation analysis of the districts; consulting with provincial and district stakeholders regarding an optimal set of PHC indicators for mental health; developing data collection tools; training district and provincial information officers, health service managers and clinicians; and collecting data using the new system over a 1-year period (April 2009 - March 2010). Semi-structured interviews were conducted with information management, health service

management, mental health programme and PHC clinical staff to assess their experience of the process and preliminary impact of the system. The interviews were transcribed verbatim and analysed thematically using NVivo qualitative data analysis software.

RESULTS: The MHIS provide data that were not previously available regarding service utilisation (gender, age and diagnosis), interventions (number of psychopharmacological and psychosocial interventions) and referrals, integrated into the DHIS. The data can be used to inform planning and management decisions for mental health, as a key component of primary health care. Stakeholders identified a number of factors that facilitated the development of the system, namely senior management support for MHIS development in one province; regular communication between mental programme and information management staff; early consultation with a range of stakeholders in the design of the system; and repeated training and trouble-shooting workshops. Barriers included low priority for mental health; human resource shortages among general PHC staff, information staff and mental health programme staff; lack of mental health skills among general PHC nurses (e.g. in diagnosis); weak general HIS; and lack of coordination of mental health information at district hospital level.

CONCLUSION: Integration of mental health indicators into the DHIS is feasible in South Africa, given the appropriate senior management support, and ongoing consultation and support for stakeholders at district and provincial level.

MENTAL HEALTH ASPECTS OF SOUTH AFRICAN EMIGRATION

Maria Marchetti-Mercer

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In the past few decades South Africa has witnessed different types of emigration fluxes, which have often been linked to specific political periods. A number of explanations have been put forth for what is also often termed as a 'brain drain', leaving South Africa short of many essential skills. These perspectives often tend to centre around economic or political interpretations, while the mental health impact of this phenomenon is often ignored. This paper will focus on the initial findings of a NRF-supported project carried out by the author exploring the psychological impact of emigration on South African families. This study explored South African emigration from a family systemic perspective with a particular interest in the experiences of those family members and friends staying behind. The mental health impact of emigration as a whole on the South African social fabric was also highlighted.

In this paper some of the most salient experiences of the families that were interviewed prior to emigration, as well as those of some of their family members and friends who have stayed behind, will be described. Specific psychological aspects which were identified in the course of the research will be highlighted. The author will also propose some possible preventive measures which may be of use to mental health professionals working with families affected by emigration.

WHAT SERVICES SADAG CAN OFFER YOUR PATIENTS

Elizabeth Matare

South African Depression and Anxiety Group

The South African Depression and Anxiety Group (SADAG) is South Africa's largest mental health NGO. After 16 years of service to all South Africans, SADAG still educates and counsels people about mental

illness in order to improve treatment, and destigmatise this misunderstood medical area.

SADAG offers toll-free counselling to those in need of care and supports educational programmes across the country. Its trained counsellors provide a haven of hope and care to people who are often feeling neglected and isolated. SADAG runs the country's only toll-free suicide crisis line and operates a 15-line call centre 7 days a week from 8 am to 8 pm, opening doors for the millions of South Africans trapped in the lonely private prisons of depression, anxiety, post-traumatic stress disorder, bipolar disorder and other mental illnesses that affect our communities. With over 400 calls per day, SADAG is the 'go-to' organisation when patients, concerned loved ones, or the media have questions that need answering.

SADAG will go through the services it offers, including: diversity of brochures (8); medication compliance service via sms, email and phone calls; Diepsloot counselling centre in container; online videos with psychiatric experts on website; sms and e-mail services available; what 150+ support groups can do to help your patients; what lobbying we do with government and medical schemes; how we establish Mental Health Days, i.e. Bipolar and Panic, on government calendars; speaking books on mental health, depression and AIDS, and teen suicide prevention; corporate wellness days and workshops; and school projects on teen suicide and substance abuse.

SADAG is a powerful NGO with a huge heart and guts, and is making a huge impact on the mental wellness of all South Africans.

CULTURE AND LANGUAGE IN PSYCHIATRY

Dan Mkize

Head, Department of Psychiatry, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban

Culture is a definition highly misunderstood and misused, thus the need for an explanation. Culture refers to the following ways of life, including but not limited to: Language; Arts & Sciences; Thought; Spirituality; and Social activity. All of these collectively define the meaning of Culture.

Language is a term most commonly used to refer to so-called 'natural languages' – the spoken forms of communication ubiquitous among humankind. By extension the term also refers to the type of thought process that creates and uses language. Essential to both meanings is the systematic creation, maintenance and use of systems of symbols, which dynamically reference concepts and assemble according to structured patterns to form expressions and communicate meaning.

Psychiatry is the medical specialty devoted to the study and treatment of mental disorders – which include various affective, behavioural, cognitive and perceptual disorders. Speakers who are not psychiatrically normal may show their psychiatric state through the language they use. Therefore, a functional study of the language of speakers with psychiatric disorders is not the study of a side phenomenon or an epiphenomenon. It is the study of what makes the lay and clinical communities notice that something is unusual about an individual, leading ultimately to the diagnosis of a disorder.

There is a necessary relationship between language and psychiatric disorders. These disorders are largely characterised by the way individuals speak, both in the community where some atypicality is first noticed, and in the clinical setting where the clinician probes atypicalities and considers diagnoses. This presentation is an attempt to conceptualise psychiatric categories in terms of culture and language.

LATEST PSYCHOTIC EPISODE**Povl Munk-Jorgensen**

Aalborg Psychiatric Hospital, Aarhus University Hospital, Unit for Psychiatric Research, Aalborg, Denmark

A wide range of physical illnesses is prevalent and mortality rates from these illnesses are very high in patients with psychoses, in particular schizophrenia; suicide, social deterioration and other complications are also common.

Persons admitted for their 'latest episode psychosis' account for 95% of in- and outpatient admissions for psychoses, and those with first-episode psychosis for the remaining 5%.

Persons with long-term psychiatric illnesses are most likely to develop physical illnesses. The time has come to counteract the development of these added burdens, specifically in patients with schizophrenia. Some examples from promising clinical initiatives will be presented.

THE FORENSIC PROFILE OF FEMALE OFFENDERS**Mo Nagdee, Helmut Erlacher**

Fort England Hospital, Grahamstown, E Cape

INTRODUCTION: The demographic profile, incidence of criminality, pattern of offending behaviour and its relationship to mental ill-health of female offenders differs in comparison with their male counterparts. There is a paucity of information on the forensic profile of female offenders, particularly in the South African context.

METHODS: A review of aetiological factors, issues around women in prison, mental illness in female offenders, and medico-legal aspects of psychiatric disorder in women will be outlined. A cross-sectional, retrospective analysis of the forensic clinical records of accused women referred for observation under the Criminal Procedure Act (1977) to Fort England Hospital (Grahamstown, Eastern Cape) has been conducted.

RESULTS: The initial results of the descriptive analysis of demographic, clinical and forensic parameters of the population under study will be presented.

CONCLUSION: While women offend much less than men, there is a lack of reliable data on their forensic and clinical profile, especially in the context of developing countries such as South Africa. There is even less published information on women who commit violent offences (especially the phenomenon of child killing), an area of particular interest to our research group. The current study forms the initial phase of a larger, multi-centre, national study we are planning.

THE INTRA-PERSONAL EMOTIONAL IMPACT OF PRACTISING PSYCHIATRY**Margaret Nair**

Private Practice, KZN

There is a dearth of literature on the subject of intra-personal stress in psychiatrists. Most of the available literature pertains to psychologists. *Are psychiatrists in denial?* As psychiatrists have a relatively high incidence of depression and suicide, it is an important matter to address.

This presentation will discuss the causes of emotional trauma and stress in psychiatrists, as well as the emotional 'overload' and demands of the discipline psychiatry. Self-awareness, coping strategies, stress-relief techniques such as 'down-time', being mentored and colleague support will be discussed.

HIGHLY SENSITIVE PERSONS (HSPs) AND IMPLICATIONS FOR TREATMENT**Margaret Nair**

Private Practice, KZN

The concept of the highly sensitive person has not been incorporated into the DSM-IV diagnoses. It may well be that it is not a pathological disorder. However 20% of people in the world are HSPs. As they react to stimuli, stress and external events in a different way, they often consult psychiatrists and psychologists. In the light of the fact that the concept of HSP is not openly acknowledged, these patients are often misdiagnosed or labelled as 'PDs'.

This presentation will discuss the concepts of HSP, its differentiation from borderline personality disorder, the coping techniques used to assist such patients, and the creative and altruistic contribution HSPs make to society because of their high degree of sensitivity. Implications for psychotherapy and pharmacotherapy will be debated.

TASK SHIFTING IN MENTAL HEALTH - THE KENYAN EXPERIENCE**David M Ndeti**

Professor of Psychiatry, Department of Psychiatry, University of Nairobi, and Director, Africa Mental Health Foundation, Kenya

There is evidence that the prevalences of the different types of mental disorders in both resource-rich and resource-poor countries are similar. Yet the disparity in human resources between the resource-rich and resource-poor countries is overwhelmingly skewed in favour of the former. In spite of this, the resource-rich countries continue to attract skilled labour from the poor countries, driven by attractiveness of service terms. It is therefore unlikely that in the foreseeable future resource-poor countries will have adequate highly skilled personnel comparable to the West, despite having the same mental health needs. Resource-poor countries therefore need innovative strategies to address the mental health needs of their populations using whatever resources are available, affordable and sustainable.

Task-shifting involving clinical officers, nurses and other cadres of personnel has been in practice for a long time. It has proved an effective and viable alternative in providing services where there is shortage of highly skilled personnel. There is a shortage of these cadres in all areas of health, but this shortage is most acute in mental health services. Kenya has come up with innovative but short-term strategies to address this problem.

Faith healers and traditional healers have always been consulted by the people and are plentiful. They provide an untapped pool of resources if they are appropriately trained, at least to recognise the different types of mental illness; to apply interventions that do not need highly skilled training such as self-help groups; and to know when to refer. There is a pilot study in Kenya to loop in this pool of potential resources.

BRIDGING THE GAP BETWEEN TRADITIONAL HEALERS AND MENTAL HEALTH IN TODAY'S MODERN PSYCHIATRY**David M Ndeti**

Professor of Psychiatry, Department of Psychiatry, University of Nairobi, and Director, Africa Mental Health Foundation, Kenya

For centuries man has used traditional means for treating ailments, and despite advancements in modern medicine, traditional medicine, also known as alternative medicine, continues to be used alongside modern medicine today.

The application of diagnosis and treatment methods in traditional medicine is largely influenced by the culture and beliefs dominant in a particular community, to the extent that they may be ineffective when applied in a different context. The influence of the particular culture is important in the determination of the effectiveness of the traditional medicine and healer; it can only be determined within a social context. For example, effectiveness can be based on the community's acceptance of the practitioner and not so much the effectiveness of the remedies; the manner in which the individual became a practitioner – perhaps it was handed down from generation to generation in a family, or the practitioner was trained by a highly specialised traditional healer; or the physical and mystical environment within which medicine is practised, for example the rituals, incantations, charms, symbols and beliefs that play an important role in African traditional medical practice.

In developing countries, the distribution of modern medicine personnel is uneven, with most being based in urban centres as opposed to the rural areas, and few being found in the informal settlements. This is particularly marked in relation to mental health. To meet their medical needs, the majority of these people turn to traditional healers to fill this gap. Traditional healers are the first professionals contacted for mental illness in many parts of Africa. They are sufficient in numbers in the communities, are accepted, do home visits, do not stigmatise mental illness, are often consulted and are known to see many people with mental disorders, are willing to learn, and also are willing to collaborate with hospital-based health professionals for a holistic approach to patient management. They are enshrined in the minds of the people, are respected in their communities, are often opinion leaders, and are the first to respond in the case of an emergency. Ways and means should therefore be found to help traditional and modern medicine engage in constructive and positive dialogue so that they can complement each other.

INTEGRATING TO ACHIEVE MODERN PSYCHIATRY

David M Ndeti

Professor of Psychiatry, Department of Psychiatry, University of Nairobi, and Director, Africa Mental Health Foundation, Kenya

Mental health problems are estimated to account for 12% of disability-adjusted life-years and are expected to rise to 15% by 2020. This is complicated by the fact there is a gap between need and service provision. This gap is worst in the low-income developing countries, where it is estimated that 90% of people with mental disorders and living in the communities have no access to mental health services. The gap between the need for mental health services and the actual provision of services is also found at other levels of health services, over and above primary health care levels. For example at Kenyatta National Hospital and other hospitals in Kenya, which treat mainly physical conditions, up to 47% of patients have identifiable psychiatric illness but only about 4% of both adults and children were suspected to have a mental disorder by the clinicians. This means that many patients with physical disorders also have mental disorders that go undetected and in the process compromise the overall care and prognosis. The reverse is also true, with treatment gaps in patients with mental illness who happen to also have physical disorders. This is all the more urgent given the alarming evidence that people with mental illness have a higher rate of mortality due to physical illness than people with no mental illness.

There are several possible ways of addressing these gaps to achieve integrated and holistic management of the person – i.e. taking an integrated physical, psychological, social and even spiritual approach.

There are also several challenges: shortage of human and physical resources; stigma; and promotion of liaison medicine, in which psychiatry/mental health is a major player. All of these must however be evidence based. Each one of these challenges needs custom-made solutions.

NON-MEDICAL PRESCRIBING: OUTCOMES FROM A PHARMACIST-LED POST-TRAUMATIC STRESS DISORDER CLINIC

A Parkinson

Lead Pharmacist, Lancashire Care NHS Foundation Trust, Parkwood, Lancashire

AIMS: To promote the role of pharmacists working as part of the multidisciplinary mental health team in improving the quality and safety of medicines management and show the benefits of pharmacists and nurses functioning as non-medical prescribers in a mental health setting.

BACKGROUND: Lancashire Care NHS Foundation Trust has one of the largest teams of psychiatric pharmacists in the UK. The role of the pharmacist in the Trust includes monitoring of prescribing in a traditional way. The Trust also actively promotes involvement of pharmacists in clinical decision making, teaching, and treatment of and advocacy for the patient. The intervention recording system provides evidence of the success of this model, and this has been recognised nationally in National Patient Safety Agency (NPSA) reports. The role of the pharmacist within the Trust has expanded into non-medical prescribing. Data from a specialist post-traumatic stress disorder (PTSD) clinic where the prescriber was a pharmacist, clearly demonstrate patient satisfaction and a good clinical outcomes. This system has also been shown to improve access to mental health services for patients.

CONCLUSION: A specialist psychiatric pharmacy service has been proven to improve safety and quality of prescribing in a mental health setting. The extended role of pharmacist and nurse prescribers has improved access to medication within the following treatment settings: a specialist PTSD clinic, community mental health teams, crisis teams and substance misuse services. The provision of this specialist service had a beneficial impact on patient experience and improved patient care across the Trust.

IS THERE A CAUSAL RELATIONSHIP BETWEEN ALCOHOL AND HIV? IMPLICATIONS FOR POLICY, PRACTICE AND FUTURE RESEARCH

Charles Parry

Alcohol and Drug Abuse Research Unit, Medical Research Council, and Department of Psychiatry, Stellenbosch University, W Cape

South Africa currently faces enormous health and social problems due to the high prevalence of HIV and AIDS and from high levels of problematic drinking, especially over weekends. From a review of published literature and from systematic reviews and meta-analyses specifically commissioned for a WHO/MRC technical meeting on alcohol and infectious diseases held in 2008 in Cape Town, it can be argued that there is conclusive evidence for a causal linkage between heavy drinking patterns and/or alcohol use disorders and the worsening of the disease course for HIV. However, while alcohol use is consistently associated with the prevalence or incidence of HIV, further research is needed to substantiate causality (in terms of the acquisition of this disease). The burden attributable to alcohol use in South Africa in 2004 has been estimated to be 1.3 million years in terms of years lost through premature death caused by alcohol and

years lived with an alcohol-related disability (or just over 6% of all years lost from all causes). Of all years lost through death and disability that can be attributable to alcohol, 10% for men and 28% for women can be directly attributed to alcohol's impact on the progression of HIV in infected individuals. The implications of the above will be discussed in terms of research gaps that need to be addressed and broader policy responses that are needed in the health and social services sectors. In addition, emphasis will be given to specific practices that should be considered for rollout by agencies involved in substance abuse and HIV/AIDS treatment and prevention.

GLOBAL MENTAL HEALTH – A NEW GLOBAL HEALTH DISCIPLINE COMES OF AGE

Vikram Patel

Centre for Global Mental Health, London School of Hygiene and Tropical Medicine, UK, and Sangath, Goa, India

Global mental health has its roots within the broader remit of global health, 'an area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide'. This lecture will briefly chart the history of global mental health, documenting the key historical milestones that have led to its emergence as a legitimate and vibrant new global health discipline. The bulk of the lecture will seek to explore the research agenda of this discipline. So far, the discipline has been focused on the large treatment gaps and human rights violations experienced by people living with mental disorders in developing countries, a clear moral and ethical priority. Beyond this, it will be proposed that the discipline will reach maturity only when it recognises its potential to bring about improved mental health care and outcomes, and reduced inequities in all world regions. Thus, while the current research priorities in global mental health are rightly focused on 'implementation science', i.e. the search for better understanding on how to deliver what we know works, the search for a better understanding of the causes of mental disorders and expanding the range of affordable and effective treatments is of importance to improving the lives of people living with these disorders in all countries. In doing so, the discipline seeks to emphasise the importance of the 'global' perspective, not only to improve the outcomes of people living with mental disorders in developing countries, but to achieve better outcomes for people in all countries and to fundamentally strengthen the evidence base of the mental health sciences. What is the effectiveness of delivering treatments through non-specialist health workers to improve the coverage of mental health care at an affordable cost? What can researching mental disorders in diverse populations teach us about the basic causes of these conditions? What can the historic traditions of mental health care in non-Western societies contribute towards expanding the relatively limited range of effective treatments currently available? Answering these questions is the ultimate research goal of global mental health.

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INTEGRATING MENTAL HEALTH INTO PRIMARY HEALTH CARE: LESSONS FROM PILOT DISTRICT DEMONSTRATION SITES IN UGANDA AND SOUTH AFRICA

Inge Petersen¹, Arvin Bhana^{1,2}, K Baillie¹ and MhaPP Research Programme Consortium

¹School of Psychology, University of KwaZulu-Natal; ²Human and Social Development, Human Sciences Research Council

INTRODUCTION: Decentralised and integrated primary mental health care at a district level forms the core of many mental health policies in

LMICs. In the context of scarce resources and large treatment gaps for mental disorders, this study piloted the use of a common implementation framework involving a multi-sectoral community collaborative forum and a task shifting approach to integrated primary mental health care in district demonstration sites in South Africa and Uganda.

METHOD: A common implementation framework for the integration of mental health care into primary health care across the case study sites was evaluated using mixed methodologies involving quantitative and qualitative methods before and after the intervention. The implementation framework included establishing multi-sectoral community collaborative forums to manage the integration process; providing training and support to non-specialist primary health care personnel and community based workers in the identification and management of mental disorders within a supervisory framework, and promoting community-based rehabilitation through the development of user-carer groups.

RESULTS: While the implementation framework proved useful in guiding the integration process across the country sites, the content and focus varied depending on the country-specific gaps in services and resources available. The multisectoral community collaborative forums proved useful for harnessing resources for mental health across both sites, as well as improving mental health literacy and demand for mental health services, reducing stigma, and promoting culturally competent services. Task shifting is a promising mechanism for increasing access to mental health care, with the South African site demonstrating that it is feasible to train community-based workers to deliver manualised non-pharmacological treatment for common mental disorders. The development of user-carer groups in Uganda also suggests that this approach can assist in the provision of psychosocial rehabilitation programmes in scarce-resource contexts.

CONCLUSION: A common implementation framework incorporating a multisectoral and community collaborative task shifting approach helped to facilitate the integration of mental health care into primary health care across the district country sites, allowing for the actual form and content of the services developed to be responsive to the varying needs and resources available within the different country scenarios.

The Mental Health and Poverty Project (MHaPP) is a Research Programme Consortium (RPC) funded by the UK Department for International Development for the benefit of developing countries. The views expressed are not necessarily those of DfID.

PERSONALITY DISORDERS – THE ORPHAN CHILD IN THE AXIS I-AXIS II DICHOTOMY

Willie Pienaar

Stellenbosch University and associated psychiatric hospitals of the Western Cape

The categorical diagnostic approach to the classification of personality disorders as in the DSM-IV does not exhaust the diversity of personality pathology in practice. A dimensional approach is being suggested for the DSM-V. The diagnosis of 'personality disorder' may also move from Axis II to Axis I. The pros and cons of such a move will be debated by exploring the broad and vague definition of a 'mental disorder'. Should the entity of an illness be defined in pure scientific terms or a socio-political value concept? Should the diagnosis of 'personality disorder' be classified as a psychiatric disorder on axis I, what would be the implications for teaching, treatment availability, affordability and personal responsibility and accountability in the forensic system? The philosophy of respect for autonomy, human rights and other contemporary moral discourses will be discussed in the context of those who are diagnosed with a personality disorder. Suggestions will be made as to the way forward.

CASE STUDIES IN PSYCHIATRIC ETHICS**Willie Pienaar**

Stellenbosch University and associated psychiatric hospitals of the Western Cape

Case studies of patients with psychiatric disorders that presented challenging moral and bioethics dilemmas will be presented, argued, and debated using contemporary moral theories.

CORONARY ARTERY DISEASE AND DEPRESSION: INSIGHTS INTO PATHOGENESIS AND CLINICAL IMPLICATIONS**Janus Pretorius**

Department of Psychiatry, University of the Free State

The relation between coronary artery disease and depression seems to be related to depression severity, with a threefold increased risk in patients with major depressive disorder. Patients with co-morbid depression and various cardiovascular disorders have a much poorer outcome than those without co-morbid depression, with long-term survival inversely related to severity of depression.

Depressed patients have been shown to have multiple defects in the platelet clotting cascade, resulting in an increased likelihood of thrombus formation. Furthermore, increased markers of inflammation associated with depression have long been known to play a role in the pathophysiology of ischemic heart disease. Endothelial dysfunction and reduction in heart rate variability have also been demonstrated in patients with depression.

Current evidence of inflammatory processes involved in the pathogenesis of mood disorders and clinical implications thereof will be reviewed during this talk.

IMPACT OF THE MENTAL HEALTH CARE ACT NO. 17 OF 2002 ON DESIGNATED HOSPITALS IN KWAZULU-NATAL: TRIUMPHS AND TRIALS**Suvira Ramlall¹, Jennifer Chipps²**

Departments of ¹Psychiatry and ²TeleHealth, University of Kwa-Zulu Natal

BACKGROUND: The South African Mental Health Care Act (the Act) No. 17 of 2002 legislated that regional and district hospitals be designated to admit, observe and treat mental health care users (MHCUs) for 72 hours before they may be transferred to a psychiatric hospital. In KZN, most of these designated hospitals had never previously admitted or cared for psychiatrically ill patients. A survey was conducted to evaluate the impact of the Act on these hospitals in KwaZulu-Natal (KZN).

METHODS: A survey was conducted of 49 of the 50 designated hospitals in KZN. Medical managers were surveyed on infrastructure, staffing, administrative requirements and MHCU case load pertaining to the Act for the month of July 2009. The study received ethical clearance from the Human and Social Sciences Research and Ethics Committee of the University of KwaZulu-Natal and the Research Committee of the Department of Health in KZN.

RESULTS: 36 (74%) of designated hospitals responded to the survey. Most of the hospitals (30, 83.3%) felt that the Act improved mental health care for MHCUs. Thirty-three hospitals (91.7%) reported having the necessary MHCA forms available and 24 hospitals (66.7%) reported that their staff were reasonably proficient in completing these forms. Twenty-six hospitals (72.2%) reported no visits from the Review Board in the preceding 6 months and 16 (44%) hospitals reported that forms were not being forwarded to the Review Boards.

Eleven (30.6%) of the hospitals felt that their staff had received adequate

support to provide 72-hour observations of MHCUs and staff generally felt inadequately trained to manage MHCUs. Twenty-five hospitals (69.4%) felt inadequately staffed to provide care to MHCUs.

Ten of the hospitals (27.8%) had a psychiatric unit, 13 (36.1%) reported having general ward beds dedicated for psychiatric admissions, and 24 (66.7%) provided an outpatient psychiatric service. Sixteen (44.4%) of the hospitals had some form of seclusion facility. Seventy-six per cent of admissions were as involuntary or assisted MHCUs. Having a dedicated psychiatric unit was associated with higher admission rates and the availability of seclusion facilities and appropriately trained psychiatric staff.

CONCLUSION: The implementation of the Act has increased the availability and accessibility of Mental Health Care services and facilitated the integration of mental health into the District Health System. Investment in infrastructure, staffing and training at designated hospitals could improve the quality of psychiatric services being rendered.

BIOLOGICAL BASIS OF ADDICTION**Solomon Rataemane**

University of Limpopo, South Africa

There is still no clarity on whether addiction should be understood as a brain disease or a moral condition. The latter increases the stigma attached to addiction and access to treatment. It is motivated by the extent to which we hold addicted individuals responsible for their behavior. There is substantial evidence for a disease model, but this does not fully exclude the focus on voluntary control. The effects of alcohol and drugs on the brain; subsequent impairment in cognitive control of behavior; response to medications that reduce craving and promote abstinence; and the additional response to psychological interventions will be discussed in an attempt to strengthen the hypothesis of addiction as a disease of the brain.

GENETICS OF SCHIZOPHRENIA**Louw Roos**

University of Pretoria, Weskoppies Hospital

Communicating scientific findings in the clinical setting. The expected identification of susceptibility genes for psychiatric disorders may bring new opportunities and expectations from patients and families for the clinical translations of research findings in psychiatric genetics.

In this talk, providing information about familial risk of schizophrenia is discussed and the theory behind individualising recurrence risks is highlighted. Recent new findings regarding the new genetic frontier copy number variations (CNVs) are summarised and the genetic architecture of familial and sporadic schizophrenia applicable to the clinical situation is reviewed. A scenario in which genetic testing could be applied in velocardiofacial syndrome (VCFS)-type schizophrenia is debated. Referring to genetic discrimination in mental disorders, reference is made to the implementation of the Federal Genetic Information Non-discrimination Act (GINA) of 2008 in the USA and the Mental Health Care Act of 2002 in SA.

MANAGEMENT OF DELIRIUM - RECENT ADVANCES**Shaquir Salduker**

Private practice

Delirium has long been regarded as a reversible disorder of cognition. It is more common than anxiety disorders and mood disorders. Referral to psychiatrists is often too late, and most surgeons, physicians and

anaesthetists are more interested in getting patients out of their ICU than concerned with the outcome.

Recent studies into delirium suggest that we can: predict high-risk patients, prevent delirium, choose better medication combinations, and improve overall outcomes.

Approximately 40% of delirious patients are never the same again cognitively. Most of the drugs we currently use make the outcomes worse in the long term. Some of the non-drug measures used also worsen outcomes.

This talk aims to revisit the topic and suggest some new strategies and approaches together with new data to back them up.

SOCIAL NEUROSCIENCE: BRAIN RESEARCH ON SOCIAL ISSUES

Manfred Spitzer

University of Ulm, Transfer Center for Neuroscience and Learning (ZNL), Germany

During the past few years, a large number of experiments have been performed on social phenomena, such as trust, empathy, fairness, punishment and social norm compliance. The results have not only largely increased our knowledge and understanding of social behaviour, but can also provide us with new ideas of how to construct social environments that work. Finally, finding out about the 'human condition' also helps to reframe hotly debated philosophical problems and can add new data to old discussions.

EXPERIMENTS ON THE UNCONSCIOUS

Manfred Spitzer

University of Ulm, Transfer Center for Neuroscience and Learning (ZNL), Germany

Three hundred years ago, the philosopher-mathematician Gottfried Wilhelm Leibniz formed the idea of tiny, non-conscious mental processes that have large-scale behavioural effects when summed up. This idea of unconscious mental processing was taken up by Francis Galton, who was read by Freud, who in turn popularised the idea on a global scale. Owing to anti-academic currents within the psychoanalytic movement, there was almost no experimental research on the unconscious up to the 1980s. This has changed. Priming effects, implicit associations and non-conscious evaluation, as well as motor-cognitive interactions, have been intensely studied. The emerging new view of the unconscious is discussed through examples, including the psychology of money, free will, moral judgement, creativity and prejudice.

THE PSYCHOLOGY AND NEUROSCIENCE OF MUSIC

Manfred Spitzer

University of Ulm, Transfer Center for Neuroscience and Learning (ZNL), Germany

For about a decade, neuroscience and experimental psychological work on music has provided us with insights into the nature and function of music. Almost every aspect of music – rhythm, melody, harmony, emotionality and sociality – has psychological and neuroscientific underpinnings that tell us more about the mechanisms of performance and perception. Examples from auditory scene analysis, experiments on young infants, studies on musically trained subjects, and the physics and physiology of sound are presented and discussed within a common neuroscience framework.

MENTAL DISORDERS IN DSM-V

Dan Stein

Department of Psychiatry and Mental Health, University of Cape Town and Groote Schuur Hospital

This paper describes ongoing work on DSM-V from the perspective of a participant in one of the Workgroups (the Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Workgroup). Some conceptual debates in nosology are reviewed, and ongoing progress towards DSM-V is described, in order to provide the relevant general background. Examples from work on the anxiety disorders in general, and the obsessive-compulsive spectrums in particular, are detailed, in order to provide some more specific foci of attention. There are opportunities for the field to participate in the development of DSM-V, and it is important that we do so in order to optimise the process going forwards.

PERSONALITY, TRAUMA EXPOSURE, PTSD AND DEPRESSION IN A COHORT OF SA METRO POLICEMEN: A LONGITUDINAL STUDY

Ugashvaree Subramaney

University of the Witwatersrand, Johannesburg

INTRODUCTION: Certain populations are at increased risk of trauma exposure by virtue of their occupation. These include emergency workers, firemen and policemen. There is a paucity of research into the impact of trauma in SA Metro policemen, specifically with regard to personality style and responses to traumatic events.

METHODS: 145 new recruits at the Johannesburg and Tshwane Metro police academy volunteered for this study, and were followed up for 1 year at 3-monthly intervals. At baseline, they filled in a biographical questionnaire, the Millon Clinical Multiphasic Inventory (MCMI III), and the Hamilton Rating Scale for depression (HAM-D). At visit 2, the Clinician Administered Scale for Posttraumatic Stress Disorder (CAPS) and the revised version of the Impact of Events scale (IES-R) were administered together with the HAM-D, and these were repeated at V3, V4 and V5. Data were analysed using the SAS version 9.1 statistical program. The ANOVA test for repeated measurements of continuous variables was performed to analyse differences within visits (1 to 5 or 2 to 5). For 2 by 2 comparisons between visits the Bonferroni correction was applied. To determine associations between personality variables and CAPS, IES-R and HAM-D scores, the Wilcoxon-Mann-Whitney was used.

RESULTS: 120 subjects completed all 5 visits. High base rates were present for scales of anxiety, paranoia, major depression, delusional disorder and thought disorder on the MCMI III. Narcissistic clinical pattern was significantly associated with the IES-R score at visit 3 ($p=0.0221$), and thought disorder was the severe syndrome personality variable found to be significantly associated with the HAM-D score at visit 1 ($p=0.0005$). 99% of subjects had experienced at least one traumatic event in their lifetime; 61.1% had experienced 2 or more events. The commonest non-duty-related traumatic event was experiencing the unexpected death of a loved one (47.1%), followed by experiencing a motor vehicle accident (MVA) (25.9%). The commonest duty-related traumatic event was MVAs, followed by dealing with cases of domestic violence and assault. Mean scores of HAM-D, CAPS and IES-R were generally low across all 5 visits, with females having a significantly lower HAM-D score at baseline compared with men ($p=0.0226$). Thought disorder was the only personality variable found to be statistically significant in terms of its association with the HAM-D score at visit 1 ($p=0.0005$). The following were found to have a statistically significant association with current CAPS scores: aggression ($p=0.0341$ at visit 5), and antisocial ($p=0.0248$ at

visit 5). The variable narcissistic was found to be borderline significant with the current CAPS score at visit 2 ($p=0.0572$), and the variable schizoid was found to be borderline significant with the CAPS score at visit 5 ($p=0.0513$). For lifetime PTSD, the personality variable schizoid was significantly associated with CAPS scores at visit 5 ($p=0.0405$). At visit 2, the p -value was borderline significant ($p=0.0533$). The IES scores were significantly lower across the 5 visits, with significant differences at visit 2 versus visits 3, 4, and 5; and visit 3 versus visits 4 and 5. Stepwise regression analysis showed that traumatic events, shooting incidents, robbery, armed robbery, guarding dead bodies, mortuary exposure and murder were more likely to cause a change in HAM-D scores ($R^2=0.50$, $p=0.005$).

CONCLUSION: This prospective study of SA Metro policemen showed that before exposure to duty-related traumas almost all subjects had been exposed to at least one traumatic event in their lifetimes, with the majority having experienced 2 or more events. MVAs were commonly experienced as both non-duty and duty related trauma, but scores for depression and traumatic stress were generally low across time, with some traumas causing greater changes in scores for depression. Some personality variables were found to be more significantly associated with scores for HAM-D, CAPS and IES-R at different times.

EATING DISORDERS: AN AFRICAN PERSPECTIVE

Christopher Szabo

Professor and Chair; Head: Division of Psychiatry, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg

The documented existence of eating disorders in Africa extends back to the 1970s. The literature is dominated by South African content and has predominantly been descriptive in nature. The conceptualisation of eating disorders as 'culture bound' has evolved as a consequence of this and other developing world literature. This has implications for awareness, teaching and service orientation.

AN EVALUATION OF THE WHO AFRICAN REGIONAL STRATEGY FOR MENTAL HEALTH 2001 - 2010

Thandi van Heyningen, M Majavu, C Lund

Department of Psychiatry and Mental Health, University of Cape Town

INTRODUCTION: In 2001, the World Health Organization (WHO) African Regional Office (AFRO) developed a 10-year Regional Strategy for Mental Health. The aim of this study was to assess the impact of this strategy in the 46 AFRO member states, and the extent to which governments have achieved the objectives set out in the strategy document.

METHODS: The study was undertaken in two parts:

1. A qualitative component entailed country visits to five African countries which were chosen to represent geographical, language, political and socio-economic diversity on the continent, namely Congo DRC, Cote d'Ivoire, Ethiopia, Mozambique and Tanzania. Semi-structured interviews were conducted with purposefully selected, key stakeholders in mental health in each country. The interviews were recorded, translated where necessary and transcribed. A coding frame was developed and thematic analysis of the data was conducted using AtlasTi qualitative data analysis software.
2. A quantitative component entailed the development of a survey instrument with the WHO, which was later disseminated electronically as part of the WHO Atlas 2010 to all 46 African member states. The WHO Atlas instrument is a tool specifically designed by the WHO for

collecting country and regional level data on mental health indicators. It is conducted every 5 years in a global survey. Data were analysed using descriptive statistical methods.

RESULTS: Preliminary results from the Atlas survey show that although about 77% of countries mention mental health in the general health policy and 71% have a mental health programme, only around 53% have dedicated mental health legislation and policy. Incorporation of mental health care into primary care is a clearly stated goal for 68% of countries; however, lack of adequate resources means that a substantial gap exists between policy and service delivery. Shortage of human resources and funding remain the most urgent problem for mental health systems in Africa, with the overwhelming majority of countries spending less than 1% of their health budgets on mental health. Thus mental health remains a low priority on the government agenda, perpetuated by pervasive stigmatisation and marginalisation of mental illness.

CONCLUSION: The objectives of the WHO AFRO Regional Strategy for Mental Health (2001 - 2010) have not been achieved in most African countries. Mental health care systems in Africa are incapacitated by lack of resources which is perpetuated through the low prioritisation of mental health on the government agenda. Without effective policy and legislation, it is unlikely that these systems of care will develop adequately to address the burgeoning needs of populations in the region.

A UNITARY MODEL FOR THE MOTOR ORIGIN OF BIPOLAR MOOD DISORDERS AND SCHIZOPHRENIA

Jacques J M van Hoof

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The core problem in brain research of schizophrenia and bipolar disorders is the lack of an adequate physiological model. An attempt was made to bridge the gap between biological and psychological phenomena.¹ In this model, it is assumed that the relevant problems are the manifestation of an imbalance between two mechanisms in the brain: the first is motor power or drive and the second is steering or guidance. Both mechanisms are used to control movements. The core of this model's thesis is that during the normal phylo- and ontogenesis of the human brain both of these mechanisms are implemented in a repetitive way from the 'how to do' motor domain into the 'what to do' intentional (limbic) domain through cortical-subcortical circuits. The first, striatal mechanism (parallel information processing), is necessary to initiate and calibrate movements and intentions, such as intimidation or affiliation. This intentional drive mechanism is organised primarily by a circuit located in the ventral part of the brain. The second, cerebellar (serial information processing) mechanism is necessary for guidance. The intentional variant of the representational guidance mechanism is organised primarily in a circuit located in the dorsal part of the brain. The repetitive application of both mechanisms during brain development allow the creation of unique human capacities, viz. the ability to create (meta) representations, language and consciousness, but also an increased capacity to deal with conflicting demands and emotions. This development is the neuronal correlate for the process called mentalisation. Evidence is accumulating that the principally genetically based reliance on one or both types of mechanisms has a bimodal distribution. A genetically based insufficient development of one of both mechanisms and an exaggerated reliance on the other mechanism cause an imbalance. The repetitive implementation of these mechanisms will increase this imbalance and create a situation where comparatively small stressors produce a tipping of the scale manifesting itself as schizophrenia or a bipolar disorder. This model has a greater explanatory power than current alternatives and therefore it will provide a useful framework for further research.

1. Van Hoof JJM. A motor hypothesis of the origin of schizophrenia. *Schizophr Res* 2003;62:183-185.

THE ORIGIN OF MENTALISATION AND THE TREATMENT OF PERSONALITY DISORDERS

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In investigating the effects of psychotherapy in personality disorders there is a great problem: the lack of an adequate physiological model. An attempt was made to bridge this gap between biological and psychological phenomena.^{1,2} In this model, it is assumed that the relevant psychological problems are the manifestation of an imbalance between two mechanisms in the brain: the first is *motor power* or *drive* and the second is *steering* or *guidance*. Both mechanisms are used to control movements. The core of this model's thesis is that during the normal phylo- and ontogenesis of the human brain both of these mechanisms are implemented in a repetitive way from the 'how to do' motor domain into the 'what to do' intentional (limbic) domain through cortical-subcortical circuits. The first, striatal mechanism (parallel information processing) is necessary to initiate and calibrate movements and intentions, such as intimidation or affiliation. This intentional drive mechanism is organised primarily by a circuit located in the ventral part of the brain. The second, cerebellar (serial information processing) mechanism is necessary for guidance. The intentional variant of the representational guidance mechanism is organized primarily in a circuit located in the dorsal part of the brain. The repetitive application of both mechanisms during brain development allow the creation of unique human capacities; viz. the ability to create (meta) representations, language and consciousness, but also an increased capacity to deal with conflicting demands and emotions. This development is the neuronal correlate for the process called mentalisation. Evidence is accumulating that in personality disorders these developments are disturbed.

In most cases special forms of psychotherapy can be helpful to overcome this disturbance of the inner balance.

1. Van Hoof JJM. 2003. Een nieuw psycho-analytisch model. In: *Handboek voor Psychologische Interventies bij Chronisch Lichamelijk Lijden* (in press).
2. Van Hoof JJM. A motor hypothesis of the origin of schizophrenia. *Schizophr Res* 2003;62:183-185.

HOW TO ACCOUNT PRACTICALLY FOR 'THE CAUSE' IN PSYCHIATRIC DIAGNOSTIC CLASSIFICATION

C W (Werdie) van Staden

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This paper argues that ICD and DSM psychiatric diagnostic classifications can do better in accounting for both cause and description. The need for causes being taken up in classifications is not at issue. Rather, the challenge is to allow for the complexities of causes in mental disorder without shipwrecking the classifications owing to a lack of knowledge about these complexities. In dealing with this challenge hitherto, description has been pursued *instead of* causes. To do better, classifications should pursue both causes and description as far as feasible and fully distinguished from another.

Given the paucity of knowledge about the causes of mental disorder, DSM and ICD classifications in effect have been guided by Aubrey Lewis, who said in 1961 '...we should eschew categories based on theoretical concepts and restrict ourselves to operationalized, descriptive type of classification', and in discussion with Erwin Stengel took his suggestion

from Carl Hempel's insights. Thereby, categories were meant to be defined by description of symptoms and signs and not by cause, at least until complexities about causes of mental disorder could be sorted.

This approach, in which description is pursued instead of cause, left the classifications inadequate regarding causes. Causes have not been eradicated completely, however. Some have remained even at high categorical level, but in limited range and kind. These are whether a disorder is due to an organic (general medical) condition, due to substances and, for some disorders, due to trauma or stressful life events. It should not be that limited, if a psychiatric diagnostic classification aspires to account for causes properly. It should allow for the complexities in range and kinds of causes as well as for the complexity of causation in mental disorders – a complexity that recognises the differences between necessary, sufficient, contributory and multiple causes.

I suggest that a way to do better practically is to keep description and cause properly separate, yet connected, and do justice to both. I venture to provide some examples that show how this may look, which promises to be both person-centred and in tandem with the usual practical sequence followed in the encounter between patient and health care provider.

Poster Presentations

PROBLEM DRINKING AND PHYSICAL AND SEXUAL ABUSE AT WSU FACULTY OF HEALTH SCIENCES, MTHATHA, 2009

Orlando Alonso Betancourt, Maricela Morales Herrera, E N Kwizera, J L Bernal Muñoz

Walter Sisulu University, Mthatha, E Cape

BACKGROUND: There is evidence that people with a history of sexual abuse may have an increased risk of developing alcohol and drug problems. Some studies have shown that women who experienced any type of sexual abuse in childhood were roughly three times more likely than un-abused girls to report drug dependence as adults.

OBJECTIVE: To determine the association between alcohol use (problem drinking) and physical and/or sexual abuse among students at Walter Sisulu University, Mthatha.

MATERIAL AND METHODS: The Alcohol Use Disorders Identification Test (AUDIT) (cut-off point ≥ 8), embedded in a broader self-administered questionnaire that included demographic questions and two questions about physical and sexual abuse, was used as a screening tool to assess the prevalence of problem drinking among 1st- to 5th-year students attending classes on a given day at the Faculty of Medicine at Walter Sisulu University, Mthatha ($N=366$). According to the results the group was classified as problem drinking or not.

Confidentiality of study participants was ensured through anonymous questionnaires. Only students giving written informed consent were included.

Statistical procedures: Associations between variables were analysed by chi-square tests and the SPSS statistical package was used to process the data.

RESULTS: According to the AUDIT, 12.8% of the study group were classified as problem drinking individuals. Of 144 male students 25.7% were classified as problem drinking students, while in the female subgroup (222) only 4.5% were classified as such. Of 37 male students who fulfilled the criteria for problem drinking, 5 (33.3%) reported being physically abused, while 1 (12.7%) was a victim of sexual abuse. In the

female group none of the students with a classification of problem drinking reported physical or sexual abuse.

CONCLUSIONS: Sexual or physical abuse as possible risk factors leading to drinking problems were found only in male subjects. None of the female victims of sexual or physical abuse presented drinking problems.

The study was approved by the WSU Ethics and Research Committee (Ref. No. 0007/09).

PREVALENCE OF ALCOHOL DRINKING PROBLEMS AND OTHER SUBSTANCES AT WSU FACULTY OF HEALTH SCIENCES, MTHATHA, 2009

Orlando Alonso Betancourt, Maricela Morales Herrera, E N Kwizera, J L Bernal Muñoz

Walter Sisulu University, Mthatha, E Cape

BACKGROUND: The use of alcohol and other drugs among university students is a matter of concern for mental health care providers and university authorities. It is also a known cause of absenteeism and student dropouts as well as traffic accidents and other serious complications. The use of alcohol and other drugs in campuses countrywide is one of the selected topics for future research of the South African Community Epidemiology Network on Drug Use (SACENDU).

OBJECTIVES: The primary objective was to determine the prevalence of alcohol use (problem drinking) among medical students at Walter Sisulu University, Mthatha, and the secondary objective was to determine the prevalence of use of other drugs in the same population.

MATERIAL AND METHODS: The Alcohol Use Disorders Identification Test (AUDIT) (cut off point ≥ 8), embedded in a broader self-administered questionnaire, was used as a screening tool to assess the study objectives among 1st to 5th-year students attending classes on a given day at the Faculty of Medicine at Walter Sisulu University, Mthatha ($N=366$). The AUDIT is not a diagnostic tool and only gives general criteria of problem drinking (symptoms of hazardous or harmful drinking or dependence). The AUDIT establishes 4 risk zones according to the AUDIT score and relates them to specific interventions.

Confidentiality of all participants in the study was ensured through anonymous questionnaires. Only students giving written informed consent were included.

Statistical procedures: Associations between variables were analysed by chi-square tests and the SPSS statistical package was used.

RESULTS: According to the AUDIT, 12.8% of the study group (25.7% of the male students and 4.5% of the females) were classified as problem drinkers. Students in their final year showed the highest incidence of problem drinking (16.2%). 12% of the 343 students living on campus and 26.1% of the 23 students living off campus fulfilled the criteria of problem drinking. Of the 47 students classified as problem drinking, 61% reported cannabis use, 6.4% Mandrax use and 4.3% cocaine use. 67.8% of the students volunteered to participate in prevention programmes. 4.9% of the male students were on risk zones III and IV.

CONCLUSIONS: The results strongly suggest that alcohol is the most commonly misused substance in the population studied. The highest prevalences of problem drinking were found among males, final-year students and those not living on campus. Most of the students would like to participate in a substance prevention programme.

The study was approved by the WSU Ethics and Research Committee (Ref. No. 0007/09).

LESSONS LEARNT FROM A MODIFIED ASSERTIVE COMMUNITY-BASED TREATMENT PROGRAMME IN A DEVELOPING COUNTRY

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INTRODUCTION: A number of recently published randomised controlled trials conducted in developed countries have reported no advantage for assertive interventions over standard care models. One possible explanation could be that so-called standard care has become more comprehensive in recent years, incorporating some of the salient aspects of assertive models in its *modus operandi*. Our study represents the first randomised controlled trial assessing the efficacy of a modified assertive treatment service on readmission rates and other measures of outcome in a developing country.

METHODS: High-frequency service users were randomised into an intervention ($N=34$) and a control ($N=26$) group. The control group received standard community care and the active group an assertive intervention based on a modified version of the international model of assertive community treatment. Study visits were conducted at baseline and 12 months with demographic and illness information collected at V1 and readmission rates documented at study end. Symptomatology and functioning were measured at both visits using the PANSS, CDSS, ESRS, WHO-QOL and SOFAS.

RESULTS: At 12-month follow-up subjects receiving the assertive intervention had significantly lower total PANSS ($p=0.02$) as well as positive ($p<0.01$) and general psychopathology ($p=0.01$) subscales scores. The mean SOFAS score was also significantly higher ($p=0.02$) and the mean number of psychiatric admissions significantly lower ($p<0.01$) in the intervention group.

CONCLUSION: Our results indicate that assertive interventions in a developing setting where standard community mental services are often under-resourced can produce significant outcomes. Furthermore, these interventions need not be as expensive and comprehensive as international, First-World models in order to reduce inpatient days and also improve psychopathology and overall levels of functioning in patients with severe mental illness.

PERCEPTIONS OF PSYCHOLOGISTS REGARDING THE USE OF RELIGION AND SPIRITUALITY IN THERAPY

Otilia Brown, Diane Elkoin

Nelson Mandela Metropolitan University

Religion and spirituality are acknowledged coping resources, yet for many years the use of religion and spirituality was not practised in therapy. Psychologists were once branded the least religious of all academicians; however, there is now evidence of integration of psychology with religion and spirituality. Recently, studies have been conducted to prove the success of using religion and spirituality to cope with psychological disorders, prevent unhealthy behaviours and promote resilience. Despite this, very little research to date has explored South African psychologists' perceptions on this matter.

This study aimed to explore the perceptions of psychologists in the Nelson Mandela Metropolitan Municipality area about the use of religion and spirituality in therapy. The biosychosocial-spiritual model was used as the theoretical framework for this research. Purposive sampling was employed to obtain the sample and focus groups were used to collect the data. The data were analysed using Tesch's model of qualitative content analysis.

Many themes emerged from the content analysis process. The participants indicated that they perceive the definitions of religion and spirituality as difficult to define and reach consensus on. Nevertheless, the participants recognised that religion and spirituality are important aspects of their clients' lives and that they cannot be ignored in therapy. Particular emphasis was placed on the fact that religion and spirituality are coping mechanisms for both clients and psychologists. Most of the participants indicated that they were willing to discuss religion and spirituality with their clients if they brought it up. The participants highlighted specific factors such as having similar religious and spiritual beliefs to the client, which made it possible for them to engage with clients on religious and spiritual levels. The participants also identified barriers that made it difficult for them to engage with clients regarding these issues. These barriers included limits to competence, clashing values and morals, clashing beliefs, among others.

This study highlighted that the issues of religion and spirituality are neglected in the training of health care professionals. This study was also the first of its kind in South Africa highlighting the need for future research on this topic.

RESILIENCE IN FAMILIES WHERE A MEMBER IS LIVING WITH SCHIZOPHRENIA

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There has been limited research to date on schizophrenia and family relations in South Africa. This study aimed to explore and describe resiliency factors that facilitate adjustment and adaptation in families after a member is diagnosed with schizophrenia. The Resiliency Model of Family Stress, Adjustment and Adaptation was used to analyse the factors that enabled the families to adjust and adapt to the onset of a chronic mental illness such as schizophrenia.

Non-probability purposive sampling was used to find participants who met the inclusion criteria of the study. These included the participant having a family member living with schizophrenia residing with him/her, and being dependent (including financially) on the participant. These families were accessed via nursing sisters at primary health care sites, as well as through the Mental Health Society of Port Elizabeth.

The study was triangular in nature, with an exploratory, descriptive approach. Twenty families were surveyed using a biographical questionnaire and seven pencil-and-paper questionnaires. These questionnaires were The Family Attachment and Changeability Index 8 (FACI8), Family Crisis-Oriented Personal Evaluation Scales (F-COPES), Family Hardiness Index (FHI), Family Problem-Solving Communication (FPSC), Family Time and Routine Index (FTRI), Relative and Friend Support (RFS) and the Social Support Index (SSI).

Data from the biographical questionnaire were analysed using descriptive statistics, and content analysis was used to analyse the themes generated by participants. The quantitative data were analysed using correlation analysis. Six quantitative measures (and selected subscales) correlated with the FACI8, indicating the factors they were measuring as resources in family adjustment and adaptation. These measures also correlated in their findings with a number of the qualitative responses given by participants.

These correlations are religion and spirituality; social support; relative support; positive communication; and a commitment to work together as a family unit to solve problems. The added value of the qualitative question is that a number of additional themes to those tapped into by the quantitative measures also emerged.

The small sample size of the study resulted in there being limitations to the conclusions that could be drawn. However, the findings of this study could be used for future research on resilience in families with chronic mental illness, as well as for family resilience research in South Africa.

FUSION AND GRANDIOSITY – THE MASTERSONIAN APPROACH TO THE NARCISSISTIC DISORDER OF THE SELF

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INTRODUCTION: It is the aim of the paper to critically explore the metapsychological theory and technical approach of James F Masterson to narcissistic disorders of the self. According to the Mastersonian approach, being supported emotionally by a responsive other is central to the development of healthy internal psychological structures. An emotionally attuned other allows the infant to evolve according to its own natural developmental rhythm and takes pride in the child's growing ability to master the self and environmental demands. When maternal attunement and mirroring falls short of the latter, various difficulties can arise in a child's separation-individuation phase of development, especially so for the narcissistic patient in the *practising* sub-phase of separation-individuation, characterised by fusion and one-mindedness. Theoretically, it seems possible that the narcissistic patient did not enter or complete the rapprochement crisis and that the omnipotent unity still exists intrapsychically. Given the developmental difficulties the narcissist faced, the resulting fixation created an intrapsychic split characterised by two fused units. The intrapsychic structure of the grandiose (manifest) narcissist consists of a grandiose self-representation and an omnipotent object representation 'which have fused into one unit which is more or less continuously activated' (Masterson, 1981, p. 29). The latter activation is to defend and protect against the 'underlying aggressive or empty object relations fused unit' (Masterson, 1981, p. 29), and thus depression. The split internal world of the narcissist thus consists of a defensive/libidinal grandiose self-omnipotent object relations fused unit, that is, a grandiose object representation that contains power and perfection, fused with a grandiose self representation of being perfect, superior, entitled, with its linking affect of feeling unique, adored and admired. The opposite unit contains the aggressive object relations fused unit that consist of a fused object representation that is harsh, punitive, and attacking and a self representation of being humiliated, attacked, empty, linked by the affect of the abandonment depression that is experienced as the *self-fragmenting or falling apart*.

METHODS: A single case study method will illustrate the Masterson approach to a patient who struggled with a narcissistic disorder of the self. The in-depth approach focused on tracking the two units evident in the narcissistic disorder of the self as well as the use of pain-self-defense interpretations.

RESULTS: Through the active tracking and mirroring of various narcissistic defenses the patient was able to access and contain various vulnerable

self-representations/experiences and gain a deeper appreciation of both proximal and antecedent relationships.

CONCLUSION: It is believed that the developmental, self and object relations approach to the narcissistic disorder of the self supports the clinician in focusing on the narcissistic triad characterised by 'imperfection-painful vulnerability-grandiosity'.

NOT BEING ALLOWED TO EXIST – THE MASTERSONIAN APPROACH TO THE SCHIZOID DISORDER OF THE SELF

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INTRODUCTION: Ontological security and the emerging 'embryonic self' can be viewed as the primary substance of psychological existence. Reading various analytic scholars on schizoid disorders, the clinician is reminded of the central importance of being 'allowed to exist' in both the ministrations and mind of another. Failure of the latter may permanently relegate the Real Self to entombment, enslavement and finally, exile. It is the aim of the current paper to explore the clinical work of the Mastersonian Ralph Klein and James Masterson in understanding the ontological dilemma of the schizoid. According to Dr Ralph Klein the schizoid dilemma reflects a very unique paradigm of relatedness and development characterised by (a) not being allowed a private self, and where (b) appropriation, a form of depersonification through manipulation and coercion, was central to the maternal-child matrix. Focusing on the work of Fairbairn and Guntrip, Ralph Klein skillfully described the internal world of the schizoid consisting of two units – each with its own self-representation, object representation and linking affect. The units can be described as master/slave (attachment) and the sadistic object/self-in-exile (non-attachment) units. In the master/slave unit the object representation is one of a maternal part-object which is manipulative, and coercive. The part self representation is one of a dependent slave who provides a function for the object and is a victim. The central affect linking the part representations is of being jailed but connected, and a relief in not being totally alienated. In the sadistic object/self-in-exile unit the object representations is of a maternal part-object which is sadistic, dangerous, devaluing, depriving, and even abandoning in relation to a part-self representation of being alienated, in exile, although self-contained and self-reliant. The central affect is abandonment depression which is characterised by depression, despair, rage, loneliness, and fear of cosmic aloneness.

METHODS: A single case study method will illustrate the Masterson approach to the treatment of the schizoid disorder of the self. The case study method will focus on selective patient material to illustrate the schizoid developmental pathway, their adult dilemmas and their inner lives through dream material.

RESULTS: Through the active tracking and therapeutic interpretation of the schizoid dilemma, structure and triad (connection leads to danger leads to needing and creating a safe distance), the schizoid's impaired real self may become more evident and open to therapeutic transformation.

CONCLUSION: It is believed that the developmental, self and object relations approach to the schizoid disorder of the self supports the psychotherapist to appreciate the core anxieties evident in schizoid

pathology. Focusing and relating to the internal split units allows continual therapeutic contact and reworking of 'unsafe' feelings.

RISKY DRUG-INJECTING BEHAVIOURS IN CAPE TOWN AND THE NEED FOR A NEEDLE EXCHANGE PROGRAMME

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OBJECTIVES: The aim of this study was to investigate the nature and extent of injecting drug use, with specific focus on risky injecting behaviour and the need for a needle exchange programme in Cape Town. This study was performed as part of an MSc in Drugs and Alcohol, Policy and Intervention through the University of London.

METHOD: Semi-structured interviews with 11 key informants were conducted. Key informants included pharmacists, psychologists, emergency medical personnel and one doctor working in the addictions field in the private sector across Cape Town. Surveillance data collected by the South African Community Epidemiological Network on Drug Use (SACENDU) and recent South African literature were used to triangulate the findings.

RESULTS: Collation of the study findings, SACENDU surveillance data and recent literature provided information on the demographics, drug use, injecting paraphernalia, medical and mental health concerns, social harms, overdoses, stigma, service utilisation and policy recommendations for intravenous drug users in Cape Town.

CONCLUSIONS: A number of authors have called for harm reduction strategies and needle exchange programmes to be implemented in South Africa. Our study seems to support such a view. Recommendations regarding harm reduction strategies and a needle exchange programme in Cape Town are made. Obstacles to relevant policy formulation and implementation are highlighted.

NEUROLEPTIC MALIGNANT SYNDROME IN ADOLESCENTS IN THE WESTERN CAPE: A CASE SERIES

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INTRODUCTION: Neuroleptic malignant syndrome (NMS) is a rare but serious complication of neuroleptic use. The incidence in adults is less than 0.2%. The incidence in children and adolescents is unknown. The Lentegeur Adolescent Psychosis and Rehabilitation Unit managed the rehabilitation of 9 adolescents with a possible diagnosis of NMS between February and November 2009, an incidence of approximately 6%. A retrospective case review was performed on 4 of these cases to assist in identifying possible risk factors for the Western Cape adolescent population.

METHODS: Information from the medical records of 4 adolescents who received a possible diagnosis of NMS were reviewed.

RESULTS: Findings reveal that risk factors for the development of NMS in adolescents in the Western Cape include male gender, polypharmacy, agitation, the use of zuclopenthixol acetate and a history of Tik methamphetamine and cannabis use. A large variation exists in CPK levels and latency periods. The cases do not emphasise an overwhelming association with affective disorders and intellectual disability.

CONCLUSION: Symptoms of NMS are similar in adolescents and adults. Particular caution needs to be paid to the use of intramuscular antipsychotics, especially zuclopenthixol acetate, in neuroleptically naive and agitated psychotic adolescents where the use of benzodiazepines may be more appropriate. Further consideration needs to be given to the

role of Tik methamphetamine use as a risk factor for the development of NMS in adolescents.

EXPERIENCE AND VIEW OF LOCAL ACADEMIC PSYCHIATRISTS ON THE ROLE OF SPIRITUALITY IN SOUTH AFRICAN SPECIALIST PSYCHIATRY, COMPARED WITH A QUALITATIVE ANALYSIS OF THE MEDICAL LITERATURE

Bernard Janse van Rensburg

INTRODUCTION: The importance of having to consider the role of spirituality in health, mental health and psychiatry in South Africa has in particular been emphasised by recent legislation on African traditional health practice. In what seems to be a currently changing environment for health and mental health care delivery, it was considered important for local psychiatrists themselves to establish from within the discipline, as to what they would judge the role of spirituality to be in specialist psychiatric practice and teaching.

METHOD: This study was designed as an explorative, descriptive, contextual, phenomenological and theory-generating qualitative investigation. In the first part of the study, in-depth, semi-structured interviews with individual academic specialist psychiatrists affiliated to a local South African university were conducted as the primary data source. Interviews were audio-taped and transcribed, and field notes were compiled. Key quotations from the interviews were included in the interpreting narrative, to provide the evidence that these provisional concepts were derived from, and grounded in the interview content. The review of the international literature was used as a secondary, triangulating data source. Open data coding was used for the analysis of the thematic content of both the interviews and the sampled literature. Key references from the reviewed literature were included in the interpreting narrative on the integrated data, to provide the necessary chain of evidence that the final identified concepts were grounded in the integrated data. Measures considered to ensure the trustworthiness of the study included credibility, transferability, dependability and confirmability, as described by Guba (1981) and Lincoln and Guba (1985).

RESULTS: Data saturation was achieved after 13 interviews. According to participants, awareness of spirituality, 'mindfulness', or an open-minded approach towards spirituality should be facilitated in specialist psychiatric practice and training. Six final concepts were identified from the integrated literature and interview content: 'orientation in terms of spirituality and religion in psychiatry'; 'reality of spirituality and religion for practitioners and users'; 'routine assessment of spirituality and religion in psychiatry'; 'training of spirituality in psychiatry'; 'scope and boundaries of professional specialist psychiatric practice'; and 'referral and collaboration on spirituality in psychiatry'.

CONCLUSION: All participants, disregarding of their own personal views on spirituality and religion, agreed that under certain conditions spirituality must be incorporated into the current bio-psycho-social approach to the local practice and training of specialist psychiatry. The literature revealed a strong consensus with the interviews conducted with local psychiatrists. This central theme was therefore regarded as the core concept from the combined, integrated data content, which was subsequently used to develop and operationalise a practice-orientated model for psychiatry as a specialist clinical discipline.

THE ROLE OF DEFINED SPIRITUALITY IN LOCAL SPECIALIST PSYCHIATRIC PRACTICE AND TRAINING: A MODEL AND OPERATIONAL GUIDELINES FOR SOUTH AFRICAN CLINICAL CARE SCENARIOS

Bernard Janse van Rensburg

INTRODUCTION: An explorative, descriptive, contextual, phenomenological and theory-generating qualitative investigation was undertaken to explore an observed phenomenon that spirituality is playing an increasing role in what were previously regarded as secular sectors, for example in health, mental health and psychiatry. The study has described and analysed the views and experience of specialist psychiatrists on the academic circuit of a local department of psychiatry on the role of spirituality and specialist psychiatric practice and training. These views and experiences were then interpreted in terms of the international medical literature on the role of spirituality and psychiatry. Based on a core concept identified from the content of the integrated interview and literature data, a descriptive, practice-orientated model was constructed with operational guidelines for practical settings in which the model may be implemented.

METHOD: Four methodological steps were followed to construct this model: step 1 – concept analysis, including step 1A (identification of concepts from the interviews and literature) and step 1B (definition and classification of concepts); step 2 – relationship statements (identifying linkages between concepts and establishing the theoretical structure); step 3 – description and evaluation of the model (using analogy and graphic presentation); and step 4 – operational guidelines (for implementation of the model in different teaching and practice scenarios). These steps referred in particular to the methodology for nursing theory development according to Chinn and Kramer (1995) and James, Dickoff and Wiedenbach (1968). In the final step, operational guidelines were established for implementing the model in different practical settings, with regard to the definition of spirituality; the setting of objectives; and the outcome-directed activities for these objectives.

RESULTS: The core concept for the model is 'incorporating the role of defined spirituality into the existing bio-psycho-social approach to local practice and teaching of specialist psychiatry – within specific professional and ethical boundaries – while accommodating all cultural-religious traditions and belief systems in the heterogenous South African society equally'. The proposed model that was based on this concept provides for three steps of incorporation: awareness of the role of spirituality; acknowledgement of this role; and integration of this role amongst psychiatrists and their patients, students and colleagues.

CONCLUSION: The constructed model for South African clinical care scenarios must also be considered in the context of other models on related aspects that were discussed in the reviewed literature. These would include: Engel's 'Bio-psycho-social model' (Engel, 1977, Engel, 1980); Cloninger's model for personality (Cloninger, 2006, Cloninger & Svrakic, 2000); Lapiere's model for describing spirituality (Lapiere, 1994); Sulmasy's 'Bio-psycho-social-spiritual' model (Sulmasy, 2002); Koenig's model for 'Religion and physical health' (Koenig, 2001); and Anandarajah's two models – 'H3' and 'BMSEST' (Anandarajah, 2008).

HANDEDNESS IN SCHIZOPHRENIA AND SCHIZO-AFFECTIVE DISORDER IN AN AFRIKANER FOUNDER POPULATION

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INTRODUCTION: The first potential gene influencing human handedness, namely the Leucine-rich repeat transmembrane neuronal 1 gene (LRRTM1), was recently identified in a group of reading-disabled siblings. The same gene showed to be over transmitted paternally to patients with schizophrenia/schizo-affective disorder. An association between the LRRTM1 gene, schizophrenia/schizo-affective disorder and handedness was therefore established, although the handedness of the

patients suffering from schizophrenia and schizo-affective disorder was not clinically tested.

The aim of this study was to test the hypothesis that patients with schizophrenia and schizo-affective disorder are more non-right-handed than their non-affected first-degree relatives and a healthy control group. The association between handedness, gender and age of onset of illness in the same group of patients was also determined.

METHOD: A quantitative case-control study was done, comparing the handedness of a group of 100 (30 females and 70 males) patients with schizophrenia/schizo-affective disorder from a Afrikaner founder population, their non-affected first-degree relatives (1 relative per patient), and a group of healthy controls (100 Afrikaans-speaking medical students from University of Pretoria). Some of these patients were part of the LRRTM1 study. The age of onset of illness was extrapolated from DIGS Summary reports of the genetic study. Handedness was scientifically determined by the Edinburgh Handedness Inventory (EHI), a scale used to assess the dominance of a person's right or left hand in everyday activities.

RESULTS: Patients were found to be more right-handed than expected, with only 17 out of 100 being non-right-handed compared with 11 out of 100 non affected relatives and 36 out of 100 of the healthy control group. There was therefore no significant difference in handedness between the patients and their relatives ($p=0.308$). Unexpectedly, the student group was statistically more non-right handed than the other two groups ($p=0.001$). There was a statistically significant association at the 5% level of significance when considering right versus non-right-handedness and gender among the patients ($p=0.039$), where more females were non-right handed. There was no statistically significant difference between age of onset of illness and handedness.

CONCLUSION: Even though the majority of studies investigating the handedness of patients with schizophrenia showed a leftward shift in the handedness distribution compared with controls, non-right-handedness was not clinically established in this study. Interestingly an association between non-right-handedness and female gender in the patient group was established. Possible explanations for non-right-handedness will be given for the student control group. Whether or not LRRTM1 on chromosome 2p12 is indeed the genetic basis of handedness remains unclear.

A ROLE FOR STRUCTURAL EQUATION MODELLING IN SUBTYPING SCHIZOPHRENIA IN AN AFRICAN POPULATION

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INTRODUCTION: Subtyping is one of the strategies employed to limit clinical heterogeneity and thereby assist in the search for some genetic underpinning in schizophrenia. An ongoing multi-centre genetic study in an African population, the Xhosa, has previously reported on an exploratory factor analysis of SAPS and SANS items that supported a five-factor model similar to that found in Caucasian samples. This finding of similar core factors supported the notion of the universality of schizophrenia. However, additional findings such as a low prevalence of co-morbid obsessive compulsive disorder and a low rate of chromosomal abnormalities (including chromosome 22q11 micro-deletions) suggest population-specific illness factors. Concordance analysis of the SANS and SAPS items was therefore performed in a Xhosa sib pair sample, and this revealed higher than expected concordance for eye contact

($p=0.027$), auditory hallucinations ($p=0.010$), global hallucinations ($p=0.017$) and delusions of control ($p=0.001$). As these items may offer a mechanism to subtype schizophrenia in this population, the aim of this follow-up study was to investigate the role of structural equation modeling in subtyping schizophrenia in the Xhosa population.

METHODS: Subjects were recruited from in- and outpatient hospital services and community centres throughout the Western Cape, South Africa, as part of a large multi-site genetic study. Participants were of Xhosa ethnicity, meeting DSM-IV-TR criteria for schizophrenia. The lifetime presence and SANS/SAPS scores of the items identified in the concordance analysis formed the basis for the construction of path analysis models. Cannabis use and abuse were included in the models as this sample (with the exclusion of one individual) reported no other illegal drugs of abuse and thus offer the opportunity to investigate the role of cannabis in the pathogenesis of schizophrenia.

RESULTS: At the time of this analysis 737 subjects had been included in the analysis (211 in the affected sib pair group (SG) and 526 in the non-sib pair group (NG)). The majority (SG 80.1%; NG 82.7%) were male with a mean age at interview and age at onset of (SG 37.9 years/35.1 years; NG 23.21 years/23.36 years). Eye contact abnormalities were noted in 43.6% (SG) and 47% (NG), auditory hallucinations in 97.2% (SG) and 97.5% (NG), and delusions of control in 30.8% (SG) and 18% (NG). Path analysis models using these manifest variables as well as additional variables including cannabis use and abuse, showed a good fit with significant direct effects between eye contact and group status and significant indirect effects between cannabis use/abuse and group status as well as cannabis use/abuse and delusions of control.

CONCLUSIONS: This proposed model, with the significant direct and indirect effects in which cannabis use or abuse plays a significant role, has implications for understanding of the role of each of the concordant items in the pathophysiology of schizophrenia in an African population.

CAREGIVERS OF DISABLED ELDERLY PERSONS IN NIGERIA

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INTRODUCTION: In less resourced countries, informal source of care provision may be the only one available to elderly persons with such need.

METHOD: The interview was part of a larger survey on the mental and physical health status conducted in the Yoruba-speaking states of Nigeria. These states account for about 22% of the Nigerian population (approximately 25 million people). A face-to-face interview was conducted among 210 caregivers of disabled elderly persons. Evaluations of their socio-demographic and psychological factors were made. Burden of caring was assessed with the Sheehan Disability Scale and the General Health Questionnaire.

RESULTS: Results show a preponderance of females among the respondents. Persons younger than 20 years of age constituted about a quarter, and those older than 70 years about 5%. More than half of the caregivers were married. A quarter had no formal education. Caring for elderly disabled persons was a burden for a substantial proportion of the caregivers. Between 28% and 42% were impaired in the performance of household, work, relationship and social roles. Disability in the performance of work was more likely among caregivers caring for elderly persons with probable dementia (odds ratio (OR) 3.5; 95% confidence interval (CI) 1.3 - 9.4) and those who lacked contact with other family members (OR 2.9; 95% CI 1.2 - 7.2) as well as those who reported

lacking emotional support (OR 2.5; 95% CI 1.0 - 6.4). Caring for a depressed elderly person as well as not been in contact with other family members were associated with psychological distress.

CONCLUSION: Certain factors inherent in both the elderly and their carers are associated with the burden and psychological distress experienced by the caregivers. Lack of social support from family members in particular was the most consistent predictor of burden in the carers.

HIV SEROPOSITIVITY IN RECENTLY ADMITTED AND LONG-TERM PSYCHIATRY INPATIENTS: PREVALENCE AND DIAGNOSTIC PROFILE

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OBJECTIVES: Research on HIV in South Africa has not reflected the impact of the epidemic on psychiatric patients. The aims of this study were to determine and compare the HIV prevalence among different patient groups in Weskoppies Hospital, to determine and compare the psychiatric diagnoses of the infected and non-infected, to assess self-reported intravenous drug use and high-risk sexual behaviour, to establish the co-morbidity between syphilis and HIV, and to investigate the performance of the rapid test as screening method, compared with the confirmatory ELISA test.

METHOD: One hundred and ninety-five patients were selected using a multi-stage sampling strategy, and categorised according to duration of admission and gender. The study was designed to have an equal gender ratio. HIV rapid testing, ELISA, syphilis RPR and TPHA testing were performed.

RESULTS: The HIV prevalence in the sample was 12% and was significantly associated with gender and duration of admission ($p=0.03$), with long-term female patients having the highest HIV prevalence (20%) and long-term male patients the lowest (2%). Recently admitted patients had a prevalence of 14% with equal gender distribution. There was no significant association between HIV infection and psychiatric diagnoses or self-reported intravenous drug use, but a significant association between HIV infection and self-perceived high-risk sexual behaviour was found ($p=0.002$). Significant co-morbidity occurred between HIV and syphilis, with 7 of the 24 HIV infected patients also having reactive TPHA tests ($p=0.012$). Compared with the confirmatory ELISA test, the HIV rapid screening test had a sensitivity of 91.7% and a specificity of 98.2%.

CONCLUSION: The overall HIV prevalence in psychiatric inpatients at Weskoppies Hospital remains low compared with the national average, but has increased substantially during the past decade. Long-term female patients have the highest risk of being HIV infected and long-term male patients the lowest. The significant co-morbidity between HIV and syphilis should be taken into account when testing for HIV. The current practice of screening for HIV with the rapid test, and confirming positive results with ELISA testing, is satisfactory overall, but in selected cases of strong clinical suspicion an ELISA test may be indicated despite a negative rapid test.

SYPHILIS SEROPOSITIVITY IN RECENTLY ADMITTED AND LONGTERM PSYCHIATRY INPATIENTS: PREVALENCE AND DIAGNOSTIC PROFILE

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OBJECTIVES: South African syphilis research has neglected psychiatric patients. Furthermore, traditional screening has been reported to be inadequate. The aims of this study were to determine and compare the

prevalence of syphilis among different patient groups at Weskoppies Hospital, to determine and compare the psychiatric diagnoses of the infected and non-infected, to assess self-reported high-risk sexual behaviour, to establish the co-morbidity between syphilis and HIV, and to investigate the performance of the non-treponemal RPR test as screening method, compared with the confirmatory TPHA test.

METHOD: One hundred and ninety-five patients were selected using a multi-stage sampling strategy and categorised according to gender and duration of admission. The study was designed to have an equal gender ratio. Non-treponemal RPR, TPHA, HIV rapid testing and ELISA were performed. A reactive TPHA test indicative of exposure to syphilis, although not necessarily of active disease, was used to diagnose syphilis.

RESULTS: The prevalence of syphilis was 12% (23 of 195) as indicated by TPHA seropositivity, and was equally distributed among the subgroups. Since none of the 23 patients could give a history of treatment for syphilis, they were all presumed to be in the latent phase of syphilis infection. Mood disorders tended to be more prevalent in patients with syphilis, but no statistically significant association was found between syphilis and psychiatric diagnosis. Significant co-morbidity was found between syphilis and HIV, with 7 of the 23 syphilis patients also being HIV infected ($p=0.012$). Compared with the TPHA test the non-treponemal RPR test performed poorly, identifying only 2 of the 23 patients who had a TPHA seropositive test (sensitivity 8.7%, specificity 100%).

CONCLUSIONS: The overall prevalence of syphilis in psychiatric inpatients at Weskoppies Hospital as determined by TPHA testing was higher than anticipated. The significant co-morbidity between syphilis and HIV should be taken into account when testing for either one. The current practice of screening for syphilis with a single RPR test is inadequate in the psychiatric population, and it is recommended that the RPR test be combined with a specific treponemal test such as TPHA.

'THE GREAT SUPPRESSION'

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INTRODUCTION: It was seen that the reasons for admission of patients to Crescent Clinic were all associated with feeling suppressed by life stresses as the demands of modern life has increased basic stress levels. Crescent Clinic embodies a vision of being a Centre of Psychotherapeutic Excellence. In line with this vision, a diverse programme is conducted that caters for the unique diagnosis, intellectual and emotional capabilities of its diverse patients. These differing interventions were formulated based on a qualitative research method that investigated the needs of patients.

METHOD: Employing a phenomenological method of enquiry, each patient was briefly interviewed on admission, resulting in the emergence of data revealing both individual and general needs of treatment. The common themes that emerged were utilised to place patients in appropriate groupings, and devise different programmes suitable for each group thereby ensuring maximum benefit in terms of participation and internalisation of treatment. An anonymous feedback form was then devised to assess the efficacy of the constructed programme in catering for the treatment demands of the patients.

RESULTS: Findings from the research called for the differential placement of patients into three separate groups each receiving a uniquely devised intervention customised for their particular intellectual, emotional, and social functioning, for a 3-week period.

The Red Group caters for patients suppressed by illness and requiring individual intervention from an occupational therapy approach, with the focus on stabilising the patient's mood and cognitive functioning.

The Green Group caters for patients suppressed by work and financial stresses and thus requiring practical life management techniques and occupational therapy focus, essentially for patients unable to attend a full-day intervention programme.

The Blue Group caters for patients suppressed by personal stresses, thus requiring assistance in managing higher-order issues such as emotional expressiveness, interpersonal effectiveness and enhanced self-esteem.

Findings from the anonymous feedback forms demonstrate the efficacy of the different programmes in meeting the treatment needs of the patients in all three groups, with patients demonstrating shifts in feelings, thoughts and behaviour upon discharge. The need for an outpatient facility and programme is further highlighted to meet the self-actualisation demands of the patients touched by the programmes.

CONCLUSION: In order to provide a Centre for Psychotherapeutic Excellence, treatment programmes must be devised to meet the unique needs of patients seeking treatment. Qualitative research allows for the discovery of common needs, and programmes customised to meet these articulated needs ensure recovery.

NOT BEING ALLOWED TO GROW UP – THE MASTERSONIAN APPROACH TO THE BORDERLINE PERSONALITY

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INTRODUCTION: The term 'borderline' has received considerable attention from within all psychotherapeutic modalities. Initially approached as a 'midway diagnosis' between the neurosis and the psychosis, various theorists such as Meissner, Rinsley, Kernberg, Fonagy and Masterson have greatly added to our understanding of the borderline patient.

It will be the aim of the current paper to present the developmental, self and object relations approach of James Masterson and the Masterson Institute. Emphasis will be on the intrapsychic development of the disorder and how the clinician can access and successfully treat the internal life of borderline patients. The Masterson method pays special attention to the various *developmental expressions* of a failed *separation-individuation* process characterised by the internalisation of a withdrawing-rewarding mother. The latter is argued to create an internal world characterised by both a *split ego* and *split object relations units*. The split object relations units are seen as specific internal structures compromising of two split units, each with its own self and object representations and linking affect. According to Masterson the units can be described as the *withdrawing object relations part unit* (WORU), and the *rewarding object relations part unit* (RORU). In the WORU the object representation is one of a maternal part object which is experienced as critical, hostile, and angry and withdraws support in the reality of the child asserting his or her independence. The part self representation of the WORU is characterised by inadequacy, helplessness, guilt, and emptiness and the linking affect is frustration, chronic anger and resentment that masks the underlying abandonment depression. The RORU is characterised by a maternal part object that is loving, approving and supportive of regressive and clinging tendencies. The part self representation is of being a good, compliant

and passive child and the linking affect is of feeling good and being gratified.

METHODS: A single case study method will illustrate the Masterson approach through 5 phases of therapy that was completed over a 2-year period. The in-depth approach allows the tracking of defences and the borderline triad, that is, self-activation leads to anxiety/depression that leads to defence. Emphasis will also be on the art of confrontation as a way of strengthening the reality ego.

RESULTS: Through the active tracking and confrontation of various borderline defences the patient was able to contain various self-destructive behaviours and as such start working on the impaired real self and various abandonment experiences.

CONCLUSION: It is believed that the developmental, self and object relations approach to the borderline disorder of the self allows the clinician to track the various intrapsychic units effectively to strengthen the ego and commence work on the deep and painful experiences referred to as abandonment depression.

EXPLORING THE INTERNAL CONFIGURATION OF THE CYCLOID PERSONALITY: A RORSCHACH COMPREHENSIVE SYSTEM STUDY

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INTRODUCTION/OBJECTIVES: Exploring the experience of self (self representation), of others (object representation) and its implication on affect regulation is of importance in the understanding of the internal world of the cycloid. Mapping the cycloid temperament has been attempted throughout the ages, starting with the notations of Aretaeus of Cappadocia (c. AD 150) and culminating in the brilliant observations of the psychiatrist Emil Kraepelin (1856 - 1926). Contemporary psychiatric approaches have estimated that cycloid pathology, most evident as bipolar disorder (BD), accounts for more than 1% of the population and is thought to be the sixth leading cause of all illnesses. Despite the latter it remains a desperately understudied area, especially *psychologically*. Theoretically, BD is known for: (i) its complex epidemiology; (ii) its costly treatment; (iii) frequent occupational impairment; (iv) negative interpersonal effects; (v) negative domestic effects; (vi) forensic consequences; (vii) deaths due to suicide and accidents; and finally (viii) diminished quality of life. It is with this in mind that the current study focused on assessing the modulating of affect (adequately, pleasurably in moderation), viewing oneself (maintaining adequate self-esteem, promoting positive self regard, enhancing self awareness, forming a stable sense of identity) and finally, relating to others (sustaining interpersonal interest, involvement and comfort, anticipating interpersonal intimacy and security, and balancing interpersonal collaboration with acquiescence with competitiveness and assertiveness, remaining interpersonally empathic).

METHOD: Fifty mostly inpatient bipolar patients at two provincial hospitals were selected through opportunity sampling and evaluated through the Comprehensive Rorschach System (CS). The CS has a rich tradition in studying bipolar phenomena. The various variables chosen were analysed using descriptive statistics (R version 2.9.1, 2009, The R Foundation for Statistical Computing), and emphasis was given to the mean and standard deviation of the variables. Special attention was also

given to meaningful differences between the standard deviation and the mean of the variables themselves.

RESULTS: It was found that for the majority of the sample a *neglected self* seems evident characterised by difficulties in modulating affect in moderation, difficulties in paying sufficient attention to the self, negative judgements about the self in relation to others, limited experience and promotion of self acceptance, self respect and self confidence, chronic low self esteem (which probably dates back to childhood and may show very little situational fluctuation), and finally, a general attitude towards others coloured by feelings of threat (although it does not exclude interest in or involvement with others).

CONCLUSION: Self regulation, possible perceptual differences in sensory-affective reactivity and processing, the formation and maintenance of relationships as basis for the capacity for object relatedness and intimacy, as well as difficulties in representational elaboration and differentiation need further exploration.

A SURVEY TO DETERMINE THE LEVEL OF HIV RELATED KNOWLEDGE AMONG ADULT PSYCHIATRIC PATIENTS ADMITTED TO WESKOPPIES HOSPITAL

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INTRODUCTION: Studies have reported an increased prevalence of HIV infection among psychiatric patients. Among several factors responsible for the increased risk of HIV infection in the mentally ill is inaccurate HIV knowledge, but few studies have specifically looked at this factor. The aim of the present study was to determine the knowledge of HIV and its transmission among adult psychiatric patients admitted to Weskoppies Hospital and to determine the relationship between HIV knowledge and HIV risk behaviour.

METHOD: A cross-sectional quantitative descriptive survey was conducted at Weskoppies Hospital. Structured interviews were conducted with 113 consenting adult patients, who were divided into three groups according to their length of hospital stay. A focused interview was administered to each subject by the research clinicians. The first part of the interview consisted of demographic data and the patient's diagnosis. The second part was the AIDS Risk Behaviour Knowledge Test (AIDS-KT), which consisted of 13 knowledge questions and 14 risk-behaviour questions. Subjects who scored 13 out of 13 on the AIDS-KT were considered to have accurate knowledge of HIV and its transmission, those who scored between 10 and 12 to have good knowledge, and those who scored 9 and below to have poor knowledge.

RESULTS: Of the 113 subjects, 42 (37%) were new patients, 37 (33%) acute patients and 34 (30) chronic patients. The mean age was 38 years, and 74% had a level of education of more than high school and 27% less than high school. The diagnostic groups were as follows: psychotic disorders 76, mood disorders 29, substance-related disorders 15, cognitive disorders 7, and personality disorders 13. A total of 39 subjects (35%) scored 13 out of 13 in the knowledge questions and a total of 65 (58%) scored between 10 and 12. The mean score for knowledge was 12 throughout the three groups. A total of 104 (92%) subjects had good knowledge of HIV and its transmission. There is no significant linear association between knowledge and risk behaviour scores (Spearman's correlation coefficient $r=0.09$ ($p=0.310$)).

CONCLUSIONS: The findings indicate that mentally ill patients have good knowledge of HIV, and that lack of knowledge is not a major factor that puts them at an increased risk for contracting HIV.

A SURVEY OF RISK BEHAVIOUR FOR CONTRACTING HIV AMONG ADULT PSYCHIATRIC PATIENTS ADMITTED TO WESKOPPIES HOSPITAL

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BACKGROUND: Various studies have reported an increased prevalence of HIV infection among psychiatric patients. Several factors seem to be responsible for the increased risk. It has been reported that mental illness may impair appreciation of the consequences of one's behaviour, which leads to these patients engaging in HIV-related risk behaviour. Although psychiatric patients are considered a high-risk group for HIV infection, they have been undervalued in terms of their behaviour in comparison with other high-risk groups. We attempted to establish the prevalence of HIV risk behaviour and to determine the association between risk behaviour and demographic and clinical variables.

METHODS: Participants were 113 consenting adult patients admitted to Weskoppies Hospital, categorised into three groups according to duration of hospitalisation (new, acute and long-term admissions). A structured interview was conducted with each participant by the researchers. The structured interview recorded the presence or absence of each HIV risk behaviour. Total risk behaviour score was then calculated. From the risk score, three risk behaviour categories were identified as follows: 0 = no risk; 1, 2, 3 = medium risk; 4, 5, 6, 7, 8, 9 = high risk. Associations between HIV risk behaviour and six demographic and clinical variables were analysed: gender, level of education, sexual orientation, history of treatment for sexually transmitted diseases, duration of hospitalisation and psychiatric diagnosis.

RESULTS: Of the 113 participants, 68% were males and 32% females. The mean age was 38 years. Regarding prevalence of HIV risk behaviour, 48% of participants fell into the no-risk group, 29% into the medium-risk group and 23% into the high-risk group. There were more females in the medium-risk and fewer in the no-risk and high-risk group categories. There was no statistical association between duration of hospitalisation and the three risk categories. Females, those with history of treatment for sexually transmitted disease and those with a diagnosis of personality disorder showed significant association with being sexually abused. The other problem seems to be multiple sexual partners, which was associated with diagnoses of substance-related disorders and cognitive disorders. There was moderate to significant association between having sex with someone known for less than 24 hours and long-term hospitalisation and diagnoses of cognitive and personality disorders.

CONCLUSION: The study highlighted what has been reported in the literature – that mentally ill patients are a vulnerable group and easily victimised by individuals who may expose them to HIV infection. The study also shows that mental illness may impair appreciation of consequences of one's behaviour, leading to engaging in high-risk behaviour for contracting HIV. In view of the findings from this study, special care should be taken to protect psychiatric patients, especially females and those in psychiatric institutions.

A RETROSPECTIVE REVIEW OF STATE SECTOR OUTPATIENTS (TARA HOSPITAL) PRESCRIBED OLANZAPINE: ADHERENCE TO METABOLIC AND CARDIOVASCULAR SCREENING AND MONITORING GUIDELINES

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INTRODUCTION: Reports of treatment-emergent adverse events in patients receiving second-generation antipsychotics have increased in

recent times. This has led to growing concern about the link between metabolic complications and their use, with consequent reconsideration of the implications of prescribing. The study aimed to establish the extent to which metabolic and cardiovascular screening and monitoring has been undertaken on patients who have been prescribed olanzapine, in a specialist psychiatric South African setting. The study objectives were to describe the demographic profile, clinical diagnosis and risk factors for metabolic complications in a sample of patients receiving olanzapine, and further to establish the extent to which metabolic and cardiovascular screening and monitoring had been undertaken on patients prescribed olanzapine and to what extent patient demographics, diagnosis and metabolic risk factors influenced the treating doctor's adherence to screening guidelines.

METHOD: This retrospective descriptive study was undertaken at Tara Hospital (outpatient department). A convenience sample of patients prescribed olanzapine was selected as the study group. Descriptive statistics were used to describe the sample. Frequencies for the presence or absence of evidence of screening or monitoring for metabolic complications were established, as per American Diabetes Association monitoring protocol requirements. Screenings were studied in relation to the diagnosis, gender and patient group (inpatient or outpatient initiated) using Fisher's exact test, to ascertain whether any of these descriptive variables influenced the treating doctor's adherence to screening guidelines.

RESULTS: The sample comprised of 19 females and 20 males (48.72% female and 51.28% male). The mean age of the females was 52.38 years (SD=16.20) and the mean age of the males 41.28 years (SD=17.05). The sample were predominantly single (61.54%, N=24) with the majority being white (79.49%, N=31); most had either tertiary (43%, N=17) or secondary (53.85%, N=21) levels of education. Only 2.56% (N=1) had only primary-level education. With regard to the diagnoses of patients in the sample, 17.95% (N=7) were diagnosed with bipolar 1 disorder, 7.69% (N=3) with major depressive disorder with psychosis, 20.51% (N=8) with schizo-affective disorder and 53.84% (N=21) with schizophrenia. The percentage of screening for all the parameters was generally less than 20% and it continued to decline to less than 20% until 4 months. The exception was weight, where the frequency increased slightly over time. Comparing inpatient with outpatient-initiated treatment, there were apparent differences in the extent of screening, i.e. greater for inpatient-initiated treatment, specifically with respect to weight and blood pressure.

CONCLUSION: While one can only speculate on the basis for non-adherence, having established the status quo, there is a requirement for an appropriate strategy to address the deficit, given the implications of inadequate monitoring.

REPORTED RAPES AT A HOSPITAL RAPE CENTRE: DEMOGRAPHIC AND CLINICAL PROFILES

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BACKGROUND: South Africa has one of the highest incidences of rape and the most violent types of rape in the world. The consequences of rape potentially include medical and psychological difficulties. Rape survivors have specific health needs, ideally met by providing integrated and holistic post-rape services. This study aimed to provide an overview of the demographic, clinical, and rape characteristics of children and adult rape survivors presenting to a rape centre in the Western Cape province.

METHODS: We conducted a retrospective review of patient records for all rape survivors who presented to the Karl Bremer Hospital Rape Centre from 1 August 2007 to 31 July 2008. Data from patient records included age of rape survivors, day of the week that the rape was reported, alcohol and drug use of the rape survivor, number of perpetrators involved, whether the perpetrator was known/unknown to the rape survivor, injuries sustained during the rape, HIV status of the rape survivor, and the type of rape committed.

RESULTS: A total of 1 132 confirmed rape cases were identified. There was clinical evidence of alcohol use in 20.7% of rape survivors, and of drug use in 3.0%. In 10% of cases, there were 2 or more perpetrators. In 67.8% of cases, the perpetrator was known to the survivor. In 18.5% of all cases, physical injuries were documented. 10.9% of female survivors tested HIV positive. Among females, vaginal rape was reported in 93.7% of cases and anal rape in 2% of cases.

CONCLUSION: Our study provides useful comparisons between male and female rape survivors. Overall, our findings underscore the importance of providing survivors of sexual assault with comprehensive, gender-sensitive health services that are supportive of both the physical and psychological consequences of the ordeal.

EXIT EXAMINATION IN FINAL-YEAR MEDICAL STUDENTS: MEASUREMENT VALIDITY OF ORAL EXAMINATIONS IN PSYCHIATRY

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INTRODUCTION: There are several methods of evaluating medical students' performance in examinations, such as written, oral and objective structured clinical examination. Many studies have focused on the reliability and validity of these methods, but very few studies have been done on comparison between these methods. The aim of our study was to compare students' final overall and discipline-specific examination marks with the examination marks in psychiatry.

METHODS: We included 343 final-year medical students presenting for the psychiatry rotation at Stellenbosch University during 2008 and 2009. We collected marks obtained by the students in all the disciplines and compared their class mark with their final examination mark across all disciplines. Psychiatry is the only discipline where the final examination consists of an oral examination only. In other disciplines the oral examinations only form a part of the final examination. Bland-Altman analysis was used to assess the level of agreement between the class mark and the exam mark. Cases below the lower threshold were compared with all other cases across all disciplines, and the odds ratio for group status was calculated for gender distribution of examiners.

RESULTS: On average, students had lower examination marks compared with their class marks. However, the psychiatry class mark and oral mark provided similar measures. There were no significant differences between psychiatry examination outcomes and outcomes in other disciplines. Cases below the threshold had poorer performance in other disciplines as well. The gender distribution of the oral examiners (female-female) significantly increased the odds ratio for poorer performance.

CONCLUSION: Our results showed that a group of students underperform in their final examination independent of method of evaluation. Future research should focus on identifying and modifying factors that contribute to poor performance of medical students in their final examination, in order to help students perform better.

TRENDS OF SUICIDE IN THE TRANSKEI REGION OF SOUTH AFRICA

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BACKGROUND: Poverty leads to many social ills including suicide. Hanging is the method of choice for a poor person in committing suicide. Transkei is one of the poor regions of the Eastern Cape in South Africa.

OBJECTIVE: To study the trend of suicides in the Transkei region and to follow the link between suicide and poverty.

METHOD: This was a retrospective study carried out at Mthatha (Umtata) Hospital Complex mortuary from 1996 to 2006. More than 1 000 medico-legal autopsies are conducted annually, catering to a population of 400 000.

RESULTS: 10 138 medico-legal autopsies were conducted between 1996 and 2006. Of these 552 (5.4%) were hangings (average of hangings 13.3/100 000 population). The number has increased from 6.7/100 000 population in 1996 to 21.7 in 2006. Males outnumbered females 5.9:1. The highest proportion (33.9%) of deaths were of people between 21 and 30 years. Based on this trend, it can be estimated that in the year 2020 the suicide rate will have doubled. There is circumstantial evidence that growing financial difficulties along with HIV/AIDS have contributed to these deaths.

CONCLUSION: There is an increasing incidence of suicide in the Transkei region of South Africa. Poverty appears to contribute to these deaths.

FUNCTIONAL NEURO-IMAGING IN SURVIVORS OF TORTURE

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INTRODUCTION: Throughout the world, deliberate and intentional physical and psychological harm is inflicted upon individuals. As a result of this torture, survivors have long-term physical, psychiatric and psychological sequelae. Torture represents a traumatic experience in which horror, helplessness and hopelessness are extreme. It can therefore be expected that trauma-related disorders, e.g. post-traumatic stress disorder (PTSD) and major depressive disorder (MDD), are present at higher rates in torture victims than in other psycho-traumatised individuals.

Few studies have looked at the actual functional neuro-imaging of survivors of torture. Only one study showed that severe psychological trauma induced by torture can cause neurobiological alterations (Mirzaei S et al., 2001). The aim of this study was to determine whether survivors of torture exhibit any psychopathology, whether they have a high prevalence of abnormal findings on brain-SPECT imaging, and whether correlations exist between PTSD, MDD, brain-SPECT findings and initial self-reporting questionnaire (SRQ8) scores.

METHODS: The South African Council for Torture Survivors (SACTS) is situated in Johannesburg, South Africa. Consecutive volunteers between 18 and 65, both male and female, visiting SACTS for the first time, were recruited in a non-randomised manner. Fifteen clients with psychopathology who had been exposed to torture and 21 controls without psychopathology who had been exposed to torture were invited to participate. Clients were excluded if they were pregnant, medically unstable, psychotic, suicidal, or had a drug/alcohol disorder or a prior psychiatric history.

Clinical characteristics of the participants, the SRQ8 score and information pertaining to the actual torture were obtained from the SACTS case records. Each participant was assessed during a clinical interview by a psychiatrist. The Impact of Event Scale Revised and the Montgomery Asberg Depression Rating Scale were administered. Each participant underwent Brain-SPECT imaging. The brain-SPECT imaging was analysed by a consultant in the Department of Nuclear Medicine. The remaining data were analysed with the assistance of a statistician.

RESULTS: The primary psychiatric diagnoses seen in participants were PTSD, MDD or both. The participants with psychopathology had a high prevalence of abnormal findings on brain-SPECT imaging than participants without psychopathology. Preliminary results suggest that the temporal lobes and thalami are mostly involved. Higher SRQ8 scores are also associated with diagnoses of PTSD or MDD and subsequent abnormal imaging.

CONCLUSION: Abnormal imaging findings correlate with the presence of psychiatric diagnoses in survivors of torture. The abnormal imaging is not dependent upon the type and severity of torture sustained. The results of this study reinforce the urgent need to diagnose and treat psychopathology in survivors of torture early. It is hoped that this research will increase the awareness of the torture still being perpetuated in sub-Saharan Africa and also assist organisations assisting torture survivors to access funding.

NEWLY DIAGNOSED HIV+ IN SOUTH AFRICA: DO MEN AND WOMEN ENROLL IN CARE?

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INTRODUCTION: Despite the roll-out of ART in southern Africa, life-threatening delays in initiating ART are a growing concern. Late ART initiation is major factor in mortality shortly after ART initiation. The success of recently proposed test and treat protocols will depend in part on the ability to promptly engage newly diagnosed individuals in care. Little is known about what helps individuals become linked to care. Most studies of treatment delay have been conducted among those already receiving care. Information is needed about the proportion of newly diagnosed individuals who become enrolled in care, factors that influence enrollment, and individuals' immediate psychosocial concerns.

METHODS: We interviewed 214 women and men before they underwent HIV testing at two types of venues in Durban, South Africa: 55 women and 18 men at a primary health care clinic (PHC), and 141 women presenting for screening to a prevention (microbicide) trial (MT). Those who tested HIV positive and who had not previously been diagnosed (by self-report), were telephoned at 3 months to determine whether they had obtained HIV primary care. MT women were included because we anticipated they would be more likely to be asymptomatic and unsuspecting of an HIV diagnosis. Their experiences would offer insights into challenges likely to emerge as widespread testing identifies more people early in disease.

RESULTS: Of the 214 tested, 73 were HIV positive (29% MT women, 46% PHC women, 44% PHC men); 69 reported being newly diagnosed (95%).

Newly diagnosed: 30% had clinical symptoms associated with AIDS (20% of the MT women; >40% of the PHC women and men). Stigma-related factors were most often cited as barriers to returning for care.

3-month FU: Of the newly diagnosed, 61 (87%) were successfully re-contacted 3 months later. Of these, 61% had sought HIV-related medical care. Those who had disclosed were more likely to have obtained care. MT women were less likely to have obtained care than the PHC clients, but were not less likely to disclose.

CONCLUSION: Individuals who fail to obtain care following diagnosis (39% in this sample) may represent a significant proportion of those initiating ART late or not at all. There is a need for strong referral and follow-up procedures at this early stage. Disclosure may be an important behaviour on the pathway to engaging in care. Routine testing without such procedures may fail to increase the number receiving timely ART.

DIAGNOSTIC UTILITY OF THE INTERNATIONAL HIV DEMENTIA SCALE FOR ASYMPTOMATIC HIV-ASSOCIATED NEUROCOGNITIVE IMPAIRMENT AND HIV-ASSOCIATED NEUROCOGNITIVE DISORDER IN SOUTH AFRICA

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Preliminary reports from sub-Saharan Africa suggest that over two-thirds of HIV-positive persons suffer from HIV-associated neurocognitive symptoms or deficits. The diagnosis of these conditions is challenging but must be addressed. Seventy participants were randomly recruited from an HIV voluntary testing and counselling clinic in Durban, South Africa. The diagnostic utility of the International HIV Dementia Scale was analysed using a Receiver Operating Characteristic model. The results show that this scale is a useful and valid diagnostic screening test for HIV-associated neurocognitive conditions in a clinical setting in South Africa. The sensitivity is highest for the most severe condition, HIV-associated dementia.

THE PSYCHOLOGICAL SEQUELAE OF FIRST TRIMESTER TERMINATION OF PREGNANCY (TOP): THE IMPACT OF RESILIENCE

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INTRODUCTION: The Choice of Termination of Pregnancy Act (1996) replaced the Abortion and Sterilisation Act of 1975 giving freedom of choice to women seeking abortion in the first trimester, and under certain conditions to women who are further advanced in their pregnancies. Despite liberalisation of the law, termination of pregnancy remains a contentious issue, and the decision to have a TOP, regardless of the reason, is not an easy one to make. Research into whether TOP is associated with any negative sequelae is conflicting, and there is a dearth of South African research into this area.

METHODS: This was a descriptive analytical study of a longitudinal nature in which 102 women, 51 each from two distinct socio-economic regions in Johannesburg, were compared using a mixed methodology approach. They were assessed in terms of their responses to the termination over 3 visits, before the TOP, 1 month later and 3 months after the event. Measures employed were the BDI, IESR, the CD RISC, the Chronic Burden Scale, and the Crisis Support Questionnaire. Statistical analysis was done using STATA version 9. The two groups were compared on primary outcome measures (IESR for PTSD, BDI for depression), in addition to clinical and other demographic variables using chi-square tests (for dichotomised variables) and Student's t-tests (for continuous measures). For all analyses, statistical significance was set at $p < 0.05$ and all tests were two-tailed. Bivariate analyses were done to ascertain whether any of

the demographics, chronic burden, crisis support and CD-RISC had any effect on depression and PTSD at T2 and T3. A qualitative analysis was employed to elicit the women's subjective experience of the procedure.

RESULTS: Outcome measures of depression and PTSD over time show that for the BDI, for site 1, there was no significant difference between mean scores at visit 1 (T1) versus visit 2 (T2). There were significant differences in scores for T2 versus T3 ($p < 0.0001$), as well as for T1 versus T3 ($p < 0.0001$). For site 2, within subjects, there were no significant differences between mean scores for T1 versus T2. There was a significant difference between mean scores for the BDI at T1 versus T3 ($p < 0.0001$). Between sites, there were no differences at T1 but significant differences between T2 and T3. For the IES-R, there was a significant difference in mean scores for T2 versus T3 ($p < 0.0001$), for site 1 as well as for site 2 ($p < 0.0001$).

CONCLUSIONS: The experience of a TOP is contentious, and difficult to study, across the SES spectrum. Qualitative analysis provided a richer understanding of the emotional impact of first trimester TOP. Risk factors for the development of traumatic stress and depressive symptoms cannot be concluded. Crisis support does not lend protection against these symptoms 1 - 3 months after the procedure, regardless of SES.

DRUGS AND OTHER THERAPIES UNDER INVESTIGATION FOR PTSD: AN INTERNATIONAL DATABASE

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BACKGROUND: ClinicalTrials.gov was established by the US National Institutes of Health (NIH) in order to provide up-to-date information on clinical trials for a wide range of diseases and conditions. This registry lists both interventional and observational trials.

METHODS: We searched the registry to identify all interventional trials related to PTSD and conducted a hand search to obtain the relevant information.

RESULTS: A total of 442 studies were listed. Of these, 22.8% were acute stress disorder (ASD) or posttraumatic stress disorder (PTSD) prevention trials, so these, in addition to the observational studies and those that were not PTSD related, were excluded. We were therefore left with a total of 358 trials. The majority of these (96.1%) were conducted in high-income countries with the USA being dominant. More than half the trials (56.1%) used behavioural mechanisms as the form of treatment, 34.4% used medication only, and 6.7% used a combination of the two. A small number (2.8%) used other mechanisms such as transcranial magnetic stimulation. Of medication trials 35.0% used a novel treatment, with only 15.8% of the medications having FDA approval for the treatment of PTSD. 87.4% were controlled trials (active control 50.6%; placebo control 36.9%), and 88.8% were for primary treatment. 19.9% of trials addressed co-morbid physical or mental disorders. Estimated sample sizes ranged from 3 to 6 500 participants and trial duration ranged from a single treatment session up to 1 year, with follow-up ranging from zero to 4 years. 91.0% of trials were in adults and the remainder in children or adolescents. 84.8% of trials were for acute PTSD.

CONCLUSION: Although this review is limited by missing information, it gives an overview of the types of treatments and populations being investigated. In particular, it highlights that trials in low- and middle-income countries as well as in children and adolescents are lacking.

FREQUENCY AND CORRELATES OF HIV TESTING IN PATIENTS WITH SEVERE MENTAL ILLNESS

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BACKGROUND: The rate of HIV seroprevalence testing in patients with severe mental illness (SMI) has been reported to be low in South Africa. Whereas ethical considerations are likely reasons, factors associated with both SMI as well as poor adherence to antiretrovirals (ARVs) such as homelessness, poor social support and substance abuse could impact on the decision to test. In turn these factors may have implications for care packages for those who test positive.

OBJECTIVES: We aimed to determine the frequency and clinical correlates of HIV testing and the prevalence of factors associated with HIV risk behaviour and poor ARV adherence in a group of patients with SMI.

METHOD: We conducted a cross-sectional survey using a structured questionnaire over a 2-week period on all adult patients admitted to the acute service at Valkenberg psychiatric hospital.

RESULTS: The total sample included 167 patients. The period prevalence for HIV testing was 20.9% (95% confidence interval (CI) 15 - 27.9%). Homelessness occurred in 9.7% (95% CI 5.6 - 15.2%) and poor social support in 10% of all admissions (95% CI 5.8 - 15.7%). The 12-month prevalence of DSM-IV substance abuse or dependence in the total sample was 51.1% (95% CI 43.3 - 58.9%). The most common drugs of abuse were cannabis followed by methamphetamine. There was a significant upward trend in the proportion of patients tested for HIV over length of inpatient stay ($p < 0.01$). Female patients were significantly more likely to receive HIV tests (female 31.7% v. male 10.6%, prevalence ratio (PR) 2.99, $p < 0.001$) and less likely to abuse substances. Polydrug and methamphetamine users were less likely to receive HIV tests. This finding was no longer significant when adjusting for the effect of gender. We found no association between housing status, social support and HIV testing.

CONCLUSION: The frequency of HIV seroprevalence testing reported in this sample is low. Reasons for this are unclear. Increased duration of stay was associated with higher rates of testing, possibly reflecting concerns around capacity in the acute phase of admission. Of concern is the negative association between testing and exposure to known factors for risky behaviours such as drug use. Gender may be important in influencing decisions about HIV testing in the context of SMI and drug abuse. As HIV status is likely to have important implications for diagnosis and treatment planning, all mental health care users should be offered an opportunity for testing.

A PROPOSED MENTAL HEALTH SERVICE AND PERSONNEL ORGANOGRAM FOR THE ELIZABETH DONKIN PSYCHIATRIC HOSPITAL

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INTRODUCTION: The Elizabeth Donkin Hospital in the Nelson Mandela Bay Metro has been under severe strain for many years. A new psychiatric hospital has been proposed by the Eastern Cape Department of Health. The development of the hospital will have to rely on quality population data and reliable projections of future population trends, while simultaneously taking into account local service needs.

METHODOLOGY: A basic literature review was followed by a number of focus groups and face-to-face meetings with mental health professionals. Service needs were identified and a hospital service structure proposed. Staff and bed requirements were calculated according to the National Department of Health Norms for Severe Psychiatric Disorders, using population data from Statistics South Africa. Norms were created or amended through a consensus process where they did not exist, or were deemed to be inadequate. Projections for service needs were done until 2020.

RESULTS: The result is a simple, organised, flexible service-based hospital organogram, which is presented in a graphic format. The model is easily adapted to serve regional population mental health needs. It is simple to maintain, by updating bed and human resource requirements as population statistics change.

CONCLUSION: A mental health service and personnel organogram is proposed for the planned new Elizabeth Donkin Psychiatric Hospital. It is hoped that it will serve as a discussion and planning document to assist the Eastern Cape Department of Health as well as involved architects and construction companies.

A BRIEF REPORT ON THE CURRENT STATE OF MENTAL HEALTH CARE SERVICES IN THE EASTERN CAPE

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INTRODUCTION: The Eastern Cape Province (EC) faces serious challenges in providing adequate hospital and community mental health care services (MHSs). The organisation of these services impacts on service delivery and whether they meet the EC Department of Health (ECDoH)'s policy aims and objectives for mental health care.

METHODOLOGY: A brief overview of the literature was done, and epidemiological estimates calculated. A situational analysis of current EC MHSs was done with the help of mental health care practitioners (MHPs) across the province, and is presented in summarised format. Lastly, general challenges are summarised and some solutions proposed.

RESULTS: The EC had an estimated population of 6.744 million persons by mid-2010, of whom 2.21 million were aged <15 years (33%) and 4.53 million ≥ 15 years (67%). Over a 12-month period, the total number of severe mental disorders expected in the population aged 15 years and older is approximately 742 822. The total persons expected at full MHS coverage is approximately 647 704 (178 119 at minimum coverage). Figures exclude personality disorders, obsessive-compulsive disorder, and mental disorders due to substances or medical conditions.

The EC has 11 private psychiatrists and 13 government-employed psychiatrists (psychiatrist/population ratio 1:281 000). Seven psychiatrists are close to or past retirement age. An effective mechanism to attract and retain MH professionals, including psychiatrists, is lacking. State MHSs for adults remain under severe strain across the board, with serious deficits in the provision of psychiatric acute and rehabilitation beds (chronic overcrowding) as well as community MHSs. Except for Fort England Hospital (Grahamstown), there are hardly any forensic and government substance rehabilitation services. No comprehensive MHSs for children and adolescents (CAMs) or elderly persons exist. The ECDoH has 2 properly functioning electroconvulsive therapy machines, and the private sector 2. MHSs in the private sector are generally in better condition, although strained. The condition of infrastructure in the private sector,

although inadequate in capacity, is good. The majority of ECDoH facilities leave much to be desired and human rights are under threat in a number of facilities. The Directorate of Specialised Services (responsible for MHS) continues to function without a permanent director.

CONCLUSION: By mid-2010, the infrastructure for MHSs in the EC was in need of urgent reconditioning, maintenance and expansion, and there was a serious shortage of MHPs. The following recommendations are made: increasing the budget for MHSs; creating a dedicated Directorate of Mental Health Care Services with a full-time director; bringing all MHSs under the auspices of the Directorate (primary, secondary and tertiary); establishing a board of clinical advisors to the Directorate that includes the academic head of psychiatry and a psychiatrist from each of the 6 main MH catchment areas; establishing community mental health teams; increasing provincial MH bed capacity – especially acute beds in general hospitals/medium-long stay and forensic aftercare (state patient) beds in specialised MH facilities; developing CAMSs; immediately purchasing 5 ECT machines (ECDoH); and increasing personnel (especially psychiatrists and nurses).

AN INTEGRATED MENTAL HEALTH CARE SERVICE MODEL FOR THE NELSON MANDELA BAY METRO

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INTRODUCTION: The mental health care system in the Nelson Mandela Bay Metro has been under severe strain for many years, owing to serious deficits in human and infrastructure resources. It is postulated that one of many reasons for this unsatisfactory state of affairs could be the lack of a simple, well-organised, comprehensive, structured mental health care service model. This project attempts to address this need.

METHODOLOGY: A basic literature review was followed by a number of focus group and face-to-face meetings with mental health professionals in primary, secondary and tertiary care services. Service needs were identified and a multi-level mental health care service structure developed. Staff and bed requirements were calculated according to the National Department of Health Norms for Severe Psychiatric Disorders, using population data from Statistics South Africa. Norms were created or amended through a consensus process when they did not exist, or were deemed to be inadequate. Projections for service needs were done up to 2020.

RESULTS: The result is a simple, flexible and well-organised mental health care model, which is presented in graphic format. The model is easily adaptable to serve regional population mental health care needs, by adapting, adding or deleting service clusters.

CONCLUSION: A mental health care service model is proposed, which can hopefully serve as a discussion and planning document for the revitalisation and development of mental health care services in the Nelson Mandela Bay Metro.

TRADITIONAL AND ALTERNATIVE HEALERS: PREVALENCE OF USE IN PSYCHIATRIC PATIENTS

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BACKGROUND: Studies show many patients consulting doctors also consult traditional or alternative healers (70 - 84% in South Africa). Patients

may receive potions that can contain unknown ingredients. The South African Stress and Health study (SASH) reported that 5.7% of people with a mental disorder had received any [conventional] mental health care in the preceding 12 months. In comparison, 5.8% consulted complementary or alternative medicine practitioners (CAMPs) and traditional healers (THs), and 6.6% consulted religious, spiritual or social work practitioners in the preceding 12 months.

AIMS AND METHOD: This study investigates the number of psychiatric patients who consulted THs, CAMPs or religion-aligned healers (RAHs) in the past 12 months in Port Elizabeth. Subjects ($N=252$) were recruited from 6 in- and outpatient sites. A questionnaire regarding the use of THs/RAHs/CAMPs in the previous 12 months was piloted with 10 patients before being extended to the rest of subjects.

RESULTS: Demographics: black 154 (61%), of whom 153 were Xhosa speaking; coloured 53 (21%); white 42 (17%); Indian 3 (1%); male 117 (46%); female 135 (54%). Education: primary 43 (17%), secondary 131 (52%), tertiary 78 (31%).

In total 77 (31%) consulted a TH/RAH/CAMP in the previous 12 months, compared with 175 (69%) who did not. Of the consulters 75% were black, 12% coloured, 12% white and 1% Indian. The percentage of consulters within each race group was: black 38% (58/154), coloured 17% (9/53), white 21% (9/42), and Indian 33% (1/3).

Of the 77 total patients in the consulting group 58% had consulted a TH, 43% an RAH and 4% a CAMP. Seven (9%) had consulted more than 1 type of healer. Emotional, physical or sexual abuse by a TH or RAH was reported by 25%, with none by a CAMP. Despite this, absolute or near-compliance with the TH/RAH/CAMP's prescription was reported by 88% and 71% said they would definitely or probably consult a TH/RAH/CAMP again.

Concerning regular medical treatment, no advice was given by the healer in 62% of cases, 30% were told to continue treatment as usual, 5% to stop medication permanently, and 1% to stop and restart later. Some could not remember the advice they were given (2%).

CONCLUSIONS: Results show a much higher 12-month prevalence of consulters than the SASH study (31% v. 5.8%). Black, Xhosa-speaking patients were more likely to consult THs/RAHs than other ethnic groups. The high compliance rate with the TH/RAH/CAMP's treatments and the fact that only a small percentage of healers advised patients to stop their regular medication indicate potential for collaboration between healers and mental health practitioners. The high rate of abuse (25%) is of concern. A limitation of the study is the small number of Indian subjects.